Inpatient SOAP Presentation and Note Template

Chief Complaint/Concern
[Insert chief complaint/concern, ideally in the patient's own words – use quotation marks when possible]

[Insert ID statement that briefly sums up hospitalization from time of admission]

Subjective
[Include interval events in the hospital (e.g., patient had successful bronchoscopy with biopsies taken]
[Include pertinent OLDCAART, pertinent positive ROS, pertinent negative ROS]

Active Past Medical History
[Insert pertinent active past medical history]

Medications
[List medications (grouped by INDICATION) in the following order – name, dose, route, frequency. If patient is not taking it/taking it differently than prescribed, please note that]

Objective
Exam
[Insert vitals range from past 24 hours and most recent vitals]
[Insert pertinent positive and negative exam findings]

Labs
[Insert pertinent labs and relevant trends]

Imaging
[Insert pertinent imaging dates, modalities, and results]

Other studies
[Insert pertinent EKG, microbiology, pathology results]

Assessment and Plan
[Insert assessment here - the one-liner that also includes an ASSESSMENT of what you think is going on with the patient]

[Insert problem, chronicity, trajectory]: Differential diagnosis includes [insert differential from MOST to LEAST likely]. [Explanation for each differential and why they are more or less likely].
- [Diagnostic interventions (includes more exam maneuvers, labs, imaging, inpatient consultation, some procedures)]
- [Therapeutic interventions (includes mediations, some procedures, outpatient consultations)]
- [Patient counseling - examples: patient encouraged to hydrate, avoid salty foods, etc.]
- [Contingency planning - example: return to clinic if "X" symptom worsens]

[Insert each active problem with above template. Organize them from most to least active]

Chronic/Resolved:
[Insert problem, chronicity]: Continue [insert ongoing management]
[Insert problem, resolved]: [Insert brief explanation of why it happened and how it resolved]
[Insert each chronic or resolved problem with above templates]

FEN/GI: [Insert diet and bowel regimen here]
DVT prophylaxis: [Insert DVT prophylaxis here]
Stress ulcer prophylaxis: [Insert stress ulcer prophylaxis here]

Code status: [Insert code status here]
Disposition: [Insert steps needed to safely transition to next level of care, barriers to this, and location of next level of care]

Emergency contact: [Insert name of emergency contact and relation to patient and contact number]

Blue and purple are your script
Blue text should always be included in the oral presentation
Red text should always be included in the written note
Purple text should always be included in the oral presentation AND written note
[Items in brackets are the parts that you need to fill out]

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