Outpatient SOAP Presentation and Note Template

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

Subjective
[Insert ID statement + version of chief complaint, this time using medical terminology]
[Include OLDCAART, pertinent positive ROS, pertinent negative ROS, pertinent past medical history, pertinent family history, pertinent social history]

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]

Allergies
Patient is allergic to [insert drug and food allergies and reaction that occurs]

Social History
[Insert smoking, alcohol, drug use not covered in HPI. Provide sense of home and work environment. If relevant to chief complaint, include sexual history, travel history, pets, and occupational exposures.]
[Insert full HEEADSSS assessment]

Exam
[Insert vitals range since admission and most recent vitals]
[Insert pertinent positive and negative exam findings]

Labs
[Insert pertinent labs and relevant trends]

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

Other studies
[Insert relevant 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]

Healthcare maintenance: [Include cancer screening, surveillance testing, vaccinations, goals of care discussions]

Code status: [Insert code status here if discussed with patient]
Emergency contact: [Insert name of emergency contact and relation to patient and contact number]

Return to clinic in [Insert estimate follow-up window (e.g., one week, two months, etc.) and specific items to follow up on]

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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