

## S.O.A.P. Format of Report Writing

- **S- Subjective:** this is what the patient tells you, in their exact words, not yours, **THEIRS**. If a patient tells you their “belly hurts” that is what you write, not they are c/o abdominal pain. You would write Patient states they are having belly pain, and then you go along with the OPQRST, and the SAMPLE, PMH, and pertinent negatives. Because these are things the patient is telling you.
- **O- Objective:** this is your initial assessment, abc’s, vital signs, neuro. exam, and your physical whether it be a detailed, rapid, or focused.
- **A- Assessment:** this is what you think is wrong with the patient. (Back to the example about the “belly pain”, possible abd. pain, everything is possible, because we do not diagnose patients. If a patient is having chest pain we would write possible cardiac related chest pain as long as we have ruled out non-cardiac related chest pain.
- **P- Plan:** this is what you have done for the patient, and in the order that you have performed your treatment. For example: P/E, V/S, Oxygen, ntg., etc. After you do the order of the treatment performed you would write how your patient responded to the treatment. On these reports I want you to write the treatment that you would offer as an EMT-B, not what the rescue or the hospital staff did for the patient.

## S.O.A.P. ORGANIZATION & REPORTING

**SUBJECTIVE:** What you hear on scene.

1. Primary Complaint: C/C (Chief Complaint) or Patient c/o (complain of).
2. Signs and symptoms.
3. Events leading to the cause of the present illness/accident.
4. Previous Medical History (Hx.)
5. Current Medications (Rx.)
6. Allergies.
7. Pertinent positives and/or negatives.

**Note:** Above information may come from bystanders, family, friends, health care professionals, law enforcement, etc. Always document where or from who the information was obtained from. If you are unable to obtain any of the pertinent information, document the reason for not getting these facts.

**OBJECTIVE:** What you observe.

1. Patient age and sex: 35 y/o/m (year/old/male) or 35 y/o/f (year/old/female).
2. Position and location where the patient was found.
  - a) Brief description of the scene, if applicable.
3. Patient's general condition: AVPU and Orientation (AAOX3 or CAOX3)
4. Patient's air way patent or not.
5. Patient's breathing: symmetric, labored or non-labored, quality of respirations.
6. Bi-Lateral Breath Sounds (BBS)
7. Patient's pulses: regular/irregular, rate, and quality.
8. Patient's skin: (warm/cool/normal) (dry/moist/diaphoretic/normal) (color).
9. Head and Neck: HEENT (Head, Ears, Eyes, Nose, and Throat).
  - a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
  - b) BTLS (Bruising, Tenderness, Lacerations, Swelling.)
  - c) TIC (Tenderness, Instability, Crepitus.)
  - d) PEARL (Pupils Equal and Reactive to Light)
  - e) Periorbital ecchymosis, Battle Sign (late sign),
  - f) Blood and/or CSF (Cerebral Spinal Fluid) from ears, nose, and/or mouth.
  - g) Cervical Spine (C-Spine) injuries.
  - h) JVD (Jugular Vein Distention), Tracheal deviation, Subcutaneous (Sub-Q) emphysema.
10. Chest
  - a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
  - b) BTLS (Bruising, Tenderness, Lacerations, Swelling.)
  - c) TIC (Tenderness, Instability, Crepitus.)
  - d) Symmetric expansion, accessory muscle use
  - f) BBS (Bi-lateral Breath Sounds): Equal and Clear, Wheezes, Rhonchi, Rales, decreased sounds, or absent sounds.
11. Abdomen

- a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
- b) BTLS (Bruising, Tenderness, Lacerations, Swelling.)
- c) Inspect for distention and palpate for rigidity or tenderness. Note any masses or pulsating masses.

**Note:** Specify which quadrant(s) that you have found the abnormalities.

12. Pelvis

- a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
- b) BTLS (Bruising, Tenderness, Lacerations, Swelling.)
- c) TIC (Tenderness, Instability, Crepitus.)
- d) Priapism or incontinence.

13. Extremities – Upper and Lower

- a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
- b) BTLS Bruising, Tenderness, Lacerations, Swelling.)
- c) TIC (Tenderness, Instability, Crepitus.)
- d) Any rotation or difference in length of extremities.
- e) Assess distal Neurological Status:
  - 1) Peripheral PMSX4 – Pulses, Motor, and Sensory in all Extrem.
  - 2) Cap Refill – brisk or delayed (more than 2 seconds)

14. Back

- a) DCAP (Deformities, Contusions, Abrasions, Penetrating injuries.)
- b) BTLS Bruising, Tenderness, Lacerations, Swelling.)
- c) TIC (Tenderness, Instability, Crepitus.)

**Note:** If this is a Trauma patient, you must document how you moved the patient to assess his/her back (i.e. Log Roll.)

**Special Pertinent Information**

MVC (Motor Vehicle Accident) must also have the following:

- 1) Were seat belts (shoulder and/or Lap belts) used/ not used at time of collision. Air bags deployed.
- 2) Patient's location in the vehicle, at time of impact. As well as their location at time of our arrival.
- 3) Interior deformity (i.e. steering wheel, windshield, dashboard.)
- 4) Where was vehicle damaged (exterior), & the location of the damage.
- 5) Intrusion into the patient compartment.
- 6) Speed at time of impact, and skid marks.

**Note:** Give a little description of the scene (i.e. yellow escort traveling at moderate speed in the West bound lane of Lake Worth Road. The car was found overturned onto its roof, in the East bound lane of Lake Worth Road.)

**ASSESSMENT:** What's your Differential Diagnosis (Dx)?

- 1) What is the problem(s) that you are going to be treating the patient for?

**Note:** If a Fracture (Fx.) is open, with a bone exposed, you can make a direct statement. Example: A – Open Fx. of the right Humerus. This also applies to soft tissue injuries or other obvious injuries that do not require an X-Ray or more definitive Diagnosis (Dx.)

**PLAN** -- This section includes ALL Tx. (treatment) and any +/- (positive or negative) changes (Δ) in the patients status.

- 1) On scene Treatment (Tx.) and the results of your treatment (Tx.)
  - a) Part of your treatment (Tx.) includes Primary Survey (P/S), Secondary Survey (S/S), and Vital Signs (V/S).
  - b) Use of airway adjuncts (document size of adjunct, & how it was secured.) {i.e. *80 mm Oral Pharyngeal Airway (OPA), that was secured with tape. Airway bock was cleared with use of adjunct.*}
  - c) Oxygen administration that is correct for the patients needs. {i.e. *Patient was placed on a Non-Rebreather Face Mask (NRFM) at 15 LPM(Liters Per Minute.)*}
  - d) Hemorrhage control, if needed. {*9 inch laceration to the left thigh was cleaned with Hydrogen Peroxide, and dressed with a Trauma Dressing and Kling (roller gauze). PMS were checked before and after dressing application, without change.*}
- 2) How did the patient get onto your stretcher?
  - a) Ambulate (walk) with/without assistance.
  - b) Carried or sheeted onto the stretcher.
  - c) Consider documenting how patient was secured to the stretcher.
- 3) Both basic and advanced Tx. (treatment) must be listed, and the results of the treatment must be documented.
  - a) Any additional treatment needed enroute to the hospital?
- 4) If patient needed an I.V. (Intra venous) Line, what was the size of the catheter, location of the I.V., tubing size, drip rate, and the volume that was infused.
- 5) Remember, when listing Medications (Rx.) that have been given/assisted with, state the proper units (g {grams}, mg {milligrams}, LPM {Liters Per Minute – Oxygen administration}.) Also, give the route of the administration correctly (Dopamine – I.V. Drip, Nitroglycerine (NTG) Spray – S.L. (Sub lingual), Aspirin (ASA) – p.o. (oral).
- 6) You must document what hospital was contacted, and how they were contacted (i.e. cell phone, land line, or radio [MEDCOM]), and if there were orders given (document who was giving the orders). If there was no contact, there must be a documented reason (i.e. *radio stopped working, ran out of time, etc.*)
- 10) Document if the patient was transported with/without incident.
- 11) How was patient moved from your stretcher, onto the Hospital bed/stretcher. (i.e. Patient was sheeted over from stretcher, onto bed at E.R without incident. Side rails were placed in the up position, and the stretcher/bed was placed in the low position.)
- 12) How was patient turned over? (i.e. *Patient was TOT (Turned Over To) E.R. R.N., with verbal and written preliminary report.*)