



University of Vermont Graduate Writing Center SOAP Notes: A Writer's Guide

What is a SOAP Note?

A SOAP note is a written document that a healthcare professional creates to describe a session with a patient/client. The information included is: **Subjective, Objective, Assessment, Plan (SOAP)**.

Many fields rely on SOAP notes to transfer information between professionals. The usefulness of SOAP notes is evident based on the following example:

A speech-language pathologist (SLP) named Maura receives an order to check on the swallowing function of a hospitalized patient who has been recovering from a stroke for the past week. Though Maura has never seen the patient before, the patient has been seen by other SLPs during her stay. Before the SLP goes to see the patient, she will look at the hospital's electronic documentation system to read the patient's chart. While doing so, she reads the SOAP note that another SLP wrote about this patient when they treated her 2 days before. It contains important information regarding the treatment approaches that were taken and recommendations for future treatment. Now Maura is prepared to see this patient, knowing where she stands in the course of her treatment.

This is just one example of the usefulness of SOAP notes. They may also help a professional track the progress of a patient and understand the other types of treatment and therapy the patient is receiving.

When Writing a SOAP Note:

Do

- Be concise
- Be specific
- Write in the past tense

Don't

- Make general statements
- Use words like "seem" and "appear"

You'll find an example of a complete SOAP Note at the end of this handout.

The Parts of a SOAP Note (in order!):

Subjective

This is typically the shortest section (only 2-3 sentences, usually) and it describes the patient's affect, as the professional sees it. This information is all subjective (it isn't measurable).

- Include information that may have affected the patient's performance, such as if they were sick, tired, attentive, distractible, etc.
- Was the patient on time or did they come late?
- May include a quote of something the patient said, or how they reported feeling

Examples

1. Patrick was participatory and engaged throughout the therapy session. He was talkative throughout and had a generally positive affect, which was maintained throughout the session.
2. Stacey arrived 15 minutes late to today's session. She reported that she was tired and was observed to rest her head in her hands on multiple occasions throughout the session. Stacey leaped with joy following the end of the session when the clinician told her the session was over.

Objective

This section includes factual, measurable, and objective information. This may include:

- Direct patient quotes
- Measurements
- Data on patient performance

The objective section should document important information for future clinicians to refer to. It contains the data to track a client's progress. Depending on the professional or setting, this information may be bulleted. It may even be a list of the goals with a simple note about whether the goal was "met," "not met," or "partially met" during the session.

Examples

1. Isaac accurately produced the target sound /r/ in 60% of opportunities.
2. Tracy stated, "This is so hard," during the Activities of Daily Living simulation.
3. Camilla will independently produce bilabial stops /p/ and /b/ in the final positions of CVC combinations with 80% accuracy. **Not Met**

Assessment

This section should be the meat of the SOAP note. It contains a narrative of what actually happened during the session. There may be information regarding:

- Whether improvements have been made since the last session
- Any potential barriers to success
- Clinician's interpretation of the results of the session

Examples

1. Jay's accuracy was decreased from last week, which is suspected to be due to his limited ability to sustain attention throughout the session.
2. Alicia's statement, "that was fun" indicated an increased tolerance and acceptance of her stuttering behaviors.

Plan

This is another short section that states the plan for future sessions. In most settings, this section may be bulleted.

Examples

1. Continue targeting Objectives 1 and 2 using motivating activities.
2. Next session, Susanna will focus on the production of word-initial bilabial stops /p/ and /b/.
3. Lilian's parents will join for the last 15 minutes of next week's session to discuss home carry-over.

SOAP Note Example

S: Mrs. J was awoken from a nap when the clinician entered the room and asked, "What time is it?" Though she exhibited signs of being tired at the start of the session, she maintained engaged and participatory throughout.

O:

- Mrs. J experienced communication breakdowns in the form of paraphasias 10 times during the course of the session (e.g. "this bed is actually pretty condominium" "My granda-da-bar brought me mac 'n cheeps")
- Mrs. J acknowledged paraphasias in 80% of opportunities
- Mrs. J experienced anomia 8 times during the session (e.g. "I like to....to...")
- Mrs. J was able to recall the lost word with first syllable phonemic cuing in 4 out of 8 opportunities

A: Mrs. J has continued to make progress with her language goals. Her ability to recognize the paraphasias she produces is a positive sign that she is aware of her language challenges. This will help her as she continues to improve because she will be able to repair her communication breakdowns independently. Her ability to recall words when presented with a phonemic cue has also improved from her only being able to recall 60% of words in yesterday's session. Mrs. J's positive affect and high level of familial support continue to support her as she makes progress.

P: Next session, Mrs. J should be encouraged to identify her own paraphasias and attempt to repair them. The clinician will continue to provide cues and prompts as needed. Mrs. J's family will be invited to attend the next session to provide them with strategies to support Mrs. J's communication as she continues to recover.