SOAP Documentation Note Evaluation and Comments

Key to specific parts of your note:

E = extraneous information

NBU = not backed up; missing data in S/O area which would back up assessment or plan

MI = misplaced information (information in wrong part of note); e.g., new data in assessment or plan

V = vague or unclear information; needs quantification or qualification

R = lack of supportive reasoning or justification for problem or plan

Superlatives will be noted also!

Heading	
• Date, time	
• Identification of pharmacy note	
• One phrase overview of reason for note	
Subjective/Objective Information	
• Enough information to support assessment statements	
• Only information directly pertaining to assessment is included (i.e. no extraneous information)	
Assessment	
• Clear identification of problem	
• Logical reasoning supporting existence/importance of problem	
• Identification of reasonable goals for therapy	
• *Brief* discussion of therapeutic alternatives (if appropriate)	
Recommendation	
• One recommendation clearly stated	
• Therapeutic recommendation complete/detailed (i.e. drug, dose, route, frequency, duration of therapy)	
• Detail of patient education content and comprehension	
• Plan for monitoring complete for both efficacy and toxicity (what will be monitored, who will monitor, how often monitoring will occur, when therapeutic improvement or goals should be reached)	
• Justification for expensive/involved medication plan	
• *Brief* identification of backup therapeutic recommendation if primary plan fails	
Closing	
• Closing statement, if appropriate	
• *Legible* signature, printed ID (e.g., RPh, PharmD, pharmacist), contact information if appropriate	