

Patient SOAP Note

Date	Time	Location
PATIENT'S NAME		Sex
Email		Phone
Address		Weight
		Height
		Age
CONTACT'S NAME		Phone
Relationship	Email	
PATIENT FOUND <input type="checkbox"/> R Side <input type="checkbox"/> L Side <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking Other _____		
DESCRIBE MOI <input type="checkbox"/> Trauma <input type="checkbox"/> Environmental <input type="checkbox"/> Medical If Trauma, tell a brief story that addresses speed, dispersal of force, & location of impact.		
<input type="checkbox"/> MOI for Spinal Injury		
DESCRIBE WEATHER CONDITIONS Current Temperature _____ <input type="checkbox"/> Sun <input type="checkbox"/> Partly Cloudy <input type="checkbox"/> Overcast <input type="checkbox"/> Wind <input type="checkbox"/> Rain <input type="checkbox"/> Snow <input type="checkbox"/> Impending Storm		
BASIC LIFE SUPPORT PROBLEMS <input type="checkbox"/> No Respirations <input type="checkbox"/> No Pulse <input type="checkbox"/> Severe Bleeding <input type="checkbox"/> Acute Respiratory Distress <input type="checkbox"/> Vomiting <input type="checkbox"/> Blocked Airway <input type="checkbox"/> V P U on arrival <input type="checkbox"/> Possible Heat Stroke <input type="checkbox"/> Possible Hypothermia		
BASIC LIFE SUPPORT TREATMENT <input type="checkbox"/> Direct Pressure <input type="checkbox"/> Pressure Bandage <input type="checkbox"/> Tourniquet _____ <input type="checkbox"/> Conversion _____ <input type="checkbox"/> Chest Compressions <input type="checkbox"/> Rescue Breathing <input type="checkbox"/> AED <input type="checkbox"/> Abdominal Thrust <input type="checkbox"/> Suction <input type="checkbox"/> Protect Spinal Cord <input type="checkbox"/> Remove Wet Clothes <input type="checkbox"/> Hypothermia Package <input type="checkbox"/> Shelter <input type="checkbox"/> Cool Patient <input type="checkbox"/> Recovery Position <input type="checkbox"/> Glucose <input type="checkbox"/> Meds _____		
<input type="checkbox"/> Return of Pulse <input type="checkbox"/> Return of Respirations <input type="checkbox"/> Awakens during BLS <input type="checkbox"/> Urgent Evac		

Subjective Information = What the patient tells you

SYMPTOMS (OPQRST) Describe onset, provocation & cause, quality & character, region & radiation, severity (1-10), and timing of chief complaints as they apply to the MOI.

Time			
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ALLERGIES Local Systemic Describe cause, severity, & treatment.

MEDICATIONS Prescription, over-the-counter, herbal, homeopathic, & recreational.

DRUG	REASON	DOSE	CURRENT
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes

PAST RELEVANT MEDICAL HISTORY related to MOI
 Last Menstrual Period _____ Possible Pregnancy Confirmed Pregnancy

LAST INTAKE & OUTPUT over the past 24 hours

Time & Content of Last Meal	Water Intake Liters _____	Sodium Intake <input type="checkbox"/> Adequate <input type="checkbox"/> Low
	Urine Color _____ Output _____	Stool <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Color _____ Consistency _____

Caloric Intake Adequate Low

EVENTS Patient's description of what happened. Amnesia

Objective Information = What you see, feel, & hear

PHYSICAL EXAM Look for discoloration, swelling, bleeding, CSF, & deformity. Check ROM & CSM. Feel for tenderness, crepitus, & instability. Listen for lung & bowel sounds.

Time							
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VITAL SIGNS Note normal vital signs if known, then get a current set. Monitor and record significant changes over time.

Time	AVPU	Pulse	Resp	Skin	Temp	BP	O ₂ Sat
Normal							

FOCUSED SPINE ASSESSMENT

Time	General P F <input type="checkbox"/> <input type="checkbox"/> Reliable Patient <input type="checkbox"/> <input type="checkbox"/> No Spine Pain <input type="checkbox"/> <input type="checkbox"/> No Midline Spine Tenderness	Motor Exams P F <input type="checkbox"/> <input type="checkbox"/> Squeeze 1st & Ring Finger <input type="checkbox"/> <input type="checkbox"/> Press Down on Hand or Fingers <input type="checkbox"/> <input type="checkbox"/> Press Up on Foot or Big toe
	Sensory Exams P F <input type="checkbox"/> <input type="checkbox"/> Distinguish between Pin-prick & Light Touch on hands and feet <input type="checkbox"/> <input type="checkbox"/> No Shooting, Tingling or Electric-like Pain radiating to arms or legs	

Pass Fail

Assessment = What you think is wrong

POSSIBLE PROBLEMS	CURRENT PROBLEMS	
<p>Traumatic Problems Musculoskeletal Injury to:</p> <ul style="list-style-type: none"> • Spine • Head • Chest • Abdomen • Pelvis • Extremities <p>Soft Tissue Injury</p> <hr/> <p>Critical System Problems</p> <ul style="list-style-type: none"> • Spinal Cord Injury • Concussion / Increased ICP • Respiratory Distress • Volume Shock 	Time	
<p>Environmental Problems Dehydration / Hyponatremia Sun Injury Heat Exhaustion / Heat Stroke Exertional Rhabdomyolysis Minor Heat Injury Thermal ± Respiratory Burn Lightning Injury Cold Response / Hypothermia Freezing Injury / Non-freezing Injury Drowning Toxic Reaction Local Allergic Reaction Anaphylaxis Acute Mountain Sickness SCUBA / Free Diving Injury</p>		
<p>Medical Problems Non-urgent Px = No Red Flag S/Sx Urgent Px = Red Flag S/Sx</p>		

NON-URGENT S/SX FOR MEDICAL PROBLEMS REQUIRING A LEVEL 3 EVAC

- Any problem that is persistent, uncomfortable, and not relieved by or responding to Tx OR needs advanced assessment and Tx beyond what is possible in a field setting.

RED FLAG S/SX FOR MEDICAL PROBLEMS REQUIRING A LEVEL 2 EVAC

- Abdominal pain, loss of appetite and fever ± non-specific tenderness and chills that are NOT accompanied by diarrhea.
- Abdominal pain and tenderness accompanied by stomach or intestinal bleeding (coffee ground vomitus, black tar-like stools, or wine-colored stools).
- Abdominal pain accompanied with a positive heel-drop test.
- Pain that begins slowly and gradually gets worse over a period of days.
- Intracranial, thoracic, and abdominal pain, even mild pain, from an unknown medical mechanism in pts > 60 years of age.
- Open globe injury to the eye.

RED FLAG S/SX FOR MEDICAL PROBLEMS REQUIRING A LEVEL 1 EVAC

- An abrupt change in mental status or vision loss that does not spontaneously resolve within a few minutes or reoccurs.
- All VPU pts. Consider hypoglycemia in the insulin dependant diabetic.
- Abrupt, new, and severe, intracranial and thoracic pain—and similarly debilitating abdominal and/or flank pain not clearly attributable to a kidney stone.
- Chest pain or pressure not clearly attributable to heartburn.
- Acute respiratory distress from an unknown cause or severe, high-risk asthma attack.
- Large amounts of bright red blood from the mouth or anus.
- Vaginal bleeding when bleeding exceeds 5 soaked maxi-pads per day.
- Severe abdominal pain with guarding and tense (rigid) abdominal muscles. Pt typically presents on back with knees bent. Movement increases the pain.
- Abdominal pain that becomes specific or is accompanied by rebound pain.
- Abdominal pain and tenderness with the clinical pattern of volume shock.

Treatment Plan = How you are going to treat your patient

MONITOR	FIELD TREATMENT
Anticipated Px & S/Sx	

ADDITIONAL PATIENT NOTES

Evacuation Plan = How you are going to evac your patient

Develop one plan to address your patient's current problem and another to address any anticipated problems that require a more urgent evacuation.

Time	Level	Type
1 2 3 4	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Carry <input type="checkbox"/> Litter <input type="checkbox"/> Surface Vehicle <input type="checkbox"/> Air Transport	
1 2 3 4	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Carry <input type="checkbox"/> Litter <input type="checkbox"/> Surface Vehicle <input type="checkbox"/> Air Transport	
1 2 3 4	<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Carry <input type="checkbox"/> Litter <input type="checkbox"/> Surface Vehicle <input type="checkbox"/> Air Transport	

NON-URGENT LEVEL 3 EVACUATION PLAN

Evacuation Assistance Requested from _____ at _____

URGENT LEVEL 1 OR LEVEL 2 EVACUATION PLAN

Evacuation Assistance Requested from _____ at _____

RESPONDER'S NAME

Email	Phone
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WFA WAFA WFR WEMT EMT Paramedic Nurse PA Physician