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CHARTING EXAMPLES FOR PHYSICAL ASSESSMENT SKIN, HAIR AND NAILS Skin pink, warm, dry and elastic. No lesions or excoriations noted. Old appendectomy scar right lower abdomen 4 inches long, thin, and white. Sprinkling of freckles noted across cheeks and nose. Hair brown, shoulder length, clean, shiny. Normal distri-

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ROUTINE SOAP NOTE EXAMPLES S: "I feel like I can't empty my bladder."

O: Patient is febrile at 100.4 with pain in low back 4/10. A: Patient has symptoms consistent with UTI with increased complaints of pain and low grade fever requiring addressing, managing, and monitoring of symptoms.

A SOAP note template comes in a very structured format though it is only one of the numerous formats health or medical professionals can use. A SOAP note template by a nurse practitioner or any other person who works with the patient enters it into the patient's medical records in order to update them.

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GUIDELINES FOR WRITING SOAP NOTES and HISTORY AND PHYSICALS

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(This information is from page 676 of Portable RN: The All-In-One Nursing Reference, Third Edition, published by Lippincott, Williams & Wilkins, 2007) These examples of soap and soapie charting come from page 677 of the same reference...

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SOAP Notes - Dentistry - Example | Sbar nursing, Soap note ...

The assessment section of a SOAP note is just what it sounds like: the nurse documents her assessment of the patient's physical and emotional status. For example, her SOAP note might state, "Wound edges slightly reddened -- patient at risk for infection.

From this lesson, you will learn why nurses use SOAP notes to write about patients, as well as what each section of the SOAP notes stand for along with specific examples.

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CHARTING SYSTEMS 1. Narrative Format This is the most familiar method of documenting nursing care. It is a diary or story format in chronological order. It is used to document the patient's status, care, events, treatments, interventions, and patient's response to the interventions.

Example: Participant reported he has had a "dull headache for the past week." Document any changes mentioned by the participant related to his medication regimen, diet, blood pressure, blood glucose levels, etc. Example: Participant reported he went to the doctor this week for a regular visit and the doctor told him his "blood pressure

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very hard to find this kind

of stuff on the internet because of hipaa and confidentiality issues. if there is a class you can take then take it. there are also books on the market on documentation for nurses. you should also do a search of this thread for "documentation" or "charting" as this subject comes up from time to time. here are a few links i have to samples of charting:

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