SOAP Documentation

S: Subjective Information
- Information the participant gives
- May include information from family or caregivers
- Observations made by RD, Nutritionist, IBCLC

O: Objective Information
- Measurable information
- Lab results, height, weight, Hgb, blood glucose, etc.

A: Assessment
- RD, Nutritionist, IBCLC assessment and interpretation of participant status based on information provided
- Interventions, education, discussion completed during high-risk visit

P: Plan
- Documentation of client identified goals or plans for behavior change
- Follow-up information and referrals

SOAP Note Example 1

S: Faces, client states that she feels badly because she has morning sickness and nausea when she eats. She has tried taking an anti-emetic, but it just makes her tired and dizzy. She has tried eating small meals and that helps her nausea a little.

O: (see Assessment Section)

A: 132: maternal wt loss; 301: hyperemesis gravidarum

P: Client wants to try drinking ginger ale with crackers in the morning, eating crackers all day between meals, and eating ginger chews when she feels nauseous. Client also wants to try taking anti-emetic at nighttime. F/u with wt check in 3 months

SOAP Note Example 2

S: Mom states that Dean is growing very well. He is eating all foods groups, and just avoids spicy foods. Client has been on neocate since he was an infant, 34 ml/hour continuous drip, Dx: short bowel syndrome. No concerns today.

O: (see Assessment Section)

A: 360: short bowel syndrome, has consistent visits with MD and nutritional care plan is highly monitored

P: Continue to follow MD recommendations. Please have client see CPA at all future appointments unless his health/growth status changes or parent requests to see RD.