SOAP NOTE

This is a SOAP Note to use in reporting an accident/incident. This is a common format that all rescue personnel use. ***S: Subjective****—What you found, how the patient currently is, and what the patient has said to you (Scene Survey; Initial Assessment);* ***O: Objective****—What you have found (Head to Toe Exam, Vital Signs, SAMPLE–OPQRST);* ***A: Assessment*** *(Problems & Anticipated Problems);* ***P: Plan*** *for Treatment*

Scene Survey (safety, initial impression, gloves)

# of patients	MOI (if observed):	Location:	Time:	Description of Scene:

Initial Assessment (ABCDE) —Stop & Fix immediate threats to life

Airway:	Breathing:	Circulation:	Decision:	Environment/Expose:

Patient Information

Patient Name: _____ Age: ____ Sex: ____ Phone #: _____ Address: _____

City, State, Zip: _____ Emergency Contact Name/Phone: _____

Focused Exam & Patient History (Head to Toe, Vital Signs, SAMPLE)

If Trauma, start with Head to Toe; If Medical, start with SAMPLE

Head to Toe Exam

(palpate; look for DOTS—Deformities, Open Wounds, Tenderness, Swelling & check CSM's—Circulation, Sensation, Movement in all extremities)

Head, Face, Neck
Shoulders
Chest
Abdomen, Pelvis
Lumbar Region
Upper & Lower Extremities
Back & Spine

SAMPLE

S: Symptoms:
A: Allergies:
M: Medications:
P: Past History
L: Last Intake/Output
E: Events

OPQRST

O: Onset:
P: Preventative/Palliative:
Q: Quality
R: Radiates/Refers
S: Severity (1-10)
T: Time:

Vitals

Norms	*AOx3 or 4*	*60-100 (sr)*	*12-16(ru)*	*PERRL*	*PWD*
Time	LOC's	HR	RR	Pupils	SCTM

Focused Spinal Assessment (FSA): To be done only after a complete **Focused Exam & Patient History** has been done.

Yes	No	One or more hour from definitive care
Yes	No	Currently AOx3 or 4?
Yes	No	No distracting injuries?
Yes	No	No alcohol/drugs: recreational, OTC's, prescription?
Yes	No	Normal CSM's in all extremities?
Yes	No	No spinal pain or tenderness upon palpation of spine?

Important! Only do this step if you have been trained to do so. If you have not been trained in FSA you must maintain spinal precautions. *If the answer to each of these 5 questions is "Yes" you* ***may*** *release spinal precautions. If the answer to ANY of these 5 questions is "No" you* ***must*** *maintain spinal precautions.*

Verbal Report for radio transmission. Complete all information.

I have a _____ year old _____ (male, female). Patient's **chief complaint** is: _____.

Patient states _____.

(what patient said in their own words.)

Patient is currently: _____ (most current LOC).

Patient found in _____ (position).

Patient exam reveals (results of head to toe exam, read from above). Then state, "No other injuries found."

Give vitals: give one set of vitals. If nothing has changed since your first set, simply say "vitals unchanged since original assessment."

SAMPLE: If anything relevant was found in sample let them know what is relevant only.

Assessment (Problem List) & Anticipated Problems & **Plan:** Info you wrote on back page

Assessment/Anticipate Problems & Treatment Plan

Assessment (Problem List)	Anticipated Problems	Treatment Plan

Additional Information

Definitions & Helpful Information

ABCDE's
Airway management; Look in mouth, clear obstructions
Breathing adequacy: Look, listen, feel
Circulation: Assess for pulse & major bleeding; control bleeding, treat for shock.
Decision: Maintain manual stabilization of the spine unless patient has no significant MOI.
Environment/Expose: Assess and treat environmental hazards; expose serious potential life threatening wounds.

AVPU Scale (use for LOC's—Level of Consciousness)
AOx4: Alert & Oriented to Person, Place, Time & Events
AOx3: Alert & Oriented to Person, Place & Time
AOx2: Alert & Oriented to Person & Place
AOx1: Alert & Oriented to Person
V: Verbally responsive – responds to verbal stimuli
P: Painfully Responsive – responds to painful stimuli
U: Unresponsive – does not respond to any stimuli

Head to Toe – DOTS: When performing a head to toe exam you want to careful examine & palpate each body section for DOTS. Don't be too gentle! You might not find an injury if you are too gentle. Make sure to remove/move clothing as necessary. You want to get down to skin in injured or possibly injured areas.

SAMPLE
Symptoms: ex: Headache? Dizziness? Nausea?
Allergies: to medications, OTC's, Foods, Insects, Pollens
Medications: Prescription, OTC's, Alcohol or recreational drugs
Pertinent Medical History: Medical history that relates
Last Intake/Output: Food/Water; Urination, Vomiting
Events: Events leading up to incident/illness

OPQRST
Onset: Was the onset sudden or gradual?
Provokes/Palliates: What makes it worse? Better?
Quality: Describe the pain, sharp vs dull; constant vs erratic
Radiates/Refers: Does the sensation move anywhere?
Severity: How does this rate on a scale of 1-10?
Time: How long has it been going on?

Vital Signs
LOC's: See AVPU scale.
Heart Rate (HR): Beat per minute; regular/irregular, strong/weak
Respiratory Rate (RR): Breaths per minute; labored/unlabored
Pupils: PERRL (Pupils are Equal, Round & Reactive to Light)—this is a late changing sign
Skin (SCTM): Skin color, temperature, moisture

Contact Info: Mazama Office: 503.227.2345 — Mazama Lodge: 503.272.9214

Rescue Request

Patient Name, Age:

Vitals	Time	LOC's	HR	RR	Pupils	Skin
1st						
Last						

Date: **Time:**
Injuries
Description:
Location:
Terrain/Weather:

Party Information:

Cell Phone #: **FSR Radio Channel:**
 # remaining at scene:
Equipment at scene:
Equipment needed:
On-scene plan:

Initial Patient Assessment

Stop! Size-up the scene.

1. Survey the scene for hazards. NEVER CREATE A SECOND PATIENT!
   - Check for immediate danger to rescuers.
   - Check for immediate danger to bystanders.
   - Check for immediate danger to patients.
2. Determine the mechanism of injury. (MOI)
3. Establish body substance isolation. (BSI)
4. Determine the number of patients.
5. Form a general impression of the patients.
   - Very Sick/Very Hurt: Need Rapid Assessment and Rapid Transport.
   - Not So Sick/Not Seriously Injured: Focused History and Exam and Transport Soon.

Stop! Survey the patient for immediate threats to life.

Initial Assessment: This is a Stop and Fix survey!

1. Identify self and level of training. Obtain consent to treat.
2. Establish responsiveness and C-Spine control. Stabilize the spine and assess for verbal or pain response. IF UNRESPONSIVE OR NOT BREATHING:

NEW

3. **COMPRESSION:** Give 30 compressions to center of the chest
4. **AIRWAY MANAGEMENT:** Look in the mouth; clear obstructions.
5. **BREATHING:** Quickly give two (2) breaths to see chest rise.

IF BREATHING

6. **CHECK CIRCULATION:** Assess pulse and look for major bleeding; control bleeding and treat for shock.
7. **DISABILITY:** Assess for spinal injury and disability; maintain manual stabilization of spine unless patient has no significant MOI.
8. **ENVIRONMENT/ EXPOSE:** Assess and treat environmental hazards; expose serious potentially life threatening wounds.

Stop! Complete a "Focused Exam and History."

PATIENT EXAM: Inspect, Inquire, Palpate, and Auscultate from head to toe. Check for Circulation, Sensation, and Motion. (CSM)

HEAD, FACE and NECK, including Cervical Spine. Check for Medical I. D. Tag.
SHOULDERS
CHEST
ABDOMEN
PELVIS
LOWER BACK including Lumbar Spine
GENITALS as needed
LOWER EXTREMITIES, one at a time from hip to toes looking for changes in CSM.
UPPER EXTREMITIES, one at a time from upper arm to fingers looking for changes in CSM. Check for Medical I. D. Tag.
SPINE AND BUTTOCKS: If a spinal injury is suspected, exam should be done by log rolling the patient with support for the cervical spine. If not, the patient may sit up. Reach under clothing to ensure accurate palpation of the spine.

VITAL SIGNS: Note the time

LEVEL OF CONSCIOUSNESS (LOC) (Normal LOC: A+O x 4)

A+O x 4: Alert and oriented to Person, Place, Time and Events
A+O x 3: Alert and oriented to Person, Place, and Time
A+O x 2: Alert and oriented to Person and Place
A+O x 1: Alert and oriented to Person
V: Verbally responsive
P: Responds to pain
U: Unresponsive

HEART RATE (HR) (Normal HR: 50-100/regular/strong)
Beats per minute, Rhythm and Quality

RESPIRATORY RATE (RR) (Normal RR: 12-20/regular/unlabored)
Breaths per minute, Rhythm and Quality

SKIN (SCTM) (Normal SCTM: Skin pink, warm and dry) (SPWD)
Color, Temperature and Moisture

BLOOD PRESSURE (BP) (Normal BP: 140-90/90-60)
Auscultate, Palpate, or Estimate
Systolic/diastolic. Note: BP is a late changing sign

PUPILS (P) (Normal Pupils: Pupils are Equal, Round, Regular and react to Light (PERRL). Note: Pupils are a late changing sign

TEMPERATURE (T) (Normal Temperature: 98.6° ± 2°)

AUSCULTATION OF LUNGS (Normal Auscultation: Breath sounds equal bilaterally and clear without rales or wheezes.)

PATIENT HISTORY:

CHIEF COMPLAINT ("What hurts?)
Onset (Sudden or gradual?)
Provokes/Palliates (What makes it better or worse?)
Quality (Is it sharp, dull, constant, intermittent, or throbbing?)
Radiation/Region/Referred (Does the pain move anywhere?)
Severity (Rate the pain on a scale of 1 to 10.)
Time (How long has it hurt? Is it getting better or worse with time?)

MECHANISM OF INJURY (MOI) or HISTORY OF PRESENT ILLNESS (HPI)
SAMPLE History
Symptoms, Other: Headache? Dizzy? Nausea? Hot? Cold?
Allergies: Foods? Medicines? Insects? Pollens?
Medications: Over the counter? Prescription? Alcohol or recreational drugs?
Pertinent Medical History: Same problem before? Diabetic? Heart trouble? Have seizures?
Last Intake/Output: Food? Water? Urination? Defecation? Vomiting?
Events leading up to the incident/illness.

CLEARING THE SPINE:

Patient must be reliable, sober, have no distracting injuries, and have A+O x 3 or 4.
Patient must have normal circulation, sensation and motion in all extremities unless otherwise explained by another injury.
Patient must deny spinal pain and tenderness, and this must be confirmed by a second examination.