

**APPENDIX: S****TITLE: S.O.A.P. GUIDELINES****REVISED: February 9, 2010**

Run Report Organization shall (when appropriate) contain the following information. Computerized charting may differ somewhat due to software parameters:

**S.O.A.P. Format:** DOCUMENT AS APPROPRIATE PER CALL

**SUBJECTIVE:****Subjective information:**

- Medic unit responding
- Reason for call
- Chief complaint (C/C)
- Information obtained from bystanders and other sources
- Other pertinent history and information
- Response Times (Dispatch, On scene, etc.)
- History of C/C
- Pertinent Negatives

**Misc. information (unless included elsewhere)**

- Allergies
- Medications
- Past Medical History
- Last meal,
- OPQRST (Onset, Provokes, Quality, Radiation, Severity, Time since onset)

**OBJECTIVE:****Physical Exam Including:**

- LOC
- Level of distress
- Skin
- HEENT
- Chest/lung sounds
- Spine C-T-L
- ABD
- Pelvis
- Extremities
- Neurological Assessments
- Cardiovascular Assessments

**Diagnostics including:**

- BG
- EKG
- SPO2
- 12-Lead EKG
- Vitals
- Motor Function
- ET CO2

**ASSESSMENT:**

Working field diagnosis - consistent with your findings and treatments

# APPENDIX

# S

## S.O.A.P. GUIDELINES

### **PLAN:**

Plan should include:

- Document patient contact time.
- ALL treatments, including name and agency of person performing ALS treatment, routes, number of attempts, medications, and doses.
- Treatment per SWO, V.O. (Verbal Order) or specific protocol.
- Results of/response to the treatment and justification for treatment.
- Equipment used.
- Method of removing patient to MICU.
- Destination hospital noted and reason for choice (i.e. patient request).
- Type of transport (non-emergency vs. emergency).
- Any changes or incidents while enroute.
- Report given to whom.
- Disposition of patient on discharge from ALS care, including the patency/position of ET tubes, mental /hemodynamic status, etc.
- Any personal possessions left, removed, or transferred to hospital staff.
- Patients, who refuse care or are treated-and-released, require documentation of informed refusal of services, etc.

### **Some further notes on SOAP charting:**

- Correct spelling, grammar, legibility, proper use of medical terminology, and approved abbreviations will be used.
- Written reports should be written in BLACK ink.
- Complete patient reports and submitting a copy to the destination hospital in a reasonable amount of time.
- Most BLS reports should be completed within 30 minutes, most ALS reports in about 45 minutes.
- Reports with three (3) or more errors will be re-written.
- Reports will include a printed signature block with the printed name and Ada Number corresponding to the signature.
- Responses to treatment should include both subjective and objective changes when possible.