SOAP Documentation

S: Subjective Information
- GTHM tool used, feeling related to topic
- Information the participant gives
- 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 Medical Screen)

A: 132: maternal wt loss r/t N/V d/t hyperemesis gravidum

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 night time. F/u with wt check in 3 months

SOAP Note Example 2

S: Paint chips. 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 d/t short bowel syndrome. No concerns today.

O: See Medical Screen

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 CNW at all future appointments unless his health/growth status changes or parent requests to see RD.