N‌‌‌‍‍‌‍‍‌‍‌‍‌‍‍‌‌‌‌URS 623 Adult Health Care SOAP NOTE: Adult with Pink Eye Master of Science in Nursing concentration Family Nurse Practitioner BOOK NAME <https://ambassadored.vitalsource.com/#/user/signin> READ: Primary care: The art & science of advanced practice nursing-an interprofessional approach Advanced Health Assessment & Clinical Diagnosis in Primary Care Bate’s Guide to Physical Examination & History Taking Pharmacotherapeutics for advanced practice: A practical approach Topic Create a 2 page SOAP NOTE on an patient who is newly diagnosed with Pink Eye this visit. You would need to create the INFORMATION that goes in the SOAP Note. Please write your plan as Nurse Practitioner who works in primary care. I have uploaded an EXAMPLE of the Typhon Documentation that out instructor requires for us to upload every week for clinicals, so it can assist you with writing this SOAP Note. INSTRUCTIONS: Include the Typhon encounter number that this SOAP note (I will do this) Include the ICD-10 codes utilized for the identified encounter. Include the CPT Evaluation and Management code assigned for that encounter. Subjective (S): CC: chief complaint - What are they being seen for? This is the reason that the patient sought care, stated in their own words/words of their caregiver, or paraphrased. HPI: history of present illness - use the “OLDCART” approach for collecting data and documenting findings. [O=onset, L=location, D=duration, C=characteristics, A=associated/aggravating factors, R=relieving factors, T=treatment, S=summary] The HPI would flow better if you use oldcart information in paragraph form using complete sentences PMH: past medical history - This should include past illness/diagnosis, conditions, traumas, hospitalizations, and surgical history. Include dates if possible. Allergies: State the offending medication/food and the reactions. Medications: Names, dosages, and routes of administration. Social history: Related to the problem, educational level/literacy, smoking, alcohol, drugs, HIV risk, sexually active (monogamous, multiple partners, men, women, or both, condoms, birth control), caffeine, work and other stressors. Cultural and spiritual beliefs that impact health and illness. Financial resources. Family history: Use terms like maternal, paternal and the diseases and the ages they were deceased or diagnosed if known. Health Maintenance/Promotion - Required for all SOAP notes: Immunizations, exercise, diet, etc. Remember to use the United States Clinical Preventative Services Task Force (USPSTF) guidelines for age appropriate indicators. This should reflect what the patient is presently doing regarding the guidelines. ROS: review of systems - [Refer to your course modules and the Bickley Etext (Bates Guide) as a guide when conducting your ROS to make sure you have not missed any important symptoms, particularly in areas that you have not already thoroughly explored while discussing the history of present illness.] ROS would be easier to read if you don’t run all systems together. Start each system on a new line. You would also want to include any pertinent negatives or positives that would help with your differential diagnosis. For acute episodic (focused) visits ([i.e](https://i.e/). sprained ankle, sore throat, etc.) you may be omitting certain areas such as GYN, Rectal, GI/Abd, etc. While the list below is provided for your convenience it is not to be considered all-encompassing and you are expected to include other systems/categories applicable to your patient’s chief complaint. General: May include if patient has had a fever, chills, fatigue, malaise, etc. Skin: HEENT: head, eyes, ears, nose and throat Neck: CV: cardiovascular Lungs: GI: gastrointestinal GU: genito-urinary PV: peripheral vascular MSK: musculoskeletal Neuro: neurological Endo: endocrine Psych: Objective (O): PE: physical exam - [Refer to your course modules and the Bickley Etext (Bates Guide) as a guide when determining what physical assessments, you want to include to further explore what you have learned from your subjective data collection] Both ROS and PE would be easier to read if you don’t run all systems together. Start each system on a new line. Perform either a focused ex‌‌‌‍‍‌‍‍‌‍‌‍‌‍‍‌‌‌‌am or comprehensive exam to ensure a comprehensive physical assessment. This area should confirm your findings related to the diagnosis. For acute episodic (focused) visits ([i.e](https://i.e/). sprained ankle, sore throat, etc.) you may be omitting certain areas such as GYN, Rectal, Abd, etc. All SOAP notes however should have physical examination of CV and lungs. Ensure that you include appropriate male and female specific physical assessments when applicable to the encounter. Your physical exam information should be organized using the same body system format as the ROS section. Appropriate medical terminology describing the objective examination is mandatory. While the list below is provided for your convenience it is not to be considered all-encompassing and you are expected to include other systems/assessments applicable to your patient’s chief complaint. Gen: general statement of appearance, if there is any acute distress. VS: vital signs, height and weight, BMI Skin: HEENT: head, eyes, ears, nose and throat Neck: CV: cardiovascular Lungs: Abd: abdomen GU: genito-urinary PV: peripheral vascular MSK: musculoskeletal Neuro: neurological exam Diagnostic Tests: This area is for tests that were completed during the patient’s appointment that ruled the differential diagnosis in or out ([e.g](https://e.g/). – Rapid Strep Test, CXR, etc.). Assessment (A): Diagnosis/Diagnoses: Start with the presenting chief complaint diagnosis first. Number each diagnosis. A statement of current condition and all other chronic illnesses that were addressed during the visit must be included ([i.e](https://i.e/). HTN-well managed on medication). Remember the data you provide in the ‘S’ data set and the ‘O’ data set must support this diagnosis (or these diagnoses if more than one is listed). Pertinent positives and negatives must be found in the write-up. Plan (P): These are the interventions that relate to each individual, numbered diagnosis. Document individual plans directly after each corresponding assessment (Ex. Assessment- Plan). Address the following aspects (they should be separated out as listed below): Diagnostics: labs, diagnostics testing - tests that you planned for/ordered during the encounter that you plan to review/evaluate relative to your work up for the patient’s chief complaint. Therapeutic: changes in meds, skin care, counseling, include full prescribing information for any pharmacologic interventions including quantity and number of refills for any new or refilled medications. Example: acetaminophen 325mg PO, 1 tablet every 6 hours, for 14 days, #56, no refills. Educational: information clients need in order to address their health problems. Include follow-up care. Anticipatory guidance and counseling. Consultation/Collaboration: referrals, or consult while in clinic with another provider. If no referral made was there a possible referral you could make and why? Advance care planning. Follow up: When does patient need to follow up? NOTE: please input N/A where appropriate for the above 4 categories, do not assume that your clinical faculty person will know it was not applicable Grading Rubric: ICD-10 Code 1. ICD-10 Code provided with appropriate modifiers congruent with the clinical information provided E&M CPT Code 1. Clinical information provided is congruent with and supports the CPT Code identified in the encounter Subjective Data 1. Elements of subjective data (CC, HPI, PMH, Allergy identification, Medication Reconciliation, Social History, Family History, Health Promotion, and ROS) are adeptly documented and demonstrate consistent information across all aspects represented Objective Data 1. Elements of objective data are adeptly documented and demonstrate consistency relative to the information documented in the CC, HPI, PMH, and ROS Assessment 1. Assessment designations and other elements in this section are adeptly documented and demonstrate congruence with information documented in the CC, HPI, PMH, ROS, and the objective data Plan 1. Elements of the plan are adeptly documented, demonstrate application of current clinical practices for the identified assessment designations, and demonstrate congruence of information a‌‌‌‍‍‌‍‍‌‍‌‍‌‍‍‌‌‌‌cross all aspects represented