APA Title page, running head, page numbers, reference sheet. Use Level 1 and 2 headings to make identifying the components of the paper easier. – 5 points after grade calculated from rubric.

TO be successful in the clinical setting do the following:

You need a APA cover sheet, running head and reference page for anything you turn in (Journal, SOAP note, Time Log).

Do Not change the template.

Do use the template located in the Doc Sharing. This is the explanation of the template...this is not the template.

READ every line of this document please.

You must site 2 journal articles in addition to Epocrates/Medscape and text book failure to do so is -10 points outside of the rubric.

All grades are final. No revisions. Do not ask for revisions of SOAP grades.

Nurse Practitioner SOAP Notes

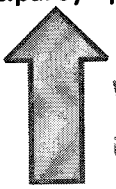
Purpose: To explain what each section of the SOAP note should include. Remember that Nurse Practitioners treat patients in a holistic manner and your SOAP note should reflect that premise. DO NOT INCLUDE IN NOTE

Subjective data value @ 15 points

SUBJECTIVE DATA: What the patient tells you but organized by you in logical fashion

Chief Complaint (CC): One to three words explaining why patient came to clinic value 1 point

History of Present Illness (HPI): Paint a picture of what is wrong with the patient. You need to start EVERY HPI with age, race, gender. (Example: 34-year-old AA male) Must include the 7 attributes of **each principal symptom**: value 7 points hint: OLD CART



Write your paragraph in the order of old cart & chart as well

if missing paragraph -3.5 if missing list -3.5

Onset	
Location	
Duration	
Characteristics	
Aggravating Factors	
Relieving Factors	
Treatments/Therapies	

Each of these are valued at 0.5 points (maximum 4 points)

Medications: list each one by name with dosage and frequency

Allergies: include specific reactions to medications, foods, insects, environmental

Past Medical History (PMH): Illnesses, hospitalizations, risky sexual behaviors. Include childhood illnesses

Past Surgical History (PSH): Dates, indications and types of operations

OB/GYN History: (if applicable) Obstetric history, menstrual history, methods of contraception and sexual function

Personal/Social History: Tobacco use, Alcohol use, Drug use. Patient's interests, ADL's IADL's if applicable. Exercise, eating habits. Pediatrics: school status, parental smoking hx, birth history etc

Immunizations: Last Tdp, Flu, pneumonia, etc. Pediatrics- (per pediatric schedule for age)

Family History: Parents, Grandparents, siblings, children

Review of Systems: Go Head to toe. Cover each system that covers the **Chief Complaint, History of Present Illness and History (this includes the systems that address any previous diagnoses). YOU DO NOT NEED TO DO THEM ALL UNLESS YOU ARE DOING a TOTAL H&P. Remember, this is what the patient tells you. Delete the system if not addressing. DO NOT put wnl or no complaints be specific.** Value 3 points

General: any recent weight changes, weakness, fatigue, or fever
Skin: rashes, lumps, sores, itching, dryness, changes, etc.
HEENT:
Neck:
Breasts:
Respiratory:
Cardiovascular:
Gastrointestinal:
Peripheral vascular:
Urinary:
Genital:
Musculoskeletal:
Psychiatric:
Neurological:
Hematologic:

Endocrine:

Total points for objective date -15.

OBJECTIVE DATA: This is what you see, hear, feel when doing your physical exam. Again, you go head to toe and you only need to examine the systems that are pertinent to the CC, HPI, and History unless you are doing a total H&P. **Do not use WNL or normal. You must describe what you see. Only list systems related to diagnosis. If you did a physical exam you must have that system listed in the ROS>**

Here is where the vital signs go. Include ht and wt and BMI value 1 point

For pediatric please include height, weight and bp percentile value 1 points

This section value 12 points except 1 point for Respiratory and Cardiac

General: General state of health, posture, motor activity and gait. Dress, grooming, hygiene. Odors of body or breath. Facial expression, manner, affect and reactions to people and things. Level of conscience.

SKIN:

HEENT:

Neck:

Chest/Lungs: ALWAYS INCLUDE IN YOUR PE value 1 point

Heart/Peripheral Vascular: ALWAYS INCLUDE THE HEART IN YOUR PE value 1 point

Abdomen:

Genital:

Musculoskeletal:

Neurological:

ASSESSMENT section value @ 30 points. Hint List the priority diagnosis in bold and it should be the first diagnosis (2 points), the positive findings from the patient of that diagnosis (2 points) ,the negatives of that diagnosis from your patient (2 points), rationale (3 points) reference used (1 pt). Please include the same for the differentials. The above is an example of how the points are broken down for this section but depends on how many diagnosis patient has.

ASSESSMENT: Need to ***list*** your priority diagnosis(es) first and in bold. For each priority diagnosis, list 2 differential diagnoses. Support your selection with evidence.

Diagnosis	Positives	Negatives	Rationale & Reference
Iron deficiency Anemia	low h/h, low iron, high tibc, low mcv	- none	Type supporting evidence from textbook, journal etc
Anemia of chronic disease	low h/h, low iron, low mcv	high tibc	
Pernicious Anemia	low h/h	low iron, low mcv, high tibc	

Lab/Imaging (Results)	**Patient results**	**Rationale & Reference**

For holistic care you need to include previous diagnoses and indicate whether these are controlled or not controlled and remember to include that in your treatment plan. Example

Holistic Care

Chronic Condition	Status	Plan
Diabetes	Controlled	Continue current medication

Lab/Imaging (Results)	Patient results	Rationale & Reference

PLAN: Value 15 points- APA format please for works sited. General guideline for assignment of points: 1 pt. for non pharmacological, 4 pts. for meds, 4 points for test/diagnostics, 2 pts. for f/u, 2 pts. for health promotion, 2 pts. for disease prevention

PLAN: Treatment plan. Labs, x-rays, etc. Include both pharmacological and nonpharmacological strategies. Include alternative therapies. When do they need to follow-up? Any referrals? Consultations?

Condition	Pharmacological	Nonpharmacological & Alternative Treatments	Test	Follow up & Referral	Rationale & Reference

Health Promotion: What does the patient/ family need to do to promote their health? Exercise, healthy diet, safety, etc. You must go to the USPTF site for Adults, Bright Futures for Kids. This is not related to the diagnosis this is based on patient age and gender.

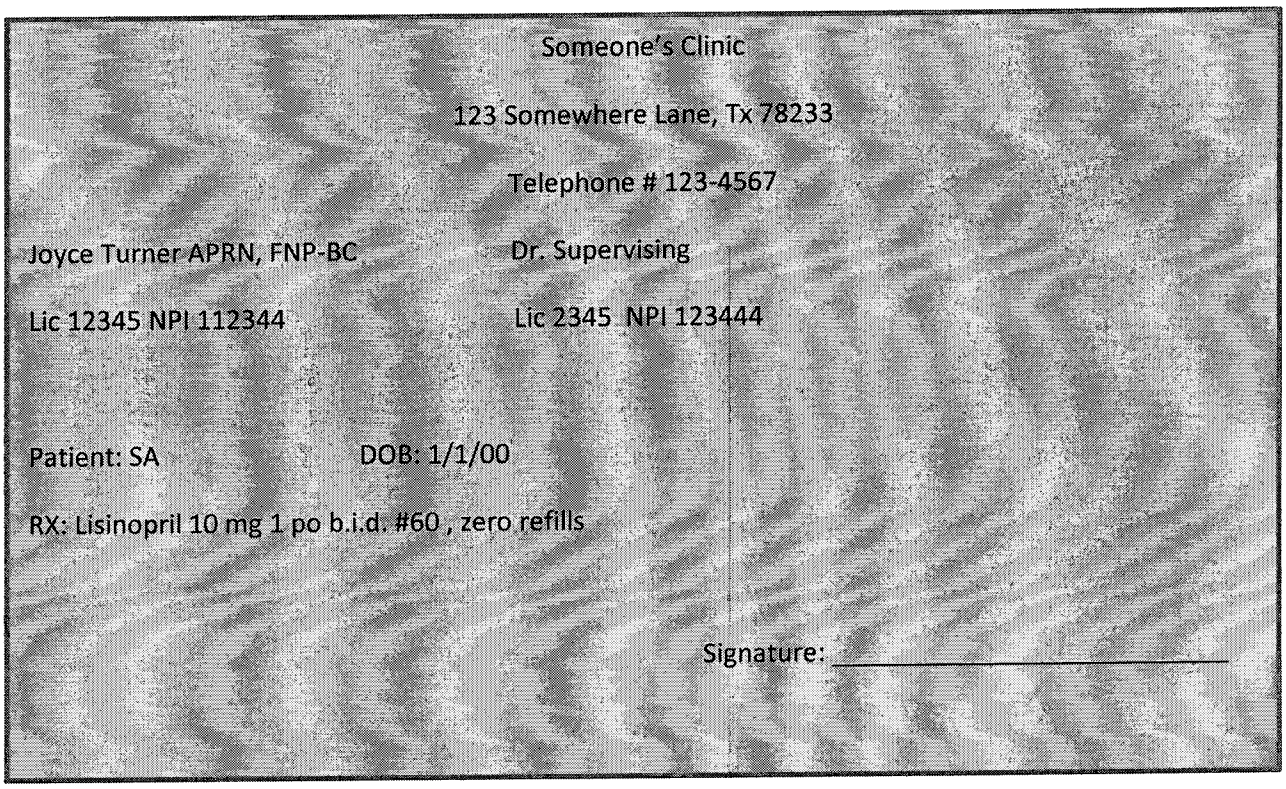
Disease Prevention: For the patient's age, what needs to be done to detect disease early...fasting lipid profile, mammography, colonoscopy, immunizations, etc Use the UPSTF guideline for Adults or for Pediatrics Bright Futures. The website will show you the specifics based on patients age and gender.

REFLECTION section is worth 25 points

REFLECTION: What did you learn from this experience? What would you do differently? Do you agree with your preceptor based on the evidence? Really think about what you are doing in clinical.

REFLECTION section is worth 25 points with following general guideline for points: 5 pts experience description, 5 pts agree/disagree with preceptor, 5 pts. Include how plan would be different for the uninsured vs insured patient, 5 pts for community resources, 5 pts for creating at least one state approved RX using the Walmart $4 plan. Your sentence introduction should be clear that you are referring to the above items.

PRESCRIPTION: Create a prescription per your state guideline



THIS IS NOT SPECIFIC THIS IS TO GIVE YOU A GENERAL GUIDELINE FOR GRADING METHOD

Chief Complaint
est care

History of Present Illness
32-year-old G2 P2 presents to establish care. She has a complaint of painful cycles for the first 2-3 days of her menstrual cycle. She also states that she has been having pelvic pain since April 22. Her last menstrual period was April 16. Menses occur every 36 days and last 7 days. She is not currently on anything for birth control but has been on pills in the past. She also is concerned about weight gain and states that she cannot fit into her clothes however she has not actually gained a lot of weight. She complains of frequent urination and fatigue that has been present for about 1 month.
In regards to her menstrual cycles she states that she had her normal menstrual cycle in February and then in March she had a cycle for March 19 of April 15 where she had continuous spotting and then from April 16 2 April 23 had a regular flow. She states that she feels sporadic cramps sometimes at her C-section incision.
Pap: 2015 negative with Dr. T[redacted] been
Mammogram: 2015 negative
Past medical history negative
Past surgical history C-section ×2
Social: Patient smokes 5 cigarettes per day and has been smoking for 10 years, occasionally drinks, denies any illicit drug use and works as a quality assurance analyst

Review of Systems

Review of Systems
Constitutional: Negative.
Respiratory: Negative.
Cardiovascular: Negative.
Breast: Negative.
Gastrointestinal: Negative.
Genitourinary: Negative.
Gynecologic: Negative except as documented in history of present illness.
Hematology/Lymphatics: Negative.
Endocrine: Negative.
Immunologic: Negative.
Musculoskeletal: Negative.
Integumentary: Negative.
Neurologic: Negative.
Psychiatric: Negative.

Physical Exam

Vitals & Measurements
HR: 101 (Peripheral) **BP:** 125/79
HT: 64 in **WT:** 178.6 lb **BMI:** 30.65

Gen.: Alert and oriented, not acute distress
Respiratory: Lungs are clear to auscultation, respirations are nonlabored, breath sounds are equal
Cardiovascular: Regular rate and rhythm
Gastrointestinal: Soft, nontender, nondistended
Breast: , no masses, no discharge, no pain to palpation
Abdominal: Nontender nondistended, bowel sounds present,
Genitourinary:
Vagina: Within normal limits
Labia: Within normal limits
Cervix: No cervical motion tenderness
Uterus: Within normal limits
Neurologic: Alert and oriented
Psychiatric: Cooperative, appropriate mood and affect

Assessment/Plan

Problem List/Past Medical History
Ongoing
- Obesity
- Tobacco user

Historical
- Pregnancy
- Pregnancy

Medications
Sprintec 0.25 mg-35 mcg oral tablet, 1 tab(s), po, daily, 11 refills

Allergies
NSAIDs (hives)

Social History
Alcohol
- Never, Previous treatment: None. Alcohol use interferes with work or home: No. Drinks more than intended: No. Others hurt by drinking: No. Ready to change: No. Household alcohol concerns: No.

Employment and Education
- Employed, Work/School description: Quality Assurance Analyst 2.

Home and Environment
- Marital status: Married.

Nutrition and Health
- Type of diet: Regular.

Sexual
- Sexually active: Yes. Sexual orientation: Heterosexual. History of STD: No. History of sexual abuse: No.

Substance Abuse
- Never, Previous treatment: None. IV drug use: No. Have you ever shared needles: No. Drug use interferes with work/home: No. Ready to change: No. Household substance abuse concerns: No.

Tobacco
- Current every day smoker, Cigarettes, Previous treatment: None. Ready to change: No. Household tobacco concerns: No.

Family History
Diabetes mellitus type II: Father.
Endometriosis: Sister.
Fibroids.....: Sister.
High blood pressure: Father and Sister.
Hypercholesterolemia: Mother.
Mental illness: Mother.
Stroke: Grandmother (M).

Lab Results
Results (Last 90 days)

Laboratory

Hematology

CBC

CBC.: (04/27/17 12:44 PM EDT)

Hct: **L 30.1** % (Range 34.1 - 44.9) (04/27/17 12:44 PM EDT)

1. Encounter for gynecological examination (general) (routine) without abnormal findings

Encouraged healthy eating, regular exercise of 150min per week and regular seatbelt use.

2. Fatigue

Treat per results

Ordered: CBC w/o Diff (Request), Menorrhagia | Fatigue
Thyroid Stimulating Hormone w/ Reflex (Request), Menorrhagia | Fatigue

3. Menorrhagia

Discussed contraception options with patient and she will proceed with oral contraceptives. These will also be helpful for her cycle. CBC obtained today as well as TSH to evaluate

Ordered: ethinyl estradiol-norgestimate, 1 tab(s), po, daily, Instructions: starting on the first Sunday after menstruation, # 28 tab(s), 11 Refill (s), Type: Maintenance, Pharmacy: CVS/pharmacy #4156, 1 tab(s) po daily,x28 day(s),Instr:starting on the first Sunday after menstruation
CBC w/o Diff (Request), Menorrhagia | Fatigue
Thyroid Stimulating Hormone w/ Reflex (Request), Menorrhagia | Fatigue

4. Urinary frequency

UA negative.

Ordered: 81003 urnls dip stick/tablet rgnt auto w/o microscopy (Form/Charge), Quantity: 1, Urinary frequency

Hgb: **L 9.0** (Range 11.2 - 15.7) (04/27/17 12:44 PM EDT)
MCH: **L 23.1** pg (Range 25.6 - 32.2) (04/27/17 12:44 PM EDT)
MCHC: **L 29.9** (Range 32.2 - 35.3) (04/27/17 12:44 PM EDT)
MCV: **L 77.4** fL (Range 79.4 - 95.3) (04/27/17 12:44 PM EDT)
MPV: **H 12.8** fL (Range 9.4 - 12.3) (04/27/17 12:44 PM EDT)
Platelet: 249 K/uL (04/27/17 12:44 PM EDT)
RBC: 3.89 (04/27/17 12:44 PM EDT)
RDW CV: **H 17.5** % (Range 11.6 - 14.4) (04/27/17 12:44 PM EDT)
RDW SD: **H 49.9** fL (Range 36.4 - 46.3) (04/27/17 12:44 PM EDT)
WBC: 6.8 K/uL (04/27/17 12:44 PM EDT)

Miscellaneous Lab
Misc Test Result
Misc Test Result (04/27/17 12:31 PM EDT)
See Comments (04/27/17 12:31 PM EDT)

Urinalysis
UA Dipstick
Blood Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Glucose Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Ketones Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Leukocytes Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Nitrite Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Protein Urine Dipstick: Negative (04/27/17 12:28 PM EDT)
Urine Appearance Urine Dipstick: Clear (04/27/17 12:28 PM EDT)
Urine Color Urine Dipstick: Yellow (04/27/17 12:28 PM EDT)
pH Urine Dipstick: 7 (04/27/17 12:28 PM EDT)

Signature Line

[redacted] on 04/28/2017 01:04 PM EDT