



DEPARTMENT OF FAMILY MEDICINE

Expectations For Chart Notes

Chart Notes

Key issues for outpatient and inpatient chart notes:

- The patient's medical record, often called a chart, is a legal document. Be bold in your oral presentations but conservative in your charting.
- Write fluently and legibly; do not leave blank lines in between your text.
- If dictating, do not speak in full sentences but in point form. Avoid extraneous words but make sure your meaning is clear.
- If you make a mistake, cross out the unwanted part, whether it is one word or several sentences, then write "error" beside the mistake and initial it. Those who read and examine medical records must be able to see mistakes and know who is responsible for crossing a word or sentence out. **DO NOT SCRIBBLE WORDS OUT.**
- For any handwritten note, always sign your name and then print your name, along with the proper credential i.e. John Smith—John Smith FMR1.
- For a dictated note where your name has been typed—you may initial your name
- Always work with an up-to-date problem list at the front of the chart

SOAP Notes

- Done for patients seen in an ambulatory or clinic setting.
- Not necessary to use complete sentences. Be clear and to the point.
- If dictating or writing, the structure is always the same.
- Start with the date
- Indicate the major reason (or reasons) for the visit in a title

SUBJECTIVE

This section contains information you have learned from the patient or from people caring for the patient.

- Average length 2-3 lines
- Deal with patients' symptoms.
- Include a description of concerns or complaints.



- When appropriate, your note should refer to onset, duration, location, severity, relieving or aggravating factors, associated symptoms, pertinent negatives gathered in the history. As well, comments on patients' feelings, fears, impact on functioning and patient expectations could be noted.
- Include pertinent information contributed by family members.

OBJECTIVE

- Deals with clinical findings and patients' signs.
- These include things you, as an observer, can: see, hear, touch, feel, or smell. Your note should refer applicable: important vital signs, physical examination findings (key normal and abnormal findings), mental status, observations (such as gait), lab data, imaging results, and procedure results.
- Limit physical exam findings to appropriate organ system(s).
- For patients on multiple medications, periodically summarize the medications they are receiving or refer to an updated medication list.
- You may refer to pertinent past diagnosis, as well as target values for lab tests.
You may consider commenting on how the patient has responded to past treatments.

ASSESSMENT

- Your diagnosis / diagnoses of the patient's condition(s)
- Include what you feel is the patient's differential diagnosis and why. You may find it easier, when there is more than one issue.
- Comment on any health maintenance issues that were addressed.

PLAN

- Base your plan on your assessment.
- How will you treat each problem?
- List changes in existing management strategies as well as new medications, lab tests ordered, procedures you want done, and patient referrals to be made.
- Be specific with medication including, at the minimum, name and dose. Use generic names of drugs.
- Comment on recommendations for patient follow-up.

A/P

- When multiple problems exist, consider combining assessment and plan—discuss each problem with its specific plan sequentially.

SUMMARY

- In summary, a SOAP note should briefly express the following:
- Date and purpose of the visit



- The patient's own observations and concerns
- Your objective observations and relevant measurements / tests
- Your assessment of the data and the plan for the patient based on the assessment.

Complete History and Physical

Use the following format:

- Identifying data & entrance complaint
- History of present illness
- Past medical history
- Current medications
- Social supports and social history
- Family history
- Review of systems
- Physical examination
- Key laboratory and imaging findings
- Assessment
- Discharge planning issues

Ensure problem list is generated / updated.

Progress Notes

- Done for in-patients cared for on hospital wards—use a focused history gathering technique and focused clinical examination.
- Progress notes are to be written daily except for long stay patients.
- Different from the comprehensive admission note (which is often called the History and Physical)
- Sums up the progress from the last note.
- Always work from an up-to-date problem list at the front of the chart and structure your progress note to address the active problems:
- Changes in pertinent signs or symptoms
- Current physical examination findings and significant changes
- New laboratory data, imaging study results or procedure findings
- The plan for the patient
- Patient disposition or discharge planning issues
- The length of the note will vary with the specialty you are working with.



- Start your note right after the last note in the chart so it will be chronological.
- Date and time your note—it is helpful to start with the number of days the patient was spent in hospital so far.
- Comment on each active problem
- Always sign your name and then print your name along with the proper credential i.e. John Smith—John Smith FMR1