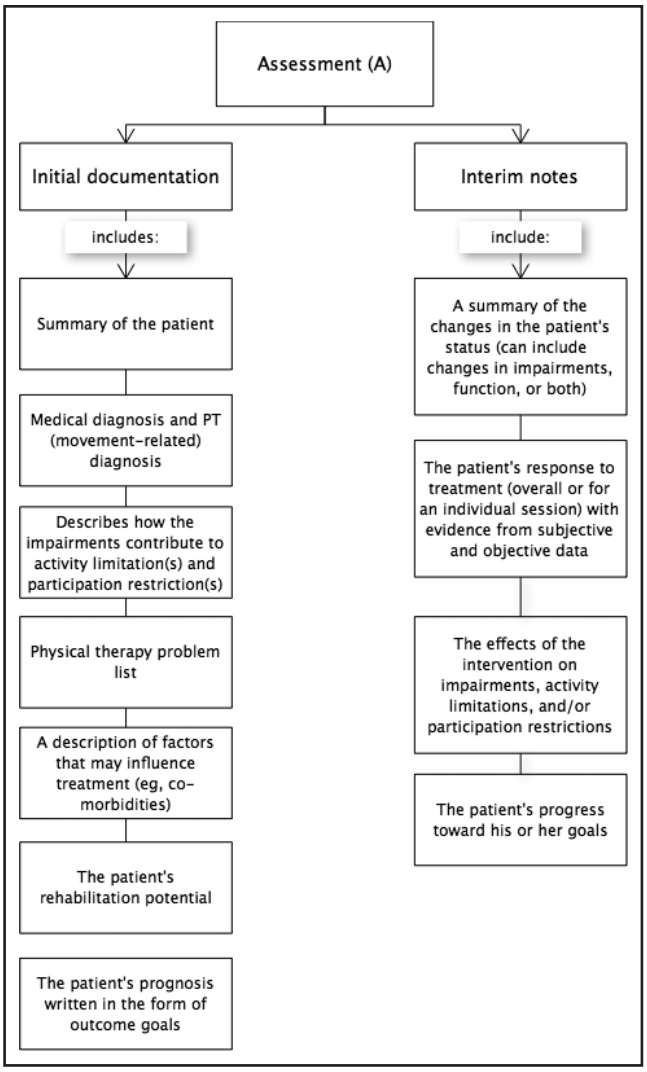

Figure 5-3. Information included in the "A" or Assessment section of the SOAP note.

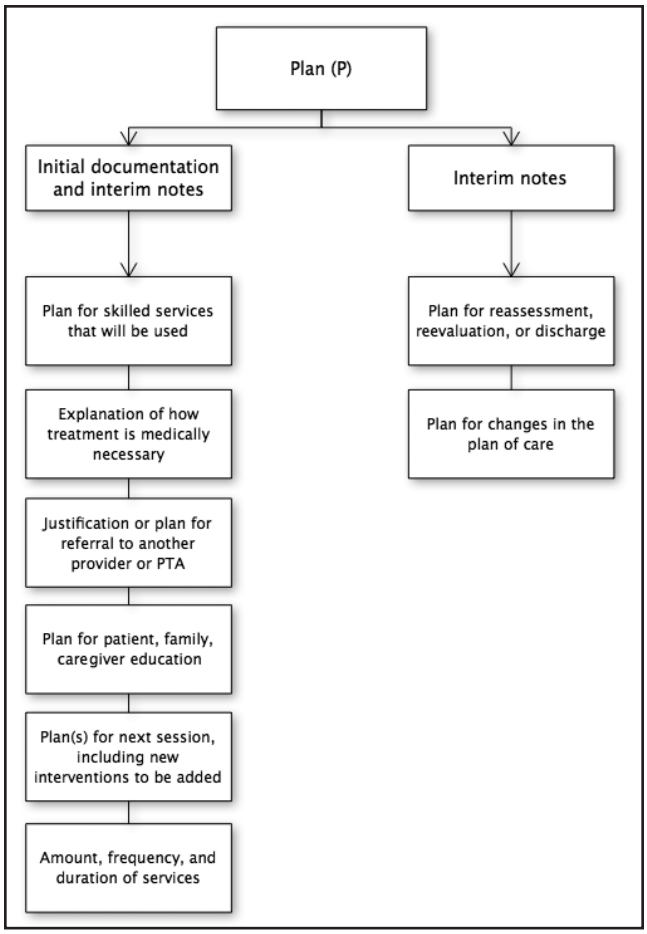

Figure 5-4. Information included in the "P" or Plan section of the SOAP note.

should be some general consistency in the documentation format used, although there may be times when another format (eg, narrative) is needed. These reasons have been described. It is the author's experience that the SOAP format continues to be most widely used, but the integration of patient function (like that described in the FOR) is increasingly more common. In addition, there are electronic documentation packages incorporating various aspects of each of the documentation formats, including the problem-status-plan format. Although there is no evidence suggesting superiority of one format over another, you will soon find that in real-world clinical practice, you are likely to apply principles from the different formats; therefore, it is important to be familiar with the different ones available.

The authors of this text have selected the basic SOAP format to provide a framework for learning documentation skills. Readers will be exposed to information that should go into the S, O, A, and P portions of the note. In addition, readers will be exposed to how aspects of the patient/client management model can fit into the basic SOAP structure (Table 5-3). The SOAP format was selected because of its prevalence in clinical practice and because of its adaptability to a variety of documentation styles and physical therapy practice settings. It is also a good format for students who are learning basic documentation skills. The authors believe teaching the SOAP format provides learners with the essential knowledge of required components. Once in the clinical setting, the individual can reorganize the components into the clinical setting's format, transferring what they have learned about the traditional SOAP structure into the setting's format. Well-written clinical documentation, however, does not depend on the format being used; the key to quality documentation is the content. Well-written records include pertinent subjective and objective data and justify a reasonable, medically necessary, and skilled plan of care. Well-written records are necessary for physical therapy practice and, therefore, quality and content are emphasized.