Organizing the P in a SOAP note

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The Subjective, Objective, Assessment, Plan (SOAP) format of the progress note is widely recognized by clinicians in many specialties, including psychiatry.[1] An online search for how to format a psychiatric SOAP note provides a plethora of styles from which to choose.[2,3] While the suggestions for how to write the Subjective, Objective, and Assessment sections are fairly consistent, suggestions for how to write the Plan section vary widely.

The Plan section should be organized in a way that is systematic and relevant across many psychiatric settings, including outpatient, inpatient, emergency room, jail, pediatric, geriatric, addiction, and consultation-liaison. To best accomplish this, I have designed a format for this section that consists of 6 categories:

1. Safety: Which safety issues need to be addressed?

Examples: If your patient is an inpatient, what precautions are required? If outpatient, Tarasoff? Involuntary hold? Police presence? Child or Adult Protective Services? Access to a firearm?

2. Collateral: Would it be helpful to obtain collateral information from any source?

Examples: Family? Friend? Caregiver? Teacher? Primary care clinician? Therapist? Past medical or psychiatric records?

3. Medical: Are there any medical tests or resources to consider?

Examples: Laboratory studies or imaging? Consult with a specialist from another field? Nursing orders?

4. Nonpharmacologic: What interventions or assessments would be helpful?

Examples: Psychotherapy? Cognitive testing? Social work? Case manager? Housing assistance? Job coach?

5. Pharmacologic: What interventions or assessments would be helpful? (I placed this category fifth to slow myself down and consider other strategies before quickly jumping to prescribe a medication.)

Examples: Medication? Long-acting injectable? Check pill count? Prescription drug monitoring program?

6. Disposition/follow-up: What is the disposition/follow-up plan?

Examples: If outpatient, what is the time frame? If inpatient or an emergency room, when should the patient be discharged?

Using these 6 categories in the P section of my SOAP notes has helped me stay organized and think holistically about each patient I assess and treat. I hope other clinicians find this format helpful.

References

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3. Aftab A, Latorre S, Nagle-Yang S. Effective note-writing: a primer for psychiatry residents. Psychiatric Times. http://www.psychiatrictimes.com/couch-crisis/effective-note-writing-primer-psychiatry-residents. Published January 13, 2017. Accessed August 20, 2018.

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