# Nursing SOAP note form

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## NURSING SOAP NOTE

Patient

Date and time

Nurse

Setting

Reason for contact or focus of this note:

## S: SUBJECTIVE

Patient's main concern, in their words:

Onset, location, duration and what makes it better or worse:

Pain score (0 to 10) and description:

Other symptoms the patient reports (nausea, dizziness, breathlessness, sleep, appetite):

Relevant history, medications taken and allergies (as reported):

What the patient or family understands, and what worries them:

## O: OBJECTIVE

Vital signs

General appearance, alertness, orientation:

Focused physical assessment (system or area related to the concern):

Skin, wounds, dressings, lines and drains:

Intake and output, weight, blood glucose if relevant:

Test results and treatments given so far:

Falls, pressure injury or other risk scores:

## A: ASSESSMENT

Nursing diagnosis or clinical impression (problem, related to, as evidenced by):

Response to care so far (improved, unchanged, worse), with evidence:

Risks and priorities:

## P: PLAN

Nursing interventions (what, how often, who):

Monitoring (what to measure, how often, what values to report):

Teaching and how you will check understanding:

Who was notified, and orders received:

Follow-up, referral or review time:

Signature and credentials:


Educational template, not medical or legal advice. Follow your employer and regulator rules.