SOAPIE note template

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SOAPIE NOTE (NURSING)

Patient _____

Date and time _____

Nurse _____

Problem or reason for this entry:

S: SUBJECTIVE

What the patient said, in their words (symptoms, concerns, ratings):

O: OBJECTIVE

What you observed, measured or examined (vital signs, findings, test results):

A: ASSESSMENT

Your clinical judgment of the problem and its status:

P: PLAN

What you intend to do, monitor or report, and when:

I: INTERVENTION

What you actually did (care given, teaching, calls made, orders carried out):

E: EVALUATION

Time of reassessment:

How the patient responded:

Is the problem resolved, improving, unchanged or worse?

Changes to the plan:

Signature and credentials:

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