

Soap For Family Medicine

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Emphasizing the patient's clinical problem, not the diagnosis, this pocket-sized quick reference teaches both clinical reasoning and documentation skills and is ideal for use by medical students, Pas, and NPs during the Family Medicine rotation. A new Introduction offers templates, tips, and guidelines for writing SOAP notes.

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SOAP is actually an acronym and it stands for: S ubjective – This basically refers to everything the patient has to say about the issue, concern, problem and intervention procedures. O bjective – This, on the other hand, refers to what the health professionals have observed and what their treatments or intervention procedures are.

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The SOAP note is a method of documentation employed by healthcare providers to write out notes in a patient's chart, along with other common formats, such as the admission note. Documenting patient encounters in the medical record is an integral part of practice workflow starting with appointment scheduling, patient check-in and exam, documentation of notes, check-out, rescheduling, and medical billing. Additionally, it serves as a general cognitive framework for physicians to follow as they ass

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