

Grader: \_\_\_\_\_ Student: \_\_\_\_\_ Group: \_\_\_\_\_

Date of Encounter: \_\_\_\_\_

## SOAP Note Grading Rubric for Clinical Encounters – updated Jan 2022

100

SUBJECTIVE	Score	Weight	Value
<b>HPI</b> is appropriate to the case (onset of symptoms, location, duration, character, alleviating/aggravating factors, radiation, temporal) and <b>10-12 relevant questions</b> for associated manifestations or symptoms listed in HPI instead of ROS.	0 3 4 5	3	
<b>Relevant PMH, Trauma Hx, PSH, SH and FH is included</b> (“reviewed, no changes” is acceptable – be sure to list anything relevant to CC/HPI here)	0 3 4 5	1	
<b>Meds</b> should list all including OTC– generic name, dose, mode of delivery (PO, IV, IM...), frequency, indication and <b>Allergies</b> (drugs/foods/latex) with reaction	0 3 4 5	1	
	<b>SUBTOTAL</b>		<b>/25</b>

OBJECTIVE	Score	Weight	Value
<b>Vital signs</b> (BP, pulse, resp, temp, pain, weight, height, BMI) and <b>General impression</b> (e.g. distress level, A&O, nourished/developed or body habitus)	0 3 4 5	1	
<b>Appropriate physical exam</b> All systems examined should correspond to Primary/Working dx and Differential dx	0 3 4 5	2	
<b>Osteopathic structural exam</b> – regions examined all correspond to Primary/Working dx and Diff dx, all components of TART are listed for regions examined	0 3 4 5	2	
	<b>SUBTOTAL</b>		<b>/25</b>

ASSESSMENT / PLAN	Score	Weight	Value
<b>Summary Statement:</b> includes name, age, gender, PMH, presenting with chief complaint with duration	0 3 4 5	1	
<b>Appropriately supported primary/working diagnosis</b> + $\geq 3$ Differential Diagnoses for medical diagnoses with primary dx supported by at least 4 items from history and physical exam; Diff dx supported with two items from Hx and PE	0 3 4 5	2	
<b>Somatic dysfunction</b> is listed as at least one of the assessments.	0 3 4 5	1	
<b>6 point plan</b> for all assessments: Labs, Imaging/Studies, Meds, OMM, Pt Ed, Follow-up. (“not applicable” may be acceptable)	0 3 4 5	2	
<b>ABCs (Autonomics, Biomechanics, Circulation and Screening)</b> are listed as part of OMM plan along with what regions/segments are to be treated	0 3 4 5	1	
<b>Follow up from last visit</b> prior problem mentioned as an assessment, status updated (resolved, ongoing, etc), new plan if applicable	0 3 4 5	1	
	<b>SUBTOTAL</b>		<b>/40</b>

FORMATTING/OVERALL FLOW TO NOTE	Score	Weight	Value
Note typed, information (SOAP) correctly categorized, data organization easy to follow and makes sense	0 3 4 5	1	
Does this note adequately reflect the encounter and inform the next physician of the plan for future visits?	0 3 4 5	1	
	<b>SUBTOTAL</b>		<b>/10</b>

0- Not acceptable

Incomplete or Inaccurate

3- Needs Improvement

Some components listed; &lt;80% relevant data present

4- Competent

Accurate with &gt;80% relevant data present

5- Masters

Concise, comprehensive with all info included AND no extraneous info listed