

**First Year Pharmacy Student Experience  
Patient Visitation Program – Fall Semester 2005  
Presentation Guidelines**

During your scheduled Skills Lab I meeting in November 16 – 22, 2005, each student will present his or her patient using information obtained during the first and second patient visits. A typed SOAP note (described below) will also be required to be handed into your assigned Skills Lab Faculty (Dr. McElhannon or Dr. Brown) on the day of your verbal presentation.

**Presentation Format:**

The length of the verbal presentation is expected to be 5 minutes. The format for both the verbal and written presentation is the SOAP format, which is frequently used by medical professionals to discuss patient cases. Your task is to present this patient in an organized format that will allow your peers to have a feel for who this person is and the conditions in which they exist: home environment, support system, disease states, and medications taken. Also, you need to try to identify the primary medical issues for this patient by connecting their diseases and prescribed medications. Patient confidentiality should be maintained throughout the presentation.

The information for your presentation will be gathered from the medication history conducted during visits one and two. Additional information about the patient's diseases and medications can be obtained from textbooks such as:

- (1) DiPiro JT, et al. Pharmacotherapy: A Pathophysiologic Approach, 6<sup>th</sup> edition. Appleton and Lange, 2005.
- (2) Lacy CF, et al. Drug Information Handbook, 2004-2005, 13<sup>th</sup> edition. Lexi-Comp, 2005.

Although you will not be expected to be an expert, you will be expected to be familiar with your patient's disease states and prescribed medications.

**SOAP Format**

The SOAP format is a common documentation style used by many types of healthcare providers. The emphasis of the note, however, is determined by the type of healthcare provider. Physician SOAP notes outline diagnosis and management of medical problems, whereas pharmacy SOAP notes are written to outline and manage drug related problems. SOAP stands for the following: Subjective, Objective, Assessment and Plan. In this exercise, we will focus on the Subjective and Assessment parts of the SOAP note. When constructing the note, only information pertinent to the medical issues of the patient should be included. As you are just beginning your pharmacy career, it might be difficult for you to decide if the information is pertinent. Inclusion of extraneous information in this case will be acceptable. Abbreviations should be avoided to prevent miscommunications. This is especially important when documenting patient medications.

**Subjective (S):**

Information for the subjective section of the note is obtained from interviewing the patient or caregiver. If the source is not the patient, the information source should be documented in the note. Information in this section includes the following:

- A. General Information (provides overall sketch of the patient)
  - 1. Two Initials (for patient confidentiality reasons, do not use the patient's actual initials)
  - 2. Approximate Patient Age
  - 3. Patient Sex
  - 4. Employment
  - 5. Short description of living arrangements (if important)
  - 6. General Health (how are they feeling today)
- B. Past Medical History
- C. Medication History (Prescription, Nonprescription including vitamins and herbals)
- D. Allergies
- E. Social History
- F. Family History

Objective (O):

Information for the objective session is obtained from direct observation (physical exam) or verifiable sources (lab values, prescription records). All information included should support the assessment or plan section. All other extraneous information should be omitted. Since you will not be privy to objective data, this section will likely be blank.

Assessment (A):

The assessment section is used to assess the patient's medical and drug related problems. The assessment should contain a statement supporting your assessment that a problem exists and should include justification of the therapeutic goal and brief discussion of treatment alternatives. For the purposes of this assignment, you are only expected to link medical problems with medications.

Plan (P):

The plan should recommend your suggested treatment (for medications: include name, dose, frequency) and monitoring / follow up parameters (e.g. what should be measured, frequency of measurement, follow up appointment, etc)

SOAP Example:

S: Identification (ID): RJ is a male in his 50's.

Past Medical History (PMH):

High Blood Pressure, diagnosed 5 years ago

Appendectomy, 20 years ago

Medication History:

Prescription Medications:

Toprol XL 25mg, one tablet daily for 2 years

Nonprescription Medications:

Centrum, one tablet daily

Allergies: History of sulfa allergy, denies history of environmental allergies

Social History (SH):

Employed as an accountant; married with 3 children; exercises 3 times per week. Height 5'8, Weight 190 lbs

Recreational Drug Use:

Occasional alcohol use: 3 – 4 drinks / week

Denies history of tobacco use

Family History (FH):

Father died of heart attack at age 52

- O: Documented BP / Heart rate readings from past week:
- 10/11/04: 156/96, heart rate 90 beats / min
  - 10/12/04: 145/90, heart rate 82 beats / min
  - 10/13/04: 160/98, heart rate 88 beats / min
  - 10/14/04: 152/94, heart rate 96 beats / min
  - 10/15/04: 162/98, heart rate 84 beats / min
  - 10/16/04: 150/88, heart rate 92 beats / min
  - 10/17/04: 154/96, heart rate 86 beats / min
- A: High Blood Pressure: BP is currently uncontrolled as documented by measured BP readings above from the past week. Patient states that he has been compliant with his medication. Based on JNC Guidelines, BP should be <140/90. Currently, patient is tolerating medication well and no side effects have been detected.
- P: Increase Toprol XL to 50mg tablet once per day. Instruct patient to monitor and record BP and heart rate daily using home monitor. Patient will report any dizziness. Patient should return to physician in 2 weeks for BP check.

## SOAP Presentation Evaluation Form

**Student** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructor** \_\_\_\_\_

*Experience programs not only teach the technical skills necessary deliver pharmaceutical care, but also instruct students in the art of professionalism. To emphasize this point, the evaluation of this exercise will be divided into two sets of competencies.*

<b>Professional Competency</b>	<b>Not Met</b>	<b>Met</b>	<b>Exceptional</b>
Displays appropriate dress and personal grooming. (10 points)			
Demonstrates confidence (10 points)			
Demonstrates dependability (arrives prepared and brings appropriate information) (10 points)			
Demonstrates a professional caring attitude (10 points)			
Complies with regulations regarding confidentiality of information (10 points)			
<b>Presentation Competency</b>			
Presents verbal information in an organized manner using the SOAP format. (10 points)			
Presents written information in an organized manner using the SOAP format. (10 points)			
Communicates effectively, using appropriate level of terminology (10 points)			
Maintains control and direction of the verbal presentation. (10 points)			
Student is able to answer patient related questions commensurate with their level of understanding. (10 points)			

**Assessment:**

Professionalism Points (Max 50 points) \_\_\_\_\_

Presentation Points (Max. 50 points) \_\_\_\_\_

Total Points (MAX 100 points) \_\_\_\_\_

**Additional Comments:**