



# Surgical Presentation (SOAP Note)

## One liner of patient:

*This is a XX year old male/female who is post-op day #XX from XX.*

## Subjective

### PADBUNS

- Pain
- Ambulation
- Diet
- Bowel movements/flatus
- Urination
- Nausea/vomiting
- Significant events (check in with overnight nurse -- shift change is around 7am at our hospital)

## Objective

- Vitals overnight
  - Any fevers, episodes of tachycardia, or hypotension? Did oxygen requirement increase or decrease? If there are abnormalities, include it as a range (ex: temperature ranged from 101-103.9F)
- Ins and Outs
  - EMR should have an I/Os tab that will include how much fluid the patient received via IV lines, how much they lost via urination, etc. (note overall output as well as net difference)
- Tubes and lines (chest tubes, catheters, etc.)
  - Note color (serous, serosanguineous, biliary, clear) and quantity of output. If they have a chest tube, did you see bubbles in the chamber? That could be indicative of an air leak
- Labs within the last 24 hours (make note of all of them, but only verbally report relevant values)
- Imaging results within the last 24 hours
- Culture results within the last 24 hours
- Physical exam findings (including general appearance of the patient and inspection of surgical site)

## Assessment and Plan

Repeat one liner:

*So, this is a XX year old male/female who is post-op day #XX from XX.*

- If relevant, mention "post-operative course has been complicated by XX."
- What needs to be monitored
- What needs to be followed up on
- When they can go home/current barriers to discharge