INSTRUCTIONS ON HOW TO USE EXEMPLAR AND TEMPLATE—READ CAREFULLY

If you are struggling with the format or remembering what to include, follow the Focused SOAP Note Evaluation Template ***AND*** the Rubric as your guide. It is also helpful to review the rubric in detail in order not to lose points unnecessarily because you missed something required. After reviewing full details of the rubric, you can use it as a guide.

In the Subjective section, provide:

* Chief complaint
* History of present illness (HPI)
* Past psychiatric history
* Medication trials and current medications
* Psychotherapy or previous psychiatric diagnosis
* Pertinent substance use, family psychiatric/substance use, social, and medical history
* Allergies
* ROS

Read rating descriptions to see the grading standards!

In the Objective section, provide:

* Physical exam documentation of systems pertinent to the chief complaint, HPI, and history
* Diagnostic results, including any labs, imaging, or other assessments needed to develop the differential diagnoses.

Read rating descriptions to see the grading standards!

In the Assessment section, provide:

* Results of the mental status examination, *presented in paragraph form.*
* At least three differentials with supporting evidence. List them from top priority to least priority. Compare the *DSM-5* diagnostic criteria for each differential diagnosis and explain what *DSM-5* criteria rules out the differential diagnosis to find an accurate diagnosis. *Explain the critical-thinking process that led you to the primary diagnosis you selected. Include pertinent positives and pertinent negatives for the specific patient case*.
* Read rating descriptions to see the grading standards!

Reflect on this case. Include: Discuss what you learned and what you might do differently. Also include in your reflection a discussion related to legal/ethical considerations (***demonstrate critical thinking beyond confidentiality and consent for treatment***!), health promotion and disease prevention taking into consideration patient factors (such as age, ethnic group, etc.), PMH, and other risk factors (e.g., socioeconomic, cultural background, etc.).

(The FOCUSED SOAP psychiatric evaluation is typically the *follow-up visit* patient note. You will practice writing this type of note in this course. You will be focusing more on the symptoms from your differential diagnosis from the comprehensive psychiatric evaluation narrowing to your diagnostic impression. You will write up what symptoms are present and what symptoms are not present from illnesses to demonstrate you have indeed assessed for illnesses which could be impacting your patient. For example, anxiety symptoms, depressive symptoms, bipolar symptoms, psychosis symptoms, substance use, etc.)

EXEMPLAR BEGINS HERE

**Subjective:**

**CC** (chief complaint): A brief statement identifying why the patient is here. This statement is verbatim of the patient’s own words about why presenting for assessment. For a patient with dementia or other cognitive deficits, this statement can be obtained from a family member.

**HPI**: Begin this section with patient’s initials, age, race, gender, purpose of evaluation, current medication and referral reason. For example:

N.M. is a 34-year-old Asian male presents for medication management follow up for anxiety. He was initiated sertraline last appt which he finds was effective for two weeks then symptoms began to return.

Or

P.H., a 16-year-old Hispanic female, presents for follow up to discuss previous psychiatric evaluation for concentration difficulty. She is not currently prescribed psychotropic medications as we deferred until further testing and screening was conducted.

Then, this section continues with the symptom analysis for your note. Thorough documentation in this section is essential for patient care, coding, and billing analysis.

Paint a picture of what is wrong with the patient. First what is bringing the patient to your follow up evaluation? Document symptom onset, duration, frequency, severity, and impact. What has worsened or improved since last appointment? What stressors are they facing? Your description here will guide your differential diagnoses into your diagnostic impression. You are seeking symptoms that may align with many *DSM-5* diagnoses, narrowing to what aligns with diagnostic criteria for mental health and substance use disorders.

**Substance Use History:** This section contains any history or current use of caffeine, nicotine, illicit substance (including marijuana), and alcohol. Include the daily amount of use and last known use. Include type of use such as inhales, snorts, IV, etc. Include any histories of withdrawal complications from tremors, Delirium Tremens, or seizures.

**Current Medications**: Include dosage, frequency, length of time used, and reason for use. Also include OTC or homeopathic products.

**Allergies**:Include medication, food, and environmental allergies separately. Provide a description of what the allergy is (e.g., angioedema, anaphylaxis). This will help determine a true reaction vs. intolerance.

**Reproductive Hx**:Menstrual history (date of LMP), Pregnant (yes or no), Nursing/lactating (yes or no), contraceptive use (method used), types of intercourse: oral, anal, vaginal, other, any sexual concerns

**ROS**: Cover all body systems that may help you include or rule out a differential diagnosis. Please note: THIS IS DIFFERENT from a physical examination!

You should list each system as follows: General: Head: EENT: etc. You should list these in bullet format and document the systems in order from head to toe.

Example of Complete ROS:

GENERAL: No weight loss, fever, chills, weakness, or fatigue.

HEENT: Eyes: No visual loss, blurred vision, double vision, or yellow sclerae. Ears, Nose, Throat: No hearing loss, sneezing, congestion, runny nose, or sore throat.

SKIN: No rash or itching.

CARDIOVASCULAR: No chest pain, chest pressure, or chest discomfort. No palpitations or edema.

RESPIRATORY: No shortness of breath, cough, or sputum.

GASTROINTESTINAL: No anorexia, nausea, vomiting, or diarrhea. No abdominal pain or blood.

GENITOURINARY: Burning on urination, urgency, hesitancy, odor, odd color

NEUROLOGICAL: No headache, dizziness, syncope, paralysis, ataxia, numbness, or tingling in the extremities. No change in bowel or bladder control.

MUSCULOSKELETAL: No muscle, back pain, joint pain, or stiffness.

HEMATOLOGIC: No anemia, bleeding, or bruising.

LYMPHATICS: No enlarged nodes. No history of splenectomy.

ENDOCRINOLOGIC: No reports of sweating, cold, or heat intolerance. No polyuria or polydipsia.

**Objective:**

**Diagnostic results**: Include any labs, X-rays, or other diagnostics that are needed to develop the differential diagnoses (support with evidenced and guidelines).

**Assessment:**

**Mental Status Examination:** For the purposes of your courses, this section must be presented in paragraph form and not use of a checklist! This section you will describe the patient’s appearance, attitude, behavior, mood and affect, speech, thought processes, thought content, perceptions (hallucinations, pseudohallucinations, illusions, etc.)., cognition, insight, judgment, and SI/HI. See an example below. You will modify to include the specifics for your patient on the above elements—DO NOT just copy the example. You may use a preceptor’s way of organizing the information if the MSE is in paragraph form.

He is an 8-year-old African American male who looks his stated age. He is cooperative with examiner. He is neatly groomed and clean, dressed appropriately. There is no evidence of any abnormal motor activity. His speech is clear, coherent, normal in volume and tone. His thought process is goal directed and logical. There is no evidence of looseness of association or flight of ideas. His mood is euthymic, and his affect appropriate to his mood. He was smiling at times in an appropriate manner. He denies any auditory or visual hallucinations. There is no evidence of any delusional thinking.   He denies any current suicidal or homicidal ideation. Cognitively, he is alert and oriented. His recent and remote memory is intact. His concentration is good. His insight is good.

**Diagnostic Impression**:You must begin to narrow your differential diagnosis to your diagnostic impression. You must explain how and why (your rationale) you ruled out any of your differential diagnoses. You must explain how and why (your rationale) you concluded to your diagnostic impression. You will use supporting evidence from the literature to support your rationale. Include pertinent positives and pertinent negatives for the specific patient case.

**Also included in this section is the reflection.** Reflect on this case and discuss whether or not you agree with your preceptor’s assessment and diagnostic impression of the patient and why or why not. What did you learn from this case? What would you do differently?

Also include in your reflection a discussion related to legal/ethical considerations (**demonstrating critical thinking beyond confidentiality and consent for treatment!**), health promotion and disease prevention taking into consideration patient factors (such as age, ethnic group, etc.), PMH, and other risk factors (e.g., socioeconomic, cultural background, etc.).

**Case Formulation and Treatment Plan**

Includes documentation of diagnostic studies that will be obtained, referrals to other health care providers, therapeutic interventions including psychotherapy and/or psychopharmacology, education, disposition of the patient, and any planned follow-up visits. Each diagnosis or condition documented in the assessment should be addressed in the plan. The details of the plan should follow an orderly manner. **\*See an example below. You will modify to your practice so there may be information excluded/included. If you are completing this for a practicum, what does your preceptor document?**

Risks and benefits of medications are discussed including non- treatment. Potential side effects of medications discussed (be detailed in what side effects discussed). Informed client not to stop medication abruptly without discussing with providers. Instructed to call and report any adverse reactions. Discussed risk of medication with pregnancy/fetus, encouraged birth control, discussed if does become pregnant to inform provider as soon as possible. Discussed how some medications might decreased birth control pill, would need back up method (exclude for males).

Discussed risks of mixing medications with OTC drugs, herbal, alcohol/illegal drugs. Instructed to avoid this practice. Encouraged abstinence. Discussed how drugs/alcohol affect mental health, physical health, sleep architecture.

Initiation of (list out any medication and why prescribed, any therapy services or referrals to specialist):

Client was encouraged to continue with case management and/or therapy services (if not provided by you)

Client has emergency numbers: Emergency Services 911, the Client's Crisis Line **1-800-\_\_\_\_\_\_\_**. Client instructed to go to nearest ER or call 911 if they become actively suicidal and/or homicidal. (only if you or preceptor provided them)

Reviewed hospital records/therapist records for collaborative information; Reviewed PMP report (only if actually completed)

Time allowed for questions and answers provided. Provided supportive listening. Client appeared to understand discussion. Client is amenable with this plan and agrees to follow treatment regimen as discussed. (this relates to informed consent; you will need to assess their understanding and agreement)

Follow up with PCP as needed and/or for:

Labs ordered and/or reviewed (write out what diagnostic test ordered, rationale for ordering, and if discussed fasting/non fasting or other patient education)

Return to clinic:

Continued treatment is medically necessary to address chronic symptoms, improve functioning, and prevent the need for a higher level of care.

**References (move to begin on next page)**

You are required to include at least three evidence-based, peer-reviewed journal articles or evidenced-based guidelines which relate to this case to support your diagnostics and differentials diagnoses. Be sure to use correct APA 7th edition formatting.