Surgery Post-Op SOAP Note

Subjective:
- Control pain (How's your pain?)
- Bowels (Have you passed gas? Have you had a bowel movement? Have you urinated?)
- Nausea, vomiting
- Tolerating PO (meds, liquids/solids)
- Ambulating (Are you getting up walking around?)

Objective: Vitals: Tm/Tc, HR, RR, BP, PulseOx
Inputs/Outputs: (Always ask your resident how to present I/Os. Each attending likes it a little different.)

PE: (Inspect, Palpate, Percuss, Auscultate, except abdominal Auscultate before Percuss), Normal in *italics*

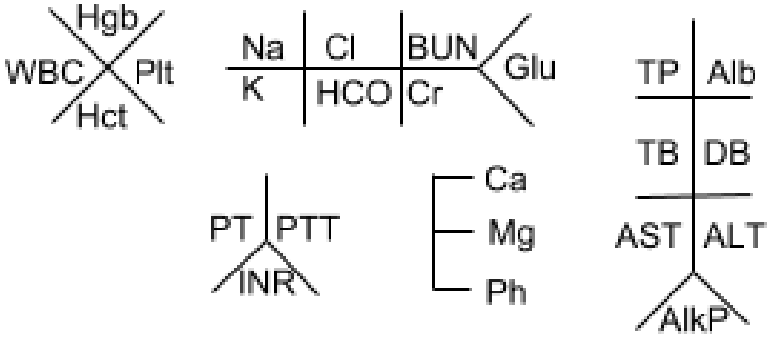
Lungs: Clear to auscultation? Wheezes, crackles?
Lungs clear to auscultation bilaterally, no wheezes or crackles

CV: any new murmurs? Tachycardia/bradycardia?
Heart regular rate and rhythm; no murmur, rubs, or gallops

ABD: bowel sounds? (Important deciding factor in when to advance diet)
Abdomen soft, non-tender, non-distended, positive bowel sounds

Incision: clear, dry, and intact? (C/D/I). Good granulation? (Report anything unusual. Ask intern/resident if you should/can remove bandage to inspect wound. If not, just inspect and report bandage.)
Bandage clear, dry, and intact. No surrounding erythema.

Ext: any edema or signs of DVT (warm, red, swollen)? Check both legs.
Extremities no edema, no warmth, erythema, swelling bilaterally
Labs/Studies/Imaging/Path:



Assesment/Plan: Brief statement of overall impression- pay attention to how intern/resident presents their A/P. Mimic them). Always include post-op day! (Day of Surgery is POD#0; next day is POD#1).
Usually part of every plan:
- Pain medications (d/c PCA, change to PO, increase interval between doses, etc)
- Diet (To advance or not to advance?)
- PT/OT (Read their recommendations)
- Follow-up (Do you need to schedule a follow up appointment? When and with who?)