

CHART Documentation Format Example

The CHART and SOAP methods of documentation are examples of how to structure your narrative. You do not need to format the narrative to look like this; you can simply use these as an example of how to properly form a baseline structure for your narrative.

C (Complaint)

- The Pt. is a 50 y.o. male complaining of substernal chest pain and nausea. The complaint is described as a heavy pressure mid-sternum with radiation to the left shoulder.

H (History)

- The chief complaint began approximately 2 hours prior to the patient calling EMS (estimated onset time @ 09:30)
- Pt. has a Hx. of HTN, diabetes and elevated cholesterol
- The Pt. states he considers himself in good health, but acknowledges that his physician has recently informed him that if he does not stop smoking and lose weight that it will have an adverse impact on his health
- The Pt. reports recent episodes of shortness of breath. He denies any other health issues with any body system. He indicates that his blood glucose levels are “normal” (his words). He indicates that he averages 100-120 mg/dl.
- Medications: Metformin (Glucophage), Lisinopril and Zocor. Pt. states he is compliant with his medications
- Allergies: NKDA
- Last Oral Intake: Approximately 8:15 today (light breakfast, consistent with normal amount and carbohydrate/caloric intake.
- No precipitating events, no palliation or provocation

A (Assessment)

- Airway is intact, respirations are 20, regular and full, pulse is initially 90, strong and regular, B/P 160/98 and the skin is cool, moist and pale.
- The impression of the Pt. is that he is in an emergent condition and ER assessment and intervention is indicated.
- Physical exam:
 - o Head: Symmetrical and unremarkable

- o Face: Pupils are PERRLA and 7 mm each.
- o Neck: No JVD. Trachea is midline
- o Chest: Breath sounds are clear and equal bilaterally in all anterior and posterior fields. Heart tones are clear and regular with distinct S1 and S2 sounds and they are consistent with the pulse (allowing for MPI to radial artery delay). ECG: sinus rhythm, no ectopy. 12-lead: ST elevation in the inferior leads (II, III and aVF), ST depression in high lateral leads (Lead I and aVL). A second 12-lead for V4R reveals ST elevation in V4R. The Pt. rates the chest pain as a “9” on the pain scale of 1-10. The description is a heavy pressure that is mid-sternum.
- o Abdomen: Soft not tender, no masses or pulses appreciated on examination.
- o Pelvis: Stable. Pt. denies any changes or abnormalities with their bowel habits or stool, or with their urination or urine.

A (Assessment - continued)

- o Back/Spine: Pt. denies any pain or discomfort between the scapulas. No abnormalities found on assessment, and no pre-sacral edema noted on assessment.
- o Extremities: Pt. complains of pain to the left shoulder that is described as the heavy pressure radiating from the chest and that began when the chest pain began. He assigned a pain level of “9” on the pain scale of 1-10. Reflexes/Pulse/Motor/Sensation (RPMS) are present and equal in all extremities. No edema noted to the lower extremities.
- Diagnostic tests:
 - o 12-lead ECG: Possible acute inferior wall MI, right wall involvement and lateral wall ischemia.
 - o Blood glucose assessment: 154 mg/dl
 - o SaO2 95% on room air and 99% on NRB @ 15 LPM O2
 - o ETCO2 @ 37 mm/hg
- Field diagnosis:
 - o Acute Coronary Syndrome (ACS)
 - o Abnormal 12-lead consistent with inferior/right wall MI and lateral wall ischemia
 - o Mild elevation of blood glucose

Rx. (Treatment)

- O2 @ 15 LPM was administered via non-rebreather mask (during assessment)
- Pt. was advised of the assessment findings and advised of the need to seek medical care at the ER. Pt. initially wanted to delay transport to the ER citing the need to obtain permission through their insurance company and the need to make an appointment for their PCP physician.

- The Pt. was counseled that such delays would only worsen his condition possibly to the point of cardiac arrest, that time was intervention were essential components of their care and that in a potentially life threatening situation, the insurance company was not an issue.
- The Pt. agreed to transport to the ER. His initial request was for Green Giant ER. It was explained to him that Green Giant ER did not have a cardiac catheterization lab available 24 hours daily and that another hospital would be in his best interest. The Pt. requested Memorial-Hermann hospital ER, which was acceptable as a receiving facility.
- ASA, 162 mg was administered orally.
- The Pt. was assisted to the stretcher, straps secured and rails raised and locked. The stretcher was then rolled out to Unit 651 and loaded without incident.
- An IV of 0.9% NaCl was initiated in the left forearm using an 18 gage catheter on the first attempt. Due to the presence of an inferior/right wall STEMI, a fluid bolus of 500 ml was administered while enroute to the ER.
- During transport, 0.4 mg NTG spray was administered SL
- Following the IV bolus, 0.4 mg NTG SL spray was administered one time.
- A Pt. report was called to the ER Ambulance Triage and the call receiver was advised of a possible STEMI ACS Pt.
- The Pt. did not report any pain improvement with the initial NTG. A second 0.4 mg SL spray was administered.

Rx. (Treatment-continued)

- On arrival @ the ER, the stretcher was removed from the ambulance, rolled into the ER and to the CPC Bed 2 and the Pt. transferred to the bed without incident.
- The Pt. was reported and released to the ER CC staff. A copy of the PCR was left with the ER CPC nurse.

T (Transport)

- Memorial Hermann Hospital (Recommended based on level of care and facilities not available at the pts. initial hospital request (Green Giant ER)
- Pt. was transported by ground
- Pt. reported slight improvement in chest pain (from an initial “9” down to a “7”) following the O2, fluid bolus and the second NTG
- The Pt. remained stable during transport
- The Pt. was reported to the ER via cell phone and to the ER CPC staff on arrival
- Pt. was released to the ER CPC staff in an improved

SOAP Format Documentation Example

S. EMS was dispatched @ 04:02 to 123 Main St. for a report of a person experiencing chest pain. Response to the scene was delayed due to heavy fog. Ambulance 1 arrived on the scene @ 0409 and found a 52 y.o. female complaining of pain in the epigastric region. She states she awoke from sleep with the pain. She also complains of nausea, but has not vomited. The Pt. has no previous Hx. of a similar event. Her other medical Hx.: hypertension, anxiety, elevated cholesterol and a breast biopsy in Sept. 2000 (benign). OB/Gyn Hx.: G2, P2, Ab 0, L 2. Medications; Vasotec, Lescol, ASA. Allergies: PCN and seasonal allergies. Physician: Dr. C. L. Stethoscope.

O.

INITIAL: GCS = 15, Airway is intact. Resp. 16, regular, full, non-labored. SaO₂ is 98% on room air. Pulse. 86, regular, full @ Lt. Radial artery. B/P 138/88 (sitting). Skin is cool, pink and moist. No obvious external bleeding is noted.

HEAD: No complaint, symmetrical on palpation, no discharge from ears, no discoloration on mastoids, no obvious trauma noted. Skin of the scalp has no sensory deficits. Memory is accurate and reasoning is intact as indicated by simple interpretation (Pt. repeats "You can't teach an old dog new tricks." She then explained: "That means that older people are stuck in their ways" (her words).

FACE: No complaint, face is symmetrical, her eyes are open, clear, appropriate gaze, pupils PERRLA @ 9 mm each. Eyes track and follow object appropriately. No discharges noted from eyes, nose or mouth. No odors noted from mouth. Front teeth (incisors) appear intact. Tongue protrudes appropriately. The Pt's. speech is clear. Facial skin has no sensory deficits. No injury noted on examination.

NECK: No complaint. No tenderness noted on exam. Pt. has no limitations, rigidity or limits to motion. No injury noted on examination.

THROAT: No complaint. Trachea is midline, no JVD noted. No swelling of glands noted. No injury noted on examination.

CHEST: Complaint of pain near the epigastric area. She describes the pain as dull. When requested, Pt. placed fingers on the lower sternum/xiphoid region. Pt. relates their pain as an "8" on the scale of 1-10. She indicates the pain does not radiate beyond the immediate epigastric region. She has no relief from the pain, nor does she note any specific aggravation. She describes the pain as constant. Breath sounds are clear bilaterally in upper and lower regions, both front and back. Chest excursion is equal and symmetrical. EKG: Monitor shows sinus rhythm. 12-lead indicates S-T elevation of 1.5 mm in L II, III and AVF. No injury is noted on examination.

ABDOMEN: Complaint of epigastric pain. Pt. reports nausea since the onset of the pain. She denies any vomiting. She last ate approximately 18:30. That meal was a hamburger. The abdomen is symmetrical, soft, not tender, no pulsations or masses are noted on palpation. No injury noted on examination.

PELVIS: No complaint. Pelvis is stable in 3 planes. Pt. reports her LNMP was 3 weeks ago, and that the flow was normal. She has not experienced any discharges or break through bleeding. She denies any chance of pregnancy indicating that her husband has had a vasectomy for the past 5 years. She indicates she has not noticed any changes in bowel movements or stool, nor has she noticed any changes in urination or urine. She denies any injury to the pelvis. No visualization of the area was performed. BACK/SPINE: No complaint. Palpation of the area finds no tenderness. The area was visualized by raising the Pts. Night shirt. No injury or abnormal findings were visualized. As indicated previously, breath sounds auscultated on the back were clear and equal in all fields. The Pt. denies any injury to the area.

EXTREMITIES: No complaint. Pulses are present and equal bilaterally in the radial arteries and posterior tibialis arteries. The Pt. has intact sensory and motor function in all extremities. Strength was equal bilaterally in all extremities. On examination, there was no arm drift noted. An approximately 1" x 1" abrasion was noted on the dorsal aspect of the left forearm. It appeared to have occurred within the past 2-3 days. The Pt. indicated it was the result of a fall 3 days ago. The fall occurred while the Pt. was power walking. She denies any associated trauma from that fall. She did not seek medical attention for that injury. The Pt. appears to have a full range of motion and use of the extremities.

OTHER: Blood glucose is 124 mg/dl.

A.

Field Impression: 1) Possible coronary syndrome, 2) Possible inferior wall injury to the myocardium, 3) Possible gastritis or gastric distress.

P.

1) Pt. was assessed (see vital signs block for times), 2) During assessment, O₂ @ 6 LPM was administered via nasal cannula (Pt. could not tolerate a non-rebreather mask). @ 0412. 3) Pt. was advised she should seek immediate medical care due to her symptoms and her assessment findings. She initially wanted to wait until morning to see her PCP physician, but she was advised that doing so risked causing a decline in her condition or possibly causing death. She then agreed to seek medical care at the ER. 4) She was assisted to the stretcher, the straps were secured, rails raised and the stretcher raised without incident. 5) The stretcher was rolled to the ambulance and loaded without incident. 6) An IV of .9% NaCl was initiated in the left forearm, using an 18 ga. catheter, an

aseptic technique, and was accomplished in one attempt @ 0421. The IV flow rate was set at TKO. 7) NTG ,4 mg SL spray administered X1 @ 0422. The Pt. reported relief @ 0424. 8) ASA 160 mg was administered @ 0422. 9) Transport was initiated @ 0422. Transport was non-emergency (Pt. was stable). 10) A Pt. report was called in to the ER via cell phone @ 0423. Jan Jones, RN took the over the phone report. She was advised of the findings of the 12-lead EKG. 11) The vitals were repeated (see vitals section of report for specific findings and times), and the Pt. was reassessed. The Pt. reported pain relief following the NTG. 12) On arrival @ the ER, the stretcher was removed with the straps secured and the rails up. She was moved into the ER without incident. Per the direction of the ER staff, she was rolled directly into the CPC, where she was assisted to the ER bed without incident. 12) The Pt. was verbally reported to the ER staff physician (Dr. Morebucks) and the ER staff nurses. A copy of the report and the 12-lead was given to Jan Jones, RN. 13) A copy of the EMS Dept. HIPAA policy was given to the Pts. spouse due to the activity at the Pts. bedside. 14) The ambulance was returned to service @ 0512.