

SOAP NOTE CHECKLIST

Use this one-page checklist for a quick final review before submitting or finalizing your SOAP note.

S SUBJECTIVE ☐ Chief complaint / reason for visit is clear ☐ Symptoms and pain are documented specifically ☐ Relevant history and patient concerns are included ☐ Pertinent negatives are included when relevant ☐ Patient-reported information stays in Subjective ☐ No objective findings or personal conclusions are mixed in	O OBJECTIVE ☐ Vital signs / measurements are recorded when relevant ☐ Assessment findings are specific and factual ☐ Relevant diagnostics / results are included if available ☐ Abnormal findings are clearly identified ☐ Objective data is observable or measurable ☐ Vague opinions are replaced with specific findings
A ASSESSMENT ☐ Nursing problem / clinical impression is clearly stated ☐ Assessment is supported by S and O ☐ Priority problem is identifiable ☐ Patient status / response is noted when relevant ☐ No unsupported diagnosis or conclusion is introduced ☐ Assessment is concise and clinically focused	P PLAN ☐ Interventions address the identified problem ☐ Monitoring / reassessment is included ☐ Patient education is documented ☐ Treatments / medications are noted as ordered ☐ Follow-up / referral / escalation is included when appropriate ☐ Plan is specific enough that the next action is clear

FINAL CHECK

- ☐ SOAP note flows logically from S → O → A → P
- ☐ Assessment is supported by the documented findings
- ☐ Plan responds directly to the Assessment
- ☐ Note is clear, concise, specific, and easy to understand
- ☐ Unnecessary repetition has been removed
- ☐ Required instructor / clinical-site format has been followed

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Educational resource only. Always follow your instructor's, nursing program's, or clinical site's documentation requirements.