

## 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*

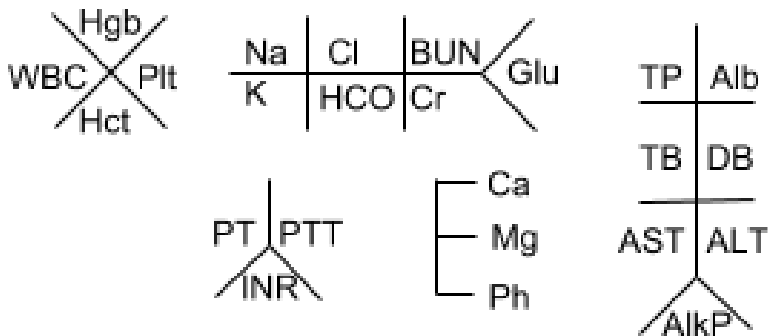
Incision: clear, dry, and intact? (C/D/I). Good granulation? (Report anything unusual. Ask intern/resident if you should/can remove bandage to inspect wound. If not, just inspect and report bandage.)

*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?)