# Cardiology SOAP Note

## Instructions

Use the case provided in the interactive cardiology case to complete this assignment. Create a comprehensive SOAP Note using information provided below which is similar to the AG-ACNP format. Complete all sections.

## Subjective History

### Chief Complaint

*(Use the patient’s words in quotes)*

### History of Present Illness

*(Add information below)*

### Past Medical History

*(In list format)*

### Medications

*(In list format)*

### Medication Allergies

*(Add information below)*

### Surgical History

*(In list format)*

### Family History

*(Add information below)*

### Social History

*(Add information below, at a minimum document Tobacco, EtOH and illicits)*

### Review of Systems

*(In this section, list the ROS you would perform for this patient. Focus your questions on the patient’s presenting complaint, medical history and pertinent findings)*

### After reviewing the subjective history provided in the case, what additional 10 questions would you prioritize asking the patient to clarify missing information or expand on information provided?

*(List 10 questions below)*

## Objective Findings

### Vital Signs

*(Mark abnormal findings with (H) or (L), provide BMI)*

### Physical Examination (PE)

*(In the space below, document the PE provided in the case. For findings that were described as ‘normal’, your PE should describe your documentation of the normal finding. For example, a ‘normal’ nasal exam would describe nares equal and patent without erythema, drainage or lesions to nasal mucosa)*

### Labs

*(Use list format and mark abnormal findings with (H) or (L))*

### EKG Interpretation

*(Describe your EKG interpretation below, including rhythm, approximate rate, and other significant findings)*

### Risk Assessment Calculation

*Provide the TIMI Risk Score, documenting the positive findings that contributed to the score.*

## Assessment

### Differential Diagnosis (DDx)

*(List your abnormal findings below and provide 2 – 3 differential diagnosis considerations for each finding. Remember to prioritize your considerations based on the patient presentation and history, listing the most likely consideration first)*

1.

2.

3.

4.

5.

### References (DDx)

*(Provide 3 references you used for developing your differential diagnosis considerations above. Review the resources on* [*the Maryville Library ACNP Recommended Resources page*](http://libguides.maryville.edu/nursing/recommended-books-and-resources) *for e-book options.)*

1.

2.

3.

### Assessment Paragraph

*(Summarize your suspected diagnosis, most pertinent findings and severity of presentation. Only include key elements from HPI, do not restate the entire HPI.)*

## Plans

*Write your orders for this patient. Medication orders should include name, dose, route, frequency. Orders should be comprehensive, addressing diagnostic testing and other pertinent evaluation and management of the patient’s acute complaint. See the AG-ACNP SOAP template in NURS 641 for reference.*

### Problem #1

Diagnosis:

Plan:

### Problem #2

Diagnosis:

Plan:

### Problem #3

Diagnosis:

Plan:

### Problem #4

Diagnosis:

Plan:

### Problem #5

Diagnosis:

Plan:

### References (Management Plan)

*(Provide 3 references you used for developing your management plan above. Review the resources on* [*the Maryville Library ACNP Recommended Resources page*](http://libguides.maryville.edu/nursing/recommended-books-and-resources) *for e-book options.)*

1.

2.

3.

## Case Analysis

*Complete a brief analysis of the case discussing how the patient’s history, risk factors and clinical presentation impacted your medical decision making and development of your management plan for this patient. Limit your analysis to 2 pages.*