DOCUMENTATION AND PROGRESS NOTES

Progress Notes serve as documentation of the therapy plan, course and outcome of therapy and the delivery of service. The **SOAP** format is the familiar form for writing Progress Notes. The following is an explanation of SOAP notations and a sample note documenting a therapy session.

S (Subjective) How the client reacted to procedures, materials, interactions, etc. Signs and symptoms observed which may be cause for referral of further testing. Client behavior; can include direct statements made by client.

O (Objective) Concrete observations about the client including raw data from testing or therapy. Documents progress or lack or progress stating goals and specific performance data, i.e. percentages.

A (Assessment) Includes the clinician's interpretation of subjective and objective data. Includes client's diagnosis. What does the information from "S" and "O" mean? Anything in "A" should have been referred to in "S" or "O," and should be resolved in "P."

P (Plan) Includes therapeutic, diagnostic, and treatment plans for future or next session. May include any recommendations the clinician has regarding the care and educational plans for the client and family members. What are you going to do about "A"? Anything in this section should have a reference in one of the preceding sections, except in the case of statements such as "Continue Tx 2x/week."

The student should always sign the Progress notes and leave a space for the clinical educator to sign.

S - Cooperative and attentive. Oriented X2. Episodes of crying during session. Completed home assignments. Continues to be highly motivated to ^ skills. Client's daughter reports an ^ in following instructions.

O - Progressing in all target goals. Ms. Ross has ^ed 1-step commands from 55% to 65%. Client's reliability for simple questions ^ed from 50% to 55%. Client oriented to person and place, continued difficulty with time. With daily oral motor exercises through imitation and use of a mirror, Ms. Ross' oral mobility ^ed to 70%; thus, ^ing intelligibility in connected speech from 50% to 65% accuracy.

A - Moderate Expressive and Receptive Aphasia, Moderate to Severe Dysarthria. Completes all requested therapy tasks. Met with Ms. Ross'

daughter to review target goals, therapy activities and progress. Gesture cues helpful to ^ client's accuracy in completing simple commands. Intelligibility ^s with contextual cues. Needs prompting to ^ oral mobility during verbal productions.

P - Continue speech therapy as ordered. Recommend client's daughter observe next scheduled therapy session to assist with carryover of learned skills and ^ expressive skills at home.

(Always sign name and title - no initials.)

The following example is a progress note for a 4-year old child with severe language impairment:

S - Child separated easily from mother. He was cooperative with consistent verbal reinforcement. Mother reports increased use of three word utterances in the home setting.

O - With barrier game activities, Jack used three word utterances (agent-action-object) with (70%) consistency. Spontaneous speech used in conversational context consisted primarily of one and two word utterances. Questioning (Wh questions) from 20% to 50% in appropriate context was demonstrated (What that, Where go).

A - Severe Receptive and Expressive Language Impairment. Reviewed strategies with Mrs. O'Lantern for expanding Jack's utterances in the home setting. Continued use of modeling during book reading activities was encouraged.

P - Continue language therapy as recommended. Next therapy session is canceled due to Halloween (full moon).