Daily progress note

 Daily Progress Note (SOAP Format)

Patient Name:

Date:

Post-op Day (if applicable):

Service: (e.g., Neurosurgery)

Responsible physician/team:

 S – Subjective Patient report: How the patient feels today, any new complaints (pain, headache, dizziness, nausea, weakness, urinary retention, etc.)

Family concerns: if relevant

Pain control: e.g., “Pain 3/10, well controlled with paracetamol”

 O – Objective Vital signs: T°, HR, BP, RR, $SatO_2$

Neurological exam: (GCS, pupils, motor/sensory status, cranial nerves if needed)

Wound status: clean, dry, intact; signs of infection

Drains / catheters: output, appearance, if planned for removal

Labs/imaging: pertinent results from bloodwork or radiology

Mobility: out of bed, assistance required, PT/OT notes

 A – Assessment Post-op status / diagnosis update: e.g., “POD#2 after L4-L5 decompression. Stable neurologically. No signs of CSF leak or infection.”

Clinical progress: improving, stable, worsening

 P – Plan Medical management: continue antibiotics, adjust pain meds, taper steroids

Follow-up tests: e.g., repeat CT brain tomorrow, labs daily, plan for MRI

Mobilization / rehab: PT/OT daily, ambulation as tolerated

Disposition: monitor on floor, transfer to rehab, discharge planning

Patient/family communication: updated about recovery and expected plan

 Optional Add-ons DVT prophylaxis: on LMWH or SCDs

Nutrition status: tolerating diet, NPO for test, needs nutrition consult

Code status / goals of care: if relevant