Patient Name:

MRN:

Date:

S - SUBJECTIVE

(E.g., Patient's complaints, symptoms, self-reported information)

O - OBJECTIVE

(E.g., Vital signs, physical examination, lab results, observable data)

A - ASSESSMENT

(E.g., Clinical impressions and diagnosis)

P - PLAN

(E.g., Treatment plan, medication, follow-up actions, consults)