GENERAL

soap ems report example

Published: September 3, 2026 | Index ID: #-

Introduction

When emergency medical technicians (EMTs) and paramedics respond to a call, they are expected to document every detail of patient care. This documentation serves as the official record that informs subsequent medical decisions, supports billing, and provides evidence for quality improvement initiatives. In the United States, the most widely accepted format for documenting EMS care is the **SOAP report**, an acronym that stands for Subjective, Objective, Assessment, and Plan. A well crafted SOAP report is not only a clinical necessity but also a legal safeguard that protects providers and ensures continuity of care.

Despite its prevalence, many EMS professionals still find the SOAP format intimidating, especially when they are first learning how to translate a chaotic on scene encounter into a structured narrative. That's why this article will walk you through the fundamentals of a SOAP EMS report, present a clear example, and provide practical tips that will help you write accurate, concise, and compliant reports every time.

What Is a SOAP Report?

The SOAP format originated in the medical school curriculum of the 1960s and has since become the gold standard for clinical documentation across multiple healthcare settings. Each letter of the acronym represents a distinct section of the note:

- S – Subjective: The patient's or witness's description of symptoms, history, and concerns.
- O – Objective: Measurable data such as vital signs, physical exam findings, and diagnostic test results.
- A – Assessment: The clinician's interpretation of the data, including a differential diagnosis or final diagnosis.
- P – Plan: The course of action taken or recommended, including interventions, medications, and disposition.

In EMS, the SOAP report is typically entered into a Computer Aided Dispatch (CAD) system or a mobile electronic health record (EHR) before the patient is transported to a hospital. Because EMS providers often operate under time pressure and in high stress environments, the SOAP format helps keep notes organized and ensures that critical information is not omitted.

Why a SOAP Report Is Critical for EMS

There are several reasons why the SOAP format is indispensable in emergency medical services:

- Standardization: A uniform structure allows receiving physicians to quickly understand the patient's status, regardless of who performed the EMS care.
- Legal Protection: Accurate documentation is a key defense in malpractice claims. A SOAP report that clearly documents assessment and interventions can demonstrate that the provider met the standard of care.
- Billing and Reimbursement: Many payors require SOAP documentation to validate services rendered. Incomplete or ambiguous reports can lead to denied claims.
- Quality Improvement: Aggregated SOAP notes provide data for performance metrics, morbidity and mortality conferences, and system wide process improvements.
- Continuity of Care: A clear SOAP report ensures that hospital staff can quickly assess the patient's condition and continue appropriate treatment without redundant questioning.

Structure of a SOAP EMS Report

A SOAP EMS report typically follows a concise, bullet point style that can be completed in under a minute. Below is a typical layout used in many agencies:

1. Header: Date, time, location, unit, dispatcher ID, patient demographics.
2. Subjective: Chief complaint, relevant history, and any pertinent information from the patient or bystanders.
3. Objective: Vital signs, physical exam findings, diagnostic test results (e.g., ECG, pulse oximetry).
4. Assessment: Final diagnosis or differential, including any changes in condition during transport.
5. Plan: Interventions performed, medications administered, transport destination, and any instructions given to the patient.

Each section should be brief yet complete. Use abbreviations that are widely understood within your agency, but avoid jargon that could confuse the receiving team.

Writing the Subjective Section

The Subjective (S) portion captures the patient's own words and any information gathered from witnesses. When writing this section, keep the following points in mind:

- Use direct quotes when possible: "I've been feeling short of breath for the last two hours."
- Record relevant history: Previous medical conditions, medications, allergies, and recent events (e.g., fall, trauma).
- Include the patient's level of consciousness: Are they alert, confused, or drowsy?
- Document the context: Time of onset, location, and circumstances of the incident.

Example: *Chief complaint: "Severe chest pain radiating to the left arm." History of present illness: Patient reports sudden onset of pain 30 minutes prior while at home. Past medical history: Hypertension, type 2 diabetes. Medications: Lisinopril, Metformin. Allergies: None known.*

Writing the Objective Section

The Objective (O) section focuses on measurable data. Accuracy is paramount; double check vital signs and ensure they are recorded in the correct units.

- Vital signs: Temperature, pulse, blood pressure, respiratory rate, oxygen saturation.
- Physical exam: Inspection, palpation, percussion, auscultation findings.
- Diagnostic tests: ECG findings, capillary glucose, pulse oximetry trends.
- Interventions: Airway status, oxygen administration, IV access, medications given.

Example: *Vitals: BP 140/90 mmHg, HR 110 bpm, RR 22/min, SpO2 96% on 2 L/min O2. ECG: Sinus tachycardia, ST segment depression in leads II, III, aVF. Capillary glucose: 210 mg/dL. Interventions: 2 L/min O2 via nasal cannula, 500 mL normal saline IV, 1 mg morphine IV.*

Writing the Assessment Section

The Assessment (A) is the clinician's interpretation of the data. It should include a concise diagnosis or a differential diagnosis, along with any changes in the patient's status during transport.

- Diagnosis: If you are confident, state the final diagnosis (e.g., acute myocardial infarction).
- Differential: If uncertain, list the top possibilities (e.g., pulmonary embolism, aortic dissection).

- Progress notes: Note any deterioration or improvement (e.g., pain decreased from 10/10 to 6/10).

Example: *Assessment: Acute myocardial infarction (STEMI) based on chest pain, ECG changes, and elevated cardiac enzymes. Patient is stable on transport.*

Writing the Plan Section

The Plan (P) details what was done and what is expected next. It should be actionable and time specific.

- Interventions: Medications, oxygen, fluids, airway management.
- Disposition: Hospital destination and reason (e.g., PCI-capable facility).
- Communication: Any information relayed to the receiving hospital (e.g., “Patient has STEMI, en route to ER with 2 L/min O2 and morphine.”).

Example: *Plan: Continue 2 L/min O2, monitor vitals every 5 minutes. Transport to City Hospital, cardiac care unit. Notify receiving team of STEMI and current vitals.*

Common Mistakes to Avoid

Even experienced EMS providers can fall into documentation pitfalls. Here are some frequent errors and how to prevent them:

- Over documentation: Writing long narratives can obscure critical information. Stick to concise bullet points.
- Under documentation: Failing to record vital signs or interventions can lead to incomplete records.
- Inconsistent abbreviations: Use agency approved shorthand to avoid confusion.
- Missing timestamps: Each entry should include the exact time of assessment or intervention.
- Delayed entry: Waiting until after transport to document can result in lost details. Aim to record in real time or immediately after.

Sample SOAP EMS Report Template

Below is a clean, agency ready template that you can copy into your CAD or EHR system. Feel free to adapt it to your local protocols.

<h3>SOAP EMS Report</h3>
Header: Date: 2026-09-05 | Time: 14:23 | Location: 123 Maple St. | Unit: 12 | Dispatcher: D123 | Patient: 45F
S – Subjective: Chief complaint: “Chest pain radiating to left arm.” HPI: Sudden onset 30 minutes ago, pressure like, 10/10. PMH: HTN, DM2. Meds: Lisinopril, Metformin. Allergies: None.
O – Objective: BP 140/90 mmHg, HR 110 bpm, RR 22/min, SpO2 96% on 2 L/min O2. ECG: Sinus tachycardia, ST depression II, III, aVF. Capillary glucose 210 mg/dL. Interventions: 2 L/min O2, 500 mL NS IV, 1 mg morphine IV.
A – Assessment: Acute myocardial infarction (STEMI). Stable on transport.
P – Plan: Continue 2 L/min O2, monitor vitals q5 min. Transport to City Hospital, cardiac unit. Notify receiving team of STEMI and vitals.

Example Case Study: A Real World SOAP Report

Let’s walk through a complete SOAP report for a patient who suffered a sudden cardiac event. This example demonstrates how each section flows logically and concisely.

Case Overview

A 58 year old male was found collapsed at his apartment. EMS arrived within 4 minutes and performed the following assessment.

SOAP Report

Header: Date: 2026-09-05 | Time: 13:45 | Location: 456 Oak Ave. | Unit: 8 | Dispatcher: D456 | Patient: 58M

S – Subjective:

Chief complaint: “I’ve been feeling dizzy and nauseated.” Patient’s wife reports he was sitting on the sofa when he suddenly fell. No known allergies. PMH: Hypertension, hyperlipidemia. Meds: Amlodipine 10 mg daily.

O – Objective:

Vitals: BP 90/60 mmHg, HR 45 bpm, RR 18/min, SpO2 94% on room air. Patient is unconscious with GCS 8. ECG: Ventricular tachycardia, HR 180 bpm. Interventions

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