# SOAP Case Study - Diabetes Mellitus

Experiment 8 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

## Aim

To prepare a structured assessment and care-plan record for a fictional diabetes mellitus case.

## Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

## Fictional Case and SOAP Guide

| Section | Model teaching content |
|---|---|
| S - history | A fictional adult with type 2 diabetes misses doses and reports thirst and frequent urination. |
| O - supplied findings | Supplied HbA1c 8.2%; renal function, current glucose and medication details require confirmation. |
| A - assessment | The teaching record suggests above-target glycaemic control; symptoms and adherence need timely review. |
| P - professional plan | Confirm the prescribed plan, assess for urgent illness and arrange clinical review of control and relevant complications. |

## Counselling and Monitoring

### Counselling

Explain medicine routine, feasible food/activity changes, foot care and the individual low-glucose plan if relevant.

### Monitoring

Clinician-set glucose/HbA1c goals and renal, eye and foot assessments.

### Urgent Review

Vomiting, dehydration, altered consciousness, severe low-glucose symptoms or acute illness.

## Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

## Practice Scenario

Original fictional case for discussion only.

## Activity Procedure

### 1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

### 2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

### 3. Prioritise

Check emergency/referral needs before routine counselling.

### 4. Plan

State the authorised review, counselling and monitoring steps.

### 5. Write

Complete the blank SOAP record and a concise handover using the model guide.

## Record and Observations

| SOAP field | Student record |
|---|---|
| S - subjective history | _____ |
| O - objective information | _____ |
| A - assessment / priorities | _____ |
| P - actions / review | _____ |
| Monitoring / follow-up | _____ |

## Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

## Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

## Viva Questions and Answers

### 1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

### 2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

### 3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

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