

Family Medicine Clerkship, Parts 1 and 2 – Preceptor Scoring Sheet for Student Focused H&P SOAP Note

Directions for Preceptors: Students are required to write a SOAP Note for each of the two Focused H&P's he/she performs during both parts of the Family Medicine Clerkship. As preceptor, please complete this FM 1 Clerkship – H&P SOAP Note Scoring Sheet form for each observed Focused H&P.

The form is divided into 5 sections: Subjective, Objective, Assessment, Plan, and Overall Performance.

1. Each section has a list of criteria that should be included in the student's SOAP note, **IF** it is pertinent to the patient's chief complaint.
2. Please review the criteria in each category labeled: Unacceptable, Standard, and Superior, then circle the most appropriate rating for each section using the scale of 1 – 9.

Two completed copies of this form are required in order for the student to receive a grade for Part 1 and Part 2 of the clerkship. Please discuss your comments with the student, sign and date the form, and have the student submit the form to their CORE staff no later than the last week of the rotation.

SOAP Note Scoring Sheet

	Unacceptable (below expectations)	Standard (appropriate for training level)	Superior (exceeds expectations)	Comments
Subjective	0	1	2	
<ul style="list-style-type: none"> • Chief Complaint w/ history of present Illness • Past Medical History • Injuries • Medications • Allergies • Surgical History • Hospitalizations 	<ul style="list-style-type: none"> • Omits many key elements of history • Provides irrelevant details • Records incorrect information 	<ul style="list-style-type: none"> • Provides sufficient, important, correct details 	<ul style="list-style-type: none"> • All recorded information is accurate • Lists all key elements (Chief Complaint, History of Present Illness with OPQRST) • Includes pertinent positives and negatives • Reasonably concise 	
Objective	0	1	2	
<ul style="list-style-type: none"> • Physical Exam • Pertinent Lab data 	<ul style="list-style-type: none"> • Omits many key findings • Records incorrect information 	<ul style="list-style-type: none"> • Includes VS and general appearance of patient • Records enough accurate detail to determine assessment and develop plan 	<ul style="list-style-type: none"> • Records comprehensive and detailed data • Clearly lists all pertinent positives and negatives • Includes structural findings 	
Assessment	0	1	2	
<ul style="list-style-type: none"> • Impression • Differential Diagnosis 	<ul style="list-style-type: none"> • Impression or D/Dx is inconsistent with findings 	<ul style="list-style-type: none"> • Records logical impression • Reasonable but superficial differential diagnosis 	<ul style="list-style-type: none"> • Assessment is accurate and complete • Differential diagnosis is accurate and inclusive 	
Plan	0	1	2	
<ul style="list-style-type: none"> • Diagnostic tests • Treatment (incl. OMM) • Referrals • Follow-up plans 	<ul style="list-style-type: none"> • Includes unnecessary, dangerous, inappropriate, overly expensive or contraindicated tests, treatments or referrals 	<ul style="list-style-type: none"> • Plan is reasonable and logically flows from history, exam data and assessment • May lack some details or some key elements 	<ul style="list-style-type: none"> • Further diagnostic work-up (if any) is reasonable and consistent with case data • Efficient therapeutic plan includes lifestyle modification and OMT where applicable 	
Overall Performance	0	1	2	
<ul style="list-style-type: none"> • Overall Synthesis • Organization • Legibility • Accuracy 	<ul style="list-style-type: none"> • Notes are disorganized, illegible • Rationale for assessment and / or plan unclear 	<ul style="list-style-type: none"> • Notes follow logical sequence, legible • Includes adequate detail • May include some inaccuracies 	<ul style="list-style-type: none"> • Organized, legible, accurate. • Comprehensive but concise • Includes patient-centered elements 	

Preceptor Signature _____ Date _____

Student Signature _____ Date _____