Zorginformatiebouwsteen:

nl.zorg.SOAPReport-v1.3

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Nictiz
Betere gezondheid
door betere informatie

Inhoudsopgave

1. nl.zorg.SOAPReport-v1.3

DCM::CoderList	
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	
DCM::CreationDate	25-5-2020
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.13.6
DCM::KeywordList	Notitie, Verslag, SOEP
DCM::LifecycleStatus	Final
DCM::ModelerList	Zib centrum
DCM::Name	nl.zorg.SOEPVerslag
DCM::PublicationDate	15-10-2023
DCM::PublicationStatus	Prepublished
DCM::ReviewerList	
DCM::RevisionDate	05-09-2023
DCM::Supersedes	nl.zorg.SOEPVerslag-v1.2
DCM::Version	1.3
HCIM::PublicationLanguage	EN

1.1 Revision History

Publicatieversie 1.0 (01-09-2020)

Publicatieversie 1.1 (01-12-2021)
Bevat: ZIB-1418, ZIB-1473.

Publicatieversie 1.2 (10-06-2022)
Bevat: ZIB-1474.

Publicatieversie 1.3 (15-10-2023)
Bevat: ZIB-1841, ZIB-1920.

1.2 Concept

A SOAP report is a textual report of (partial) contact of the consultation with regard to one problem according to the SOAP method. SOAP (acronym for subjective, objective, assessment, plan) is a method used by health professionals to structurally record information that comes up during contact between the patient and a health professional in the patient's record.The following standardized format is used for reporting:

- Subjective: the patient's complaint and request for help and the amnesic data.
- Objective: the findings from the physical and supplementary examination.
- Assessment: the working hypothesis and the thinking process, for example a differential diagnosis of the healthcare professional.
- Plan: the diagnostic plan or treatment plan and what has been discussed or agreed with the patient.

1.3 Mindmap

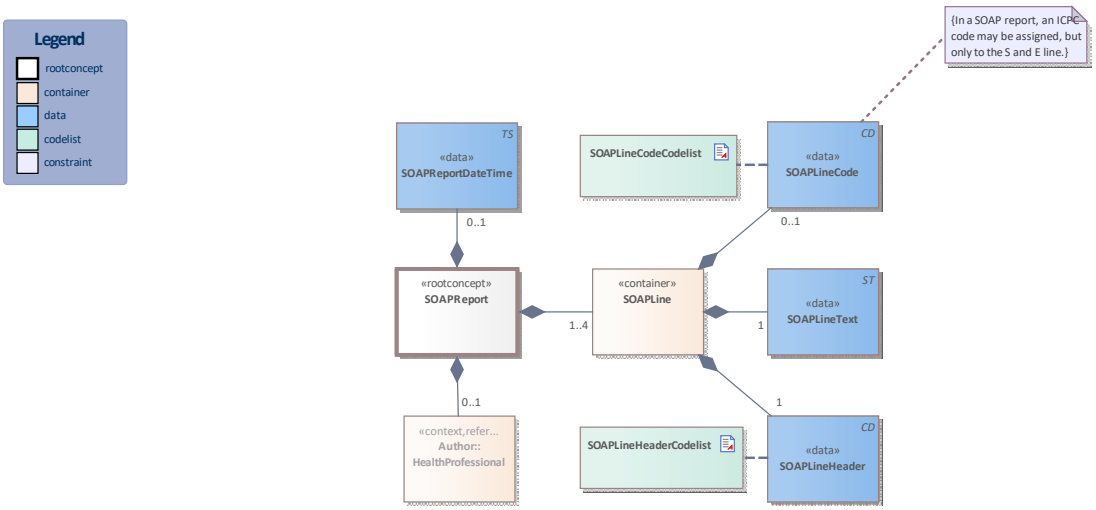
1.4 Purpose

The structure of a SOAP Report offers a care provider the opportunity to record information in a structured manner in free text about one problem and a (partial) contact with a patient. Due to the standardized method of recording SOAP reports over time, it is also possible to follow the patient's condition and its treatment over time.
The SOAP report is mainly used in general practice care.

1.5 Patient Population

1.6 Evidence Base

1.7 Information Model



«rootconcept»	SOAPReport	
Definitie	Root concept of the SOAPReport information model. This root concept contains all data elements of the SOAPReport information model.	
Datatype		
DCM::ConceptId	NL-CM:13.6.1	
Opties		

«data»	SOAPReportDateTime	
Definitie	Date and time when the report was recorded.	
Datatype	TS	
DCM::ConceptId	NL-CM:13.6.2	
Opties		

«context»	Author::HealthProfessional	
Definitie	The healthcare professional who prepared the report and who is responsible for its content.	
Datatype		
DCM::ConceptId	NL-CM:13.6.3	

DCM::ReferencedConceptId	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
Opties		

«container»	SOAPLine	
Definitie	Container of the SOAPLine concept. This container contains all data elements of the SOAPLine concept.	
Datatype		
DCM::ConceptId	NL-CM:13.6.4	
Opties		

«data»	SOAPLineCode	
Definitie	Coded values can be added to a line that describe essential aspects of the line. In a SOAP report an ICPC code may be assigned, but only to the S and A line.	
Datatype	CD	
DCM::ConceptId	NL-CM:13.6.5	
DCM::DefinitionCode	SNOMED CT: 11591000146107 Patient encounter report	
DCM::ValueSet	SOAPLineCodeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.13.6.1
Opties		

«data»	SOAPLineHeader	
Definitie	The name of the SOAP line as a coded description. In a SOAP report this can be one of the following: subjective, objective, assessment or plan.	
Datatype	CD	
DCM::ConceptId	NL-CM:13.6.6	
DCM::ValueSet	SOAPLineHeaderCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.13.6.2
Opties		

«data»	SOAPLineText	
Definitie	The actual content of the section as free formatted text.	
Datatype	ST	
DCM::ConceptId	NL-CM:13.6.7	
DCM::DefinitionCode	SNOMED CT: 422813005 Document section	
Opties		

«document»	SOAPLineCodeCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Required	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.13.6.1	
HCIM::ValueSetLanguage	--	
Opties		

SOEPRegelCodeCodelijst	**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.13.6.1**	
Codes	Coding Syst. Name	Coding System OID
Alle waarden	ICPC-1 NL	2.16.840.1.113883.2.4.4.31.1

«document»	SOAPLineHeaderCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Required	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.13.6.2	
HCIM::ValueSetLanguage	--	
Opties		

SOEPRegelNaamCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.13.6.2	
Concept Name	**Concept Code**	**Coding Syst. Name**	**Coding System OID**	**Description**
Subjective	255362007	SNOMED CT	2.16.840.1.113883.6.96	Subjectief, (S)
Objective	260224007	SNOMED CT	2.16.840.1.113883.6.96	Objectief, (O)
Evaluation	129265001	SNOMED CT	2.16.840.1.113883.6.96	Evaluatie, (E)
Management - action	129271007	SNOMED CT	2.16.840.1.113883.6.96	Plan, (P)

	Legend
Definitie	
Datatype	
Opties	

	Constraint
Definitie	In a SOAP report, an ICPC code may be assigned, but only to the S and E line.
Datatype	
Opties	

1.8 Example Instances

SOEP Verslag	
SOEPVerslagDatumTijd	21-07-2019
Auteur	
Medewerkerscode	01299
AGBCode	01999999
Initialen	H.A
Geslachtsnaam	Janszens
ZorgverlenersRol	Huisarts
SOEPRegel	
SOEPRegelNaam	S
SOEPRegelTekst	Sinds 2 maanden hoesten. Begonnen na start enalapril. Een weekje gestopt, klachten toen weg. Na hervatten klachten weer terug gekomen.
SOEPRegelCode	Hoesten, ICPC code R05
SOEPRegel	
SOEPRegelNaam	O
SOEPRegelTekst	Keelinspectie geen bijzonderheden, pulmonaal vesiculair ademgeruis (VAG)
SOEPRegel	
SOEPRegelNaam	E
SOEPRegelTekst	bijwerking ACE-remmer
SOEPRegelCode	Geneesmiddelbijwerking, ICPC code A85
SOEPRegel	
SOEPRegelNaam	P
SOEPRegelTekst	Overzetten van enalapril naar telmisartan. Evaluatie over 2 weken.

1.9 Instructions

1.10 Interpretation

1.11 Care Process

1.12 Example of the Instrument

1.13 Constraints

1.14 Issues

1.15 References

1.16 Functional Model

1.17 Traceability to other Standards

This health and care information model is based on the information model template ClinicalNote-v1.0.

1.18 Disclaimer

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Nictiz
Postbus 19121
2500 CC Den Haag
Oude Middenweg 55
2491 AC Den Haag

070-3173450
info@nictiz.nl
www.nictiz.nl

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