Health & Care Information Model:

nl.zorg.SOAPReport-v1.3

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1. nl.zorg.SOAPReport-v1.3

DCM::CoderList	
DCM::ContactInformation.Address	*
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DCM::ContentAuthorList	
DCM::CreationDate	25-5-2020
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
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DCM::RevisionDate	05-09-2023
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DCM::Version	1.3
HCIM::PublicationLanguage	EN

1.1 Revision History

Publicatieversie 1.0 (01-09-2020)

Publicatieversie <u>1.1</u> (01-12-2021) Bevat: ZIB-1418, ZIB-1473.

Publicatieversie <u>1.2</u> (10-06-2022)

Bevat: ZIB-1474.

Publicatieversie <u>1.3</u> (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.

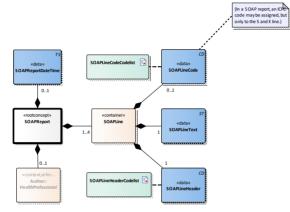
The SOAP report is mainly used in general practice care.

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::ReferencedConc	NL-CM:17.1.1	This is a reference to the rootconcept of
eptId		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		
Onties			

«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::ValueSetLangu	
age	
Opties	

SOEPRegelCodeCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.13.6.1	
Codes Codin		g 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::ValueSetLangu			
age			
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	0		
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

1.17 Traceability to other Standards

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

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