

SOAP Case Study - Depression

Experiment 11 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional depression 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 30-year-old reports low mood, loss of interest and disturbed sleep for several weeks.
O - supplied findings	The instructor provides a completed clinical assessment; current safety, supports and any medicine plan still need review.
A - assessment	Depressive symptoms require professional assessment and a direct, respectful safety check; other causes and bipolar history matter.
P - professional plan	Arrange mental-health review and assess immediate self-harm risk; imminent danger requires emergency help and supportive presence.

Counselling and Monitoring

Counselling

Explain the clinician's psychological/medicine plan, follow-up and reaching trusted support without stigma.

Monitoring

Symptoms, function, safety and any prescribed-treatment adverse effects.

Urgent Review

Immediate self-harm intent, inability to stay safe or other acute mental-health crisis.

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.

Pharmacotherapeutics

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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