

SOAP Case Study - Tuberculosis

Experiment 12 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional tuberculosis 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 has a programme-confirmed TB diagnosis and asks about missed appointments.
O - supplied findings	The supplied case sheet documents treatment under the national TB service; regimen and monitoring are confirmed by the programme team.
A - assessment	Treatment interruption risks poor outcomes; identify barriers, adverse-effect concerns and service access.
P - professional plan	Reconnect the person with the TB team for the authorised treatment and monitoring plan; do not independently change medicines.

Counselling and Monitoring

Counselling

Discuss completing the prescribed programme, ventilation and respectful household advice from the service.

Monitoring

Programme-defined adherence, symptoms, weight and medicine-specific safety checks.

Urgent Review

Severe illness, breathing difficulty or serious suspected treatment toxicity.

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.

Continue Learning with FirstHope

Complete Notes on the FirstHope App

Complete subject and semesters are available on FirstHope app only.

- Get complete subject and semester notes in the FirstHope app.
- Available for B.Pharm, D.Pharm, M.Pharm and Pharm.D students.

[Click here to get the FirstHope app](#)

Join the FirstHope Telegram Channel

Join FirstHope Notes and keep up with channel updates.

[Click here to join Telegram](#)

Instagram

@firsthope.official

[Click here to follow Instagram](#)

YouTube Channel

FirstHope-Pharmacy / Live streams

[Click here to watch the YouTube channel](#)

WhatsApp Channel

Follow FirstHope on WhatsApp.

[Click here to join the WhatsApp channel](#)

FirstHope Website

firsthopenotes.com

[Click here to visit the website](#)