

SOAP Case Study - Viral Infection - Influenza

Experiment 14 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional viral infection - influenza 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 fever, aches and cough for two days; risk factors and breathing symptoms must be assessed.
O - supplied findings	The instructor supplies a clinically assessed uncomplicated influenza case; current hydration and high-risk status are reviewed.
A - assessment	Viral illness does not automatically require an antibiotic; higher-risk or severe illness needs clinical review.
P - professional plan	Discuss suitable supportive measures and clinician assessment of antiviral eligibility where indicated; document safety-net advice.

Counselling and Monitoring

Counselling

Explain hydration, rest, respiratory hygiene and the individual preventive-vaccination review.

Monitoring

Symptoms, hydration, breathing and progression; high-risk patients need earlier review.

Urgent Review

Breathing difficulty, confusion, dehydration or marked deterioration.

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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