

SOAP Case Study - Hyperlipidaemia

Experiment 4 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional hyperlipidaemia 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 48-year-old has missed statin doses and asks whether the drug is necessary without symptoms.
O - supplied findings	Supplied lipid report: LDL cholesterol 165 mg/dL; other risk factors and previous cardiovascular history are incomplete.
A - assessment	Lipid risk cannot be assessed from one value alone; adherence and overall cardiovascular-risk information are needed.
P - professional plan	Review the prescription, interactions and risk context with the clinician; document a feasible adherence plan.

Counselling and Monitoring

Counselling

Explain preventive purpose, food/activity choices and reporting unexplained significant muscle symptoms.

Monitoring

Lipid follow-up and drug-specific safety assessment as prescribed.

Urgent Review

Severe muscle symptoms, dark urine or acute cardiovascular symptoms need prompt assessment.

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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