

SOAP Case Study - Diabetes Mellitus

Experiment 8 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional diabetes mellitus 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 with type 2 diabetes misses doses and reports thirst and frequent urination.
O - supplied findings	Supplied HbA1c 8.2%; renal function, current glucose and medication details require confirmation.
A - assessment	The teaching record suggests above-target glycaemic control; symptoms and adherence need timely review.
P - professional plan	Confirm the prescribed plan, assess for urgent illness and arrange clinical review of control and relevant complications.

Counselling and Monitoring

Counselling

Explain medicine routine, feasible food/activity changes, foot care and the individual low-glucose plan if relevant.

Monitoring

Clinician-set glucose/HbA1c goals and renal, eye and foot assessments.

Urgent Review

Vomiting, dehydration, altered consciousness, severe low-glucose symptoms or acute illness.

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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