

SOAP Note Documentation Activity: Challenging Patient Encounter

Objective:

Students will practice documenting a challenging behavioral health encounter using the SOAP note format (Subjective, Objective, Assessment, Plan).

Case Study:

You are a Behavioral Health Consultant (BHC) working in a primary care clinic. You are asked to meet briefly with a patient, Mr. J., a 45-year-old male with a history of depression and anxiety. During the visit, Mr. J. expresses frustration with his primary care provider (PCP). He states that he feels unheard and disagrees with the PCP's recommendation to restart antidepressant medication. Mr. J. reports: "My doctor doesn't listen to me. I'm not going back on meds—I had side effects before. I'm thinking about switching clinics altogether." He appears visibly irritated, avoids eye contact at times, and speaks in a raised tone when discussing his PCP. He denies suicidal ideation but reports difficulty sleeping and increased stress related to work and family responsibilities.

Student Task:

Using the SOAP format, write a clinical note based on this encounter. Include the following elements:

- Subjective: Patient's reported concerns, statements, and symptoms
- Objective: Behavioral observations and relevant measurable information
- Assessment: Clinical impressions, including level of risk and contributing factors
- Plan: Recommended interventions, follow-up, and coordination of care

Consider the Following:

- How do you document disagreement between the patient and PCP in a neutral, professional manner?
- How do you assess risk given denial of suicidal ideation but presence of stress and sleep disturbance?
- What brief interventions could you provide in this encounter?
- How will you support continuity of care if the patient is considering leaving the clinic?