

SOAP RHS 327 Exam

1- What is the main information that should be in the subjective part?

- Personal data (general data
- Description of problem
- Hx op present illness
- PMHx
- Psycho-social history

2- What are your sources for pt information?

- Pt's Medical File.
- Patient itself.
- Health team.
- Pt's Family

3-What is The Purpose of a Patient's documentation?

- For commutation with other team members.
- Legal Decampment.
- To protect you self
- To continuing evaluation for pt condition
- assist in treatment plan

4- What is the benefit of recording the past level of activity?

- Help us in our plan of treatment & goale .
- To see the maximum result that pts' can get it. (Expectations)

5- What is the Assessment? What is the component of Assessment?

- It is the professional clinical opinion in picture of analysis of your pt condition.
- Analysis Component: Disease – impairment – limitations – brief of treatment - progress
- Problem list : all problems to be treated

6- What is the component for writing a Goal? (3 at least)

- Specific
- Measurable
- Timed
- Realistic / Achievable
- Functional

7- What is the assessment information in discharge note?

- Professional summary of effect of Rx course.

8- In Observation what are the things you should check it?

- Posture
- Deformity
- Equipment

9- What is the Plan for after discharge?

- Recommendations for HEP.
- Outpatient appointment if necessary.

10-What is the total musculoskeletal assessment? (4 at least)

- Pt History
- Observation
- Examination of movement
- Special Tests
- Reflexes and cutaneous distribution
- Joint play movement
- Palpation
- Diagnostic imaging

11- You gave your patient some home instruction and a booklet; should you write it on your SOAP? If yes, what subtitle would you use and under what part of your SOAP you will put it?

- yes, under education (Ex). Which should be written under the plan.

12- What are your three priorities with pt? Why?

- Ambulation
- ROM
- Muscle power

13- Ask your patient full Question profile about pain?

- Onset of complaint
- Provoking or palliative
- Quality of pain
- Radiating
- Site & severity
- Time frame

14- Define the Inert tissue and contractile tissue and give example for ache one.

- Inert tissue (all tissue that is not contractile)
- Contractile tissue (muscles, tendons and their attachments)

15- Why you are take pt history?

- To obtaining information useful in formulating a diagnosis and providing medical care to the patient.