

## **VIRGINIA BOARD OF VETERINARY MEDICINE GUIDANCE DOCUMENT FOR INDIVIDUAL ANIMAL RECORDS**

A lack of quality medical records continues to be a concern to the Board. When cases are presented, the Board takes a position that “if it is not in the record, it did not happen.” Medical records are not only invaluable from the standpoint of providing quality care, but are essential in defending yourself against complaints.

*A medical record should be kept in a problem-oriented (SOAP) format that allows any veterinarian, by reading the record, to proceed with the proper treatment and care of the animal and allow the Board or other agency to determine the advice and treatment recommended and performed by the practitioner.*

The problem oriented veterinary medical record or SOAP format is the most widely used format by our profession. It includes the following elements:

The “S” in SOAP stands for subjective findings or signalment: These are things that are communicated to you in the patient’s history such as name, age, date of visit, including vaccination history along with the current complaint. These are essential in properly identifying the animal in the record and giving you information that may be essential as your examination proceeds. For the most part they are accepted as true, but you must always be aware of false information or inaccurate perceptions.

The “O” or objective part of the record includes everything you observe about the patient. It should include all of your physical exam findings and everything you see, feel, touch, or smell. Examples include, but are not limited to temperature, weight, body condition, assessment of all organs and any data obtained by instrumentation.

Next is the “A” or assessment portion of the record. This is where you assimilate the information gathered above and make your diagnosis or tentative diagnosis for every problem so you can formulate a plan for each and how to proceed

Under “P” or plan, you will document your recommendations to the client and go over your *therapeutic plan* in which you will prescribe medications or make recommendations or a *diagnostic plan* if you need additional tests or information to make a final diagnosis. Communicate to the client your assessment and plan. You must document your recommendations, the client’s decision, and any further treatments, diagnostic tests, or additional recommendations. Each problem must be handled in the same way.

If an animal is hospitalized, an abbreviated version of the SOAP, including an assessment of the patient’s progress and condition should be added to the record daily.

In order to save time and to reduce the amount of writing, the use of preprinted forms, stamps, or stickers is encouraged. In addition, standardized medical abbreviations may be used as well to make your recordkeeping more efficient. Additionally, it is important to date each record entry and identify the person making the entry.

Handwritten records must be legible to be useful. If your practice is using computer records, these same principles apply.

If the veterinarian discovers that the record is incomplete or in error, the veterinarian may amend the record, being sure to date and initial the amendment.

Individual records shall be maintained on each animal, except that records on food, fiber, milk animals, flocks of birds, and herds of horses may be maintained on an individual client basis.