MARVIX AI

SAMPLE PEDIATRICS SOAP NOTE

COMMUNITY-ACQUIRED PNEUMONIA WITH ASTHMA FLARE

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Amara J. Whitfield

DOB
03/19/2020

AGE / SEX
6 yrs / Female

MRN / PATIENT ID
PED-40912

DATE OF SERVICE
08/05/2026

PROVIDER
Nadia Oyelaran, MD

CREDENTIALS
MD, FAAP

PARENT / GUARDIAN PRESENT
Mother — Danielle Whitfield

VISIT TYPE
Sick Visit — same-day, unscheduled (third contact this illness)

CARE SETTING
Outpatient pediatric clinic; seen in urgent care 08/02/2026

INFORMANT / COLLATERAL SOURCE
Mother (primary); urgent care record 08/02; school nurse note 07/31

PRIMARY CARE PROVIDER
This practice — Dr. Oyelaran, continuity since age 2

CC CHIEF COMPLAINT

2 PRIMARY PEDIATRIC CONCERN

"She's been coughing for a week and now she's breathing fast and won't eat. The albuterol used to fix it in a day and it isn't working this time." — mother, reporting day 8 of respiratory illness with a fourth day of fever and escalating rescue inhaler use.

S SUBJECTIVE

3 PATIENT- AND CAREGIVER-REPORTED HISTORY

3a REASON FOR VISIT & HISTORY OF PRESENT ILLNESS

Reason for Pediatric Visit

Acute illness with failure of home asthma rescue therapy, in a child with known persistent asthma. Secondary agenda raised by the mother: the inhaler and spacer supply has run out and the family cannot fill the controller prescription.

History of Present Illness

Illness began 07/28 with clear rhinorrhea and a dry cough after her older brother developed the same symptoms; he attends the same summer program. Cough became wet and paroxysmal by 07/30, worse at night and waking her 3–4 times. Fever began 08/01, maximum 39.4°C axillary, and has recurred daily despite alternating acetaminophen and ibuprofen. Seen in urgent care 08/02 — diagnosed as a viral illness, given one albuterol nebulizer treatment with reported improvement and discharged without imaging or steroids. Over the following 72 hours the cough became productive-sounding, she developed right-sided chest pain with deep breaths, and rescue albuterol frequency rose from twice daily to every 3–4 hours with only partial and short-lived relief. Yesterday she stopped eating solids, and this morning her mother noticed "her ribs pulling in" and that she was too breathless to finish sentences while playing.

3b SYSTEMS-BASED SYMPTOM REVIEW

Fever / Infectious Symptoms

Tmax 39.4°C axillary on 08/03; fever daily for four days, most recently 38.9°C at 06:00 today. Antipyretics reduce the temperature by roughly 1°C for 3–4 hours only. Marked decreased activity — normally an energetic child, she has spent two days on the couch. Sick contact: brother with an identical upper respiratory illness one week earlier, now well. Two other children in her summer program reportedly sent home with fever. No travel, no known COVID-19 or influenza exposure, no rash.

Respiratory Symptoms

Wet paroxysmal cough, post-tussive emesis twice yesterday. Audible wheeze at home. Right-sided pleuritic chest pain, new in 48 hours. Rescue albuterol 2 puffs by spacer every 3–4 hours — escalating and incompletely effective. Controller therapy (fluticasone 44 mcg twice daily) not taken for approximately 5 weeks; the prescription lapsed and the family could not afford the refill. No apnea, no cyanosis, no stridor, no prior ICU admission or intubation.

Gastrointestinal Symptoms

Post-tussive emesis twice, non-bilious and non-bloody. Reduced appetite for 3 days, refusing solids entirely since yesterday. Taking small amounts of juice and water. Last normal stool 08/03; no diarrhea, no abdominal pain apart from cough-related soreness.

Genitourinary Symptoms

Urine output reduced — two voids in the last 12 hours by maternal report, normally 5–6 daily. Urine described as dark. No dysuria, frequency, or urgency. No new enuresis.

Skin Symptoms

Known atopic dermatitis, currently quiescent in the antecubital and popliteal fossae with post-inflammatory hyperpigmentation only. No new rash, no petechiae, no urticaria. Emollient use intermittent.

Pain / Injury Symptoms

Right lower chest pain on deep inspiration and with coughing, rated 4/10 by faces scale. No injury, no headache, no neck pain, no limb pain, no limp.

3c FEEDING, GROWTH, SLEEP & BEHAVIOR

Feeding / Nutrition

Baseline diet limited and carbohydrate-heavy. Confirmed cow's milk protein allergy in infancy, outgrown by age 3 and reintroduced without reaction; no current food allergies. Household reports running short of food in the last week of each month — two of five food insecurity screen items positive today. WIC ended at age 5; the family is not currently enrolled in SNAP.

Growth and Development

Growth has tracked the 35th–40th percentile for weight and 50th for height consistently; today's weight is 0.9 kg below her 06/2026 well-visit weight, consistent with acute illness rather than faltering growth. Milestones met on time. Fluent multi-word conversation; no speech, motor, or social concerns.

Sleep

Baseline 10 hours nightly with no snoring or witnessed apnea. Currently waking 3–4 times nightly with cough; the mother

has been sleeping in her room since 07/31.

Behavior / Mental Health

No attention, mood, or behavioral concerns at baseline. Currently clingy and subdued, consolable in her mother's arms. Screen time increased during illness. No safety concerns disclosed.

School / Daycare Functioning

Entering first grade in three weeks. Missed six days of summer program. Prior school year: nine absences, seven attributed to asthma. No IEP or 504 plan — an asthma action plan was filed with the school in 2025 but has not been updated.

3d BACKGROUND HISTORY

Past Medical History

Persistent asthma diagnosed at age 4 after three wheezing episodes requiring oral steroids; two prednisolone courses in the past 12 months and one emergency department visit 11/2025 (discharged after two nebulizers, not admitted). Atopic dermatitis since infancy. Term vaginal delivery at 39+2 weeks, birth weight 3.2 kg, no NICU stay. No surgeries, no hospitalizations. Immunizations complete through the 4–6 year series; 2025–26 influenza vaccine not given. No drug allergies.

Family History

Mother: asthma and allergic rhinitis. Maternal grandmother: asthma. Father: eczema. Brother (age 9): asthma, well controlled. No cystic fibrosis, immunodeficiency, tuberculosis, seizures, or sudden death.

Social History

Lives with mother, brother, and maternal grandmother in a two-bedroom rented apartment. Maternal grandmother smokes on the balcony; the mother believes there is no indoor smoking but reports the smell of smoke in the hallway. Visible damp patch in the bedroom, reported to the landlord twice without repair. One indoor cat. Mother works split retail shifts; transport is by bus, and she cited the two-bus journey as the reason the 08/02 visit went to urgent care rather than to this clinic.

Pertinent Negatives

No cyanosis, no apnea, no lethargy or altered mental status, no inconsolability, no stiff neck, no seizure, no severe or localized abdominal pain, no persistent bilious vomiting, no rash, no bleeding, no joint swelling, and no reported choking or foreign-body aspiration event.

ROS PEDIATRIC REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Constitutional	**Positive — daily fever 4 days (Tmax 39.4°C), decreased activity, appetite loss, 0.9 kg weight loss**
Respiratory	**Positive — wet cough, wheeze, tachypnea, pleuritic right chest pain, escalating rescue use. Negative for apnea, cyanosis, stridor**
Gastrointestinal	**Positive — post-tussive emesis ×2, reduced oral intake. Negative for diarrhea, abdominal pain, blood in stool**
Genitourinary	**Positive — reduced and concentrated urine output. Negative for dysuria, hematuria, enuresis**
Skin	**Negative for new rash, petechiae, urticaria or swelling. Chronic eczema quiescent**
Neurologic	**Negative for headache, dizziness, seizure, weakness, gait**

	change or developmental regression
Musculoskeletal	**Negative for joint pain, swelling, injury or activity limitation beyond breathlessness**
Sleep / behavior / school	**Positive — nocturnal cough waking 3–4×, subdued behavior, 6 days of summer program missed**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
38.6°C tympanic

BLOOD PRESSURE
96/58 mmHg

HEART RATE
148 bpm — sinus tachycardia

RESPIRATORY RATE
44 / min — elevated for age

OXYGEN SATURATION
91% on room air, 96% on 2 L nasal cannula

HEIGHT
116 cm (50th centile)

WEIGHT
19.4 kg (37th centile; 20.3 kg on 06/12/2026)

BMI
14.4 kg/m²

GROWTH PERCENTILES
Height 50th, weight 37th, BMI 30th — trend preserved

PAIN SCORE
4/10 faces scale, right lower chest on inspiration

5a AGE-APPROPRIATE PHYSICAL EXAMINATION

General Appearance

Alert and oriented to the room but visibly tired and quiet, sitting upright and leaning forward on her mother's lap. Speaking in 3–4 word phrases rather than full sentences. Non-toxic: she tracks, engages, and reaches for a sticker. Mildly dry mucous membranes with a moist tongue; capillary refill 2 seconds. Consolable. Developmentally appropriate throughout.

Head / Eyes / Ears / Nose / Throat

Normocephalic. Conjunctivae clear, pupils equal and reactive, no periorbital swelling. Tympanic membranes pearly and mobile bilaterally with no effusion. Nasal mucosa edematous with scant clear discharge. Oropharynx erythematous without exudate; tonsils 1+ symmetrical. Dentition intact. Lips slightly dry, no perioral cyanosis.

Neck

Full range of motion with no meningism. Small mobile anterior cervical nodes, 1 cm, non-tender. No masses.

Cardiovascular

Tachycardic at 148 with a regular rhythm. No murmur, rub, or gallop. Femoral and radial pulses full and symmetrical. Capillary refill 2 seconds, extremities warm. No edema. No hepatomegaly to suggest cardiac failure.

Pulmonary

Increased work of breathing: subcostal and intercostal retractions, tracheal tug, no nasal flaring or grunting. Respiratory rate 44 with a prolonged expiratory phase. **Focal findings right lower zone** — coarse crackles, bronchial breath sounds, reduced air entry and dullness to percussion at the right base, with increased vocal resonance. Diffuse expiratory wheeze bilaterally, greater on the right. Peak flow not attempted. Unable to complete a full sentence in one breath.

Abdomen

Soft with normal bowel sounds. Mild diffuse tenderness over the lower ribs and upper abdomen attributable to cough-related muscular soreness. No guarding, rebound, organomegaly, mass, or hernia.

Genitourinary

Not examined — no genitourinary complaint. Deferred appropriately.

Musculoskeletal

Moves all limbs freely, full range of motion, no joint swelling or tenderness. Spine straight. Gait normal when she walked to the couch.

Skin

Warm and well perfused. Post-inflammatory hyperpigmentation in both antecubital fossae with no active eczema, excoriation, or infection. No rash, petechiae, or bruising. Skin turgor mildly reduced.

Neurologic

Alert with normal tone and symmetrical strength. Reflexes 2+ and symmetrical. Coordination and gait normal. Cranial nerves grossly intact. No focal deficit; developmentally appropriate.

Psychiatric / Behavioral

Mood subdued and appropriate to illness. Affect reactive. Cooperative with examination after explanation. Age-appropriate interaction with her mother and with the examiner.

DG DEVELOPMENTAL / GROWTH ASSESSMENT

6 DEVELOPMENT & GROWTH

Growth chart review

Weight has tracked the 35th–40th centile since age 3 with no crossing of centiles. Height 50th centile, consistent with mid-parental height. Today's 0.9 kg fall over 8 weeks is acute and illness-related; BMI remains within her own channel.

Gross and fine motor milestones

Age-appropriate. Runs, hops on one foot, climbs. Draws a recognisable person with six parts; uses scissors and a tripod pencil grip.

Speech / language and social-emotional development

Fully intelligible connected speech with complex sentence structure. Reciprocal play with peers reported, cooperative and empathic. No social communication concerns.

Cognitive / school readiness; regression

School-ready for first grade; recognises letters and numbers to 20 and writes her own name. No regression in any domain.

Screening tools and referral need

No developmental screening tool indicated today. **Food insecurity screen positive (2 of 5 items)** — referral generated. No early intervention or therapy referral required.

PC PREVENTIVE CARE / WELL-CHILD ELEMENTS

7 PREVENTIVE PEDIATRIC CARE

Immunization status

Complete through the 4–6 year series (DTaP, IPV, MMR, varicella). **2025–26 influenza vaccine not received.** Deferred today given acute febrile illness; scheduled at the post-discharge review if afebrile. Pneumococcal series complete in infancy.

Vision, hearing, dental

Vision and hearing screened at the 06/2026 well visit and normal. Has a dental home, last seen 04/2026; fluoride varnish current.

Nutrition, activity, sleep, screen time

Nutrition counseling deferred to the follow-up visit given today's acuity, other than hydration instruction. Sleep discussed in the context of nocturnal symptom control.

Safety counseling

Booster seat use confirmed, appropriate for height and weight. Helmet use confirmed for scooter. **Tobacco smoke exposure counseling delivered** to the mother, with grandmother-directed cessation resources offered. No firearms in the home; smoke and CO detectors confirmed working.

Anticipatory guidance

Age-appropriate guidance on school transition, hand hygiene during respiratory season, and asthma self-recognition skills for a six-year-old. Written asthma action plan issued for school.

SC SCREENING / ASSESSMENT TOOLS

8 TOOLS USED & INTERPRETATION

FOOD INSECURITY SCREENING

Positive — 2 of 5 items (both Hunger Vital Sign items positive)

ASTHMA CONTROL ASSESSMENT

Childhood ACT 12/27 at 06/2026 visit; uncontrolled by symptom criteria today

SOCIAL DETERMINANTS OF HEALTH SCREENING

Positive for food insecurity, housing damp, and transportation barrier

DEVELOPMENTAL SCREENING

Not indicated — milestones met, no caregiver concern

LEAD RISK SCREENING

Screened age 2, level 2 µg/dL; pre-1978 housing — repeat considered at follow-up

TUBERCULOSIS RISK SCREENING

Negative risk assessment — no contact, travel, or high-prevalence exposure

VISION / HEARING SCREENING

Normal 06/2026, no repeat indicated

SCORE, INFORMANT, LIMITATIONS

Screens completed with the mother in English; child too unwell for self-report tools. Childhood ACT deferred until the acute illness resolves — scores are not interpretable during an exacerbation.

L LABORATORY AND DIAGNOSTIC RESULTS

9 RESULTS REVIEWED OR ORDERED

Point-of-Care Testing — 08/05/2026

Rapid influenza A and B negative. RSV negative. SARS-CoV-2 antigen negative. Rapid group A streptococcus not performed — no isolated pharyngitis. Capillary glucose 88 mg/dL. Urinalysis: specific gravity 1.028, no nitrites, no

leukocytes, ketones 1+ — consistent with reduced intake rather than urinary infection.

Laboratory Studies — 08/05/2026

White cells 18.6 K/µL with 82% neutrophils and a left shift; hemoglobin 11.8 g/dL; platelets 402. CRP 96 mg/L. Sodium 136, potassium 4.1, urea 18 mg/dL, creatinine 0.42 mg/dL — mild pre-renal picture. Venous gas: pH 7.38, pCO&sub2; 36 mmHg, lactate 1.4 — no hypercapnia or acidosis.

Microbiology

Blood culture drawn before the first antibiotic dose, pending. Nasopharyngeal respiratory panel sent, pending. Sputum not obtainable at this age. No urine culture — urinalysis unsupportive.

Imaging — 08/05/2026

Chest radiograph, single frontal projection: **right lower lobe consolidation with air bronchograms and a small ipsilateral pleural reaction**; no frank effusion requiring drainage, no cavitation, no pneumothorax. Cardiothymic silhouette normal. Compared with the 11/2025 film, which showed only peribronchial thickening, this is new.

Prior Records Reviewed

Urgent care encounter 08/02/2026 — viral diagnosis, single albuterol nebulizer, no imaging, no steroid, no antibiotic, no safety-net advice documented. Emergency record 11/2025. Practice growth chart and immunization record. School nurse note 07/31/2026 documenting two inhaler uses at summer program. Pharmacy dispensing history confirming **no fluticasone dispensed since 06/28/2026** and 4 albuterol canisters in 12 months.

A ASSESSMENT

10 PEDIATRIC CLINICAL INTERPRETATION

- **Community-acquired right lower lobe pneumonia, bacterial, moderate severity, with hypoxemia (SpO&sub2; 91% on air).** Focal consolidation on examination and film, four days of fever, neutrophilia of 18.6 with 82% neutrophils, and CRP 96 make this bacterial rather than viral, and three negative viral point-of-care tests support that. *Streptococcus pneumoniae* remains most likely in a fully immunized six-year-old, with atypical pathogens a secondary consideration at this age.
- **Concurrent acute asthma exacerbation, moderate, in a child with poorly controlled persistent asthma.** Diffuse wheeze, retractions, prolonged expiration, and speech limited to short phrases place this at moderate severity. The two diagnoses are compounding: infection is driving the exacerbation, and airway obstruction is worsening the hypoxemia.
- **The controller gap is the root cause of the exacerbation risk, and it is a financial one.** No inhaled corticosteroid dispensed for five weeks, against four rescue canisters in twelve months, two oral steroid courses, one emergency visit, and seven asthma-related school absences. Treating this episode without fixing the supply problem simply schedules the next admission.
- **Mild dehydration** from reduced intake and post-tussive emesis — ketonuria, specific gravity 1.028, reduced urine output, mildly raised urea with a normal creatinine, and dry mucous membranes. Perfusion is preserved and she is not shocked.
- **Admission is indicated.** Hypoxemia requiring supplemental oxygen, inability to complete sentences, refusal of oral intake, and failure of escalating home therapy each independently justify inpatient care; together they make discharge unsafe. She does not meet criteria for high-dependency care: not hypercapnic, not acidotic, not exhausted, neurologically normal.
- **Modifiable environmental and social contributors:** household tobacco smoke via the grandmother, untreated bedroom damp with a documented landlord failure, an indoor cat in an atopic child, food insecurity on two of five screen items, and a transport barrier that already diverted this family to a lower-continuity setting mid-illness.

- **A missed opportunity at the 08/02 urgent care visit** is worth naming for the record: no imaging, no steroid, no antibiotic, and no documented safety-net advice in a child with known asthma and three days of fever. This is not a criticism of one clinician but the reason a written, shared action plan matters for this family.
- Growth, development, and immunization status are otherwise reassuring, with the single exception of the outstanding influenza vaccine. No red flags for immunodeficiency, aspiration, tuberculosis, or structural lung disease — this is a first radiographically confirmed pneumonia with no recurrent focal or lobar history.

P PLAN

11 PEDIATRIC MANAGEMENT BY PROBLEM

- **Disposition:** direct admission to the pediatric ward today, accepted by the on-call pediatric team at 11:40. Oxygen by nasal cannula titrated to keep SpO&sub2; at or above 94%. Continuous saturation monitoring for the first 12 hours, then intermittent. Mother to stay in.
- **Pneumonia — antimicrobial therapy:** intravenous ampicillin 50 mg/kg (1 g) every 6 hours, first dose given in clinic at 11:15 after blood culture. Step down to oral amoxicillin 90 mg/kg/day divided twice daily on clinical improvement, completing a total 7-day course. Add azithromycin 10 mg/kg on day 1 then 5 mg/kg daily only if she fails to improve by 48 hours or atypical features emerge. No cephalosporin needed — no penicillin allergy, fully immunized.
- **Asthma exacerbation:** albuterol 6 puffs by spacer every 20 minutes for three doses, then every 2–4 hours weaned by response; ipratropium 4 puffs with the first three doses only. **Oral prednisolone 2 mg/kg (40 mg) once daily for 5 days**, first dose given in clinic. Reassess work of breathing and saturations before each bronchodilator dose.
- **Hydration and nutrition:** encourage oral fluids; intravenous maintenance fluids at two-thirds of calculated maintenance with dextrose while intake is poor, reviewed at 12 hours. Monitor input, output, and daily weight. Antipyretics as needed — acetaminophen 15 mg/kg every 6 hours, ibuprofen 10 mg/kg every 8 hours with food, and the alternating regimen explicitly reviewed with the mother to prevent double dosing.
- **Controller therapy and the supply problem — the priority action of this visit:** restart fluticasone 44 mcg two puffs twice daily via spacer, stepped up given the exacerbation history, starting in hospital so adherence begins under supervision. Pharmacy-issued spacer with mask provided today at no cost. Social work and the practice pharmacist to enroll the family in the manufacturer patient assistance program and confirm formulary coverage before discharge. **Discharge is not to occur without a dispensed inhaler in hand.**
- **Inhaler technique and action plan:** technique observed and corrected today — the mother was actuating twice into a single breath. Nurse-led teaching with a return demonstration required before discharge. New written asthma action plan with green, amber, and red zones — one copy home, one for school, one uploaded to the record.
- **Diagnostic follow-through:** blood culture and respiratory panel to be chased at 48 hours. No repeat chest radiograph if she improves — radiographic resolution lags clinical recovery. Repeat film only for failure to improve by 48–72 hours, deterioration, or suspicion of an enlarging effusion. Consider repeat lead level and screening spirometry once well; at age 6 she can perform it.
- **Immunization:** influenza vaccine at the post-discharge visit once afebrile 48 hours, with the mother and brother offered vaccination at the same appointment.
- **Environmental and social plan:** tobacco smoke exposure counseling delivered, and the grandmother to be offered a quit-line referral in her own right. Housing letter drafted to the landlord regarding the bedroom damp, copied to the local housing standards team. Advice to keep the cat out of the bedroom. Food insecurity referral to the hospital food pantry today and a SNAP eligibility appointment arranged through social work.

- **Caregiver education and return precautions:** expected course reviewed — fever should settle within 48–72 hours of antibiotics and cough may persist 2–3 weeks. Explicit red flags given verbally and in writing: increased work of breathing, blue lips, drowsiness or difficulty waking, inability to drink, fewer than three wet voids in a day, rescue inhaler needed more often than every four hours, or return of fever after it settles. Teach-back completed and documented.

F FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose

Inpatient reassessment at each nursing round and by the pediatric team at 12 and 24 hours, with the antibiotic step-down decision and culture review at 48 hours. Practice review **within 48–72 hours of discharge** for clinical reassessment, influenza vaccination, and confirmation that the fluticasone was dispensed. Asthma-focused review at 4 weeks with Childhood ACT rescored, inhaler technique re-observed, spirometry attempted, and the action plan updated for the school year. Social work contact within 1 week to confirm food pantry uptake and the SNAP appointment. Housing follow-up at 4 weeks. **Same-day return or emergency attendance** instructed for increased work of breathing, cyanosis, drowsiness, inability to drink, reduced urine output, or rescue therapy needed more often than every four hours.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT
74 minutes

COUNSELING / CAREGIVER EDUCATION TIME
26 minutes — diagnosis, admission decision, inhaler technique, action plan, red flags

CARE COORDINATION TIME
19 minutes — ward acceptance, social work, pharmacy assistance program, school action plan

RECORDS REVIEW TIME
12 minutes — urgent care note, pharmacy dispensing history, growth chart, school nurse note

PREVENTIVE COUNSELING TIME
8 minutes — tobacco exposure, influenza vaccine, hand hygiene, food insecurity

E/M LEVEL
99215 — high-complexity medical decision making: acute illness posing a threat to bodily function, hospital admission, and two prescription drug management decisions

PREVENTIVE VISIT CODE
Not billed — acute illness visit; preventive elements delivered but not the primary service

IMMUNIZATION ADMINISTRATION CODE(S)
None today — influenza vaccine deferred

SCREENING CODE(S)
Social determinants screen documented; Z59.41 food insecurity

PROCEDURE CODE(S)
94640 ×1 (inhalation treatment in office), 94760 (pulse oximetry, single)

BASIS FOR BILLING
Medical Decision Making — high complexity, with admission; time also documented

PRIMARY ICD-10
J18.1 — Lobar pneumonia, unspecified organism

SECONDARY ICD-10
J45.41 moderate persistent asthma with acute exacerbation; R09.02 hypoxemia; E86.0 dehydration; Z77.22 exposure to environmental tobacco smoke; Z59.41 food insecurity; Z91.120 patient underdosing of medication regimen due to financial hardship

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Nadia Oyelaran, MD	MD, FAAP	Pediatrics	08/05/2026	12:04 PM