Veterinary Documentation Sample Pack

Ninisina Intelligence

Clinical sample outputs for small-animal general practice. Includes SOAP, POMR, and DAP-style examples for GP, technician visits, urgent care/ER, and surgery workflows.

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What this pack is for

This PDF provides paste-ready examples of documentation that Ninisina can draft from ambient audio or clinician dictation/typed inputs. Each sample follows common veterinary charting conventions and is designed to be reviewed by a clinician before finalizing and copying into a practice management system (PIMS).

How Ninisina fits into a clinic workflow

- Capture the visit: ambient audio (optional), quick dictation, or typed bullet notes.
- Generate a draft note: structured SOAP/POMR/DAP output with optional client instructions.
- Clinician review: edit for accuracy and completeness.
- Finalize: copy/paste into Cornerstone, AVImark, or any PIMS.

Supported note styles

SOAP (Subjective, Objective, Assessment, Plan), POMR (problem-oriented medical record), and SOAP-adjacent formats such as HEAP, DAP, and SOP. Section order and phrasing can be aligned to clinic preferences.

Sample Notes

Examples below are intentionally generic and should be customized to match clinic protocols, local regulations, and clinician judgment.

Sample 1: GP Sick Visit (GI upset)

Visit type: Vomiting/diarrhea | Format: SOAP

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S: CC vomiting x 2 days, softer stool. Appetite decreased, still drinking. No
known toxin exposure. On monthly flea/tick; heartworm prevention inconsistent
last 2 months. No prior GI disease.
O: Wt 18.4 kg, BCS 5/9. T 101.6 F, HR 108, RR 28. MM pink, CRT <2s. Mild
dehydration (about 5%). Abdomen mildly tense, no pain on palpation.
A: Acute gastroenteritis with mild dehydration. DDx dietary indiscretion,
parasitism, pancreatitis, foreign body (less likely based on exam),
infectious enteritis.
P: Maropitant administered today; dispense oral antiemetic x 3 days.
Probiotic daily x 7 days. Bland diet 3 to 5 days, small frequent meals;
hydration guidance. Fecal testing recommended; deworming pending results.
Recheck 48 to 72h; ER precautions reviewed.
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Sample 2: Wellness + Vaccines (Doctor)

Visit type: Annual exam | Format: HEAP

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H: No current concerns. Appetite/energy normal. On monthly preventives. No
vomiting/diarrhea.
E: Wt 9.2 kg, BCS 4/9. Vitals WNL. PE normal. Dental: mild tartar.
A: Healthy adult. Mild dental disease (Grade I).
P: Vaccines administered per protocol (Rabies, DHPP). Preventives continued.
Dental home care discussed; estimate for dental prophylaxis if progression.
Next wellness in 12 months.
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Sample 3: Tech Appointment (Nail trim + Anal glands)

Visit type: Technician | Format: DAP

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D: Owner requests nail trim and anal gland expression. No other concerns
reported.
A: Routine tech service. Patient tolerated handling.
P: Nails trimmed. Anal glands expressed (moderate brown fluid, no blood).
Aftercare and return precautions reviewed.
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Sample 4: Urgent Care / ER style (Respiratory distress)

Visit type: Acute dyspnea | Format: SOAP

S: Acute increased respiratory effort this evening. No known trauma. Appetite decreased today.
O: T 102.1 F, HR 160, RR 60 with increased effort. MM pale pink. Oxygen supplementation initiated. Diagnostics pending; pleural effusion possible.
A: Respiratory distress. Suspect pleural space disease vs CHF vs pneumonia; prioritize stabilization.
P: Continue O2, minimize stress. Thoracic imaging/POCUS; consider thoracocentesis if effusion confirmed. Baseline labs as tolerated. Owner communication, estimates, and consent documented.

Sample 5: Surgery (Elective spay/neuter)

Visit type: Routine surgery | Format: POMR

Problem: Elective ovariohysterectomy (or orchiectomy).
Assessment: PE WNL, ASA I. Pre-op screening (if performed) WNL.
Plan: Pre-med per protocol; IV catheter; induction and intubation. Routine procedure completed without complication; EBL minimal. Analgesia per protocol. Discharge: activity restriction, incision monitoring, e-collar, meds, recheck/suture removal date.

Sample 6: GP Dermatology Visit (Pruritus)

Visit type: Itchy skin/ears | Format: SOAP

S: CC pruritus x 3 weeks, worse paws and ventrum. Intermittent head shaking. Missed last month flea preventive. Diet unchanged.
O: Wt 12.0 kg. PE: erythema ventrum, mild alopecia paws, ceruminous otitis bilaterally. Ear cytology: cocci and Malassezia (example).
A: Allergic dermatitis with secondary otitis externa. DDx atopy, flea allergy dermatitis, food allergy; secondary yeast/bacterial overgrowth.
P: Treat otitis per protocol (cleaner + topical). Anti-pruritic therapy per protocol. Reinforce monthly flea control. Recheck 2 to 3 weeks; return precautions reviewed.

Sample 7: Preventive Care (Senior Wellness + Screening)

Visit type: Senior wellness | Format: SOAP

S: Senior wellness. Mild increase in water intake; appetite normal. Activity slightly reduced. No vomiting/diarrhea.
O: Wt 28.6 kg, BCS 6/9. Vitals WNL. PE: mild dental tartar; mild stifle crepitus. Screening labs discussed (CBC/Chem/UA, BP).
A: Senior patient. Possible early osteoarthritis. Rule out metabolic disease given reported PU/PD.
P: Recommend baseline CBC/Chem/UA and blood pressure. Discuss weight management and joint support. Review results with owner and plan next steps.

Sample 8: Technician Vaccine Booster Visit

Visit type: Technician | Format: DAP

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D: Scheduled vaccine boosters. No concerns reported. Appetite/energy normal.
No vomiting/diarrhea/cough.
A: Preventive care vaccination visit.
P: Vaccines administered per clinic protocol. Document product, lot,
expiration, route, and site. Review expected post-vaccine effects and return
precautions (facial swelling, vomiting, hives, collapse). Next due dates
recorded.
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Sample 9: Urgent Care / ER (Toxin ingestion concern)

Visit type: Possible chocolate ingestion | Format: SOAP

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S: Possible chocolate ingestion 2 hours ago; amount uncertain. Mild
restlessness; no vomiting.
O: Vitals: HR mildly elevated; otherwise WNL. PE unremarkable. Risk
assessment performed based on estimated dose and time since ingestion.
A: Potential methylxanthine toxicity (risk level depends on amount ingested).
P: If indicated, decontamination per protocol (emesis and/or activated
charcoal). Monitor HR, neurologic status, GI signs. Provide strict return
precautions. Owner communication, estimates, and consent documented.
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Sample 10: Surgery (Laceration Repair)

Visit type: Traumatic wound | Format: SOAP

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S: Acute laceration lateral hind limb after fence injury. Bleeding controlled
by owner. Patient painful but ambulatory.
O: PE: 6 cm full-thickness laceration, mild contamination. Distal perfusion
intact. Sedation/anesthesia plan discussed.
A: Traumatic laceration requiring debridement and closure. Rule out deeper
tissue injury.
P: Wound clipped, lavaged, debrided; closed in layers. Analgesia and
antibiotics per protocol as indicated. Bandage applied if needed. Discharge:
activity restriction, e-collar, bandage/incision care, recheck 2 to 3 days
(bandage) and 10 to 14 days (suture removal).
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Discharge Instructions + Client Communications

Detailed, paste-ready discharge instructions and client communication drafts corresponding to the 10 sample notes in the Veterinary Documentation Sample Pack. Templates should be reviewed and customized to match clinic protocols and clinician judgment.

Sample 1: GP Sick Visit (GI upset)

Visit type: Vomiting/diarrhea | Format: SOAP

Discharge Instructions (Client Handout)

Today's visit summary: Your pet was seen for vomiting and softer stool. Findings are most consistent with acute gastroenteritis with mild dehydration.

Home care: Feed a bland diet in small, frequent meals for 3–5 days. Avoid table food and rich treats. Offer water frequently; if gulping triggers vomiting, offer smaller amounts more often. Keep activity light for 24–48 hours.

Medications: Give medications exactly as prescribed. If vomiting occurs within 30 minutes of dosing, contact us before repeating a dose.

Follow-up: Expected improvement within 24–48 hours. Recheck in 48–72 hours if not improving. Complete recommended fecal testing/deworming plan if discussed.

Go to urgent care now if: Repeated vomiting continues or worsens; blood in vomit or stool (bright red or black/tarry); marked lethargy/weakness; signs of dehydration (very dry gums, not urinating); abdominal pain/bloating or repeated unproductive retching; inability to keep water down; no improvement by 48–72 hours.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

We saw {PetName} today for vomiting/soft stool. Based on the exam, this is most consistent with acute gastroenteritis with mild dehydration. Please feed the bland diet in small meals and give the prescribed medications as directed. We expect improvement within 24–48 hours.

If {PetName} continues vomiting, has blood in stool/vomit, becomes very lethargic, seems painful, or worsens at any time, please contact us right away or go to urgent care. Otherwise, please update us if symptoms are not improving by 48–72 hours.

– {ClinicName}

Sample 2: Wellness + Vaccines (Doctor)

Visit type: Annual exam | Format: HEAP

Discharge Instructions (Client Handout)

Today's visit summary: Wellness exam findings were within normal limits. Mild dental tartar was noted.

Vaccines: Mild tiredness and localized soreness can occur for up to 24 hours. A small firm lump can occur at the injection site and typically resolves over days to weeks.

Home care: Normal diet and activity are fine. Continue monthly parasite prevention as discussed. Begin/continue dental home care (brushing, dental-approved chews).

When to contact us: Call us promptly for facial swelling, hives, persistent vomiting/diarrhea, or significant lethargy. Seek urgent care for trouble breathing or collapse.

Follow-up: Schedule the next wellness exam in 12 months (or sooner if concerns arise). Contact us if any injection-site lump grows, becomes painful, or persists longer than 3–4 weeks.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} did well today at the wellness visit and received vaccines per plan. Mild sleepiness or soreness can occur today. Please contact us if you notice facial swelling, hives, repeated vomiting/diarrhea, or any breathing difficulty.

We also noted mild tartar, so dental home care is a good next step. We can discuss a dental plan anytime.

– {ClinicName}

Sample 3: Tech Appointment (Nail trim + Anal glands)

Visit type: Technician | Format: DAP

Discharge Instructions (Client Handout)

Services performed: Nail trim and anal gland expression were performed today.

What to expect: Mild irritation or brief scooting can occur after anal gland expression. Most pets return to normal quickly.

Home care: Discourage licking/scooting when possible. You may gently wipe the area if needed. Avoid applying creams unless directed.

When to contact us: Call if there is swelling, significant discomfort, bleeding/discharge, strong worsening odor, or straining to defecate.

Follow-up: If scooting or irritation returns within 2–4 weeks, an exam is recommended to evaluate for inflammation, infection, or allergy-related issues.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} had a technician visit today for nail trim and anal gland expression. Mild irritation can occur briefly. Please contact us if you notice persistent scooting, swelling, pain, blood/discharge, or straining.

If symptoms recur within a few weeks, we recommend a medical exam to check for inflammation or infection.

– {ClinicName}

Sample 4: Urgent Care / ER (Respiratory distress)

Visit type: Acute dyspnea | Format: SOAP

Discharge Instructions (Client Handout)

Today's visit summary: Your pet was evaluated for increased breathing effort. Breathing difficulty can worsen rapidly, so close monitoring is essential.

Home care (if discharged): Keep your pet calm and strictly rested. Avoid excitement and heat. Use a harness instead of a neck collar if possible.

Medications: Give medications exactly as prescribed. Do not add new medications unless directed.

Follow-up: Recheck as directed. Additional diagnostics (imaging/labs) may be recommended to determine the underlying cause.

Go to emergency care now if: Open-mouth breathing; increased effort (belly breathing); blue/gray gums or tongue; collapse or severe weakness; inability to settle due to breathing; any sudden worsening.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

We evaluated {PetName} today for increased breathing effort. Please keep {PetName} calm and rested. If you notice any worsening, open-mouth breathing, blue/gray gums, collapse, or inability to rest comfortably due to breathing, please go to emergency care immediately.

We recommend the follow-up and diagnostics discussed to identify the cause and prevent recurrence.

– {ClinicName}

Sample 5: Surgery (Elective spay/neuter)

Visit type: Elective surgery | Format: POMR

Discharge Instructions (Client Handout)

Procedure performed: Spay/neuter surgery was completed today. Recovery at home is important for safe healing.

Activity restriction: Strict rest for 10–14 days. Leash walks only for bathroom breaks. No running, jumping, rough play, or swimming.

Incision care: Check the incision twice daily. Keep clean and dry. E-collar/cone is required to prevent licking/chewing.

Medications: Give prescribed pain medications and any additional medications as directed. Do not give human medications.

Call or seek urgent care if: Incision redness, swelling, heat, discharge, bleeding, or opening; repeated vomiting; refusal to eat >24 hours; severe lethargy; pale gums; collapse; significant abdominal swelling or pain.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} did well with spay/neuter surgery today. Please keep activity restricted for 10–14 days and keep the cone on to prevent licking. Check the incision twice daily and contact us if you see redness, swelling, discharge, bleeding, or any opening.

Give medications as prescribed. If {PetName} vomits repeatedly, becomes very lethargic, has pale gums, collapses, or seems painful, please contact us immediately or go to urgent care.

– {ClinicName}

Sample 6: GP Dermatology Visit (Pruritus)

Visit type: Itchy skin/ears | Format: SOAP

Discharge Instructions (Client Handout)

Today's visit summary: Your pet was seen for itching (pruritus). The exam findings are consistent with dermatitis, and we discussed common causes such as allergies, parasites, and secondary infection.

Home care: Use the prescribed topical therapies as directed. Avoid new foods/treats unless part of a planned diet trial. Continue parasite prevention consistently.

Medications: Administer prescribed anti-itch medication and/or antibiotics/antifungals exactly as directed. Do not stop early unless instructed.

Skin and ear care: Follow bathing/ear-cleaning instructions if prescribed. Keep ears dry. Monitor for head shaking, odor, redness, or discharge.

Follow-up / recheck: Recheck in 10–14 days (or as directed) to assess response. Contact us sooner if symptoms worsen, lesions spread, or your pet becomes uncomfortable.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

We saw {PetName} today for itching. Based on the exam, this is consistent with dermatitis, and we started treatment to reduce itch and address possible secondary infection. Please give medications and use any topical/ear treatments exactly as prescribed, and keep parasite prevention consistent.

If {PetName} worsens, develops significant redness/oozing, painful ears, or seems very uncomfortable, please contact us. Otherwise, we recommend a recheck in about 10–14 days to confirm improvement and adjust the plan if needed.

– {ClinicName}

Sample 7: Preventive Care (Senior Wellness + Screening)

Visit type: Senior wellness | Format: HEAP

Discharge Instructions (Client Handout)

Today's visit summary: Senior wellness exam performed. Screening recommendations were reviewed (lab work, urinalysis, blood pressure, etc. as appropriate).

Home care: Maintain routine diet, exercise, and medications/supplements as discussed. Monitor appetite, water intake, urination, stool, mobility, and behavior.

Screening tests: If screening labs were collected, we will contact you with results and next steps. If tests were recommended but deferred, scheduling them improves early detection of age-related disease.

When to contact us: Call if you notice increased thirst/urination, decreased appetite, vomiting/diarrhea, weight loss, coughing, exercise intolerance, or changes in mobility/behavior.

Follow-up: Next wellness in 6–12 months for seniors (clinic preference), or sooner based on results and clinical signs.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} had a senior wellness visit today. We reviewed age-related screening recommendations and discussed monitoring at home for changes in appetite, water intake, urination, mobility, and behavior. If labs were collected, we will follow up with results and any recommendations.

Please contact us if you notice increased thirst/urination, weight loss, vomiting/diarrhea, coughing, or any new concerns.

– {ClinicName}

Sample 8: Technician Vaccine Booster Visit

Visit type: Technician | Format: DAP

Discharge Instructions (Client Handout)

Service performed: Vaccine booster(s) administered today per schedule.

What to expect: Mild tiredness or soreness can occur for up to 24 hours. A small lump at the injection site can occur and typically resolves.

Home care: Normal diet and activity are fine. Monitor the injection site for swelling, heat, or pain.

When to contact us: Call for facial swelling, hives, persistent vomiting/diarrhea, marked lethargy, or significant pain at the injection site. Seek urgent care for breathing difficulty or collapse.

Follow-up: Next vaccines due per schedule. Contact us if any injection-site lump grows, becomes painful, or persists beyond 3–4 weeks.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} received vaccine booster(s) today. Mild soreness or sleepiness can occur for the next 24 hours. Please contact us if you notice facial swelling, hives, repeated vomiting/diarrhea, or any breathing difficulty.

If you see a lump at the injection site that grows, becomes painful, or does not improve over the next few weeks, let us know.

– {ClinicName}

Sample 9: Urgent Care / ER (Toxin ingestion concern)

Visit type: Possible toxin exposure | Format: SOAP

Discharge Instructions (Client Handout)

Today's visit summary: Your pet was evaluated for possible toxin ingestion. The level of concern depends on the substance, amount, and time since exposure. We discussed the plan and monitoring needs.

Home monitoring: Observe closely for vomiting/diarrhea, tremors, restlessness, weakness, drooling, abnormal behavior, or seizures. Keep your pet in a quiet, safe area.

Medications / decontamination: If medications were prescribed (anti-nausea, GI protectants, etc.), give exactly as directed. If decontamination was performed, follow aftercare instructions provided.

Diet and hydration: Offer small amounts of water. Feed a small bland meal if advised and if your pet is not vomiting.

Go to emergency care now if: Tremors, seizures, collapse; difficulty breathing; repeated vomiting; blood in stool/vomit; severe lethargy; unsteady walking; persistent drooling; any sudden worsening.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

We evaluated {PetName} today for a possible toxin exposure. Please monitor closely at home for vomiting/diarrhea, tremors, weakness, unsteady walking, abnormal behavior, or seizures. Keep {PetName} calm and in a safe area.

If any concerning signs develop (especially tremors, seizures, collapse, breathing difficulty, or repeated vomiting), please go to emergency care immediately. If you can, bring information about the substance (packaging/ingredients) to help guide treatment.

– {ClinicName}

Sample 10: Surgery (Laceration Repair)

Visit type: Wound/laceration | Format: POMR

Discharge Instructions (Client Handout)

Procedure performed: Wound/laceration repair was performed today. Healing depends on keeping the site protected and clean.

Activity restriction: Keep activity restricted for 10–14 days. Leash walks only. Avoid running/jumping that could stress the repair.

Bandage/incision care: If a bandage is present: keep it clean and dry; do not allow chewing. If the wound is uncovered: keep the area clean and prevent licking. Use an e-collar as directed.

Medications: Give antibiotics and pain medication as prescribed. Finish the full antibiotic course unless instructed otherwise.

Recheck and suture removal: Recheck as scheduled for bandage changes and wound evaluation. Sutures/staples are typically removed in 10–14 days depending on location and healing.

Call or urgent care if: Bandage gets wet/slips/odor develops; swelling, redness, heat, discharge, or bleeding at the wound; sudden pain; lameness; fever/lethargy; wound opens or stitches come out.

Client Communication Draft (Portal / SMS / Email)

Hi {ClientFirstName},

{PetName} had a laceration repair today. Please keep activity restricted and prevent licking/chewing of the site (cone as directed). Keep any bandage clean and dry. Give antibiotics and pain medication exactly as prescribed and finish the antibiotic course.

If the bandage gets wet, slips, develops odor, or if you notice swelling, redness, discharge, bleeding, or the wound opening, please contact us immediately. We will see you for the scheduled recheck/bandage change and suture removal.

– {ClinicName}