Standardized Patient Form

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| ***Role Player****: Asking someone to imagine that they are either themselves or another person in a particular situation. ​Role Players behave exactly as they feel that person would, thus would not need a case developed.*  ***Structured Role Play:*** *A person who has been provided a prepared script on one element of a scenario which articulates a learning objective.​ Improvisation meets structure.​*  ***Embedded Participant​:*** *An individual who is trained or scripted to play a role in a simulation encounter in order to guide the scenario based on the objectives.​*  ***Simulated Patient:*** *A person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician. In performing the simulation, the SP presents the ‘Gestalt’ of the patient being simulated; not just the history, but the body language, the physical findings and the emotional and personality characteristics as well.*  ***Standardized Patient:*** *Individuals who are trained to portray a patient with a specific condition in a realistic, standardized and repeatable way (where portrayal/presentation varies based only on learner performance are trained to behave in a highly repeatable or standardized manner in order to give each learner a fair and equal chance.*  *\*Please consider the lines between the six applications as porous and not as hard lines that prevent movement between applications . Source: Comprehensive Healthcare Simulation; Implementing Best Practices in Standardized Patient Methodology, Chapter 5 The Human Simulation Continuum: Integration and Application.* | |
| **Level of Standardization** | [√] Standardized Patient  [ ] Simulated Patient |
| **Standardized Patient Objectives** | Your challenge as the **Standardized Patient** is multifold:   * To appropriately and accurately reveal the facts about the role being portrayed. * To improvise only when necessary and in a manner that is consistent with the overall tone/content of the case. * Maintain the realism of the simulation i.e., stay in character. * Evaluate learners fairly based on how they performed in this encounter. * Provide patient perspective in feedback. |

**Patient Name: Johnathan "John" Miller**

**Age: 58**

**Gender: Male**

**Chief Complaint: Severe chest pain that started suddenly this morning.**

**Presentation and Resulting Behaviors (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples:**

**Affect: pleasant/cooperative/irritated**

**Speech: verbose/terse/limited**

***Note: include any changes to presentation as case progresses***

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| **Affect: Anxious and distressed**  **Speech: Rapid and slightly strained**  **Body Language: Clutching chest with left hand, appears restless, occasional grimacing**  **Non-verbal Communication: Sweating, fidgeting with clothing, avoids prolonged eye contact**  **Verbal Characteristics: Describes pain in detail, expresses fear and urgency** |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

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| **Opening Statement(s)** | **A**  **I started feeling this awful chest pain suddenly this morning. It was like a tearing sensation that just wouldn't go away.** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **I've been feeling dizzy a couple of times since the pain started.** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **Living Situation: "I live alone in an apartment downtown."**  **Social Support: "I don't have many close friends, mostly colleagues."**  **Recent Stressors: "Work has been really stressful lately with a big project deadline."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Family History: "I have a family history of heart disease, but I wasn't sure if that's relevant."**  **Medication Adherence: "I sometimes forget to take my blood pressure medication."**  **Previous Episodes: "I've had similar chest pains in the past, but I thought it was just heartburn."** |

**Sample Healthcare Interview & Physical Exam Format:**

**History of Present Illness (HPI):**

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| **Quality/Character** | **Sudden onset of severe, tearing chest pain radiating to the back.** |
| **Onset** | **Approximately 2 hours ago, while watching TV at home.** |
| **Duration/Frequency** | **Continuous since onset.** |
| **Location** | **Central chest, radiating to the back between shoulder blades.** |
| **Radiation** | **To the back and slightly to the neck.** |
| **Intensity (e.g. 1-10 scale for pain)** | **9 out of 10.** |
| **Treatment (what has been tried, what were the results)** | **Took over-the-counter pain relievers (ibuprofen) with minimal relief.** |
| **Aggravating** **Factors (what makes it worse)** | **Movement, taking deep breaths.** |
| **Alleviating** **Factors (what makes it better)** | **Staying still, applying pressure to the chest.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **No specific triggers identified; pain started spontaneously.** |
| **Associated** **Symptoms** | **Dizziness, shortness of breath, mild nausea.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Extremely worried about having a heart attack or something more serious; fears for his life and ability to work.** |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

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| Constitutional: Weight stable, no fever.  Skin: No rashes, but appears sweaty.  HEENT: No headaches, no vision changes.  Endocrine: No symptoms of hyper- or hypothyroidism.  Respiratory: Shortness of breath.  Cardiovascular: Chest pain, palpitations.  Gastrointestinal: Mild nausea, no vomiting, no abdominal pain.  Urinary: No dysuria or hematuria.  Reproductive: Not applicable.  Musculoskeletal: No recent injuries, but reports pain in chest muscles.  Neurologic: Episodes of dizziness, no syncope.  Psychiatric/Behavioral: Anxious, fearful. |

**Past Medical History (PMH): (fill in any relevant fields)**

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension (diagnosed 10 years ago), Hyperlipidemia.** |
| **Hospitalizations** | **None in the past 5 years.** |
| **Surgical History** | **Appendectomy at age 25.** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Last colonoscopy 2 years ago, up to date on vaccinations.** |
| **Medications (Prescription, Over the Counter, Herbal/Dietary Supplements)**  **Include: medication name, dosage strength, dosage form, route of administration, frequency of administration, duration of therapy, indication** | **Lisinopril 20 mg daily (for hypertension)**  **Atorvastatin 40 mg nightly (for hyperlipidemia)**  **Occasionally takes ibuprofen for headaches.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medication Allergies:**  **No known drug allergies.**  **Food Allergies:**  **Allergic to peanuts (causes hives).**  **Environmental Allergies:**  **Seasonal allergies (sneezing, itchy eyes).**  **Date of allergy diagnosis:**  **Peanut allergy diagnosed at age 30.** |
| **Gynecologic History** | **Not applicable.** |

**Family Medical History: (fill in any relevant fields)**

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| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | **Father: Deceased at 65 from myocardial infarction.**  **Mother: Alive, age 80, has hypertension and diabetes.**  **Sibling: Younger sister, age 55, healthy.** |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | **Do not add any additional family members. Any other family is alive and well, unsure about paternal grandparents.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Father had hypertension and high cholesterol; mother manages hypertension and diabetes with medications and diet.** |

**Social History: (fill in any relevant fields)**

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| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | **Occasionally uses over-the-counter pain relievers; no recreational drug use.** |
| **Tobacco Use** | **Smokes 1 pack per day for 30 years.** |
| **Alcohol Use** | **Drinks socially, approximately 2-3 drinks per week.** |
| **Home Environment** | **Home type** | **Lives alone in a two-bedroom apartment.** |
| **Home Location** | **Downtown urban area.** |
| **Co-habitants** | **Lives alone.** |
| **Home Healthcare devices (for virtual simulations)** | **Not applicable.** | |
| **Social Supports** | **Family & Friends** | **Limited close relationships; some friends from work.** |
| **Financial** | **Stable employment, no financial stress.** |
| **Health care access and insurance** | **Has health insurance through employer.** |
| **Religious or Community Groups** | **Occasionally attends a local church.** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Business Administration.** |
| **Occupation** | **Office manager at a mid-sized company.** |
| **Health Literacy** | **Moderate; understands basic medical terms but not complex conditions.** |
| **Sexual History:** | **Relationship Status** | **Divorced, no current partner.** |
| **Current sexual partners** | **None.** |
| **Lifetime sexual partners** | **Two previous long-term relationships.** |
| **Safety in relationship** | **Not currently sexually active.** |
| **Sexual orientation** | **Heterosexual.** |
| **Gender identity** | **Pronouns** | **He/Him.** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender male.** |
| **Sex assigned at birth** | **Male.** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Casual dress, prefers comfortable clothing due to chest pain.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys reading, watching sports, and gardening.** |
| **Recent travel** | **Traveled to visit family two months ago.** |
| **Diet** | **Typical day’s meals** | **Eats three meals a day, usually home-cooked, includes red meat and vegetables.** |
| **Recent meals** | **Last ate breakfast 3 hours ago; had eggs and toast.** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **None specifically, but tries to limit salty foods due to hypertension.** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Low-sodium diet as per hypertension management.** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks daily for 30 minutes.** |
| **Recent changes to exercise/activity (and reason for change)** | **Recently walking less due to increased work stress.** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Sleeps 6-7 hours per night, quality fair, recently disrupted by stress.** |
| **Stressors** | **Work** | **High workload with upcoming project deadline.** |
| **Home** | **Lives alone, no significant home-related stress.** |
| **Financial** | **Stable finances, no current stress.** |
| **Other** | **Concern about health and recent chest pain.** |

**Physical Exam Findings: (may also include instructions on simulating/replicating/reporting findings, e.g., physical simulations, verbal prompts, findings cards, moulage, hybrid technology)**

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| General Appearance:  Anxious, clutching chest, appears uncomfortable.  Vital Signs (Learner knows from door info):  Blood Pressure: 160/100 mmHg  Heart Rate: 110 bpm  Respiratory Rate: 24 breaths per minute  Temperature: 98.6°F  Oxygen Saturation: 95% on room air  HEENT:  Pupils equal, reactive to light. No JVD.  Chest/Lungs:  Mild distress with breathing, shallow respirations.  Cardiovascular:  Rapid heart rate, regular rhythm, possible murmurs if palpated.  Abdomen:  Soft, non-tender, no distension.  Extremities:  No edema, pulses may be diminished or unequal if asked.  Neurological:  Alert and oriented, no focal deficits.  Skin:  Diaphoretic, no rashes.  Back:  Reports pain radiating to the back, but no visible signs. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **I’ve never felt anything like this before."**  **"I’m really scared something serious is happening to me."**  **"Please help me; the pain is unbearable."** |
| **Questions the SP will ask if given the opportunity** | **Do you think this could be a heart attack?"**  **"What tests will you run to find out what's wrong?"**  **"How urgent is my situation?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **The SP expects to receive a diagnosis of aortic dissection or another serious cardiac condition.**  **The SP anticipates being informed about the need for immediate imaging studies, possible hospitalization, and urgent treatment.**  **The SP may seek reassurance but understands the severity of the situation.** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **The SP is unaware of any lab results or imaging findings that the learner may have access to during the simulation.**  **The SP does not know specific details about their blood pressure being elevated or any underlying conditions beyond what they have shared.** |