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" Smith**

**Age: 68**

**Gender: Male**

**Chief Complaint: Persistent cough and fever for the past three days**

**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: Slightly anxious and fatigued but cooperative**  **Speech: Clear and moderate in pace, occasionally breathless when coughing**  **Body Language: Frequent coughing fits, uses hand to cover mouth, sits slightly hunched forward to ease breathing**  **Non-Verbal Communication: Shows signs of fatigue (e.g., drooping eyelids, slow movements), appears slightly restless due to discomfort**  **Verbal Characteristics: Provides information succinctly but may require prompting to elaborate on symptoms** |

**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**  **Initial Response to "What brings you in today?":**  **"I've been feeling really unwell for the past few days. I have a persistent cough and a fever that just won't go away."**  **Response to "Can you tell me more?":**  **"Sure. The cough started a few days ago and hasn't improved. I've also been feeling very tired and have had chills and sweats."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **After any open-ended question:**  **"I've also noticed that I'm having trouble breathing, especially when I lie down at night."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **If asked about recent activities or exposures:**  **"I recently attended a family gathering where a few people were sick with what I think was the flu."**  **If asked about smoking history:**  **"I used to smoke a pack a day for 20 years, but I quit five years ago."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **If asked about underlying health conditions:**  **"I have high blood pressure, but I manage it with medication."**  **If asked about medication adherence:**  **"I've been taking my blood pressure pills regularly, except yesterday when I forgot."** |

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

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

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| **Quality/Character** | **Cough is dry and non-productive, sometimes productive with white sputum.** |
| **Onset** | **Symptoms began three days ago.** |
| **Duration/Frequency** | **Cough occurs throughout the day, more frequent in the evenings.** |
| **Location** | **N/A (respiratory symptom)** |
| **Radiation** | **N/A** |
| **Intensity (e.g. 1-10 scale for pain)** | **Fever up to 39°C (102.2°F), cough rated 6/10 in discomfort.** |
| **Treatment (what has been tried, what were the results)** | **Took over-the-counter cough syrup with minimal relief. Started taking ibuprofen for fever.** |
| **Aggravating** **Factors (what makes it worse)** | **Cough worsens at night and with physical activity.** |
| **Alleviating** **Factors (what makes it better)** | **Rest and taking ibuprofen provide slight relief.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Recent exposure to sick individuals at a family gathering** |
| **Associated** **Symptoms** | **Fatigue, chills, sweats, mild shortness of breath, headache** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **John is concerned about his prolonged symptoms and inability to perform daily activities. He fears it might be something serious given his age and past smoking history.** |

**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: Fever, chills, fatigue  Respiratory: Persistent cough, shortness of breath, no hemoptysis  Cardiovascular: Occasional palpitations, no chest pain  Gastrointestinal: No nausea or vomiting, slight loss of appetite  Neurological: Headache, no dizziness or syncope  Musculoskeletal: Mild muscle aches  Psychiatric/Behavioral: Slight anxiety about health |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension**  **Former smoker (20 pack-years, quit 5 years ago)** |
| **Hospitalizations** | **Appendectomy at age 30** |
| **Surgical History** | **Appendectomy** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual flu vaccination**  **Up-to-date with colonoscopy** |
| **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 10 mg orally once daily for hypertension** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **No known drug allergies** |
| **Gynecologic History** | **N/A (Male patient)** |

**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 75 from myocardial infarction**  **Mother: Alive, age 90, with arthritis**  **Sibling: Younger sister, age 65, with type 2 diabetes** |
| **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** | **Sister manages diabetes with metformin 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)** | **No current recreational drug use** |
| **Tobacco Use** | **Former smoker, 20 pack-years, quit 5 years ago** |
| **Alcohol Use** | **Social drinker, 2-3 drinks per week** |
| **Home Environment** | **Home type** | **Single-family home** |
| **Home Location** | **Suburban area** |
| **Co-habitants** | **Lives alone** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Limited; has a few close friends and occasional family visits** |
| **Financial** | **Stable income from pension** |
| **Health care access and insurance** | **Medicare coverage** |
| **Religious or Community Groups** | **Attends church services monthly**  **** |
| **Education and Occupation** | **Level of Education** | **Bachelor's degree in Engineering** |
| **Occupation** | **Retired engineer** |
| **Health Literacy** | **High; understands medical terminology** |
| **Sexual History:** | **Relationship Status** | **Widowed** |
| **Current sexual partners** | **None** |
| **Lifetime sexual partners** | **Multiple in younger years** |
| **Safety in relationship** | **N/A** |
| **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)** | **Conservative attire, no notable indicators** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys reading, gardening, and walking** |
| **Recent travel** | **None in the past year** |
| **Diet** | **Typical day’s meals** | **Balanced diet with vegetables, lean proteins, and whole grains** |
| **Recent meals** | **Regular eating habits, no significant changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **No specific food restrictions** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **None** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks daily for 30 minutes** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced walking due to fatigue** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern, Length, Quality: Sleeps approximately 7 hours per night, but disturbed by coughing**  **Recent Changes: Difficulty sleeping due to increased cough** |
| **Stressors** | **Work** | **Retired, minimal work-related stress** |
| **Home** | **Living alone, slight concern about falling ill** |
| **Financial** | **Stable, no significant financial stress** |
| **Other** | **General health concerns due to current illness** |

**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: Elderly male appearing fatigued, in mild respiratory distress  Vital Signs:  Temperature: 38.5°C (101.3°F)  Blood Pressure: 140/85 mmHg  Heart Rate: 100 bpm  Respiratory Rate: 22 breaths per minute  Oxygen Saturation: 92% on room air  HEENT:  Throat: Slight erythema, no exudates  Lungs: Crackles in the right lower lobe  Cardiovascular:  Regular rhythm, no murmurs  Abdomen:  Soft, non-tender, no hepatosplenomegaly  Extremities:  No edema, pulses intact  Neurological:  Alert and oriented, no focal deficits |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Must Ask:**  **"Can you explain what might be causing my symptoms?"**  **"How serious is my condition?"**  **"What treatments are available?"**  **Must Make:**  **"I've been feeling really weak and can't seem to get my energy back."**  **"I'm worried because I've never had anything like this before."** |
| **Questions the SP will ask if given the opportunity** | **"Do I need to be hospitalized?"**  **"Are there any side effects to the medications you’re prescribing?"**  **"How long will it take to recover?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Community-Acquired Pneumonia**  **Plan: Prescription for antibiotics, recommendations for rest and hydration, possible follow-up appointment**  **Treatment: Antibiotics regimen, over-the-counter medications for symptom relief**  **Reassurance: Understanding of condition and confidence in treatment plan** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Learner Knows:**  **Vitals indicating possible pneumonia**  **Recent lab results showing elevated white blood cells**  **Chest X-ray findings suggestive of pneumonia**  **SP Does Not Know:**  **Specific lab results and imaging findings**  **Detailed medical terminology beyond general understanding** |