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: Laura "Laurie" Bennett**

**Age: 38**

**Gender: Female**

**Chief Complaint: Persistent upper abdominal discomfort and bloating for the past two months**

**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 frustrated**  **Speech: Clear and moderate pace, may become hesitant when discussing discomfort**  **Body Language: Often gestures to her upper abdomen when describing symptoms, maintains a seated posture to alleviate discomfort**  **Non-Verbal Communication: Shows signs of mild distress when mentioning symptoms (e.g., slight grimacing when discussing abdominal pain)**  **Verbal Characteristics: Provides information clearly but may need gentle prompting to discuss lifestyle factors and emotional impact** |

**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 having this persistent discomfort in my upper stomach and feeling really bloated for the last couple of months."**  **Response to "Can you tell me more?":**  **"Sure. The discomfort usually happens after meals, especially when I eat heavy or rich foods. Sometimes I feel overly full, even after eating small amounts, and it makes me uncomfortable throughout the day."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **I've also noticed that I sometimes get nauseous after eating, and it disrupts my daily activities.** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **If asked about dietary habits:**  **"I tend to skip breakfast and have large lunches and dinners because of my work schedule."**  **If asked about over-the-counter treatments:**  **"I've been taking antacids like Tums occasionally, and they help a little, but the relief doesn't last long."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **If asked about weight changes:**  **"I've lost about 8 pounds over the last two months without trying."**  **If asked about previous similar episodes:**  **"I've had occasional stomach discomfort before, but it's never been this frequent or severe."** |

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

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

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| **Quality/Character** | **Persistent upper abdominal discomfort, described as a dull ache and bloating. Occasional nausea without vomiting.** |
| **Onset** | **Symptoms began approximately two months ago, gradually worsening over time.** |
| **Duration/Frequency** | **Discomfort occurs 4-5 times a week, particularly after meals. Bloating is a constant feeling throughout the day.** |
| **Location** | **Upper central abdomen (epigastric region).** |
| **Radiation** | **No radiation to other areas.** |
| **Intensity (e.g. 1-10 scale for pain)** | **Discomfort rated 5/10, bloating rated 6/10.** |
| **Treatment (what has been tried, what were the results)** | **Uses over-the-counter antacids like Tums a few times a week with temporary relief. Has not tried prescription medications.** |
| **Aggravating** **Factors (what makes it worse)** | **Consuming heavy, rich, or fatty foods, skipping meals, stress.** |
| **Alleviating** **Factors (what makes it better)** | **Sitting upright, taking antacids, eating smaller meals.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Irregular eating patterns, high-stress periods at work, consumption of caffeine and alcohol.** |
| **Associated** **Symptoms** | **Nausea, occasional mild headaches, unintentional weight loss, increased fatigue.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Laura is concerned about the impact of her symptoms on her work performance and daily activities. She fears that if left untreated, it might lead to more serious complications like gastroparesis or functional dyspepsia.** |

**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: Unintentional weight loss (8 pounds), mild fatigue.  Gastrointestinal: Persistent upper abdominal discomfort, bloating, occasional nausea, no vomiting.  Respiratory: No shortness of breath, no cough.  Cardiovascular: No chest pain radiating to arms or jaw, no palpitations.  Neurological: No dizziness or syncope.  Musculoskeletal: No significant joint or muscle pain.  Psychiatric/Behavioral: Mild anxiety related to persistent symptoms. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Seasonal allergies**  **No history of asthma or other chronic respiratory conditions** |
| **Hospitalizations** | **None in the past five years** |
| **Surgical History** | **Appendectomy at age 25** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual influenza vaccination**  **Up-to-date with colonoscopy and Pap smears** |
| **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** | **Over-the-counter antacids (Tums) as needed for heartburn**  **Loratadine 10 mg daily for allergies** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **No known drug allergies** |
| **Gynecologic History** | **N/A** |

**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: Alive, age 75, with hypertension**  **Mother: Alive, age 73, 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 members are alive and well.**  **Unsure about paternal grandparents’ health status.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Parents manage their respective conditions with medications and lifestyle changes** |

**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** | **Non-smoker** |
| **Alcohol Use** | **Occasional alcohol consumption, about 2-3 glasses of wine on weekends** |
| **Home Environment** | **Home type** | **Two-bedroom apartment** |
| **Home Location** | **Urban area** |
| **Co-habitants** | **Lives with spouse, no children at home** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Strong support from spouse and close friends** |
| **Financial** | **Stable income from employment as a graphic designer** |
| **Health care access and insurance** | **Employer-provided health insurance** |
| **Religious or Community Groups** | **Active member of a local book club** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Graphic Design** |
| **Occupation** | **Freelance Graphic Designer** |
| **Health Literacy** | **High; understands medical terminology and instructions** |
| **Sexual History:** | **Relationship Status** | **Married** |
| **Current sexual partners** | **Spouse** |
| **Lifetime sexual partners** | **Married once, no significant extramarital relationships** |
| **Safety in relationship** | **No concerns** |
| **Sexual orientation** | **Heterosexual** |
| **Gender identity** | **Pronouns** | **She/Her** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender Female** |
| **Sex assigned at birth** | **Female** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Casual attire, minimal makeup** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys reading, painting, and yoga** |
| **Recent travel** | **Traveled to Europe last summer, no recent travel** |
| **Diet** | **Typical day’s meals** | **Balanced diet with emphasis on vegetables, lean proteins, and whole grains** |
| **Recent meals** | **Regular eating habits, no significant changes** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Avoids spicy and fatty foods due to discomfort** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **None** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Practices yoga three times a week, walks daily** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced walking frequency due to discomfort during walks from symptoms** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern, Length, Quality: Sleeps approximately 7 hours per night, disturbed by discomfort and bloating**  **Recent Changes: Increased difficulty falling asleep and staying asleep due to persistent symptoms** |
| **Stressors** | **Work** | **Managing freelance projects with fluctuating workload** |
| **Home** | **Balancing work and personal life, minor concerns about health impacting productivity** |
| **Financial** | **Stable, no significant financial stress** |
| **Other** | **Managing chronic symptoms and adjusting dietary habits** |

**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: Middle-aged female appearing slightly uncomfortable, sitting upright to alleviate abdominal discomfort  Vital Signs:  Temperature: 36.8°C (98.2°F)  Blood Pressure: 125/80 mmHg  Heart Rate: 78 bpm  Respiratory Rate: 16 breaths per minute  Oxygen Saturation: 98% on room air  HEENT:  Throat: Slight erythema, no exudates  Lungs: Clear to auscultation bilaterally, no wheezing or crackles  Cardiovascular:  Regular rhythm, no murmurs  Abdomen:  Soft, non-tender, mild epigastric bloating without guarding or rebound  Extremities:  No edema, no cyanosis  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:**  **"What exactly is causing my stomach discomfort and bloating?"**  **"How serious is my condition?"**  **"What treatments are available to help me manage my symptoms?"**  **Must Make:**  **"I’m really uncomfortable with this persistent discomfort in my stomach."**  **"I’m worried that this might affect my daily activities and overall health."** |
| **Questions the SP will ask if given the opportunity** | **Are there any long-term complications I should be aware of?"**  **"Can dietary changes alone help manage my symptoms?"**  **"Are there any side effects to the medications you’re prescribing?** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Functional Dyspepsia**  **Plan: Initiation of appropriate pharmacotherapy (e.g., proton pump inhibitors or H2 blockers), recommendations for lifestyle modifications (e.g., dietary changes, stress management, avoiding trigger foods), advice on meal timing and portion control, possible referral to a gastroenterologist for further evaluation if necessary, scheduling follow-up appointments**  **Treatment: Prescription for proton pump inhibitors (e.g., omeprazole), dietary and lifestyle modification guidelines, possible recommendation for over-the-counter antacids as needed**  **Reassurance: Understanding of functional dyspepsia as a manageable chronic condition, strategies to alleviate symptoms, encouragement to adhere to treatment and follow-up plans** |
| **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:**  **Specific diagnostic test results (e.g., endoscopy findings ruling out structural abnormalities)**  **Detailed imaging studies (e.g., abdominal ultrasound results)**  **Comprehensive lab results (e.g., Helicobacter pylori test results if applicable)**  **SP Does Not Know:**  **Exact diagnostic test values and their interpretations**  **Detailed medical terminology beyond general understanding**  **Specifics of imaging results unless the learner explains them** |