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:** John Doe

**Age:** 38 years

**Gender:** Male

**Chief Complaint:** "I've been having this really bad pain in my upper abdomen. It started a couple of days ago and has just gotten worse. It feels like it's deep in my stomach, and it’s been constant, sharp, and kind of radiates to my back. I feel nauseous, too."

**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**: Uncomfortable, occasionally grimacing in pain. A bit anxious, but cooperative.  · **Speech**: Short, terse at times due to pain, but answers questions directly when able.  · **Body Language**: Frequently shifts position, holds abdomen, and occasionally winces with palpation. Leans forward in a slightly hunched posture to alleviate discomfort.  · **Facial Expressions**: Grimacing during painful moments, occasionally tight-lipped. May show signs of distress when asked about pain levels.  · **Tone**: Mildly irritable due to pain, but otherwise cooperative. |

**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)** | "I've been having this really bad pain in my upper abdomen. It started a couple of days ago and has just gotten worse. It feels like it's deep in my stomach, and it’s been constant, sharp, and kind of radiates to my back. I feel nauseous, too." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · **When asked about the pain**: "The pain started after I ate a large meal a couple of days ago. It’s been worse after eating and hasn’t really gone away. It kind of comes in waves."  · **When asked about nausea**: "I’ve been feeling nauseous, and I even vomited twice yesterday. I haven’t really been able to keep food down." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · **When asked about alcohol use**: "I drink occasionally, usually just on weekends, but I did drink a lot more than usual last weekend. Maybe that’s related?"  · **When asked about other medical history**: "I have a history of gallstones, and I’ve had some stomach issues in the past, but nothing like this." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · **Past history of pancreatitis**: "I’ve never been diagnosed with pancreatitis before. I’m not sure if that’s related."  · **Family History**: "My father had some liver issues, but I don’t really know the details. He passed away when I was young." |

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

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

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| **Quality/Character** | Sharp, stabbing pain, deep in the upper abdomen, radiates to the back. |
| **Onset** | Began two days ago, worsening gradually |
| **Duration/Frequency** | Continuous, but with worsening intensity after meals. |
| **Location** | Upper abdomen, center, radiating to the back. |
| **Radiation** | Back pain (between shoulder blades). |
| **Intensity (e.g. 1-10 scale for pain)** | Pain level 8/10, worsens after eating, especially with greasy foods. |
| **Treatment (what has been tried, what were the results)** | Took over-the-counter antacids with minimal relief. Tried sipping water but no improvement. |
| **Aggravating** **Factors (what makes it worse)** | Eating, especially greasy or fatty foods, drinking alcohol. |
| **Alleviating** **Factors (what makes it better)** | Leaning forward or curling into a ball slightly alleviates discomfort. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | Large, greasy meal and increased alcohol intake last weekend |
| **Associated** **Symptoms** | Nausea, vomiting twice yesterday, loss of appetite. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | Concern about not being able to eat and the persistent pain. The patient is worried that it might be something serious. They are also concerned about the possibility of needing hospitalization. |

**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 (low-grade), chills, fatigue.  · **Skin**: No rashes, but occasional jaundice noted by patient (yellowish tint to skin).  · **HEENT**: Dry mouth due to vomiting. No sore throat or nasal symptoms.  · **Endocrine**: No recent changes in thirst or urination.  · **Respiratory**: No shortness of breath, normal breathing, no cough.  · **Cardiovascular**: No chest pain, no palpitations.  · **Gastrointestinal**: Nausea, vomiting, lack of appetite, bloating. No diarrhea or constipation.  · **Urinary**: Normal urination, no blood.  · **Reproductive**: Denies any recent changes or concerns.  · **Musculoskeletal**: No joint pain, no swelling.  · **Neurologic**: No headaches, dizziness, or vision changes.  · **Psychiatric/Behavioral**: Mild anxiety due to health concerns, especially regarding the pain. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | Gallstones (diagnosed a year ago), occasional indigestion. |
| **Hospitalizations** | No significant hospitalizations in the past. |
| **Surgical History** | No surgeries. |
| **Screening/Preventive (including vaccinations /immunizations)** | Routine checkups, up to date on vaccinations, no history of cancer screenings. |
| **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), one tablet 2-3 times a day for indigestion.  · **No prescription medications**. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known allergies to food, drugs, or environmental triggers. |
| **Gynecologic History** | Not relevant, as the patient is male. |

**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**: Liver issues, died at age 50, unsure of the exact cause.  · **Mother**: Healthy, age 70.  · **Siblings**: One brother, 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.)** | · **No additional family members should be mentioned** unless specifically asked about.  · **Paternal grandparents**: The patient is unsure about the health status or cause of death of paternal grandparents.  · **Other family members**: If asked about maternal grandparents or other relatives, simply say, "I don't know, we aren't very close with that side of the family" or "I don’t have any details on them. |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father’s Liver Issues**: The patient is not sure about the specifics but remembers his father having liver problems for several years. There was no clear diagnosis given, and no treatments or medications were mentioned.  · **No other known chronic diseases** in the family (e.g., diabetes, hypertension, or cancer) for any immediate family members. |

**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 recreational drug use. |
| **Tobacco Use** | Non-smoker. |
| **Alcohol Use** | Drinks socially, recent binge drinking (more than usual last weekend). |
| **Home Environment** | **Home type** | Apartment in an urban area |
| **Home Location** | Downtown, near a busy commercial district. |
| **Co-habitants** | Lives alone, no roommates or family members living with him. |
| **Home Healthcare devices (for virtual simulations)** | None. No special medical equipment or home health devices. | |
| **Social Supports** | **Family & Friends** | · The patient has a small circle of close friends, primarily from work.  · He keeps in touch with his mother (age 70) regularly, but they live in different cities, so their contact is mostly via phone.  · No significant family support aside from his mother and brother (who lives in another state). |
| **Financial** | · Financially stable, employed full-time.  · Has savings but does not have significant wealth.  · No major financial stress or difficulties reported |
| **Health care access and insurance** | · The patient has health insurance through his employer.  · He’s had no issues accessing healthcare and has seen a primary care provider annually. |
| **Religious or Community Groups** | · Not very religious, though occasionally attends a local community group for socializing.  · No regular involvement in religious activities or groups. |
| **Education and Occupation** | **Level of Education** | Bachelor’s degree in Marketing |
| **Occupation** | · Marketing Manager at a mid-sized firm.  · Works 40–50 hours a week, with occasional overtime for special projects. |
| **Health Literacy** | The patient has a good understanding of basic medical concepts and conditions but is not highly knowledgeable about more complex medical topics.  He can follow medical instructions but may need clarification for complex diagnoses. |
| **Sexual History:** | **Relationship Status** | Single, not currently in a relationship. |
| **Current sexual partners** | **None** |
| **Lifetime sexual partners** | 3 lifetime partners. |
| **Safety in relationship** | Has always practiced safe sex with previous partners and does not have any concerns about previous relationships. |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | Cisgender male. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | He/Him. |
| **Sex assigned at birth** | **Male** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Traditional male presentation (wears standard men’s clothing, no particular notes on body language or dress that would signal any deviation from typical male gender presentation). |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys playing soccer on weekends with friends.  · Likes reading, especially fiction and self-improvement books.  · Occasionally watches movies or attends local concerts and events. |
| **Recent travel** | No recent travel outside the local area, though he plans to visit family over the holidays. |
| **Diet** | **Typical day’s meals** | · Breakfast: Coffee with a muffin or toast.  · Lunch: A sandwich or salad from a local café.  · Dinner: Home-cooked meal, usually chicken or pasta with vegetables.  · Snacks: Chips or fruit. |
| **Recent meals** | Had a burger and fries for lunch yesterday, dinner was homemade chicken stir-fry. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | * Avoids fried foods, particularly deep-fried items, due to concerns about heart health. * Avoids dairy due to mild lactose intolerance. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | No specific diet. Tries to eat healthily but doesn’t follow any formal plan like keto or vegetarian. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Tries to stay active by walking or biking to work on nice days. |
| **Recent changes to exercise/activity (and reason for change)** | Recently started walking more due to some abdominal discomfort, preferring low-impact activities. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern**:  Typically goes to bed around 11 PM and wakes up at 7 AM.  Tries to get at least 7–8 hours of sleep.  **Length**:  Usually gets around 7–8 hours of sleep, but quality is occasionally disrupted due to stress or discomfort.  **Quality**:  Sleep quality has been fair, but sometimes experiences restlessness and difficulty falling asleep due to abdominal pain or discomfort.  **Recent Changes**:  Sleep quality has decreased recently, likely due to the worsening abdominal pain and nausea. |
| **Stressors** | **Work** | · Currently experiencing some stress at work due to a big project deadline.  · Feels pressure to perform well but generally manages work-related stress well. |
| **Home** | No major stressors at home, but feels some isolation due to living alone. |
| **Financial** | No significant financial stress but does feel a bit anxious about future savings and retiremen |
| **Other** | Concern about his health, particularly after the recent onset of abdominal pain and nausea, though he hasn’t yet sought urgent medical help. |

**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**: Patient appears uncomfortable, shifting in the chair, holding abdomen.  · **Vital Signs**:   * BP: 130/85 mmHg * HR: 95 bpm (tachycardic) * Temp: 99.2°F (low-grade fever) * Respirations: 18/min (normal) * O2 Sat: 98%   · **Abdominal Exam**:   * Tenderness in the upper abdomen, particularly in the epigastric region. * Guarding and rebound tenderness suggestive of peritoneal irritation. * Absent bowel sounds.   · **No jaundice** (or minimal, depending on how the learner probes the abdominal exam).  · **No other significant findings**. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | · "Can you help me figure out what's going on? This pain is really worrying me."  · "Is there anything I can do to make it better?" |
| **Questions the SP will ask if given the opportunity** | · "Could this be related to my alcohol use or gallstones?"  · "Do I need to go to the hospital?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | By the end of this visit, the learner should diagnose **acute pancreatitis**, explain its relationship to gallstones and alcohol consumption, and suggest appropriate tests (e.g., amylase/lipase levels, ultrasound, CT scan). |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | The learner may know the patient's vitals or lab results indicating possible elevated amylase/lipase levels, but the patient does not know this information. |