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: Mary Johnson**

**Age: sixty (60) years old**

**Gender: Female**

**Chief Complaint: I've been having chest pains when I exercise.**

**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: Cooperative but visibly concerned**  **Speech: Clear and steady, with moderate pace**  **Body Language: Slightly guarded posture, occasionally clutching her chest when describing pain**  **Non-Verbal Communication: Avoids prolonged eye contact when discussing symptoms, exhibits signs of discomfort when describing chest pain**  **Verbal Characteristics: Initially provides brief answers, becomes more detailed when discussing pain episodes** |

**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**  **Hi, I'm Mary. I've been having some chest pains lately, especially when I go for a walk."**  **"Lately, I've noticed discomfort in my chest when I'm active."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"The pain sometimes spreads to my left arm and jaw."**  **"I've been feeling more tired than usual these days."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **Lifestyle Factors: "I try to stay active by walking daily, but I've been limiting my activities because of the pain."**  **Dietary Habits: "I watch what I eat to manage my weight, avoiding too much salt and fat."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Family History: "I'd rather not go into my family's medical history unless it's directly related."**  **Personal Habits: "I occasionally drink wine with dinner, but it's not a regular habit."** |

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

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

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| **Quality/Character** | **Tightness and pressure in the chest, sometimes described as squeezing or burning** |
| **Onset** | **Symptoms began approximately four months ago** |
| **Duration/Frequency** | **Chest pain occurs during physical exertion such as walking or climbing stairs, lasting about 5-10 minutes each episode** |
| **Location** | **Central chest area** |
| **Radiation** | **Pain sometimes radiates to the left arm, neck, and jaw** |
| **Intensity (e.g. 1-10 scale for pain)** | **Chest pain rated 6/10 in severity** |
| **Treatment (what has been tried, what were the results)** | **Rest and nitroglycerin tablets provide relief within a few minutes** |
| **Aggravating** **Factors (what makes it worse)** | **Physical activity, emotional stress** |
| **Alleviating** **Factors (what makes it better)** | **Rest, taking nitroglycerin, sitting down** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Walking at a brisk pace, climbing stairs, experiencing stress** |
| **Associated** **Symptoms** | **Occasional shortness of breath, sweating, nausea** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Concerned about heart health and ability to continue daily activities; fears a heart attack, desires to manage symptoms and improve quality of life** |

**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: Positive for fatigue, negative for weight loss or fever  HEENT: Negative for vision changes, sore throat, or headaches  Cardiovascular: Positive for chest pain, palpitations; negative for swelling in legs  Respiratory: Positive for shortness of breath during exertion; negative for chronic cough or wheezing  Gastrointestinal: Negative for abdominal pain or changes in appetite  Neurological: Negative for dizziness or syncope  Psychiatric: Reports anxiety related to chest pain episodes; denies depression  Endocrine: Negative for polyuria or polydipsia  Musculoskeletal: Negative for joint pain or muscle weakness  Skin: Negative for rashes or lesions  Urinary: Negative for dysuria or hematuria |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **None** |
| **Hospitalizations** | **None** |
| **Surgical History** | **Hysterectomy at age 50** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Annual physical exams, mammogram one year ago with normal results** |
| **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** | **Aspirin 81 mg daily for cardiovascular health**  **Atorvastatin 20 mg nightly for cholesterol management**  **Nitroglycerin tablets as needed for chest pain** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medications: Allergic to ibuprofen (causes stomach upset)**  **Food: No known food allergies**  **Environmental: No known environmental allergies**  **Date of Allergy Diagnosis: Adolescent years** |
| **Gynecologic History** | **Menstrual History: Postmenopausal**  **Pregnancy History: Two pregnancies, no complications** |

**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 65, history of hypertension and coronary artery disease**  **Mother: Deceased at 70 due to stroke**  **Siblings: One sister, age 58, 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 introduce additional family members beyond those listed. All other family members are alive and healthy unless specifically asked.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Management/Treatment in Family: Father on antihypertensive and statin medications; sister on insulin therapy** |

**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)** | **Denies illicit drug use** |
| **Tobacco Use** | **Smokes one pack per week** |
| **Alcohol Use** | **Drinks wine with dinner, approximately 3 glasses per week** |
| **Home Environment** | **Home type** | **Owns a single-family home** |
| **Home Location** | **Suburban area** |
| **Co-habitants** | **Lives with husband and one adult child** |
| **Home Healthcare devices (for virtual simulations)** | **None** | |
| **Social Supports** | **Family & Friends** | **Supportive husband and close-knit family** |
| **Financial** | **Comfortable financial situation, no financial stress** |
| **Health care access and insurance** | **Employed with employer-provided health insurance** |
| **Religious or Community Groups** | **Attends church regularly** |
| **Education and Occupation** | **Level of Education** | **Master's degree in Education** |
| **Occupation** | **Elementary school teacher** |
| **Health Literacy** | **High; understands medical terminology and instructions** |
| **Sexual History:** | **Relationship Status** | **Married** |
| **Current sexual partners** | **One spouse** |
| **Lifetime sexual partners** | **Monogamous** |
| **Safety in relationship** | **Practices safe sex** |
| **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)** | **Dresses in professional and comfortable attire, maintains a neat appearance** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys gardening, reading, and baking** |
| **Recent travel** | **Family vacation to the beach six months ago** |
| **Diet** | **Typical day’s meals** | **Breakfast: Oatmeal with fruit**  **Lunch: Salad with grilled chicken**  **Dinner: Baked fish with vegetables** |
| **Recent meals** | **No significant changes in diet** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Limits intake of red meat and high-sodium foods** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Follows a heart-healthy diet, low in sodium and saturated fats** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks for 30 minutes daily**  **Yoga twice a week** |
| **Recent changes to exercise/activity (and reason for change)** | **Increased walking duration recently to improve cardiovascular health** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Sleeps 7-8 hours per night**  **Quality: Generally restful, occasional interruptions due to worry**  **Recent Changes: No significant changes** |
| **Stressors** | **Work** | **Managing a busy classroom with limited resources** |
| **Home** | **Balancing work and family responsibilities** |
| **Financial** | **No current financial stress** |
| **Other** | **Concern about managing heart condition and maintaining an active lifestyle** |

**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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| Vital Signs:  Blood Pressure: 145/90 mmHg  Heart Rate: 78 bpm  Respiratory Rate: 18 breaths per minute  Temperature: 98.4°F (oral)  Height: 5’6”  Weight: 160 lbs  BMI: 25.7 kg/m²  General Appearance:  Appears slightly overweight but in no acute distress  HEENT:  Eyes: No jaundice or pallor  Ears/Nose/Throat: Clear, no abnormalities  Cardiovascular:  Regular rhythm, no murmurs  Possible S4 heart sound due to hypertension  Respiratory:  Clear to auscultation bilaterally  Abdomen:  Soft, non-tender, no hepatosplenomegaly  Neurological:  Alert and oriented, no focal deficits  Musculoskeletal:  No joint swelling or tenderness  Skin:  No rashes or lesions  No signs of cyanosis  Psychiatric:  Appears mildly anxious but cooperative |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **"I've been having some chest pains when I exercise."**  **"The pain sometimes goes down my left arm and jaw."**  **"It really worries me because I'm afraid it might be a heart attack."** |
| **Questions the SP will ask if given the opportunity** | **"Do you think my stress levels could be affecting my chest pain?"**  **"Should I be making more changes to my diet or exercise routine to manage my condition?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Reinforce diagnosis**  **Plan: Evaluation of current treatment regimen, possible adjustment of medications, recommendations for lifestyle modifications**  **Treatment: Consideration of adding beta-blockers or calcium channel blockers, scheduling of stress testing or further cardiac evaluation**  **Reassurance: Understanding of condition management, importance of medication adherence, and lifestyle changes to reduce symptoms and prevent progression** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Symptomatic Vitals: Learner may have access to previous higher blood pressure readings**  **Lab Results: Learner may know about elevated LDL cholesterol levels**  **Imaging: Learner may have information from a recent EKG showing signs of ischemia** |