Standardized Patient Form

|  |  |
| --- | --- |
| ***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:** Alex Johnson

**Age:** 24 years

**Gender:** Male

**Chief Complaint:** Severe abdominal pain, primarily in the lower right quadrant, worsening over the past 12-15 hours.

**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***

|  |
| --- |
| Affect:  * Initially irritated and anxious, escalating to distressed as the scenario progresses.  Speech:  * Initially tersely cooperative, becoming more urgent and frustrated as the pain increases. |

**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.*

|  |  |
| --- | --- |
| **Opening Statement(s)** | I’ve been having severe pain in my stomach, mostly on the right side. It’s been getting worse since yesterday. |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · "I’ve been feeling nauseous and threw up once earlier today."  · "I haven’t eaten much because I feel sick." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · Pain started around the belly button but moved to the lower right side of the abdomen.  · Pain worsens with movement, especially walking or coughing.  · Mild fever (99.8°F) noticed at home, feeling flushed. |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | * No bowel movement in the last 24 hours, but some gas passing. * Sharp, stabbing pain rated as 8/10 in severity. * No significant prior episodes of this type of pain. * No history of similar symptoms in the family. |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | Sharp, stabbing pain, worsened by movement or touch. |
| **Onset** | Began about 12-15 hours ago. |
| **Duration/Frequency** | Continuous, worsening. |
| **Location** | Started near the belly button; moved to the lower right abdomen. |
| **Radiation** | No radiation noted. |
| **Intensity (e.g. 1-10 scale for pain)** | 8/10 on a pain scale. |
| **Treatment (what has been tried, what were the results)** | Took one acetaminophen with no relief. |
| **Aggravating** **Factors (what makes it worse)** | Walking, coughing, or lying on the side. |
| **Alleviating** **Factors (what makes it better)** | Staying still, lying flat on the back. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | No clear triggers; pain started after a normal day. |
| **Associated** **Symptoms** | Nausea, vomiting once, loss of appetite, mild fever. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | I’m worried it’s something serious like my appendix bursting. I’m scared of needing surgery. |

**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)**

|  |
| --- |
| **Constitutional** **Positives**:   * + **Fever**: The patient has experienced **low-grade fever** (101°F) over the past 12-15 hours.   + **Fatigue**: Significant fatigue and general malaise.   + **Chills**: Occasional chills associated with the fever.   **Negatives**:   * + **Weight Loss**: No noticeable weight loss.   + **Night Sweats**: No night sweats reported.  **Skin** **Positives**:   * + **No skin rashes or lesions**.   + **No new bruises or cuts**.   **Negatives**:   * + No itching, redness, or swelling of the skin.   + No history of **skin conditions** like eczema or psoriasis.  **HEENT (Head, Eyes, Ears, Nose, Throat)** **Positives**:   * + **Headache**: Mild headache, which is dull in nature, but not severe.   **Negatives**:   * + **No vision changes**.   + **No ear pain, ringing, or hearing loss**.   + **No nasal congestion, runny nose, or sore throat**.   + **No dizziness or lightheadedness**.  **Endocrine** **Positives**:   * + **No recent changes in temperature sensitivity** (feeling too hot or too cold).   **Negatives**:   * + **No history of thyroid issues**.   + **No unusual sweating** or changes in appetite.   + No known family history of endocrine disorders (e.g., diabetes, hypothyroidism).  **Respiratory** **Positives**:   * + **Mild shortness of breath** on exertion due to the abdominal pain, but no chest tightness or wheezing.   **Negatives**:   * + No **cough**, **wheezing**, or **difficulty breathing**.   + **No history of asthma** or **chronic respiratory issues**.  **Cardiovascular** **Positives**:   * + **No chest pain**, palpitations, or irregular heartbeats.   + **Mild dizziness** when standing up, but no syncope.   **Negatives**:   * + No history of **heart disease**, **hypertension**, or **heart murmurs**.   + No edema in the lower extremities or swelling.  **Gastrointestinal** **Positives**:   * + **Abdominal pain**: Worsening pain, mainly in the **lower right quadrant**, sharp and cramp-like, started 12-15 hours ago. Pain has progressively intensified.   + **Nausea**: Ongoing, with no vomiting.   + **Loss of appetite**: Hasn’t been eating much in the past 24 hours due to nausea and abdominal discomfort.   + **Bowel movements**: No diarrhea or constipation; **normal bowel movements** yesterday morning before the pain began.   + **Flatulence**: Some mild bloating, but no excessive gas or changes in stool appearance.   **Negatives**:   * + No **bloody stools** or **dark, tarry stools**.   + No **heartburn**, **indigestion**, or **dysphagia**.  **Urinary** **Positives**:   * + **Normal urination**: No difficulty or urgency when urinating.   + **No blood in urine**.   **Negatives**:   * + No **painful urination** (dysuria), **increased frequency**, or **incontinence**.  **Reproductive** **Positives**:   * + No sexual issues or concerns at this time.   **Negatives**:   * + No **pain during intercourse** or **genital lesions**.   + No recent **urinary tract infections** (UTIs) or sexually transmitted infections (STIs).  **Musculoskeletal** **Positives**:   * + **Mild muscle soreness** due to reduced activity and lack of movement in response to abdominal pain.   **Negatives**:   * + No joint pain, swelling, or stiffness.   + No history of musculoskeletal conditions such as arthritis or fractures.  **Neurologic** **Positives**:   * + **Mild headache** (dull and intermittent), with no focal neurological deficits.   + **No weakness or numbness** in arms or legs.   **Negatives**:   * + No **seizures**, **syncope**, or **tremors**.   + No **changes in coordination** or **balance**.  **Psychiatric/Behavioral** **Positives**:   * + Some **stress** related to health issues and work deadlines.   + **Anxiety** regarding potential diagnosis and whether surgery will be needed.   **Negatives**:   * + No history of **depression**, **mood swings**, or **other psychiatric disorders**.   + No feelings of **hopelessness**, **worthlessness**, or **self-harm thoughts**. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | No chronic illnesses, no known injuries. |
| **Hospitalizations** | None prior. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Up-to-date on vaccinations, no regular screenings due to age (24). |
| **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** | Occasionally takes acetaminophen for headaches, no regular medications. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known allergies. |
| **Gynecologic History** | **/** |

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

|  |  |
| --- | --- |
| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | · **Mother (45)**: Hypertension, otherwise healthy.  · **Father (48)**: Healthy, no chronic conditions.  · **Siblings (Younger 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.)** | · **Family Members**: Do not add any additional family members beyond those already listed (Mother, Father, Younger Brother). All other family members are either alive and well or not mentioned.  · **Paternal Grandparents**: Uncertain about the health status or details regarding paternal grandparents.  · **Family Conditions**: No known chronic or hereditary conditions in the family (such as cancer, heart disease, diabetes, etc.). |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Mother**: Managed hypertension with lifestyle changes, including diet and exercise, no current medication for hypertension.  · **Father**: No chronic conditions or treatments.  · **Younger Brother**: Healthy, no known medical issues or treatments. |

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

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | Denies any recreational or medicinal drug use. |
| **Tobacco Use** | Never smoked. |
| **Alcohol Use** | Occasional social drinker, last drink a week ago. |
| **Home Environment** | **Home type** | Lives in a small apartment with two roommates, no pets. |
| **Home Location** | A small apartment |
| **Co-habitants** | Two roommates, no pets. |
| **Home Healthcare devices (for virtual simulations)** | Thermometer | |
| **Social Supports** | **Family & Friends** | Family: The patient has supportive family members, including a mother and father, both of whom live in the same city but are not involved in daily care. They are generally supportive but not directly involved in the patient's current situation.  Friends: Lives with two roommates who are helping with transportation and providing basic support (e.g., offering fluids, ensuring the patient gets medical attention). The patient has a few close friends, though they are not immediately available for direct assistance. |
| **Financial** | The patient is employed full-time as a graphic designer with a stable income. However, they are cautious about medical bills due to potential out-of-pocket expenses and are worried about needing surgery. The patient has some savings, but financial worries may cause added stress. |
| **Health care access and insurance** | The patient has health insurance through their employer, though they are unsure of the exact coverage details for emergency procedures or hospital stays. They are concerned about co-pays and out-of-pocket expenses, particularly related to surgery. |
| **Religious or Community Groups** | Religious: The patient is not very religious but is somewhat spiritual, relying on personal beliefs for emotional comfort during stressful times.  Community Groups: The patient does not participate in any formal community or religious groups but has a network of close friends and coworkers for support. They occasionally attend social events but don't rely on any formal support structures. |
| **Education and Occupation** | **Level of Education** | College graduate |
| **Occupation** | Graphic designer. |
| **Health Literacy** | I can understand most medical information if it’s explained |
| **Sexual History:** | **Relationship Status** | The patient is in a **monogamous relationship** with a fe**male partner** for the past year. The relationship is generally supportive and stable. |
| **Current sexual partners** | The patient has **one sexual partner** at the moment. |
| **Lifetime sexual partners** | The patient has had **2-3 lifetime sexual partners**. |
| **Safety in relationship** | The patient reports **feeling safe** in the relationship. No history of abuse or unsafe sexual practices. |
| **Sexual orientation** | The patient identifies as **heterosexual**. |
| **Gender identity** | **Pronouns** | The patient identifies as **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)** | The patient presents with a **masculine gender expression**, typically wearing casual clothing such as jeans and a T-shirt. There are no notes about gender nonconformity or presentation issues. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · The patient enjoys **video gaming**, **watching movies**, and **going to local art galleries**. They also enjoy **playing casual sports** like basketball with friends.  · They recently started taking **photography** as a hobby. |
| **Recent travel** | No recent travel. The patient has not traveled outside the country in the last year. |
| **Diet** | **Typical day’s meals** | · Breakfast: Usually **coffee and toast** or sometimes a **smoothie**.  · Lunch: Often a **salad with chicken** or a **sandwich** with some fruit.  · Dinner: Prefers **quick meals**, like pasta with vegetables or a **stir-fry**. Occasionally orders takeout, especially pizza. |
| **Recent meals** | · Recent meals have included **a salad** with grilled chicken for lunch and **spaghetti** for dinner.  · The patient skipped meals today due to nausea but drank some **water and tea**. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | The patient tries to avoid **fried foods** and **excessive sweets**. They are not allergic to any foods but prefer to eat **healthier** when possible. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | No special dietary restrictions or preferences. Occasionally follows a **low-carb** diet for a few days when feeling motivated but doesn't stick to it consistently. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · The patient exercises **twice a week** with a **light gym routine** (mainly cardio and light weights).  · They also participate in **weekend basketball games** with friends. |
| **Recent changes to exercise/activity (and reason for change)** | The patient has not made significant changes to their activity levels recently but is planning to **increase gym visits** once this abdominal pain resolves. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · The patient usually sleeps **7-8 hours** a night.  · They typically go to bed around **midnight** and wake up around **8 AM**.  · Recently, they have had **trouble falling asleep** due to the abdominal pain and discomfort, but this is a temporary change. |
| **Stressors** | **Work** | The patient has a **moderate level of stress** at work, as they are currently working on a big project for a client, which involves tight deadlines |
| **Home** | The patient feels **generally calm** at home, but their roommates’ occasional noise and their own current health issues are causing some additional stress. |
| **Financial** | The patient is somewhat stressed about the **financial cost** of healthcare if surgery is needed. They are unsure how much they would need to pay out-of-pocket, even with insurance. |
| **Other** | The patient is **concerned** about their current illness potentially leading to surgery, which is causing some underlying anxiety. |

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

|  |
| --- |
| * Guarding and tenderness in the right lower quadrant upon palpation. * Rebound tenderness in the same area. * No obvious external swelling or discoloration. * Reports increased pain with leg extension. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | "Is this something serious? Should I be in the hospital?" |
| **Questions the SP will ask if given the opportunity** | "What could be causing this pain?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Learners should recognize acute appendicitis based on history and physical exam.  · Learners may order blood work, imaging (ultrasound or CT scan), and consult for possible surgical intervention.  · Learners should provide clear reassurance and a plan of action to address patient anxiety. |
| **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 (e.g., mild tachycardia, fever), potentially lab findings if prepopulated. |