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:** Jane Doe

· **Age:** 42

· **Gender:** Female

· **Chief Complaint:** "I've been having severe pain in my upper abdomen, especially after eating."

**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:** Anxious, slightly distressed due to pain, but cooperative.  · **Speech:** Clear, slightly strained due to discomfort, gives brief but complete responses.  · **Body Language:** Tense, holding her abdomen, may lean forward or wince occasionally as pain increases.  · **Non-Verbal Communication:** Fidgeting or shifting position in the seat due to discomfort.  · **Verbal Characteristics:** May occasionally pause to take a deep breath if pain increases. Her tone is mildly irritated or frustrated but respectful.  · **Changes in Presentation:** As the case progresses, the pain may intensify, and the patient may become more vocal in expressing discomfort. |

**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)** | · **SP Script:** "Hi, I’ve been having a lot of pain in my upper abdomen for the past few days. It gets worse after I eat, especially greasy or fatty foods. I’ve also been feeling nauseous, but I haven’t actually vomited yet."  · **First Response to ‘What brings you in today?’** "I’ve been having this really sharp pain right here (point to right upper abdomen) for about 3 days now. It’s been really hurting, and it seems to get worse after I eat, especially fatty or fried foods. I feel nauseous, but haven’t thrown up yet." |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · **SP Script:** "The pain started suddenly, and it’s been pretty constant. It’s worse when I lie down, but it’s not really helping when I try to sit up or walk around."  · **SP Script:** "I’ve had indigestion a few times before, but nothing like this. I have also felt a little feverish, but I didn’t check my temperature." |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · **SP Script:** "I don’t have any history of gallbladder problems, but I have been eating a lot of fried foods lately because I’ve been really busy at work."  · **SP Script:** "I’ve been under a lot of stress lately, working long hours, so I’ve been eating out a lot. But this pain is really different from anything I’ve felt before." |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **SP Script (withheld until directly asked):** "I’ve had a few bouts of mild heartburn in the past, but nothing that caused me to seek medical care. I also have a family history of gallstones (mother had gallstones, but she never had surgery)." |

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

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

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| **Quality/Character** | Sharp, stabbing pain in the upper right abdomen. |
| **Onset** | Pain started suddenly 3 days ago. |
| **Duration/Frequency** | Constant pain, increasing after eating. Pain has been present every day for the past 3 days. |
| **Location** | Right upper abdomen (subcostal area). |
| **Radiation** | Occasionally radiates to the back and between the shoulder blades. |
| **Intensity (e.g. 1-10 scale for pain)** | 8/10 on the pain scale during an episode, worsens with movement and eating. |
| **Treatment (what has been tried, what were the results)** | No treatment yet, over-the-counter antacids have not helped. |
| **Aggravating** **Factors (what makes it worse)** | Eating greasy or fatty foods, lying down, bending over. |
| **Alleviating** **Factors (what makes it better)** | Slight relief when sitting upright. |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | No clear triggers besides eating fatty foods. |
| **Associated** **Symptoms** | Nausea, low-grade fever (unconfirmed), bloating, loss of appetite. |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | The patient is worried about the severity of the pain and is concerned it might be something serious like an infection or gallstones. |

**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:** Low-grade fever (unconfirmed), fatigue, weight loss (unintentional). * **Skin:** No rashes, no jaundice. * **HEENT:** No headaches, no vision changes. * **Endocrine:** No recent changes in appetite, no increased thirst. * **Respiratory:** No shortness of breath, no cough. * **Cardiovascular:** No chest pain, no palpitations. * **Gastrointestinal:** Abdominal pain, nausea, no vomiting yet, bloating, loss of appetite. * **Urinary:** No dysuria, no hematuria. * **Reproductive:** No gynecological symptoms, no abnormal discharge, regular menstruation. * **Musculoskeletal:** No joint pain or swelling. * **Neurologic:** No dizziness, no weakness, no numbness. * **Psychiatric/Behavioral:** Increased stress due to work, no history of depression or anxiety. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | No chronic illnesses, no previous history of gastrointestinal problems. |
| **Hospitalizations** | None. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Regular screenings, including mammograms and pap smears, all up to date. |
| **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** | No regular medications, occasional ibuprofen for headaches. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known drug allergies. |
| **Gynecologic History** | · **Menstrual History:**   * · **Age of menarche (first period):** 12 years old * **Menstrual cycle:** Regular cycles every 28-30 days * **Duration of menstruation:** 4-5 days * **Menstrual flow:** Normal to light, no heavy bleeding or clotting * **Pain with menstruation (dysmenorrhea):** Mild cramping, managed with over-the-counter ibuprofen * **Last menstrual period (LMP):** 2 weeks ago * **Menopause status:** Not menopausal, still having regular periods   · **Obstetric History:**   * · **Gravida (G):** 1 (1 pregnancy) * **Para (P):** 1 (1 live birth) * **Type of delivery:** Vaginal delivery * **Complications during pregnancy:** No complications, full-term pregnancy * **Current contraceptive use:** None, does not use birth control regularly * **History of abortions/miscarriages:** No miscarriages, no elective abortions   · **Gynecologic Procedures/Surgeries:**   * · **Pap smear:** Last pap smear was 1 year ago, results normal * **Pelvic exams:** Last pelvic exam was also 1 year ago, no abnormalities found * **History of gynecologic surgeries:** None   · **Sexual History:**   * · **Relationship status:** In a long-term, monogamous relationship with a male partner for 3 years. * **Current sexual activity:** Yes, sexually active * **Lifetime sexual partners:** 3 sexual partners, all male * **Sexual orientation:** Heterosexual * **History of sexually transmitted infections (STIs):** No history of STIs * **Use of contraception:** Occasionally uses condoms; no regular use of hormonal birth control * **Sexual dysfunction:** No reported issues with sexual health or function   · **Other Relevant Information:**   * · No history of pelvic inflammatory disease (PID), ovarian cysts, or fibroids. * No family history of gynecologic cancers (e.g., cervical, ovarian, uterine). * **Pap smear:** Regular screenings with no abnormalities reported. |

**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** | **Mother:**   * + **Age:** 65   + **Health Status:** Alive, in generally good health. No significant chronic illnesses.   + **Relevant Conditions:** Gallstones (diagnosed in her late 50s), did not require surgery.   + **Cause of Death:** N/A (alive and well).   **Father:**   * + **Age:** 68   + **Health Status:** Alive   + **Relevant Conditions:** Hypertension, Type 2 Diabetes, managed with medication (metformin for diabetes, ACE inhibitors for hypertension).   + **Cause of Death:** N/A (alive and well).   **Brother (Age 38):**   * + **Health Status:** Generally healthy   + **Relevant Conditions:** No known medical conditions.   + **Cause of Death:** N/A (alive).   **Maternal Grandfather:**   * + **Age at Death:** 80   + **Cause of Death:** Heart attack, history of cardiovascular disease.   + **Relevant Conditions:** Hypertension, hyperlipidemia.   **Paternal Grandmother:**   * + **Age at Death:** 75   + **Cause of Death:** Stroke   + **Relevant Conditions:** Hypertension, history of cerebrovascular accidents (strokes).   **Paternal Grandfather:**   * + **Age:** Unknown (unable to confirm details)   + **Health Status:** Unknown   + **Relevant Conditions:** Unknown |
| **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.)** | **Mother’s Health:**   * + **Response:** "My mother has gallstones, but she has never needed surgery. She is generally in good health now and doesn't have any other chronic illnesses."   **Father’s Health:**   * + **Response:** "My father has hypertension and diabetes, but he manages them well with medication. He’s had them for many years now."   **Brother’s Health:**   * + **Response:** "My brother is in good health. He doesn't have any known medical conditions."   **Maternal Grandfather’s Health:**   * + **Response:** "My maternal grandfather had heart disease and passed away at 80 from a heart attack."   **Paternal Grandmother’s Health:**   * + **Response:** "My paternal grandmother passed away from a stroke at 75. She had hypertension and other related health issues."   **Paternal Grandfather’s Health:**   * + **Response:** "I don't have much information about my paternal grandfather's health. I’m not sure about his health status or cause of death." |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Mother’s Gallstones:**   * · **Management/Treatment:** No surgical treatment. Managed conservatively with dietary adjustments and symptom management. No major issues for several years.   · **Father’s Hypertension and Type 2 Diabetes:**   * · **Management/Treatment:** Medication (ACE inhibitors for hypertension and metformin for diabetes). Regular check-ups with primary care doctor to monitor blood pressure and blood sugar levels.   · **Paternal Grandmother’s Hypertension:**   * · **Management/Treatment:** Managed with medications. History of stroke but did not receive aggressive treatment for other cardiovascular diseases. |

**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** | Never smoked. |
| **Alcohol Use** | No tobacco use, drinks alcohol occasionally (1-2 glasses of wine a week). |
| **Home Environment** | **Home type** | · Apartment in a suburban area  · Two-bedroom apartment on the second floor |
| **Home Location** | · Located in a quiet neighborhood, about 15 minutes from the nearest hospital  · The area is mostly residential with nearby parks and shopping centers |
| **Co-habitants** | * · ives with her 5-year-old child * Her child is a boy, in kindergarten, and she is the primary caregiver for him * Her mother lives nearby and helps with childcare occasionally |
| **Home Healthcare devices (for virtual simulations)** | * + No home healthcare devices currently (e.g., oxygen, home monitoring devices)   + Has a digital thermometer and over-the-counter medications like ibuprofen for occasional pain management | |
| **Social Supports** | **Family & Friends** | · **Family:** Mother is her primary social support, lives nearby. They are close and talk frequently. Her mother helps with childcare and provides emotional support.  · **Friends:** Has a small, tight-knit group of friends; often socializes with them on weekends or special occasions  · **Social Supports:** Very supportive friend group and close family members, especially her mother |
| **Financial** | · Stable financial situation, works full-time with a steady income  · No major financial concerns currently, but occasionally worries about unexpected medical bills or expenses related to raising a child |
| **Health care access and insurance** | · Has health insurance through her employer, which covers most medical needs  · Her child is also covered under her insurance and receives regular pediatric checkups and vaccinations  · No issues accessing healthcare; she visits her primary care physician annually for routine checkups and has access to specialist care if needed |
| **Religious or Community Groups** | * + No active religious affiliation   + Occasionally participates in community events or social gatherings, such as local park clean-ups or charity events |
| **Education and Occupation** | **Level of Education** | * · Bachelor’s degree in Business Administration * Completed additional online courses related to personal finance and project management |
| **Occupation** | · Works as a project manager at a mid-sized marketing firm  · Full-time job, works 40 hours a week, and has been in this role for the past 5 years |
| **Health Literacy** | · High health literacy, understands basic health concepts and medical terminology  · Proactive in researching medical issues and discussing concerns with her healthcare provider |
| **Sexual History:** | **Relationship Status** | In a monogamous, long-term relationship (3 years) |
| **Current sexual partners** | One current sexual partner (her boyfriend) |
| **Lifetime sexual partners** | **3 lifetime sexual partners** (including current partner). |
| **Safety in relationship** | · Feels **safe and respected** in her relationship.  · Consistent use of **condoms** for contraception and STI protection. |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | She/Her/Hers. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | Female, identifies as cisgender. |
| **Sex assigned at birth** | Female. |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Feminine, with typical feminine style in dress and grooming (e.g., wears dresses, light makeup, styled hair) |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Enjoys reading, particularly mystery novels  · Likes to go hiking and visit local parks on weekends  · Enjoys spending quality time with her child, playing games, and visiting family  · Takes weekend trips with her son to nearby cities for relaxation and cultural exploration |
| **Recent travel** | * + Took a trip to the beach 6 months ago with her child   + No recent international travel |
| **Diet** | **Typical day’s meals** | · Breakfast: Oatmeal with fruit, sometimes makes pancakes for her son  · Lunch: Salad with grilled chicken or a sandwich, often shared with her son  · Dinner: Pasta with vegetables or lean meat like chicken or fish, her son enjoys this too  · Snacks: Fruit or yogurt |
| **Recent meals** | · Had a grilled chicken salad for lunch today, with whole wheat bread  · Had pasta with tomato sauce and mixed greens for dinner last night |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Not a fan of seafood, and her son also does not like it |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | Occasionally follows a low-carb diet to maintain weight but does not adhere to a strict regimen |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Goes to the gym 3 times a week  · Exercises for 30 minutes each session, focusing on cardio and strength training  · Enjoys taking walks in the park with her child on weekends |
| **Recent changes to exercise/activity (and reason for change)** | · Recently started incorporating more strength training into her routine  · The change is due to wanting to build more muscle and improve overall fitness |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · Generally goes to bed at 10 PM, wakes up at 6 AM  · Sleep is usually uninterrupted, but occasionally gets disturbed if her child is sick or has nightmares  · No recent changes in sleep habits |
| **Stressors** | **Work** | · Some stress at work due to managing multiple projects, but overall manageable  · Takes regular breaks during the day to manage stress and avoid burnout |
| **Home** | · Stress from balancing work and parenting responsibilities, especially when her child is sick or needs extra attention  · No significant stressors at home; enjoys a peaceful environment, though sometimes feels overwhelmed by her responsibilities |
| **Financial** | * · No major financial stress but occasionally worries about saving for her child’s future or unexpected medical costs |
| **Other** | Concerned about finding time for herself as a parent and managing work-life balance |

**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:** Alert, mildly distressed, sitting slightly forward, clutching her right upper abdomen.  · **Vital Signs:** Blood pressure 125/80 mmHg, heart rate 95 bpm, respiratory rate 18 breaths/min, temperature 100.2°F (37.9°C), oxygen saturation 98%.  · **Abdominal Exam:** Tenderness in the right upper quadrant, positive Murphy’s sign (pain with deep inspiration during palpation of the right upper abdomen), no palpable masses.  · **Skin:** No jaundice, no rash.  · **Cardiovascular:** Regular rhythm, no murmurs.  · **Respiratory:** Clear breath sounds bilaterally, no crackles or wheezing.  · **Other Systems:** Normal exam findings in all other areas. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | * · "Can you help me understand what might be causing this pain?" * "Is there a test you can do to figure out if I have gallstones or something serious?" * "What do you think it is? I’m really worried." |
| **Questions the SP will ask if given the opportunity** | · "Could it be something with my gallbladder? I’ve heard of people getting their gallbladder removed."  · "How long does it take to get results for something like this?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · Likely diagnosis: Acute cholecystitis, possibly gallstones.  · Possible tests: Ultrasound, blood work (liver function tests, CBC).  · Plan: Referral for further imaging, possible antibiotics, pain management, and follow-up with surgery if gallstones are confirmed. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | The SP is unaware of the results of any imaging, lab work, or any findings that may suggest infection or inflammation, which the learner may need to investigate further. |