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**: Sarah Carter

· **Age**: 58

· **Gender**: Female

· **Chief Complaint**: “I’ve been having some weird symptoms on the left side of my body that come and go, and I’m really worried.”

**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, concerned, and slightly frustrated. May exhibit signs of nervousness (tapping foot, wringing hands).  · **Speech**: Fluent, but may speak more quickly when describing symptoms due to anxiety.  · **Body Language**: Slightly tense, may use hand gestures to describe symptoms.  · **Non-verbal Communication**: Occasionally touches head or neck as if trying to relieve discomfort.  · **Note**: As the case progresses, the patient becomes more anxious about the possibility of having a stroke and may demonstrate heightened concern. |

**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’s Initial Response**: “I’ve been having some strange symptoms. Yesterday morning, I woke up and felt really dizzy. My left arm and leg felt weak, and I had trouble speaking clearly for about 10-15 minutes. It came and went, and I thought it was just because I hadn’t slept well, but it happened again today.” |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | · “It was really scary when it happened. I’ve had high blood pressure for years, but I never thought something like this could happen to me. I thought it was just stress, but I’m starting to worry it might be something worse.”  · “I don’t have a history of strokes in my family, but my father has heart disease. He had a heart attack when he was 60.” |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | · “I did call my husband when it happened, and he told me to get checked out, but I didn’t think it was serious enough to go to the doctor.”  · “I’ve been under a lot of stress at work lately and haven’t been sleeping well. I’ve also been trying to lose weight, so I’m walking more, but I didn’t have any pain when I walked.”  · “I don’t have diabetes or anything else like that. I’m just on medication for my blood pressure.” |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | · “I didn’t really want to mention this, but my father’s health has been worse lately. He’s been hospitalized a few times for heart problems, and it’s been a lot for me to handle.”  · “I’ve been drinking a little more wine than usual lately, maybe two or three glasses in the evening to wind down.” |

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

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

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| **Quality/Character** | “It felt like weakness, especially on my left side, and like my tongue was swollen or heavy. I had trouble talking, like I couldn’t get the words out. I also felt really dizzy, like the room was spinning.” |
| **Onset** | “The first time it happened was in the morning when I woke up, and then it happened again today in the afternoon. Both times, it lasted about 10-15 minutes.” |
| **Duration/Frequency** | “It seems to come and go. It was gone within 15 minutes both times, but I’m afraid it might happen again.” |
| **Location** | “It’s on the left side—my arm, leg, and even my face felt weak. I also had trouble with my speech, like I was slurring.” |
| **Radiation** | “No, it was just on the left side of my body.” |
| **Intensity (e.g. 1-10 scale for pain)** | “I’d say it was about a 4 or 5 out of 10 on the weakness scale, but the dizziness felt like a 7 or 8, especially when I stood up. |
| **Treatment (what has been tried, what were the results)** | “I just tried to rest and drink some water when it happened, and I felt better after a little while.” |
| **Aggravating** **Factors (what makes it worse)** | “I don’t think anything specifically made it worse, but I did feel more stressed lately, and maybe the lack of sleep didn’t help.” |
| **Alleviating** **Factors (what makes it better)** | “Resting and drinking water helped, but nothing else really made it go away faster.” |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | “I’m not sure—maybe I was a bit dehydrated, or the stress from work? I’ve been under a lot of pressure.” |
| **Associated** **Symptoms** | * · “No chest pain, no headaches. But I’ve had some mild headaches recently, though they’re not really the same as the dizziness.” |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | “It’s really worrying me. I have a lot of things to take care of at home and work, and I don’t want to not be able to function. I keep thinking it might be a stroke.” |

**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**:   * · “I’ve felt more tired than usual, and I’ve been a little more irritable with all the stress.”   · **Skin**:   * · “No rashes, no changes in my skin.”   · **HEENT**:   * · “No vision changes, no headaches, no neck stiffness.”   · **Endocrine**:   * · “No excessive thirst, no frequent urination.”   · **Respiratory**:   * · “I haven’t had trouble breathing or coughing.”   · **Cardiovascular**:   * · “I’ve had high blood pressure for years, but no chest pain, no palpitations.”   · **Gastrointestinal**:   * · “No nausea, no abdominal pain, no changes in bowel habits.”   · **Urinary**:   * · “No changes in urination.”   · **Musculoskeletal**:   * · “No joint pain or muscle aches.”   · **Neurologic**:   * · “The weakness and speech problems are the main thing, no numbness or tingling. No balance problems aside from the dizziness.”   · **Psychiatric/Behavioral**:   * · “I’ve been more stressed and anxious, especially after these episodes.” |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | · Hypertension for 10 years  · No history of stroke or significant neurological events |
| **Hospitalizations** | None |
| **Surgical History** | None |
| **Screening/Preventive (including vaccinations /immunizations)** | · Annual blood pressure checks  · Mammogram every two years  · Colonoscopy (last done 2 years ago, normal) |
| **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** | · **Lisinopril 10 mg** daily for hypertension  · **Aspirin 81 mg** daily (as a preventive measure for heart disease) |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known drug allergies. |
| **Gynecologic History** | **Menstrual History**:   * + **Menarche**: Age 12   + **Last Menstrual Period**: At age 50 (8 years ago). No further menstruation since then (indicating menopause).   + **Menstrual Cycle**: Regular cycles prior to menopause, lasting approximately 5-7 days, every 28 days.   + **Symptoms**: No significant premenstrual syndrome (PMS) or dysmenorrhea (painful periods). No history of heavy bleeding.   **Contraceptive Use**:   * + **Current Use**: Not currently using any form of contraception.   + **Past Use**: No history of oral contraceptives, IUDs, or other methods.   **Gynecological Issues**:   * + No history of fibroids, endometriosis, pelvic inflammatory disease (PID), or sexually transmitted infections (STIs).   + No history of abnormal Pap smears. Her last Pap smear (two years ago) was normal.   **Pregnancy History**:   * + **Gravida**: 2 (two pregnancies).   + **Para**: 2 (both children are healthy; no complications during pregnancy or delivery).   + **Miscarriages**: None.   **Menopause**:   * + Experienced natural menopause at age 50. No significant symptoms like hot flashes or night sweats. Occasional mild vaginal dryness, managed with over-the-counter lubricants.   **Sexual History**:   * + **Relationship Status**: Married for 30 years.   + **Current Sexual Activity**: Sexually active with her husband. Denies painful intercourse or sexual dysfunction.   + **Contraception**: No current contraception needed due to age and menopause.   + **Sexual Orientation**: Heterosexual.   **Health Maintenance**:   * + **Routine Screenings**: Annual mammogram (last one normal), Pap smear (last one normal), and colonoscopy (last one normal, done 2 years ago).   **Gynecologic Concerns**:   * + Occasional vaginal dryness, no significant impact on sexual activity.   + No history of pelvic pain, abnormal bleeding, or urinary symptoms related to gynecologic conditions. |

**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** | * + **Age**: 65 (Deceased)   + **Cause of Death**: Complications from heart disease (had a heart attack at age 60).   + **Health Status**: Diagnosed with hypertension and hyperlipidemia. Had a history of smoking but quit after his heart attack.   **Mother**:   * + **Age**: 84 (Living)   + **Health Status**: Healthy, no significant chronic diseases. Reports no major issues aside from occasional arthritis and mild age-related memory decline.   **Siblings**:   * + **Brother**:     - **Age**: 62 (Living)     - **Health Status**: History of hypertension and high cholesterol. Currently well-managed on medication.   + **Sister**:     - **Age**: 55 (Living)     - **Health Status**: Healthy with no known chronic conditions. Has never smoked or had any significant health issues.   **Paternal Grandparents**:   * + **Grandfather**: Died at age 80 due to a stroke.   + **Grandmother**: Died at age 75 from complications of diabetes.   **Maternal Grandparents**:   * + **Grandfather**: Died at age 79 from lung cancer (smoker).   + **Grandmother**: Died at age 82 from heart failure. |
| **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 (e.g., other aunts, uncles, or cousins). Only mention immediate family members (parents, siblings, grandparents). * If asked about the health of **paternal grandparents**, respond with "I’m not sure about my paternal grandparents’ health, but my father did have heart disease, and that’s the most relevant health issue I’m aware of." * For the **maternal grandparents**, you can simply state: "I’m not sure about their exact cause of death, but I do know my grandfather had lung cancer, and my grandmother had heart issues." |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father’s Hypertension and Heart Disease**:   * · Managed with medications (lisinopril for blood pressure, statins for cholesterol) after his heart attack at age 60. His condition was complicated by his smoking history. * The family was advised to follow up regularly with a cardiologist. His death was attributed to a heart attack at 65.   · **Brother’s Hypertension and Hyperlipidemia**:   * · Treated with lifestyle modifications (diet and exercise) and medications (lisinopril, statins). His condition is stable and under control with regular checkups.   · **Mother’s Arthritis**:   * · Managed with over-the-counter pain relievers and occasional physical therapy. She’s been active with no major health concerns aside from age-related aches. |

**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 recreational drug use. |
| **Tobacco Use** | Never smoked |
| **Alcohol Use** | Occasional, 2-3 glasses of wine in the evening to relax. |
| **Home Environment** | **Home type** | Lives in a **single-story** house with a small yard. The house is well-maintained, and there are no immediate hazards (e.g., no stairs or clutter). |
| **Home Location** | Located in a suburban area, **30 minutes outside of the city**. The neighborhood is quiet and primarily residential. It is a **rural setting**, with easy access to public transportation. |
| **Co-habitants** | · **Husband** (age 60): Sarah has been married for 30 years. He is a retired engineer. The couple has a healthy relationship, and he assists with household chores.  · **No children living at home**: Her two adult children have moved out of the house and live in nearby cities. |
| **Home Healthcare devices (for virtual simulations)** | · Sarah uses a **blood pressure monitor** regularly to track her hypertension.  · **Oxygen** is not required at home, but she occasionally uses a **nebulizer** for her COPD if needed. | |
| **Social Supports** | **Family & Friends** | · Sarah maintains a close relationship with her husband and speaks to her children regularly, though they live out of town.  · She has a small circle of close friends who live nearby and visit occasionally.  · No significant social support network in terms of extended family (e.g., aunts, uncles), but she is well-supported emotionally by her immediate family. |
| **Financial** | · Sarah and her husband are retired, and their financial situation is stable. They live comfortably off their savings, with no major financial strain.  · Sarah also receives Social Security benefits, and her husband has a pension. They both have health insurance through Medicare. |
| **Health care access and insurance** | · Sarah has **Medicare** with additional coverage through a private insurance plan (Medigap).  · She has access to primary care and specialists in the city, though travel to appointments can be difficult due to distance. |
| **Religious or Community Groups** | Sarah is a member of a **local church** and attends services weekly. She is also part of a small community group that meets for social activities and support. |
| **Education and Occupation** | **Level of Education** | Sarah has a **high school diploma**. She did not attend college but worked in various administrative roles during her career. |
| **Occupation** | · Sarah retired from her **secretarial job** at a local law firm 5 years ago.  · She had no physically demanding work and spent most of her career behind a desk, handling scheduling, correspondence, and other office duties. |
| **Health Literacy** | · Sarah has **average health literacy**. She understands basic medical terms and concepts but may need additional explanation when it comes to more complex medical information or treatment options.  · She is proactive in managing her health but prefers simple, clear instructions from her healthcare providers. |
| **Sexual History:** | **Relationship Status** | Sarah has been married to her husband for 30 years. They maintain a **monogamous relationship** and are sexually active. |
| **Current sexual partners** | **One current sexual partner**: Her husband. |
| **Lifetime sexual partners** | **Two lifetime sexual partners**: Her husband and one previous partner during her teenage years. |
| **Safety in relationship** | Sarah feels safe in her relationship and has never experienced abuse or violence. She and her husband communicate openly about their sexual health and desires. |
| **Sexual orientation** | Heterosexual. |
| **Gender identity** | **Pronouns** | She/Her. |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | Cisgender woman. |
| **Sex assigned at birth** | Female |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | Sarah’s gender presentation aligns with traditional norms. She dresses modestly in casual or semi-formal clothes, typically in feminine styles. There are no notable deviations from typical gender presentation in terms of body language, style, or dress. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | · Sarah enjoys **gardening**, **reading**, and **cooking**. She often spends time in her garden growing flowers and vegetables.  · She also enjoys **walking** and **attending local community events**. |
| **Recent travel** | No recent travel. Sarah and her husband used to travel occasionally but have not taken a trip in the last 2 years due to health concerns. |
| **Diet** | **Typical day’s meals** | · **Breakfast**: Typically has **oatmeal** with fruit or whole-grain toast with peanut butter.  · **Lunch**: Often a **salad** with lean protein (chicken or tuna), and whole grain bread or crackers.  · **Dinner**: A balanced meal with vegetables, lean protein (fish or chicken), and a small portion of carbs like rice or potatoes. |
| **Recent meals** | · Had **grilled salmon** with roasted vegetables for dinner last night.  · For lunch, she had **chicken soup** with a side of bread. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Sarah avoids **fried foods** and **high-fat snacks**. She tries to maintain a heart-healthy diet due to her family history of hypertension and heart disease. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | · Follows a **heart-healthy** diet, focusing on low sodium, high fiber, and moderate portions of healthy fats (olive oil, nuts, fish).  · Occasionally reduces **sugar** intake to manage her diabetes. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | · Sarah exercises **3-4 times a week**. She enjoys **brisk walking** around the neighborhood for 30-40 minutes.  · She also occasionally participates in **yoga** classes and has found it helps with her flexibility and stress reduction. |
| **Recent changes to exercise/activity (and reason for change)** | Sarah has reduced the frequency of her walks in the last few months due to increasing **shortness of breath**. She is concerned about her COPD and occasionally experiences fatigue. |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · **Pattern**:   * · Sarah maintains a **regular sleep schedule**, going to bed at around **10:00 PM** and waking up at **6:30 AM**.   · **Length**:   * · She typically gets about **7-8 hours** of sleep per night.   · **Quality**:   * · Her sleep quality is generally good, although she occasionally experiences **mild insomnia** or **night waking**, likely due to stress or worry about her health.   · **Recent Changes**:   * · No significant changes in sleep patterns, though she occasionally feels more **restless** due to increased health concerns. |
| **Stressors** | **Work** | Sarah is retired, so work-related stress is minimal. |
| **Home** | There are no significant stressors related to her home environment, though she occasionally worries about her health. |
| **Financial** | Sarah is not facing financial stress; however, she occasionally worries about **medical costs** and how her health will impact her future. |
| **Other** | Sarah feels some **stress related to her health** concerns (e.g., hypertension, TIA risk), which has increased recently after experiencing symptoms of transient ischemic attacks. |

**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**:   * Appears anxious but in no acute distress.   · **Vital Signs**:   * **Temperature**: 98.7°F (37.0°C) * **Heart Rate**: 78 bpm, regular * **Blood Pressure**: 142/88 mmHg * **Respiratory Rate**: 16 breaths per minute * **Oxygen Saturation**: 98% on room air   · **Neurologic Exam**:   * **Cranial Nerves**: No deficits observed * **Motor**: Mild weakness on the left side of the body (notable in the left arm and leg), resolves with time. * **Speech**: Mild dysarthria (slurred speech), improves after a few minutes. * **Coordination**: No ataxia or tremors. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | * · "Could this be a stroke?" * "Is this something I should worry about? |
| **Questions the SP will ask if given the opportunity** | · **About Symptoms and Diagnosis**   * · "Do you think my symptoms could be related to a stroke or something more serious?" * "I’ve had these episodes of dizziness and weakness, should I be worried that it could happen again?" * "Could my history of hypertension and COPD be contributing to these symptoms?" * "What exactly is a transient ischemic attack, and how does it differ from a full stroke?" * "Are there any specific tests or scans that can help confirm if I’ve had a TIA?" * "Is there a way to prevent another TIA from happening in the future?"   · **Treatment and Management**   * · "What are the treatment options for preventing future TIAs or strokes? Are there medications I should start taking?" * "I take medication for my blood pressure and diabetes already, will these need to be adjusted?" * "Are there lifestyle changes I can make to reduce my risk, especially with my COPD and family history?" * "Is there anything I can do to better manage my stress, as it seems like it could be affecting my health?" * "Should I be concerned about my diet or exercise routine in light of these symptoms?"   · **Impact on Daily Life and Activities**   * · "Are these symptoms going to affect my ability to take care of myself or do normal activities?" * "What should I do if I experience another episode of dizziness or weakness at home?" * "Can I continue with my walking and yoga routine, or should I modify my activity level?" * "How long should I rest after an episode, and when is it safe to return to normal activities?"   · **Support and Resources**   * · "Should I consider seeing a specialist, like a neurologist or cardiologist, to further evaluate my condition?" * "Are there any support groups for people with TIA or stroke risk that could help me cope with this health issue?" * "Is there a nurse or healthcare worker I can speak with regularly to help manage my care?"   · **Concerns about Health Management**   * · "I sometimes forget to take my medications regularly. How can I make sure I stay on track with my treatment?" * "Could my previous smoking history be a factor in this, even though I quit years ago?" * "How can I monitor my blood pressure and other symptoms at home, and what is considered ‘normal’ for someone like me?" * "Are there any warning signs I should look out for in case another TIA is coming on?"   · **Long-Term Outlook and Prevention**   * · "What steps can I take now to reduce the chances of having a stroke in the future?" * "Can my family history of heart disease and strokes impact my risk for another TIA or stroke?" * "What are the long-term effects of having a TIA, and will it affect my ability to live independently?" |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | · The learner should diagnose TIA, explain its transient nature, and recommend further tests or referrals to prevent future strokes. The learner should also reassure the patient and discuss management options for hypertension. |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | The patient’s vital signs and neurological exam findings are normal at the time of the visit, but the patient is worried about a stroke. |