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: 27**

**Gender: male**

**Chief Complaint:** "I've been having strange episodes where I lose control and feel like I’m shaking uncontrollably."

**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 worried but cooperative.  · **Speech:** Short, occasionally stammering, sometimes vague due to nervousness.  · **Body Language:** Nervous fidgeting, occasionally wringing hands when discussing seizures.  · **Non-verbal Communication:** Appears anxious, often looks away when describing episodes.  · **Changes as Case Progresses:** As the interview progresses, the patient becomes slightly more distressed, particularly when discussing how the episodes are affecting his daily life. |

**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 some strange episodes recently, where I lose control and shake uncontrollably. I’m not sure what’s going on, but it’s been happening more frequently.” |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | “These episodes started about 3 months ago. I’ll usually get a feeling like something’s about to happen, then I lose consciousness. I don’t remember what happens during the seizure, but my girlfriend says I have convulsions and that I bite my tongue sometimes. I feel really tired afterward and have trouble remembering things right after.” |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | “I’ve been to the emergency room twice because of these episodes, but they didn’t give me a diagnosis yet. They told me it could be a type of seizure, but they need to run more tests.” “My family has been really worried, and I’ve been avoiding driving and some activities because I’m afraid it might happen again.” |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | I don’t want to tell my coworkers, but I feel embarrassed sometimes because I’m not sure how to explain this. I’m afraid they’ll think I’m unreliable or weak if I talk about it.” |

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

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

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| **Quality/Character** | "It feels like I lose control and then start shaking uncontrollably. It usually starts with a strange feeling in my head, like a warning sign." |
| **Onset** | "It started about three months ago, but I only began noticing it more frequently in the last month." |
| **Duration/Frequency** | "The episodes last about 1-2 minutes, but I feel really out of it for at least an hour afterward. They happen about 2-3 times a week." |
| **Location** | "I don’t know if it’s a certain part of my brain, but it feels like the episodes happen without warning, anywhere." |
| **Radiation** | "No, it just affects my whole body, but mainly my limbs." |
| **Intensity (e.g. 1-10 scale for pain)** | "There’s no pain during the seizure, but afterward, I feel really exhausted and sometimes sore." |
| **Treatment (what has been tried, what were the results)** | "I haven’t started any medication yet. I’m waiting for results from the neurologist." |
| **Aggravating** **Factors (what makes it worse)** | "I don’t really know what triggers it, but I’ve noticed that I feel more stressed when the episodes occur." |
| **Alleviating** **Factors (what makes it better)** | "I rest after the episodes, but I don’t feel back to normal for a while. Drinking water and lying down helps me recover faster." |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | "I’m not sure. Sometimes I’m really tired or stressed, but it’s hard to say." |
| **Associated** **Symptoms** | "I’ve noticed some memory lapses after the episodes. My girlfriend also says I’m confused when I wake up from one." |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | "It’s affecting my job and my social life. I’m afraid to drive or go out because I don’t know when it will happen again. I’ve been thinking about changing my lifestyle or even quitting my job because of the stress and the episodes." |

**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:**   * No fever, weight loss, or fatigue (aside from post-episode exhaustion).   · **Skin:**   * No rashes, bruising, or other unusual skin changes.   · **HEENT:**   * No headaches, vision changes, or recent sinus issues.   · **Endocrine:**   * No changes in temperature sensitivity or hair growth.   · **Respiratory:**   * No difficulty breathing or chest pain.   · **Cardiovascular:**   * No palpitations or chest pain.   · **Gastrointestinal:**   * No nausea or vomiting associated with the episodes.   · **Urinary:**   * No changes in urination.   · **Reproductive:**   * No relevant symptoms.   · **Musculoskeletal:**   * No muscle weakness or pain aside from post-seizure soreness.   · **Neurologic:**   * No prior history of neurologic disorders.   · **Psychiatric/Behavioral:**   * Some anxiety and stress, especially around the episodes and their unpredictability. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | No chronic illness. |
| **Hospitalizations** | None, aside from the two ER visits related to seizures. |
| **Surgical History** | None. |
| **Screening/Preventive (including vaccinations /immunizations)** | Up-to-date with vaccinations. |
| **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** | None. |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | No known allergies. |
| **Gynecologic History** | **NA** |

**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:** 58 years * **Health Status:** Healthy, no significant medical conditions. * **Relevant Notes:** No history of epilepsy or neurological disorders in the family. * **Management/Treatment:** Not applicable.   · **Father:**   * · **Age:** 62 years * **Health Status:** Diagnosed with hypertension, managed with medication. * **Relevant Notes:** No neurological issues or history of seizures. * **Management/Treatment:** Treated with antihypertensive medication. No history of epilepsy or seizures.   · **Brother:**   * · **Age:** 24 years * **Health Status:** Healthy, no significant medical conditions. * **Relevant Notes:** No history of epilepsy or neurological disorders. * **Management/Treatment:** Not applicable.   · **Maternal Grandmother (optional):**   * · **Age at Death:** 82 years * **Cause of Death:** Natural causes, no neurological conditions. * **Relevant Notes:** No family history of epilepsy. * **Management/Treatment:** Not applicable.   · **Paternal Grandfather (optional):**   * · **Age at Death:** 78 years * **Cause of Death:** Heart disease * **Relevant Notes:** No family history of epilepsy. * **Management/Treatment:** Not applicable. |
| **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** unless explicitly asked about a family member (e.g., paternal grandmother, maternal uncle, etc.).  · If the learner asks about any **other family members**, the SP should respond:   * "I’m not sure about my paternal grandparents’ health status, but I know my mother and father are both alive and healthy. I don’t have more details about my extended family."   · If the learner asks about **specific health issues in family members not listed above**, the SP should respond with:   * "My family doesn’t have a history of neurological conditions like epilepsy or seizures, and no one else in my immediate family has been diagnosed with any serious health conditions." |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | · **Father (Hypertension):**   * · Treated with antihypertensive medication (e.g., lisinopril). * Regular check-ups for blood pressure management. * No complications reported.   · **No family members with epilepsy or other relevant conditions:**   * · The SP should maintain that no family members have a history of epilepsy or other significant neurological issues. |

**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 illicit drug use |
| **Tobacco Use** | No tobacco use. |
| **Alcohol Use** | Occasional alcohol use |
| **Home Environment** | **Home type** | Apartment, 2-bedroom unit in an urban area. |
| **Home Location** | Located in the city center, a bustling neighborhood with access to public transportation. |
| **Co-habitants** | Lives alone in the apartment. No roommates or family members co-habitating. |
| **Home Healthcare devices (for virtual simulations)** | None currently. John does not use any specialized healthcare devices at home. | |
| **Social Supports** | **Family & Friends** | · John has a supportive network of friends but no immediate family nearby. He keeps in touch regularly with his mother and brother via phone.  · He receives emotional support from a close group of friends who know about his epilepsy and help with managing stress and situations when seizures occur. |
| **Financial** | John has a stable income from his job, but he is concerned about the financial impact of his medical condition. He is covered by health insurance through his employer. |
| **Health care access and insurance** | John has private health insurance through his employer, which covers medications and doctor visits, but he sometimes feels anxious about the cost of frequent appointments or possible emergency room visits in case of seizures. |
| **Religious or Community Groups** | John is not currently involved in any religious or community groups but has expressed interest in attending a local support group for individuals with epilepsy for additional support. |
| **Education and Occupation** | **Level of Education** | Bachelor’s degree in business management. |
| **Occupation** | Full-time office worker at a marketing firm. He works 9-5, five days a week, but sometimes works extra hours to meet deadlines. |
| **Health Literacy** | John demonstrates a moderate level of health literacy. He understands his condition and treatment plan but sometimes struggles to fully comprehend medical jargon and complex side effects of medications. |
| **Sexual History:** | **Relationship Status** | In a relationship with a girlfriend. They have been together for over a year. |
| **Current sexual partners** | Girlfriend. |
| **Lifetime sexual partners** | John has had several past partners but prefers to focus on his health at the moment and is not actively seeking other relationships. |
| **Safety in relationship** | John feels safe and supported in his current relationship. There are no concerns regarding abuse or safety. |
| **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)** | John dresses casually in business attire for work, typically wearing simple, comfortable clothing. No distinctive body language or style that would signal gender identity outside of typical norms. |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | Enjoys reading, watching movies, and hiking on weekends. He is also part of a local book club. |
| **Recent travel** | Last traveled to a nearby city for a weekend trip two months ago, but does not travel frequently due to concerns about his health and the unpredictability of his seizures. |
| **Diet** | **Typical day’s meals** | · Breakfast: Oatmeal with fruit or a smoothie.  · Lunch: Salad with lean protein (chicken or tofu), often paired with a small portion of whole grains like quinoa.  · Dinner: A balanced meal of vegetables, lean protein, and a small serving of carbs (e.g., rice or sweet potatoes). |
| **Recent meals** | Last night: Grilled salmon with steamed broccoli and quinoa. |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | Avoids processed foods, too much caffeine, and fried foods. Feels that a healthy diet helps him manage his epilepsy. |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | Follows a general healthy diet. No strict dietary restrictions, but he tries to avoid triggers that could impact his condition, such as excessive sugar. |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | Typically exercises three times a week, alternating between yoga and walking. Enjoys outdoor activities like hiking during the weekends. |
| **Recent changes to exercise/activity (and reason for change)** | Recently reduced exercise frequency from four to three times a week after experiencing a seizure. John is still cautious about exerting too much energy during physical activity |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | · **Pattern:**   * · Regular sleep pattern. Typically goes to bed at 10 p.m. and wakes up around 7 a.m.   · **Length:**   * · Sleep duration of 7-8 hours per night.   · **Quality:**   * · Sleep quality is generally good, but occasionally experiences disrupted sleep due to stress or concern about seizures.   · **Recent Changes:**   * · No significant changes, although occasionally experiences a poor night's sleep after a seizure. |
| **Stressors** | **Work** | Work-related stress has increased due to pressure to meet deadlines. John has been feeling more anxious about balancing work and health. |
| **Home** | No significant stressors at home, though he feels isolated living alone. |
| **Financial** | Mild stress about medical costs and managing healthcare needs. |
| **Other** | Occasional anxiety about potential seizures, especially when in public or social settings. John is also concerned about managing his condition without overburdening his social support network. |

**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:**   * Appears slightly anxious, but otherwise well-groomed and alert.   · **Vital Signs:**   * BP: 120/75 mmHg * HR: 78 bpm * RR: 16 breaths/min * Temperature: 98.6°F * Oxygen Saturation: 98%   · **Neurologic:**   * No focal deficits on exam. No signs of recent trauma, no abnormal gait.   · **Musculoskeletal:**   * No abnormalities noted in the limbs. Mild muscle soreness after seizures, but no injury or weakness. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | · “I’ve been having these shaking episodes, and I don’t know what they are. Can you help me figure this out?”  · “I’m scared these episodes are going to affect my work and life even more.” |
| **Questions the SP will ask if given the opportunity** | “Could this be something serious? What tests do I need?” |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | “Could this be something serious? What tests do I need?” |
| **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 history of seizures and that epilepsy is a likely diagnosis, but the SP does not have that information initially. |