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: Michael Thompson**

**Age: 58**

**Gender: Male**

**Chief Complaint: I've been having severe chest pain for the last 30 minutes.**

**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 and slightly distressed.**  **Speech: Moderate pace, clear and coherent.**  **Body Language: Clutching chest with one hand, occasional shallow breaths, sits slightly hunched forward.**  **Non-Verbal Communication: Sweating, pale complexion, intermittent grimacing due to pain.**  **Verbal Characteristics: Expresses discomfort clearly, uses phrases like "tightness in my chest" and "pain radiates to my left arm."** |

**Opening Statement, Open-Ended Questions, and Guidelines for Disclosure**

Note: this section is to give the SP guidance on how to answer open-ended questions. Scripted answer(s) to initial open-ended questions like “what brings you in today?” and “Can you tell me more?” should go in Box A. Further open-ended questions like “anything else going on?” should go in box B below, as well as any information the SP should volunteer at the first given opportunity. Box C is for information that the SP should freely offer, but wouldn’t consider mentioning until the learner introduces a relevant topic. Box D is for information that needs to be withheld unless specifically asked, (e.g. things the patient doesn’t remember until prompted or things the patient may feel shame about).

*Example: let’s say the patient’s roommate is ill. If the patient is having similar symptoms, that information probably goes in box B–it’s highly relevant to the patient and on the top of their mind. If the patient has somewhat differing symptoms, the information might go in box C and could be revealed if the learner brings up living situation, social support, or sick contacts. If the patient would assume the roommate’s illness is unrelated, the information might go in box D and only be revealed when the learner asks about sick contacts.*

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| **Opening Statement(s)** | **A**  **Initial Response to "What brings you in today?"**  **"I've been having severe chest pain for the last half hour. It feels like a heavy weight on my chest."**  **Response to "Can you tell me more?"**  **"The pain started suddenly while I was watching TV. It's a constant, squeezing sensation."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **I've also been feeling nauseous and a bit dizzy since the pain started.** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **If asked about recent activities: "I had a stressful day at work with back-to-back meetings."**  **If inquired about family history: "My father had heart disease and passed away at 60."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Smoking History: "I used to smoke about a pack a day for 20 years but quit five years ago."**  **Medication Adherence: "I've been skipping my blood pressure medication lately because I forgot."** |

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

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

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| **Quality/Character** | **It's a tight, squeezing pain."** |
| **Onset** | **Started suddenly 30 minutes ago.** |
| **Duration/Frequency** | **Constant since it began.** |
| **Location** | **Central chest area.** |
| **Radiation** | **Radiates to my left arm and jaw.** |
| **Intensity (e.g. 1-10 scale for pain)** | **I'd rate the pain an 8 out of 10.** |
| **Treatment (what has been tried, what were the results)** | **I took some aspirin, but it didn't help.** |
| **Aggravating** **Factors (what makes it worse)** | **Lying down makes it slightly worse** |
| **Alleviating** **Factors (what makes it better)** | **"Sitting upright and resting provides some relief.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **I was at rest watching TV when it started.** |
| **Associated** **Symptoms** | **Nausea, dizziness, sweating.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **I'm worried this might be a heart attack. I've had high blood pressure for years and a family history of heart disease.** |

**Review of Systems: (list any additional pertinent positives and negatives from these systems: Constitutional, Skin, HEENT, Endocrine, Respiratory, Cardiovascular, Gastrointestinal, Urinary, Reproductive, Musculoskeletal, Neurologic, Psychiatric/Behavioral)**

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| Constitutional: Positive for fatigue.  HEENT: Negative for headaches.  Cardiovascular: Positive for chest pain and palpitations.  Respiratory: Negative for shortness of breath at rest.  Gastrointestinal: Positive for nausea.  Neurological: Positive for dizziness.  Psychiatric/Behavioral: Positive for anxiety. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension diagnosed 10 years ago.**  **Hyperlipidemia.**  **Previous smoker (20 pack-years, quit 5 years ago).** |
| **Hospitalizations** | **Hospitalized for hypertensive crisis two years ago.** |
| **Surgical History** | **Appendectomy at age 25.** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Regular blood pressure checks.**  **Last cholesterol screening six months ago.** |
| **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.**  **Atorvastatin 20 mg nightly for hyperlipidemia.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Penicillin (rash).**  **No known food allergies.** |
| **Gynecologic History** | **Not applicable** |

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

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| **List all relevant and appropriate family members and their age and health status, or age at and cause of death** | **Father: Deceased at 60 due to myocardial infarction.**  **Mother: Alive, age 80, with osteoporosis.**  **Sibling: Sister, age 55, with type 2 diabetes.** |
| **Instructions for SP on how to answer questions about any family members not listed above:**  **(i.e. do not add any additional family members, any other family is alive and well, unsure about paternal grandparents, etc.)** | **Do not introduce additional family members.**  **All other family members are alive and well.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Father had coronary artery bypass grafting (CABG).**  **Sister managing diabetes with metformin.** |

**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)** | **Former smoker, quit five years ago.** |
| **Tobacco Use** | **Smoked one pack a day for 20 years, quit five years ago.** |
| **Alcohol Use** | **Social drinker, 2-3 drinks on weekends.** |
| **Home Environment** | **Home type** | **Lives in a two-bedroom apartment.** |
| **Home Location** | **Urban area.** |
| **Co-habitants** | **Lives alone.** |
| **Home Healthcare devices (for virtual simulations)** | **None.** | |
| **Social Supports** | **Family & Friends** | **Limited social support; estranged from siblings.** |
| **Financial** | **Employed as an accountant, financially stable.** |
| **Health care access and insurance** | **Has health insurance through employer.** |
| **Religious or Community Groups** | **Not actively involved in any groups.**  **** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Accounting.** |
| **Occupation** | **Accountant at a mid-sized firm.** |
| **Health Literacy** | **High; understands medical terminology.** |
| **Sexual History:** | **Relationship Status** | **Divorced.** |
| **Current sexual partners** | **Single, not currently in a relationship.** |
| **Lifetime sexual partners** | **Two.** |
| **Safety in relationship** | **N/A.** |
| **Sexual orientation** | **Heterosexual.** |
| **Gender identity** | **Pronouns** | **He/Him.** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender male.** |
| **Sex assigned at birth** | **Male.** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Conservative attire, no notable gender identity signals.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Enjoys reading and gardening.** |
| **Recent travel** | **Traveled to Florida last winter.** |
| **Diet** | **Typical day’s meals** | **Balanced diet with occasional fast food.** |
| **Recent meals** | **Had a heavy dinner two hours before chest pain.** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Limits red meat due to high cholesterol.** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Low-sodium diet for hypertension.** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks 30 minutes daily.** |
| **Recent changes to exercise/activity (and reason for change)** | **None.** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Sleeps 6-7 hours per night.**  **Quality: Generally good, but disrupted tonight due to pain.**  **Recent Changes: No recent changes.** |
| **Stressors** | **Work** | **High workload, recent promotion.** |
| **Home** | **Living alone, minimal support.** |
| **Financial** | **Stable.** |
| **Other** | **Concern about health due to family history.** |

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

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| Vital Signs:  Blood Pressure: 150/95 mmHg  Heart Rate: 100 bpm, irregular  Respiratory Rate: 22 breaths per minute  Temperature: 98.6°F (37°C)  Oxygen Saturation: 94% on room air  General Appearance:  Appears anxious, clutching chest, pale and diaphoretic.  HEENT:  Pupils equal, reactive to light.  No jugular venous distension.  Cardiovascular:  Irregular heartbeat, possible arrhythmia.  No audible murmurs.  Respiratory:  Slightly rapid breathing, no wheezing or crackles.  Abdomen:  Soft, non-tender, no hepatosplenomegaly.  Extremities:  No edema, pulses are weak but present in all extremities.  Neurological:  Alert and oriented to person, place, and time.  No focal neurological deficits. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Is there anything else I should be worried about?"**  **How long will it take to get treatment?"** |
| **Questions the SP will ask if given the opportunity** | **Have you had similar chest pain before?"**  **"Can you tell me about your lifestyle and any medications you're taking?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Expect a diagnosis of Acute Coronary Syndrome.**  **Plan may include administration of nitroglycerin, aspirin, ECG, and possible referral to the emergency department.**  **Treatment may involve medications, lifestyle modifications, and further cardiac evaluation.**  **Reassurance regarding immediate management but concern about long-term health.** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Yes, the learner may have access to vital signs indicating symptomatic vitals such as elevated blood pressure, irregular heart rate, and reduced oxygen saturation.**  **Pregnancy status is not applicable unless specifically introduced in the scenario.** |