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: Linda Martinez**

**Age: 72**

**Gender: Female**

**Chief Complaint: I've been feeling more tired than usual and my legs are swelling**

**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: Tired, slightly frustrated, and mildly anxious.**  **Speech: Soft-spoken, slow, with occasional pauses.**  **Body Language: Sits comfortably but shifts frequently to adjust position; occasionally rubs swollen ankles.**  **Non-Verbal Communication: Exhibits slight shortness of breath when sitting up, uses assistive devices (e.g., cane) subtly.**  **Verbal Characteristics: Uses phrases like "I feel exhausted," "My ankles are swollen," and "It's hard to breathe sometimes."** |

**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)** | **A**  **Initial Response to "What brings you in today?"**  **"I've been feeling more tired than usual and my legs have been swelling a lot over the past few weeks."**  **Response to "Can you tell me more?"**  **"It's been hard to get through the day without feeling exhausted, and my feet and ankles are puffy."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **I've also noticed I'm gaining weight without trying."**  **"Sometimes I wake up feeling short of breath.** |
| **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 haven't been as active lately because of the tiredness."**  **If inquired about dietary habits: "I've been trying to watch my salt intake more carefully."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Medication Adherence: "I sometimes forget to take my diuretics because of my busy mornings."**  **Symptoms Not Immediately Obvious: "I have a persistent cough at night, but I thought it was just a cold."** |

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

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

|  |  |
| --- | --- |
| **Quality/Character** | **It's a constant feeling of tiredness and heaviness in my legs.** |
| **Onset** | **The fatigue started about three months ago and the swelling began around six weeks ago."** |
| **Duration/Frequency** | **The tiredness is present every day, and the swelling is noticeable throughout the day, especially by evening.** |
| **Location** | **The swelling is mainly in my lower legs and ankles.** |
| **Radiation** | **No radiation of pain, but I do feel some tightness in my chest when I'm very tired.** |
| **Intensity (e.g. 1-10 scale for pain)** | **I'd rate my tiredness as a 7 out of 10 and the swelling as a 6 out of 10."** |
| **Treatment (what has been tried, what were the results)** | **"I've been taking my prescribed diuretics, but I'm not sure if I'm taking them correctly."** |
| **Aggravating** **Factors (what makes it worse)** | **Standing or walking for long periods makes the swelling worse** |
| **Alleviating** **Factors (what makes it better)** | **Elevating my legs when I sit helps reduce the swelling a bit** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **No specific events, it just gradually got worse** |
| **Associated** **Symptoms** | **Shortness of breath, nighttime cough, weight gain, decreased appetite.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **I'm worried that my condition is getting worse and it's affecting my ability to enjoy life. I fear I might need more invasive treatments.** |

**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: Positive for fatigue and unintentional weight gain.  HEENT: Positive for nighttime cough; negative for headaches or vision changes.  Cardiovascular: Positive for swelling in legs and ankles, occasional chest tightness.  Respiratory: Positive for shortness of breath, especially when lying flat; negative for wheezing.  Gastrointestinal: Negative for nausea or vomiting; slight decrease in appetite.  Neurological: Negative for dizziness or syncope.  Psychiatric/Behavioral: Positive for mild anxiety related to health status. |

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

|  |  |
| --- | --- |
| **Illnesses/Injuries (chronic or otherwise relevant)** | **Hypertension diagnosed 15 years ago.**  **Type 2 Diabetes Mellitus diagnosed 10 years ago.**  **Osteoarthritis in knees and hips.** |
| **Hospitalizations** | **Hospitalized for a heart attack (myocardial infarction) five years ago.**  **Recent hospitalization for a urinary tract infection two months ago.** |
| **Surgical History** | **Total knee replacement on the left knee three years ago.** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Regular HbA1c and lipid panels.**  **Annual flu 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** | **Lisinopril 20 mg daily for hypertension.**  **Metformin 500 mg twice daily for diabetes.**  **Furosemide 40 mg daily as a diuretic.**  **Atorvastatin 40 mg nightly for hyperlipidemia.**  **Ibuprofen 200 mg as needed for arthritis pain.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Sulfa drugs (rash).**  **No known food allergies.**  **N/A** |
| **Gynecologic History** | **Not available** |

**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** | **Father: Deceased at 70 due to congestive heart failure.**  **Mother: Alive, age 68, with hypertension and arthritis.**  **Brother: Alive, age 65, with prostate cancer.** |
| **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 was on multiple heart medications before passing.**  **Mother manages hypertension with medication and diet.** |

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

|  |  |  |
| --- | --- | --- |
| **Substance Use (past and present)** | **Drug Use (Recreational, medicinal and medications prescribed to other people)** | **None.** |
| **Tobacco Use** | **Former smoker, quit 20 years ago after smoking one pack a day for 30 years.** |
| **Alcohol Use** | **Occasionally drinks wine, about 1-2 glasses per week.** |
| **Home Environment** | **Home type** | **Lives in a single-story house with minimal stairs.** |
| **Home Location** | **Suburban area.** |
| **Co-habitants** | **Lives with her husband, who is retired.** |
| **Home Healthcare devices (for virtual simulations)** | **Uses a cane for walking.** | |
| **Social Supports** | **Family & Friends** | **Supported by husband; has limited contact with extended family.** |
| **Financial** | **Retired, receives pension and social security; financially stable.** |
| **Health care access and insurance** | **Has comprehensive health insurance through Medicare and supplemental plans.** |
| **Religious or Community Groups** | **Attends church services weekly; active in the church choir.** |
| **Education and Occupation** | **Level of Education** | **High school diploma.** |
| **Occupation** | **Retired school teacher.** |
| **Health Literacy** | **Moderate; understands basic medical instructions but may need clarification on complex terms.** |
| **Sexual History:** | **Relationship Status** | **Married.** |
| **Current sexual partners** | **Married to her husband.** |
| **Lifetime sexual partners** | **One (her husband).** |
| **Safety in relationship** | **N/A.** |
| **Sexual orientation** | **Heterosexual.** |
| **Gender identity** | **Pronouns** | **She/Her.** |
| **Identifies as (e.g. transgender, cisgender, gender queer)** | **Cisgender female.** |
| **Sex assigned at birth** | **Female.** |
| **Gender presentation (any notes about body language, style, or dress that may signal gender identity)** | **Dresses conservatively, prefers comfortable clothing suitable for her age and mobility needs.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Gardening, reading, participating in church choir.** |
| **Recent travel** | **Took a short trip to visit grandchildren three months ago.** |
| **Diet** | **Typical day’s meals** | **Balanced diet with emphasis on low-sodium foods; includes fruits, vegetables, lean proteins.** |
| **Recent meals** | **Skipped lunch yesterday due to lack of appetite.** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **Limits salt intake to manage blood pressure; avoids high-fat and high-sugar foods.** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **Low-sodium diet for heart failure and hypertension.** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Walks with cane twice daily for about 15 minutes each time; light gardening.** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced walking duration due to increased fatigue and swelling.** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Sleeps approximately 7 hours per night.**  **Quality: Generally good, but experiences disturbed sleep occasionally due to shortness of breath.**  **Recent Changes: Reports more frequent nighttime awakenings because of breathing difficulties.** |
| **Stressors** | **Work** | **Retired, minimal work-related stress.** |
| **Home** | **Adjusting to increased dependence on husband due to health issues.** |
| **Financial** | **Stable, no current financial stress.** |
| **Other** | **Concern about worsening health and potential need for hospitalization or advanced care.** |

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

|  |
| --- |
| Vital Signs:  Blood Pressure: 145/90 mmHg  Heart Rate: 88 bpm, regular  Respiratory Rate: 20 breaths per minute  Temperature: 98.4°F (36.9°C)  Oxygen Saturation: 95% on room air  General Appearance:  Appears fatigued, slight edema in lower extremities, uses a cane for ambulation.  HEENT:  Pupils equal, reactive to light.  No jugular venous distension.  Cardiovascular:  Regular rhythm, no murmurs audible.  Peripheral pulses are present but weak in lower extremities.  Respiratory:  Slightly increased effort when sitting up; no wheezing or crackles heard.  Abdomen:  Soft, non-tender, no hepatosplenomegaly.  Extremities:  Bilateral pitting edema in ankles and lower legs up to mid-calf.  Neurological:  Alert and oriented to person, place, and time.  No focal neurological deficits. |

**Prompts and Special Instructions:**

|  |  |
| --- | --- |
| **Questions the SP MUST ask/ Statements patient must make** | **"Is there anything else I should be worried about?"**  **"What can I do to feel better?"**  **"How long will it take to see improvements?"** |
| **Questions the SP will ask if given the opportunity** | **Can you explain more about my treatment options?"**  **"Are there any lifestyle changes I should consider?"**  **"How will this affect my daily activities?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Expect a discussion about managing Chronic Heart Failure, including medication adjustments, dietary modifications, possible referral to a cardiologist, and recommendations for lifestyle changes.**  **Plan may include optimizing diuretic therapy, discussing the importance of medication adherence, scheduling follow-up appointments, and providing resources for support groups.**  **Reassurance about managing symptoms but concern about disease progression and quality of life.** |
| **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 lab results indicating elevated BNP levels, echocardiogram findings showing reduced ejection fraction, or other diagnostic imaging results that the SP is unaware of unless specifically disclosed.**  **Any comorbid conditions or test results not mentioned in the verbal history unless introduced by the learner.** |