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: Emily Thompson**

**Age: 28**

**Gender: Female**

**Chief Complaint: I've been feeling really run down with a sore throat and cough for the past few days."**

**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: Pleasant and cooperative, with slight irritation due to discomfort.**  **Speech: Clear and moderate in pace, occasionally verbose when describing symptoms.**  **Body Language: Slightly hunched posture, frequent throat clearing, uses hand gestures when explaining discomfort.**  **Non-Verbal Communication: Blinking more frequently, rubbing her throat, shows signs of fatigue (e.g., yawning).**  **Verbal Characteristics: Describes symptoms in detail, expresses concern about not improving.** |

**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**  **"I've been having a sore throat and a persistent cough for the last four days. It's making it hard to sleep and work."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"I've also noticed some fatigue and a mild headache, but they're not too bad."**  **"I have a bit of a runny nose and some congestion."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **Living Situation: "I live alone in an apartment downtown."**  **Social Supports: "I have a few close friends and a supportive family."**  **Recent Exposures: "I started feeling sick after attending a large office meeting last week."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Smoking Status: Emily does not smoke but may only reveal this if directly asked.**  **Recent Travel: "I haven't traveled recently," unless specifically inquired.**  **Any Allergies: "I don't have any known allergies," unless probed.** |

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

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

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| **Quality/Character** | **Sore throat described as scratchy and burning.**  **Cough is dry and non-productive.** |
| **Onset** | **Symptoms began four days ago, gradually worsening.** |
| **Duration/Frequency** | **Persistent sore throat and cough throughout the day and night.** |
| **Location** | **Throat discomfort localized to the posterior pharynx.** |
| **Radiation** | **No radiation.** |
| **Intensity (e.g. 1-10 scale for pain)** | **Sore throat: 6/10**  **Cough: 5/10**  **Headache: 4/10** |
| **Treatment (what has been tried, what were the results)** | **Over-the-counter throat lozenges and cough syrup with minimal relief.**  **Increased fluid intake and rest.** |
| **Aggravating** **Factors (what makes it worse)** | **Talking and swallowing worsen the sore throat.**  **Coughing episodes disturb sleep.** |
| **Alleviating** **Factors (what makes it better)** | **Warm teas provide temporary soothing.**  **Resting helps reduce coughing frequency.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Exposure to colleagues with similar symptoms at the office meeting.** |
| **Associated** **Symptoms** | **Mild headache**  **Fatigue**  **Runny nose and nasal congestion**  **Occasional mild chills** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Impacting work performance due to inability to concentrate and persistent coughing.**  **Concerned about not recovering quickly and missing important deadlines.**  **Hopes for a swift recovery to return to normal activities.** |

**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: Fatigue, mild headache.  HEENT: Sore throat, runny nose, nasal congestion.  Respiratory: Dry cough, no shortness of breath.  Cardiovascular: No chest pain or palpitations.  Gastrointestinal: No nausea, vomiting, or diarrhea.  Musculoskeletal: No muscle aches or joint pain.  Neurologic: Mild headache, no dizziness.  Psychiatric/Behavioral: Slight irritability due to discomfort. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Generally healthy, no chronic illnesses.** |
| **Hospitalizations** | **None in the past year.** |
| **Surgical History** | **Appendectomy at age 15.** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Up-to-date with vaccinations, including annual flu shot.** |
| **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** | **Ibuprofen: 200 mg orally every 6 hours as needed for headache.**  **Cough Syrup: 10 ml orally every 8 hours for cough.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medications: None known.**  **Environmental: None.**  **Food: None.**  **Date of Allergy Diagnosis: N/A.** |
| **Gynecologic History** | **N/A** |

**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: Alive, age 55, hypertension.**  **Mother: Alive, age 53, type 2 diabetes.**  **Siblings: Younger brother, age 25, healthy.** |
| **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.**  **All other family members are alive and well unless specified.** |
| **Management/Treatment of any relevant conditions and/or chronic diseases in family** | **Father on antihypertensive medications.**  **Mother manages diabetes with diet and 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)** | **No recreational drug use.** |
| **Tobacco Use** | **Non-smoker** |
| **Alcohol Use** | **Social drinker, 1-2 glasses per week.** |
| **Home Environment** | **Home type** | **Apartment.** |
| **Home Location** | **Downtown area.** |
| **Co-habitants** | **Lives alone.** |
| **Home Healthcare devices (for virtual simulations)** | **N/A.** | |
| **Social Supports** | **Family & Friends** | **Maintains close relationships with family and a small group of friends.** |
| **Financial** | **Employed full-time as a graphic designer, financially stable.** |
| **Health care access and insurance** | **Has comprehensive health insurance through employer.** |
| **Religious or Community Groups** | **Occasionally attends local community events.** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Graphic Design.** |
| **Occupation** | **Full-time graphic designer at a marketing firm.** |
| **Health Literacy** | **Good understanding of health information.** |
| **Sexual History:** | **Relationship Status** | **Single.** |
| **Current sexual partners** | **None.** |
| **Lifetime sexual partners** | **One long-term relationship in the past year.** |
| **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)** | **Casual attire, minimal makeup, no specific notes on body language related to gender identity.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Painting, reading, yoga.** |
| **Recent travel** | **No recent travel; last trip was two years ago.** |
| **Diet** | **Typical day’s meals** | **Balanced diet with three meals and two snacks.** |
| **Recent meals** | **Regular diet; no recent changes.** |
| **Avoids eating (e.g., fried foods, seafood, etc.)** | **No specific dietary restrictions.** |
| **Special diet (e.g., vegetarian, keto, dietary restrictions, etc.)** | **None.** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Practices yoga twice a week, occasional evening walks.** |
| **Recent changes to exercise/activity (and reason for change)** | **No recent changes.**  **** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Averages 7-8 hours per night.**  **Length: Consistent sleep duration.**  **Quality: Generally good, disrupted recently by coughing.** |
| **Stressors** | **Work** | **Tight project deadlines causing mild stress.** |
| **Home** | **Living alone but managing well.** |
| **Financial** | **Stable, no significant financial stress.** |
| **Other** | **Concern about prolonged illness affecting work performance.** |

**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: (To be provided as door information if applicable)  Temperature: 100.4°F (if relevant)  Pulse: 88 bpm  Respirations: 18 per minute  Blood Pressure: 120/80 mmHg  HEENT:  Head: Atraumatic, normocephalic.  Eyes: Conjunctiva clear, no injection.  Ears: Tympanic membranes normal, no erythema.  Nose: Slight congestion, clear discharge.  Throat: Erythematous pharynx, swollen tonsils without exudate.  Neck:  No lymphadenopathy, supple.  Chest/Lungs:  Clear to auscultation bilaterally, no wheezes or rales.  Heart:  Regular rate and rhythm, no murmurs.  Abdomen:  Soft, non-tender, no hepatosplenomegaly.  Extremities:  No cyanosis, clubbing, or edema.  Neurologic:  Alert and oriented, no focal deficits. |

**Prompts and Special Instructions:**

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| **Questions the SP MUST ask/ Statements patient must make** | **Must Ask:**  **"Have you experienced any difficulty breathing or chest pain?"**  **"Have you had a fever or chills?"**  **Must Make:**  **"I've been coughing a lot, especially at night."**  **"Swallowing is a bit painful."** |
| **Questions the SP will ask if given the opportunity** | **"Do you have any other symptoms like a headache or fatigue?"**  **"Have you been exposed to anyone else who is sick recently?"**  **"How has this illness affected your daily activities?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Likely Upper Respiratory Infection (URI)**  **Plan: Symptomatic treatment, rest, hydration, possible over-the-counter medications.**  **Treatment: Recommendations for managing symptoms, follow-up if symptoms worsen or do not improve within a week.**  **Reassurance: Providing assurance about the self-limiting nature of URIs and when to seek further medical attention.** |
| **Is there anything the learner knows from the door info that the SP does not? (e.g., symptomatic vitals, pregnancy, lab results, imaging)** | **Symptomatic Vitals: If door information includes vital signs like elevated temperature, the SP should reflect this in their responses (e.g., feeling feverish).**  **Pregnancy: If applicable, the SP may not know about a patient's pregnancy unless it's part of the scenario.**  **Lab Results/Imaging: The SP is unaware of any lab results or imaging findings unless the learner orders them and discusses the results.** |