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 Rivera**

**Age: 45**

**Gender: Male**

**Chief Complaint: I've been coughing a lot and feeling really tired for the past week.**

**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: Slightly irritable due to persistent coughing but remains cooperative.**  **Speech: Clear and moderate in pace, occasionally terse when coughing interrupts.**  **Body Language: Slight hunched posture to ease coughing, frequent hand movements to cover mouth when coughing.**  **Non-Verbal Communication: Frequent throat clearing, shows signs of fatigue (e.g., drooping eyelids), minimal eye contact due to discomfort.**  **Verbal Characteristics: Describes symptoms in detail, expresses frustration about ongoing cough and fatigue.** |

**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 coughing a lot and feeling really tired for the past week. It's been hard to get through the day without stopping to cough."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"I've also been experiencing some chest discomfort when I cough."**  **"Sometimes I feel a bit short of breath after coughing fits."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **Smoking Status: "I used to smoke about a pack a day for 15 years, but I quit two years ago."**  **Recent Infections: "A few days ago, I was at a family gathering where a few people were sick with similar symptoms."**  **Work Environment: "I work in an office setting, but recently I've been handling more in-person meetings."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Alcohol Use: "I drink socially, usually on weekends."**  **Recent Travel: "I haven't traveled recently," unless specifically inquired.**  **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** | **Cough described as persistent and hacking.**  **Chest discomfort described as a tightness or soreness following coughing episodes.** |
| **Onset** | **Symptoms began approximately seven days ago, following a period of feeling generally unwell.** |
| **Duration/Frequency** | **Persistent cough occurring throughout the day and night, with episodes lasting several minutes.** |
| **Location** | **Chest area, primarily in the lower anterior regions** |
| **Radiation** | **No radiation of pain.** |
| **Intensity (e.g. 1-10 scale for pain)** | **Cough: 7/10**  **Chest Discomfort: 5/10**  **Fatigue: 6/10** |
| **Treatment (what has been tried, what were the results)** | **Over-the-counter cough suppressants with minimal relief.**  **Increased fluid intake and rest.** |
| **Aggravating** **Factors (what makes it worse)** | **Coughing spells worsen with physical activity.**  **Nighttime coughing disrupts sleep.** |
| **Alleviating** **Factors (what makes it better)** | **Using a humidifier provides some relief.**  **Warm beverages soothe the throat temporarily.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Possible viral infection, recent exposure to others with similar symptoms.**  **Increased stress at work may have contributed to a weakened immune response.** |
| **Associated** **Symptoms** | **Fatigue and generalized weakness.**  **Mild fever intermittently (if applicable).**  **Shortness of breath following coughing fits.**  **Sore throat due to persistent coughing.** |
| **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 persistent coughing and fatigue.**  **Concerned about the prolonged duration of symptoms and the possibility of a more serious condition like pneumonia.**  **Hopes for a quick recovery to resume normal activities and responsibilities.** |

**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.  HEENT: Sore throat, no nasal congestion or discharge.  Respiratory: Persistent cough, chest discomfort, occasional shortness of breath.  Cardiovascular: No chest pain unrelated to coughing, no palpitations.  Gastrointestinal: No nausea, vomiting, or diarrhea.  Musculoskeletal: No muscle aches or joint pain.  Neurologic: No headaches, dizziness, or neurological deficits.  Psychiatric/Behavioral: Slight irritability due to discomfort and disrupted sleep. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Generally healthy, history of seasonal allergies.** |
| **Hospitalizations** | **None in the past five years.** |
| **Surgical History** | **None.** |
| **Screening/Preventive (including vaccinations /immunizations)** | **Up-to-date with vaccinations, including annual flu shot.**  **Regular health check-ups with primary care physician.** |
| **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** | **Cough Suppressant (e.g., Dextromethorphan): 10 ml orally every 6 hours as needed for cough.**  **Acetaminophen: 500 mg orally every 8 hours as needed for fever or discomfort.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medications: No known drug allergies.**  **Environmental: No known environmental allergies.**  **Food: No known food allergies.**  **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 70, history of COPD.**  **Mother: Alive, age 68, hypertension.**  **Siblings: One younger sister, age 40, 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 manages COPD with inhalers and regular check-ups.**  **Mother manages hypertension with medication and diet.** |

**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** | **Former smoker, quit two years ago after 15 years of smoking a pack a day.** |
| **Alcohol Use** | **Social drinker, approximately 2-3 drinks per week.** |
| **Home Environment** | **Home type** | **Detached single-family home.** |
| **Home Location** | **Suburban area.** |
| **Co-habitants** | **Lives with spouse and two children.** |
| **Home Healthcare devices (for virtual simulations)** | **None.** | |
| **Social Supports** | **Family & Friends** | **Strong support system with a supportive spouse and close-knit family.** |
| **Financial** | **Employed full-time as an IT manager, financially stable.** |
| **Health care access and insurance** | **Comprehensive health insurance through employer.** |
| **Religious or Community Groups** | **Active member of local community sports league.** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Information Technology.** |
| **Occupation** | **IT Manager at a tech company.** |
| **Health Literacy** | **Good understanding of health information and medical terminology.** |
| **Sexual History:** | **Relationship Status** | **Married.** |
| **Current sexual partners** | **Spouse.** |
| **Lifetime sexual partners** | **One, currently in a monogamous relationship.** |
| **Safety in relationship** | **Practicing safe sex, no history of sexually transmitted infections.** |
| **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)** | **Business casual attire, no specific notes on body language related to gender identity.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Playing basketball, hiking, reading science fiction novels.** |
| **Recent travel** | **No recent travel; last vacation was six months ago.** |
| **Diet** | **Typical day’s meals** | **Balanced diet with three meals and two snacks, includes fruits and vegetables.** |
| **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.)** | **Occasionally follows a low-sodium diet due to family history of hypertension.** |
| **Exercise (activities and frequency)** | **Exercise activities and frequency** | **Plays basketball twice a week, goes hiking on weekends.** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced frequency slightly due to persistent cough and fatigue.** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Averages 6-7 hours per night.**  **Length: Consistent sleep duration.**  **Quality: Generally good, recently disrupted by nighttime coughing.** |
| **Stressors** | **Work** | **Managing a high-stress project with tight deadlines.** |
| **Home** | **Balancing work responsibilities with family obligations.** |
| **Financial** | **Stable, no significant financial stress.** |
| **Other** | **Concern about the persistent cough affecting job performance and personal health.** |

**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: 101.2°F  Pulse: 92 bpm  Respirations: 20 per minute  Blood Pressure: 130/85 mmHg  HEENT:  Head: Atraumatic, normocephalic.  Eyes: Conjunctiva clear, no injection.  Ears: Tympanic membranes normal, no erythema.  Nose: No significant congestion or discharge.  Throat: Mild erythema, no exudate.  Neck:  No lymphadenopathy, supple.  Chest/Lungs:  Inspection: Slight use of accessory muscles during coughing.  Auscultation: Rhonchi heard in the lower lobes, no wheezes or rales.  Percussion: Normal resonance.  Palpation: No tenderness.  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 noticed any changes in your breathing or experienced any wheezing?"**  **"Have you had any fevers or chills since your symptoms started?"**  **Must Make:**  **"The coughing is really persistent and sometimes wakes me up at night."**  **"I feel more tired than usual and have trouble keeping up with my daily tasks."** |
| **Questions the SP will ask if given the opportunity** | **"Do you have any history of lung problems or asthma?"**  **"Have you been exposed to anyone else with similar respiratory symptoms?"**  **"How has this illness affected your ability to perform your job?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Acute Bronchitis**  **Plan: Symptomatic treatment including rest, increased fluid intake, possible prescription for a stronger cough suppressant or expectorant.**  **Treatment: Recommendations for managing symptoms, such as using a humidifier, taking over-the-counter medications, and avoiding irritants like smoke.**  **Reassurance: Providing information about the self-limiting nature of acute bronchitis and advising when to seek further medical attention if symptoms worsen or do not improve within a couple of weeks.** |
| **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., mentioning feeling feverish).**  **Lab Results/Imaging: The SP is unaware of any lab results or imaging findings unless the learner orders them and discusses the results.**  **Chronic Conditions: If there are underlying conditions not mentioned in the history, the SP should remain unaware unless specifically introduced by the learner.** |