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: David Lee**

**Age: 38**

**Gender: Male**

**Chief Complaint: I've been having severe difficulty breathing and frequent coughing spells for the past two 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: Anxious and frustrated due to sudden breathing difficulties but remains cooperative.**  **Speech: Slightly labored with occasional pauses to catch breath; clear and coherent.**  **Body Language: Frequent use of accessory muscles (neck and chest), holding chest with one hand, leaning slightly forward to ease breathing.**  **Non-Verbal Communication: Visible signs of shortness of breath (e.g., rapid breathing, pursed lips), occasional sighs, limited eye contact due to discomfort.**  **Verbal Characteristics: Describes symptoms in detail, expresses concern about the sudden onset and severity of symptoms.** |

**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 lot more trouble breathing lately, especially at night. My coughing spells are frequent and severe, and it feels like I can't get enough air."** |
| **Other information offered spontaneously (what can be disclosed after any open-ended question)** | **B**  **"I've also been wheezing a lot, and my chest feels tight."**  **"Sometimes I feel dizzy when I can't breathe properly."** |
| **Information elicited when generally prompted (what can be disclosed in response to an open-ended question on a particular topic)** | **C**  **Environmental Triggers: "I've been doing a lot of yard work recently, and there’s been a lot of pollen in the air."**  **Exercise Routine: "I usually go jogging three times a week, but I've had to stop because of the breathing issues."**  **Recent Illnesses: "I had a mild cold about a week ago, but I thought I was getting better."** |
| **Information hidden until asked directly (what should be withheld until specific questioning)** | **D**  **Smoking Status: "I don't smoke," unless directly asked about smoking or exposure to smoke.**  **Occupational Exposure: "I work in a corporate office, so I don't think my job affects my breathing," unless specifically inquired.**  **Mental Health: Any anxiety or panic related to breathing difficulties, unless directly asked.** |

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

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

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| **Quality/Character** | **Difficulty breathing described as wheezing and shortness of breath.**  **Chest tightness feels like a heavy weight pressing down.** |
| **Onset** | **Symptoms began suddenly two days ago, with a gradual increase in severity.** |
| **Duration/Frequency** | **Persistent symptoms throughout the day and night, with peaks during physical activity and exposure to outdoor allergens.** |
| **Location** | **Chest area, primarily centralized** |
| **Radiation** | **No radiation of symptoms.** |
| **Intensity (e.g. 1-10 scale for pain)** | **Breathing difficulty: 7/10**  **Chest tightness: 6/10**  **Anxiety: 5/10** |
| **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)** | **Exposure to pollen and dust from yard work.**  **Physical exertion or exercise.**  **Cold air aggravates breathing.** |
| **Alleviating** **Factors (what makes it better)** | **Sitting upright and taking slow, deep breaths.**  **Using a fan to circulate air indoors.**  **Avoiding outdoor activities.** |
| **Precipitating** **Factors (does anything seem to bring it on, e.g. meals, environment, time of day)** | **Recent increase in household cleaning activities leading to pollen exposure.**  **Possible viral upper respiratory infection contributing to airway irritation.** |
| **Associated** **Symptoms** | **Frequent and severe coughing spells.**  **Wheezing sounds during breathing.**  **Chest tightness and discomfort.**  **Occasional dizziness from lack of oxygen.** |
| **Significance to Patient (impact on patient’s life, patient’s beliefs about origin of problem, underlying concerns/fears, hopes/desires)** | **Impacting daily activities and ability to work.**  **Concerned about the sudden onset and severity of symptoms.**  **Fear of a severe asthma attack requiring emergency care.**  **Hopes to regain control over breathing and resume 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.  HEENT: Sore throat from coughing, no nasal congestion unless related to allergies.  Respiratory: Wheezing, shortness of breath, chest tightness, persistent cough.  Cardiovascular: No chest pain unrelated to breathing, no palpitations.  Gastrointestinal: No nausea, vomiting, or diarrhea.  Musculoskeletal: No muscle aches or joint pain.  Neurologic: Mild headache, no dizziness or neurological deficits.  Psychiatric/Behavioral: Increased anxiety and frustration due to breathing difficulties. |

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

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| **Illnesses/Injuries (chronic or otherwise relevant)** | **Generally healthy with no history of asthma or chronic respiratory conditions.**  **History of seasonal allergies (hay fever) since childhood** |
| **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 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** | **Ibuprofen: 200 mg orally every 6 hours as needed for pain or fever.**  **Antihistamine (e.g., Loratadine): 10 mg once daily during allergy season.** |
| **Allergies (environmental, food, or medication – also list any known reactions) Date of allergy diagnosis** | **Medications: None known.**  **Environmental: Allergic to pollen and dust mites.**  **Food: None known.**  **Date of Allergy Diagnosis: Diagnosed with environmental allergies in childhood.** |
| **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 60, history of hypertension.**  **Mother: Alive, age 58, history of seasonal allergies.**  **Siblings: One younger sister, age 35, 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** | **Mother manages seasonal allergies with antihistamines and allergen avoidance.**  **Father controls hypertension with medication and lifestyle changes.** |

**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, approximately 2-3 drinks per week** |
| **Home Environment** | **Home type** | **Single-family home.** |
| **Home Location** | **Suburban area with a backyard.** |
| **Co-habitants** | **Lives with spouse and two children.** |
| **Home Healthcare devices (for virtual simulations)** | **Uses a fan to circulate air indoors.** | |
| **Social Supports** | **Family & Friends** | **Strong support system with a supportive spouse and close friends.** |
| **Financial** | **Employed full-time as a software engineer, financially stable.** |
| **Health care access and insurance** | **Comprehensive health insurance through employer.** |
| **Religious or Community Groups** | **Active member of a local hiking club.** |
| **Education and Occupation** | **Level of Education** | **Bachelor’s degree in Computer Science.** |
| **Occupation** | **Full-time software engineer 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)** | **Casual attire, no specific notes on body language related to gender identity.** |
| **Activities, Interests, & Recreation** | **Hobbies, interests, and activities** | **Hiking, playing guitar, reading technology blogs.** |
| **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** | **Enjoys hiking on weekends and occasional evening runs.** |
| **Recent changes to exercise/activity (and reason for change)** | **Reduced frequency of outdoor activities due to breathing difficulties.** |
| **Sleep Habits** | **Pattern, length, quality, recent changes** | **Pattern: Averages 7-8 hours per night.**  **Length: Consistent sleep duration.**  **Quality: Generally good, recently disrupted by nighttime coughing and difficulty breathing.** |
| **Stressors** | **Work** | **Managing tight project deadlines causing mild stress.** |
| **Home** | **Balancing work responsibilities with family obligations.** |
| **Financial** | **Stable, no significant financial stress.** |
| **Other** | **Concern about the persistent breathing difficulties affecting daily life and 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: 100.8°F  Pulse: 100 bpm  Respirations: 24 per minute, slightly labored  Blood Pressure: 130/85 mmHg  HEENT:  Head: Atraumatic, normocephalic.  Eyes: Conjunctiva clear, no injection.  Ears: Tympanic membranes normal, no erythema.  Nose: Slightly congested, clear discharge.  Throat: Mild erythema, no exudate.  Neck:  No lymphadenopathy, supple.  Chest/Lungs:  Inspection: Use of accessory muscles, slight chest retractions.  Auscultation: Wheezing heard bilaterally, especially on expiration.  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 experienced any recent changes in your environment or activities that might have triggered these symptoms?"**  **"Are you currently using any medications to help with your breathing?"**  **Must Make:**  **"My breathing has become really difficult, and my cough won't go away."**  **"I feel like I can't catch my breath, especially at night when I'm trying to sleep."** |
| **Questions the SP will ask if given the opportunity** | **"Do you know what might have triggered your current breathing issues?"**  **"Have you noticed any new allergens or irritants in your environment recently?"**  **"How has this breathing difficulty affected your daily activities and work?"** |
| **What should the SP expect by the end of this visit? (e.g., diagnosis, plan, treatment, reassurance)** | **Diagnosis: Acute Asthma Exacerbation (new diagnosis)**  **Plan:**  **Initiate bronchodilator therapy (e.g., albuterol inhaler).**  **Consider adding or adjusting controller medications (e.g., inhaled corticosteroids) based on assessment.**  **Provide education on avoiding triggers and proper inhaler technique.**  **Schedule follow-up appointment to monitor asthma control.**  **Treatment: Recommendations for managing acute symptoms, possible prescription for oral corticosteroids if indicated, and strategies to prevent future exacerbations.**  **Reassurance: Informing about the effectiveness of proper asthma management and the importance of adherence to the treatment plan to prevent severe attacks.** |
| **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.** |