*This template has been adapted from ASPE (Association of Standardized Patient Educators) by our SP trainer team with input from DRIVE. The template follows ASPE Standards of Best Practice and is designed to help consistently build robust cases that promote inclusion. We ask that you consider the breadth of people who are actual and standardized patients in creating your case. If elements are not essential to the objectives of the case we propose that SPs provide responses based on their ability, experience and comfort in sharing, rather than reporting details that may exclude some.*

*Please complete all sections relevant to your case and indicate where responses can be adjusted by the SP portraying this case by typing "(response can be open)” next to your entry.*

*For example: Activities -- patient plays tennis and walks (response can be open) allows a patient who uses a wheelchair to answer 'plays adaptive tennis and does upper body exercise', or a patient with limited mobility to answer 'does water exercise at the local community center' or similar.*

# Part 1 – Administrative Details

**Patient (SP) Name (legal/preferred/pronouns):**

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Pronunciation

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**Patient’s Chief complaint (in the patient’s words):**

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**Differential Diagnoses:**

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**Actual Diagnosis:**

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**Case Purpose (formative, summative, teaching, learner practice, assessment, lecture, demonstration) and location of session (iCELS SP, iCELS Sim, off-site, virtual):**

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**Program and level of the learner and discipline: (e.g. GSN, GEP 1st year)**

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**Learner’s prerequisite knowledge and skills (including prior sim interaction):**

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**Case authors, month and year written (if revised, add to original data):**

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**Learning/Case objectives (include communication, physical exam, impact of societal forces/DEI, bias and similar):**

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**List of learner assessment instruments required (e.g. results, imaging, EKG, SP checklist, post-encounter note, quiz) and modality (paper, on computer, etc.):**

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**Event format: (e.g. small group, individual, multi-station OSCE, duration)**

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**Demographics of patient/recruitment guidelines: (e.g. age range, gender identity, body type, ethnicity, ability, or other and objective/reason for that demographic – note that if race is defined the objective should address impact of racism in this patient’s care)**

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**Content Warnings: (any potentially triggering or uncomfortable case content that may impact SPs’ willingness or ability to portray the role while maintaining psychological safety)**

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**List of props needed for encounter: (e.g. moulage, SP attire, physical exam equipment, ice packs, etc.)**

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**For iCELS to complete: List of special supplies needed off-site and sent to SP:**

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**Should this case have a virtual background if possible? If so what type?**

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**Room setup on-site: (e.g. equipment, furniture, sim technology, debriefing materials)**

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# Part 2 – Door Chart/Note & Learner Instruction

**Setting (patient location, in-person/telehealth)**

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**Vital Signs: Taken on intake**

Blood Pressure:

Heart Rate:

Temperature:

Respiratory Rate:

Oxygen Saturation:

Pain scale:

BMI:

Other:

**Instructions to Learners: (adjust to case, include information on their tasks regarding history-taking, physical exam, patient discussion, other communications, paperwork, feedback)**

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| --- |
| **You will have 15 minutes to:**  1) Obtain a focused and relevant history.  2) Perform a focused and relevant physical exam. Do not perform any sensitive exams (breast, pelvic, rectal). If you wish to perform a sensitive exam, simply tell the SP that you would do it.  3) Discuss your initial diagnostic impressions, follow-up tests and initial management plans with the patient.  **You will have 10 minutes to:**  4) Leave the room and complete the paperwork related to this case.  **You will have 5 minutes to:**  5) Return to the patient room for feedback from the Standardized Patient. |

**Part 3 – Content for SPs**

**Patient Affect, Behavior and Relevant Verbal Characteristics (e.g. body language, non-verbal communication, verbal characteristics)**

**Examples: Affect: Anxiety, Behavioral descriptor: bites fingernails, wrings hands, Body language: avoids eye contact, does not smile**

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**Opening/Follow-up Statement (matching case objectives) and Guidelines for Disclosure**

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| Opening Statement:  Follow-up Statement: |

**Dealing with Open-Ended Questions and Guidelines for Disclosure (sharing case information)**

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| Information offered spontaneously (what the patient can share after an open-ended question)  Information not offered until asked directly (what the patient should share on specific questioning) |

**History of Present Illness (HPI): (consider the following)**

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| --- |
| **Quality/Character:** |
| **Onset**: |
| **Duration & frequency:** |
| **Extenuating circumstances:** |
| **Location:** |
| **Radiation** (if the word radiation is used, should SP treat this as jargon and ask learner to clarify?): |
| **Intensity** (language for SP to use – mild, moderate, severe/really bad; or pain scale? will this be part of door note?: |
| **Aggravating** **Factors (what makes it worse}:** |
| **Alleviating** **Factors (what makes it better):** |
| **Precipitating** **Factors (does anything seem to bring it on):** |
| **Past episodes:** |
| **Associated** **Symptoms:** |
| **Significance to Patient (impact on patient’s life including SDOH/work/family/community, patient’s beliefs about origin of problem, underlying concerns/fears, expectations for the visit, any cultural relevance, issues related to bias or racism):** |

**Review of Systems – do not repeat associated symptoms: (e.g. list system and pertinent positives and negatives; i.e. GI nausea no vomiting or abdominal pain. 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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**Past Medical History (PMH): (consider including the following as relevant to case objectives; N/A if not)**

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| **Significant illnesses/medical diagnoses** |
| **Injuries:** |
| **Hospitalizations:** |
| **Surgical History:** |
| **Screening/Preventive (list if relevant to age, gender):** |
| **Medications (Prescription, Over the Counter, Supplements, add dosage, strength, frequency if relevant):** |
| **Allergies (e.g. environmental, food, medication and reaction, date of allergy diagnosis if relevant):** |
| **Gynecologic History:** |

**Family Medical History: (consider the following)**

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| **Family tree (e.g. health status, age, cause of death for appropriate family members)** |
| **Relevant Conditions/Chronic Diseases** |

**Social History: (consider the following and include as relevant to your case – these are areas that are particularly suited to the SP answering based on their own ability, experience, comfort in sharing; please enter ‘response can be open’ where appropriate to support SP training)**

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| --- |
| **Substance Use (past and present; include quantity, frequency, types)**  Drug Use: (Recreational – even if legal; and medications prescribed to other people):  Tobacco Use:  Alcohol Use: |
| **Home Environment (stability, security, co-habitants)** |
| **Social determinants of health (housing status food security, insurance status, transportation):** |
| **Social Supports (friends, partner, religious organization)** |
| **Employment status and occupation (consider exposures)** |
| **Sexual History**  Relationship Status  Single or partnered  Current and lifetime sexual partner(s)  Safety in relationship  Sexual health and wellness (behaviors, pain, concerns)  Sexual orientation |
| **Gender identity**  Pronouns  Identifies as (e.g. transgender, cisgender, gender queer)  Sex assigned at birth  Gender presentation (any notes about body language, style, or dress that may signal gender identity) |
| **Activities, Interests, & Recreation**  Leisure Activities/hobbies/Interests:  Recent Travel: |
| **Diet (including caffeine)**  Recent meals  Avoids eating (e.g., fried foods, seafood, etc.)  Special diet (e.g., vegetarian, keto, dietary restrictions, etc.) |
| **Exercise (Activities and Frequency)**  Include any recent changes to exercise/activity (and reason for change |
| **Sleep Habits**  Pattern, length, quality, recent changes |
| **Stressors**  Work:  Home:  Financial:  Other: |

**Physical Exam Findings: (may also include instructions on replicating findings and test results)**

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**Prompts and Special Instructions (as applicable):**

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| Questions the patient MUST ask/ Statements patient must make |
| Questions the patient will ask if given the opportunity |

**Guidelines for Feedback: (e.g. logistics, focus, structure, amount of time and content for feedback)**

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# Parts 4-5 – SP Checklist and instructions

Learner Name: Date: SP:

**Questions must relate to objectives**

**Grading Scale (LIKERT or Dichotomous):**

*Please describe the scale to be used for each item in this section (e.g. Yes/No, Done/Not Done, etc.).*

*Include the point values for each. (e.g. Yes = 1, No=0)*

Format to be shared by event manager and discussed with SP trainer

**Part 6 – Additional Learner Materials (details of resources noted above)**

**(e.g. laboratory results/readings, images, physical exam results cards)**

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| Examples: Pre encounter labs or images, post encounter labs or images.  Please list when and where they access these. |

# Part 7 – Post-Encounter Activities

**Describe the type of activity the student will engage after the SP Encounter.**

*(Write a SOAP Note, Order Labs, Answer Multiple choice questions, etc.)*

*\*note – debriefing may also be a post-encounter activity*

**Example: Differential Diagnosis**

1. *List your top 3 differential diagnosis at this point?*

**Example: Impact of bias on care**

1. *Describe at least 2 ways that bias may have impacted this patient’s prior experiences of care.*

# Part 8 – Note Rubric or Answer Key for Post-Encounter Activities

(Insert here – criteria that make explicit for raters how learners earn credit sections/items)

# Answers should be given in a list, not prose

Need list of answers assigned points, with highest number of points at top and working down

**Example: Differential Diagnosis**

1. *List your top 3 differential diagnosis at this point?*

Diagnosis #1 [2 points]

Diagnosis #2 [1 point]

Diagnosis #3 [1 point]

Diagnosis #4 [1 point]

Diagnosis #5 [1 point]

Diagnosis #6 [1 point]

# Part 9 – Briefing/Learner Orientation/Closure

**Consistent orientation ppt template to be created by and reviewed with event manager.**

**Format and timing:**

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**Special instructions: (e.g. special equipment)**

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