TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
Simulation Program
Standardized Patient Case Template

Date:
Revised:
Case Authors:

TITLE:

Case (Patient) Name:	
Case Title:	
Classification:	Primary [*body system*]:
	Secondary [*medical diagnosis*]:
	Acuity [*low, medium, high*]: High
Gender, Ethnicity, and Age:	
Presenting Complaint:	
Objectives:	1. 2. 3. 4.
Brief summary:	
Differential Diagnosis:	
Task(s)/ Skills to be completed:	
Exam Room Needs:	
Pre-Encounter Station Needs:	
Post-Encounter Station Needs:	
Data collection tool(s): (Please attach)	
Designed for: (Student/resident)	

SP Training Notes

Case (Patient) Name	
Presenting Situation	
Psychosocial Profile	
Opening Statement/ Chief Complaint	
History of Present Illness	
Past Medical History	➢
Medications (Include over-the counter and herbs)	
Allergies	➢

Social History	
Family Medical History	➢
Past surgical History	➢
ROS	➢
Physical Exam Findings:	

Attach: STANDARDIZED PATIENT OBSERVATION CHECKLIST

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
Simulation Program

Standardized Patient Case Template
Student/Resident Instructions

Station Name:

Setting:

SBAR Report

S-situation	***Patient Name:*** ***Physician:*** ***Location:***
B-background	***Medical Diagnosis:*** ***Medical History:*** ***Home Medications:*** ***Age:*** ***Height:*** ***Weight:*** ***Allergies:*** ***DOB:*** ***Code Status (if appropriate):*** ***Current Time (if appropriate):***
A-assessment	***VS (If appropriate):*** ***Temp:*** ***P:*** ***BP:*** ***RR:***
R-recommendation/s	

INSTRUCTIONS: (Example)

You have __ minutes to perform a focused history and exam, then counsel the patient about your assessment and diagnostic/management plans. You will then have __ minutes to type a note in _____ format.

STANDARDIZED PATIENT OBSERVATION CHECKLIST (Example)
Case:

Student/Resident:
Standardized Patient:

YES	NO	Check if the student:
		1. Greets patient appropriately in a friendly manner.
		2. Introduces him/herself as a student doctor.
		3. Washes hands or uses hand sanitizer prior to initiation of exam.
		4. Starts encounter with open ended questions.
		5. Uses speech and language which is understandable
		6. Establishes rapport with body language and eye contact
		7. Allows patient to ask questions
		8. Assess patient for orthostatic hypotension.
		9. Student visually inspects neck veins to assess volume status.
		10. Elicits abdominal tenderness.
		11. Checks for hepatomegaly and splenomegaly.
		12. Informs patient that she is having a GI bleed in lay terms.
		13. Informs patient that she will need to be directly admitted to the hospital because this is an urgent/concerning matter.

FACULTY CHECKLIST (Example)
EVALUATION OF PROGRESS NOTE

(The student is asked to "Write a progress note on this encounter that will be entered into the chart.")

Yes	No	Check if the student:
		1. Plainly states Chief Complaint.
		2. Opening statement includes pertinent past medical history.
		3. Documents frequency of bloody emesis.
		4. Documents history of gnawing pain/hunger pain
		5. Documents history of relief of pain by eating.
		6. Documents history of black tarry stools/melena.
		7. Documents medication list (dose and frequency) including ibuprofen.
		8. Documents history of alcohol use.
		9. Documents family history of stomach cancer
		10. Documents orthostatic blood pressure readings.
		11. Documents abdominal tenderness on exam.
		12. Documents liver and spleen exam.
		13. Records the presence or absence of spider angiomas
		14. Differential diagnosis includes peptic ulcer disease/gastritis.
		15. Documents supporting information.
		16. Differential diagnosis includes esophageal varices.
		17. Documents supporting information.
		18. Differential diagnosis includes Mallory-Weis tear.
		19. Documents supporting information.
		20. Plan includes obtaining CBC.
		21. Plan includes coagulation studies
		22. Plan includes obtaining liver enzymes.
		23. Plan includes digital rectal exam.
		24. Plan includes upper endoscopy.

		25. Progress note is well organized.