Clinical Simulation Laboratory
AT THE UNIVERSITY OF VERMONT

PATIENT CENTERED STANDARDIZED PATIENT CASE WRITING OUTLINE

Name of Case:
Authors:
Date:

PART A: Identifying Case Factors

1. Name of case	
2. Length of the patient encounter	
3. Learning Objectives/purpose of the case	
4. Information pertaining to how the materials will be used:	○ Teaching
	○ Formative Assessment
	○ Summative Assessment
	○ All
	○ Other:_____
5. Target learner/s	
6. Type of case (may check more than one)	□ Communication:_____
	□ History only
	□ Physical Exam only
	□ History and Physical exam
	□ Complete patient encounter
	□ Other
Specific case considerations	
Specific body type or physical requirements	
Specific dress or props (religious head dress, pregnancy bellies etc)	
Make up or Moulage (include recipes and application guides if available)	
List of what is supplied or what equipment to be out for learner	
Other (EHR, lab reports, images etc)	
Other:_____	

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SETTING: outpatient, in patient, ED, home, nursing home, rehab, group etc.	
CHIEF CONCERN: What the patient will say when greeted by the student The patient's primary reason for seeking medical care often stated in his/own words.	
OTHER CONCERNS: What is other, if any, concerns patient has today- symptoms, requests, expectations, etc- will become part of set agenda.	
PATIENT PROFILE: Information about the "patient" that helps us choose an SP and that helps the learner get an understanding of him/her as a person. SP will know more information about the patient then learner will ever ask but allows SP to portray a fully developed patient.	
1. Age	
2. Race and/or ethnic	
3. Religious/spiritual background if any	
4. Gender identity/preferred pronoun	
5. Sexual Identity	
6. Intimate relationship status if any and length of current status	
7. Number of siblings, number of children	
8. Education	
9. Employment, if any - present and past, noting any current stresses	
10. Living situation – what kind of home & who they live with	
11. Financial situation- any current stresses	
12. Health insurance/underinsured/no health insurance	

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13. Habits - diet, exercise, caffeine, smoking, alcohol, drugs- other	
14. Activities - hobbies, sports, clubs, friends	
15. Important influences or belief systems	
THE PATIENT STORY: The SP will be asked to tell their symptom story and the personal and emotion impact for each of their concerns. You will want to write this is the patient voice.	
• Symptom story should be able to answer - "Tell me more about "the chief concern/other concern", starting at the beginning and bringing me up to now".	
• Personal context should be able to answer questions concerning the broader personal/psychosocial context of symptoms, especially the patient **beliefs/attributions**.	
• Emotional context should be able to ask how are you doing with this, how does this make you feel, how has this affected you emotionally? IMPACT: How has this affected your life? How has this been for your family?	

HISTORY OF PRESENT ILLNESS: Although some of the HPI will be given in the patient's symptom story, the learners will expand the story during the direct question section.	
The detailed history, usually about the chief concern, which the student must develop in order to make a useful assessment of the problem:	
1. Onset (when; gradual or sudden)	
2. Duration (how long)	
3. Time relationships (frequency, constant or intermittent)	
4. Location	
5. Quality	
6. Amount	
7. Aggravated by what	
8. Relieved by what	
9. Associated with what	
10. Attitude (what does the patient think is the problem, and how does he/she feel about it)	

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11. Attempted treatment	
PAST MEDICAL HISTORY	
Illnesses	
Vaccinations	
Surgeries	
Trauma	
REVIEW OF SYSTEMS: Significant positives and negatives- see ROS sheet	
SEXUAL HISTORY/ORIENTATION	
Number of current partners Sexual practices Use of safer sex practices Use of birth control if appropriate Risk of intimate partner violence	
FAMILY HISTORY	
Mother, Father, Siblings, Grandparents, and other significant findings.	
PHYSICAL EXAM FINDINGS	
1) Written in layman's terms	
2) General appearance- affect, appearance, position of patient at opening (i.e. Sitting, laying down, holding abdomen etc.)	
3) Vital signs	
4) Specific findings and affect	
5) Response to certain physical movements	
DIAGNOSIS AND DIFFERENTIAL	
Diagnosis with support from positive and negative history and PE findings	
Differential with support from positive and negative history and PE findings	
MANAGEMENT OR DIAGNOSITIC PLAN	
PROFESSIONALISM ISSUES OR CHALLENGES:	