Resources for Simulation Instructo **Information for Standardized Patient**
Case Summary:
Presentation and Behaviours / Emotional Tone:
Body Language, Facial expression, Eye Contact, Affect (e.g. pleasant, irritable, anxious)
Presenting complaint: When asked "what brings you here today?"
History of Present Illness: (In the format of a detailed summary or scripted responses to questions)
Responses to Open-Ended Questions and Guidelines for Disclosure (anticipate questions the learner will ask and provide specific answers)
Information offered spontaneously (examples of open-ended questions and what can be disclosed) **Information hidden until asked directly (examples of what requires specific questions to be asked)**
Past Medical History (illnesses, injuries, surgeries, hospitalization, medications, allergies, etc.)
Family History (relevant conditions or chronic diseases)
Social History (substance use, diet, exercise, relationship status, occupation, leisure activities)
Life Details (spouse, children, where they grew up, concerns or worries, etc.)
Physical Exam Findings
Assessments (anticipate any assessments they may do and responses)
Special Instructions / Questions for Patient to ask