**ISC Case Creation Template**

*We ask when completing this template, you provide as much information as possible for the Interprofessional Simulation Clinic to provide the best educational experience for our students. Once completed or if any questions during the process, please email Nita Skillman (**nskillman@elon.edu**) or Bethany Fearnow (**bfearnow@elon.edu**).*

**Faculty Lead:** Click or tap here to enter text.

**Faculty Email:** Click or tap here to enter text.

**Course:** Click or tap here to enter text.

**Date/Time:** Click or tap here to enter text.

**Indicate the purpose for this activity:**

[ ]  Formative

[ ]  Summative

[ ]  Demonstration

[ ]  Other:

**Educational Objectives *(do not exceed 5)*:**

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.

# **Case Development**

**Patient Demographics:** Click or tap here to enter text.

**Patient Age Range:** Click or tap here to enter text.

**Gender:** Click or tap here to enter text.

**Race:** Click or tap here to enter text.

**Socioeconomic Level:** Click or tap here to enter text.

**Educational Background:** Click or tap here to enter text.

**Simulation Affect *(e.g., confused)*:** Click or tap here to enter text.

**Patient Name:** Click or tap here to enter text.

**Chief Complaint:** Click or tap here to enter text.

**History of Present Illness:** Click or tap here to enter text.

**Patient Concerns:** Click or tap here to enter text.

**Effect on day-to-day life: *(e.g., afraid to walk without a walker)*:** Click or tap here to enter text.

**Patient expectations/Goals *(e.g., would like to begin walking without a walker)*:** Click or tap here to enter text.

**Current Medications:** Click or tap here to enter text.

**Past Medical History:** Click or tap here to enter text.

**Family History:** Click or tap here to enter text.

**Social History *(e.g., substance abuse, home environment, social supports, sexual history, gender identity, activities/interests, diet, exercise, stressors)*:** Click or tap here to enter text.

**Patient Presentation *(e.g., well-appearing)*:** Click or tap here to enter text.

**Physical Examination Findings *(if applicable)*:** Click or tap here to enter text.

**Patient Labs *(if applicable)*:** Click or tap here to enter text.

**MD Orders *(if applicable)*:** Click or tap here to enter text.

**Nurse’s Notes *(if applicable)*:** Click or tap here to enter text.

**Radiology *(if applicable)*:** Click or tap here to enter text.

**Additional Information:** Click or tap here to enter text.

# **Standardized Patient (SP) Additional Case Information**

**Please list any potentially triggering or uncomfortable case content that may impact the SPs willingness or ability to portray the role while maintaining psychological safety.**

Click or tap here to enter text.

**Questions/Statements the SP must ask:**

Click or tap here to enter text.

**Questions the SP could ask:**

Click or tap here to enter text.

**What should the SP expect by the end of this visit?**

[ ]  Diagnosis

[ ]  Plan

[ ]  Treatment

[ ]  Reassurance

[ ]  Other:

**Is there anything the student knows from the door note that the SP does not? *(e.g., lab results, imaging)***

Click or tap here to enter text.

# **Rubric**

*The rubric can be utilized by the SP for evaluating the student on soft skills and content. The SP will complete in the CAE software and will be calibrated prior to evaluating the student.*

***Important: Only one criterion per line.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion** | **Yes** | **No** | **Unsure** | **Comments** |
| *Soft Skills* |  |  |  |  |
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**Additional SMART *(specific, measurable, achievable, relevant, and time-based)* feedback:**

# **Student Door Note**

*The Student Door Note is placed outside of the room and will be reviewed by the student prior to entering the encounter with the patient.*

**Instructions to learners:**

Click or tap here to enter text.

**Setting *(e.g., The patient presents to you in a hospital room…)*:**

Click or tap here to enter text.

**Patient Information *(e.g., name, age, gender, chief complaint, vital signs, lab results, image results, referral, chart, intake form)*:**

Click or tap here to enter text.