UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

STANDARDIZED PATIENT DATA SHEET

A standardized/simulated patient (SP) is a person who has been coached to accurately and consistently recreate the history, personality, physical findings, emotional structure and response pattern of an actual patient isolated at a particular point in time. UAMS employs SPs in the training and evaluation of medical students, residents and other health care professionals. As an SP, you will be interviewed and examined (just as you would be by your own doctor) by male and female medical students. In the patient role, you may work with students in a one-on-one basis, or with a large group of students in a controlled teaching session.

Please complete the following information so we can add you to our Standardized Patient Data Base. Personal details such as ethnic background, date of birth, height/weight, and other physical or historical factors can be used in matching SPs to available cases. A recent snap shot of yourself will help us match you to a case.

Name: ____________________________________

Complete Mailing Address: __________________

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Home Phone: _________________________________

Cell Phone: __________________________________

Email: ____

Occupation: __________________________________

Work Phone: _________________________________

Employer: ____________________________________

Social Security No.:_________________________

Date of Birth (M/D/Y): ______________________

Height: ___________ Weight: _______________

Gender: ____ Male ____ Female

Race/Ethnic Background:____________________

Number of children: ______Ages:______________

Languages spoken: ______________________________ Languages interpreted: __________________________

1. **How did you hear about the Standardized Patient Program?**

2. **What makes you interested in working as an SP?**

3. **What special skills/abilities/experiences do you feel you bring to this role?**

4. **Briefly describe your past experiences with, and opinions of, physicians and other medical care providers:**

5. **What, if any, surgeries have you had?**

6. Briefly describe any scars, irregularities, or handicapping conditions (such as partial deafness, muscle weakness, heart murmur, etc.) that you have:

7. Do you have any chronic medical problems or conditions (such as high blood pressure, diabetes, arthritis, etc.) for which you are being or have been treated? (Describe)

8. What days of the week and times will you normally be available for work?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

9. Please list any other information you feel would be helpful to us:

10. Would you be willing to be a live "physical" model?

_______ yes ________ no _______ need more information

MALES: Are you interested in teaching students how to perform the male genitourinary/rectal examination demonstrating on your own body?

_______ yes ________ no _______ need more information

FEMALES: Are you interested in teaching students how to perform the female pelvic or breast examination demonstrating on your own body?

Pelvic exam program: _______ yes ________ no _______ need more information

Breast exam program: _______ yes ________ no _______ need more information

____ ____________________

Signature **Date**

University of Arkansas for Medical Sciences
Standardized Patient Program
Release and Non-Disclosure Form

I, the undersigned, ____, a standardized patient, standardized participant, teaching associate, or exam model, for the University of Arkansas, operated by the Board of Trustees of the University of Arkansas, hereby voluntarily agree to give my express consent to:

1. Authorize the professional staff and such assistants, photographers, and technicians to take still photographs and motion pictures and produce educational (closed circuit) television programs, including video tapes, as well as other visual and/or auditory/digital recordings.
2. Permit such photographs, motion pictures, video tapes and/or auditory/digital recordings to be published and republished in professional journals and medical books to be used for any other purpose which the staff member may deem fit in the interest of medical education or research and to be used as professional meetings of any kind.
3. Further authorize the modification or retouching of such photographs and the publication of information relating to my case, either separately or I connection with the publication of the photographs taken of me.

In addition the above, I also agree to the following:

4. Although I have given permission to the publication of all details and photographs concerning my case, it is understood that I will not be identified by name.
5. I understand that all information regarding the standardized patient case for which I have been trained is the confidential property of UAMS, and I agree that I will not disclose to any third party any information about the standardized patient case or information about the students who I have seen during the examination.
6. I understand that all rights of every kind and nature (including copyrights) in and to all photographs, motion pictures, video tapes and/or auditory digital recordings made in connection with this standardized patient case by UAMS shall be and remain vested on UAMS for purposes in perpetuity.

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Signature of SP participant, parent or guardian Date

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Witness Date