**STANDARDIZED PATIENT REQUEST FORM**

**Please note that 4-6 weeks notice is required from the date of the request.**

**Lakehead Campus**  **Laurentian Campus**

**Date of Request:** Click here to enter a date.

**UNIT / ORGANIZATION AND BILLING INFORMATION**

**Unit/Organization:** Click here to enter text.   
**Contact Name:** Click here to enter text.

**Phone number:** Click here to enter phone #.   
**Email:** Click here to enter text.

**Budget Code (NOSM Units only):** Click here to enter budget code.

**Invoice address for external organizations:**

**SIMULATION EVENT INFORMATION**

**Event/Course Name:** Click here to enter text.

**Location:** Click here to enter text.

**Requested Date:** Click here to enter a date.

**Time of Event:** Click here to enter text.

**Type and Level of Learners:** Click here to enter text.

**Do you need to reserve a room at NOSM for this session?** Yes No

**Session Type:**  Teaching  OSCE  Assessment  Remediation  Other

**Case Type:**   History-taking/Interview Physical Exam  Both

***(Please submit case notes with your request, including all checklists and feedback forms via email to the SP Coordinator)***

**Number of encounters per SP:** Click here to enter text.

**Length of each simulation encounter:** Click here to enter text. (mins / hrs)

**Simulation/Session Objectives:**

**Equipment/Props/Moulage required for simulation:** Yes No

*If YES, please specify:*

**SP feedback required?**  Yes No

**Have you ever worked with SPs?** Yes No **SP training provided by:**  NOSM SP Program   
  Other ***(Please answer the following questions)***

**SP Trainer Name:** Click here to enter text.

**SP Trainer Phone number:** Click here to enter phone #.   
 **SP Trainer Email:** Click here to enter text.

**SP Training Date:** Click here to enter a date.

**SP Training Time:** Click here to enter text.

**SP Training Location:** Click here to enter text.

**Is a practice run/dry run with the SP required prior to the simulation event?**  Yes No

**STANDARDIZED PATIENT REQUIREMENTS**

**Please indicate the number of SPs required, demographics, language, health, etc.**

**SP PROGRAM CONTACT INFORMATION**

**Please email this form to the Standardized Patient Program Coordinators at:**

**Lakehead Campus Laurentian Campus**

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