General information

Time allocation

40 minutes. An extra 5 minutes is allowed as reading time.

Test format and procedure

The Writing sub-test is specific to each profession.

This sub-test requires candidates to write a letter of referral, transfer or advice based on case notes which are provided. The case notes relate to a typical situation in each profession.

Candidates are required to write approximately 180-200 words in the body of the text.

Assessment procedure

In the OET, the piece of writing is assessed by qualified, experienced English assessors who have been trained in OET assessment procedures. The assessment is based on the following criteria:

• overall task fulfilment
• appropriateness of language
• comprehension of stimulus
• linguistic features (grammar and cohesion)
• presentation features (spelling, presentation, layout).

The Writing sub-test scripts are assessed in Melbourne. All scripts are double marked.

The sample materials

The sample materials consist of:

• sample writing tasks covering 11 health profession areas
• a sample answer for each task (from page 24).

Using the materials

• Allow enough time (40 minutes) to do the sample writing sub-test in one sitting. This will give an indication of the requirements of the OET.
• Set a timer or alarm clock for 40 minutes or ask someone to act as a timer.
• Candidates should select the task relevant to their profession.
• On completion of the letter, check your work.
• Read the sample answer provided to establish if it contains additional points or information.
• Note that some answers provided here do not meet the task requirement of 180-200 words.
Writing Test – Dentistry

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.
(Assume today’s date is 5 February 1997.)

Patient
Ms Rosie Buck
7 Horseshoe Drive
Newtown
Ph: 8491 2641
Born on 22.07.1950

Reason for Presenting
Pain associated with front tooth.
Unable to bite on the tooth.
Increasing pain; pain control tablets ineffective.

Dental History
- Radiographs (x-rays)

Previous Dental Experience
- Fillings
- Scale and clean (regularly)
- Root canal filling
- Crowns
- Wisdom teeth extraction

Medical History
- Bad reaction to local anaesthetic (probably due to adrenaline in anaesthetic)
- Allergic to penicillin
- Used to smoke cigarettes (gave up 7 years ago)

Family and Social History

Examination
01.07.1995
All teeth present except wisdom teeth (18, 28, 38, 48)
MOD amalgams in 17, 16, 27, 37, 36, 47, 45, 44
MO amalgam in 15, 25, 46
DO amalgam in 26, 35
Occlusal amalgam in 14
Composite resin filling in 13, 12, 11, 21, 23
Caries lesion in 16, 26, 24, 43, 11
Much supragingival calculus on most teeth
Subgingival calculus around most teeth
Worn biting surfaces on most teeth
Treatment Record

12.08.1995 Complete root filling 11. Temporary filling. 2.2ml Lignocaine.
15.05.1996 Routine dental examination. Scale and clean.
05.02.1997 Presents with pain on and around post crown on 11. Radiograph taken. Probing indicates deep pocket on mesial surface of tooth 11. Tooth sensitive to pressure.

Refer to gum specialist for treatment of gum abscess around tooth 11.

Writing Task

Using the information in the case notes, write a letter of referral to the specialist, Dr Perry Dontal, 10 Carpenter St, Newtown, requesting confirmation of diagnosis and treatment.

In your answer:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Dietetics

Time allowed: 40 minutes

Read the case notes below and complete the following task which follows.
(Assume today’s date is 25 January 1997.)

Patient History  James Mann was referred by Dr Smith for advice on a low fat diet for inflammation of the gall bladder due to gallstones. Will possibly have surgery for this problem in the future.

Case Notes

25.1.97  Mr James Mann
50 years old

Past Medical History  Recent acute attack of cholecystitis
No previous history of gallstones

Social History  Works on a factory line
Sedentary
Married
No children at home

Weight History  Wt = 90kg
Ht = 178cm
BMI = 28 (overweight)
Acceptable weight range for height = 63-79kg

Subjective Information  Patient happy to make changes – does not want to experience further pain

Diet History  Breakfast:  Bowl of cornflakes and full cream milk
              Tea
Morning Tea:  1 jam doughnut, tea
Lunch (from canteen at work):
              Meat pie and tomato sauce; mashed potato or chips; mashed pumpkin; beans; cold meat; salad/vegetables; 2 slices white bread and butter; flavoured milk
Afternoon tea:  Tea
After work:  2 cans of beer; small packet peanuts or crisps
Evening meal:  meat or fish or chicken (fried or grilled); potato; mixed vegetables; ice cream and fruit salad; tea
Supper:  None
Dietary Problems  Excess fat – whole milk 
– fried foods 
– pastry 
– peanuts 
– ice cream 
Excess energy 

Education Given  – Healthy eating 
– How to reduce fat intake to approx 50g/day 
– Encouraged to aim for healthy weight range in order to: 
i) reduce surgical risk 
ii) reduce risk of developing other conditions, e.g., diabetes, high blood pressure, heart disease 
– Encouraged to increase exercise 
– Review in 2 weeks 

Writing Task 

Using the information in the case notes, write a letter to the referring doctor, Dr J Smith, 765 Main Road, Newtown, informing him of your management of the patient. 

In your answer: 
• Expand the relevant case notes into complete sentences. 
• Do not use note form. 
• Use correct letter format. 
The body of the letter should be approximately 180-200 words.
Writing Test – Medicine

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.
(Imagine today’s date is 30 April 1997.)

Patient History  Mr Derek Romano is a patient in your General Practice.

20.3.97

Subjective: 46-year-old insurance clerk wants check-up
Smokes 1 pkt cigarettes per day
High blood pressure in past
No regular exercise
Father died aged 48 of acute myocardial infarction
Married, one child
No medications or allergies

Objective: BP 150/100 P 80 regular
Overweight Ht – 170cm Wt – 98kg
Cardiovascular and respiratory examination normal
Urinalysis normal

Plan: Advise re weight loss, smoking cessation
Review BP in 1 month

8.4.97

Subjective: Still smoking, no increase in exercise

Objective: BP 155/100

Assessment: Hypertension

Plan: Commence nifedipine (calcium channel blocker)
20mg daily
Check blood glucose, serum cholesterol
Cholesterol = 6.4mmol/L
23.4.97

Subjective: Mild burning epigastric pain, radiating retrosternally
   Occurs after eating and walking

Objective: BP 155/100
   Abdominal and cardiovascular exam otherwise normal

Assessment: ? Gastric reflux
   Non-compliance with anti-hypertensive medication

Plan: Add Mylanta 30ml q.i.d.
   Increase nifedipine to 20mg twice daily

---

30.4.97

Subjective: Crushing retrosternal chest pain, sweaty, mild dyspnoea
   Onset while walking, present for about one hour

Objective: BP 160/100 P 64 in obvious distress
   Few crepitations at lung bases
   ECG – inferior acute myocardial infarction

Assessment: Acute myocardial infarction

Plan: Oxygen given
   Anginine given sublingually
   Morphine 2.5mg given IV stat
   Maxolon 10mg given IV stat

You decide to call an ambulance and send this man to the Emergency Department, at Newtown City Hospital.

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Writing Task

Using the information in the case notes, write a letter of referral to the Registrar in the Emergency Department of Newtown City Hospital, Main Road, Newtown.

In your answer:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Nursing

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.

(Assume today’s date is 10 April 1997.)

Patient History
Maria Ortiz is a seven-day-old baby. Her mother has been discharged from the maternity hospital.

Baby
Maria Ortiz, 7 days old

Social History
Mother
Violetta Ortiz (Mrs)
DOB
07/08/1967
Husband
Jose, 36 years
Occupation
security guard (night shift)
Other children
Sam, 5 years (currently not attending school)
Teresa, 3 years
Accommodation
Two-bedroom flat (rented)

Nursing Notes
Normal birth
Breast fed
Mother anxious about coping with 3 children
Baby sleepy; reluctant to feed
Baby's weight: Birth – 3010g
Discharge – 3020g
Father unable to assist with children (night work)
Mother very tired
No car; 20-minute walk to shops
Discharged from hospital 10 April 1997

Writing Task

Using the information in the case notes, write a letter of referral to the maternal and child health nurse who will provide follow-up care in this case: Ms Josie Hext, Maternal and Child Health Centre, 133 Elm Grove, Oldmeadows.

In your answer:
• Expand the relevant case notes into complete sentences.
• Do not use note form.
• Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Occupational Therapy

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.
(Assume today’s date is 15 May 1997.)

The patient is to be discharged from City Hospital to a rehabilitation centre today.

Name: Jillian May Jackson (Mrs)
DOB: 23/4/59
Occupation: Librarian, unable to work for 2 years
Social: Married, supportive husband (bank manager)
No children
Diagnosis: 1/52 exacerbation of multiple sclerosis
Past History: MS for 5 years; gradual deterioration over this time
Admitted to Hospital: 6/5/97

8.5.97 Initial Assessment
Communication/Presentation Motivated, optimistic; speech ataxia (dysarthria)
Accommodation 2-storey house; 4 steps at front, 2 steps at back
Upstairs bathroom and toilet
Physical Status Mobility: manual wheelchair
Upper limb status: ® dominant; mild upper limb ataxia
Lower limb status: severe spasticity; unable to walk

9.5.97 Personal Activities of Daily Living
Difficulties bringing food to mouth, cutting food; all transfers (unable to stand);
dressing/controlled movements; managing permanent indwelling
urinary catheter; sexual activity; using telephone

10.5.97
Domestic/Community ADL Cooking, cleaning, laundry, shopping – husband doing these for the last 12 months?; home help required.

Driving/Transport Unable to drive, housebound; difficulty transferring in/out of car
Recreation
Gets bored, depressed; unable to continue previous hobbies, interests; few social contacts

Support Services
None previously; ? home help or attendant care required

Other Therapy
Speech Therapy, Physiotherapy

Assistive Devices Currently in Use
None on admission

11.5.97
Treatment
Session on personal ADL – eating and dressing
Provided adapted cutlery, plate guard
Modification of clothing begun
Motivated but progress slow and laborious
Labile

Patient Requirements
Home assessment; recommendation on modifications re wheelchair access
Assistive devices
Intervention in conjunction with Physiotherapy, i.e., transfers
Alternative to writing: ? computer
Modification to telephone

12.5.97
Continued with eating and dressing: some assistance still required

15.5.97
For discharge to rehab centre today
Modification of underclothes complete; able to dress in a T-shirt independently, requires assistance with lower limb dressing
Able to feed self using weighted cutlery; discharged with this equipment

Writing Task

Using the information in the case notes write a letter of referral to Ms Dorothy Ross, Occupational Therapy Department, City Rehabilitation Centre, Marks Street, Newtown.

In your answer:
- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Pharmacy

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.

Patient
Mrs Charlton, in her late sixties, is a regular customer of yours. Her neighbour brings in a prescription for you to dispense. You recognise that the medication is for treatment of hypertension. According to your records, Mrs Charlton is not currently taking any medication and has not previously taken this or any other anti-hypertensive medication.

Prescription
Dr B Goodrich
234 High Street
Crystal Creek
Ph: 8802 9743

Mrs V Charlton
16 White Street
Crystal Creek

Drug X 5mg
30 tabs
Sig: 1 mane pc

Prescribing information for Drug X

Actions: Anti-hypertensive with a 24-hour action.

Indications for use: As a primary measure in the treatment of mild to moderate hypertension and as an adjunct to other anti-hypertensive agents in the treatment of severe hypertension.

Contra-indications: Known sensitivity to the drug or others of its class. Drug X should not be used for patients with severe renal disease or complete renal shutdown or in patients with severe liver disease and/or impending hepatic coma.

Precautions: All patients should be observed for clinical signs of fluid or electrolyte imbalance including hyponatraemia. These include thirst, dryness of the mouth, lethargy and drowsiness. With intensive or prolonged therapy it is important to guard against hypochloraemic alkalosis and hypokalaemia.
Adverse reactions:
- Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhoea, constipation, jaundice, pancreatitis.
- C.N.S.: dizziness, vertigo, paraesthesias, headache, xanthopsia.
- Cardiovascular: orthostatic hypotension.
- Haematological: leucopenia, agranulocytosis, thrombocytopenia, aplastic anaemia.
- Hypersensitivity (dermatological): purpura, photosensitivity, rash, urticaria, vasculitis.
- Other: hyperglycaemia, glucosuria, hyperuricemia, muscle spasm, weakness, restlessness.
- Impotence has been observed with some drugs in the group when used in high doses.

Interaction:
The following have been reported:
- Alcohol & barbiturates: orthostatic hypotension may occur or be aggravated;
- Digitalis: increase digitalis toxicity;
- Ganglionic and peripheral adrenergic blocking drugs: potentiation of effect;
- Insulin: diabetic control may be altered;
- Lithium: lithium toxicity increased;
- Muscle relaxants: neuromuscular block increased;
- Noradrenaline: decreased arterial responsiveness;
- Oral antidiabetic agents: reduced effectiveness;
- Phenothiazines: shock.

Overdosage:
Symptoms: Symptoms include electrolyte imbalance and signs of potassium deficiency such as confusion, dizziness, muscular weakness and gastrointestinal disturbances.
Treatment: General supportive measures, including replacement of fluids and electrolytes are indicated.

Use in pregnancy and lactation:
Drug X should be used with caution by pregnant women and by nursing mothers since drugs in the group cross the placental barrier and appear in cord blood. Use may result in foetal or neonatal jaundice, bone marrow depression and thrombocytopenia, altered carbohydrate metabolism. In newborn infants of mothers showing decreased glucose tolerance, and other adverse reactions which have occurred in the adult: when the drug is used in pregnant women, the potential benefits of the drug should be weighed against the possible hazards to the foetus.

Australian categorisation definition:
Category C: Drugs which, owing to their pharmacological effects, have cause or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible.

Dosage and Administration:
Administered orally
Adults: Usual dose: 2.5 to 10mg once daily. To maintain an oedema-free state or as adjunct in the management of hypertension, 2.5 to 5mg once daily. Usual optimum daily dose: 5mg, maximum effective single dose is 10mg. Administer after food to minimise gastrointestinal side effects. Monitor for dizziness after initial dosage.

In the treatment of hypertension, Drug X may be either employed alone or concurrently with other anti-hypertensive with lower dosage of the component drugs and few or less severe side effects.
Writing Task

Using the drug information provided, write a letter to Mrs Charlton summarising advice on how to take her medication, what side effects to be aware of and how to cope with them.

In your answer:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Physiotherapy

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.

(Assume today’s date is 6 January 1997.)

The male patient is to be discharged today from the orthopaedic ward to a rehabilitation centre where he will attend as an outpatient.

**Patient history**
- **Surname:** Browning
- **Given Names:** John Louis
- **Birthdate:** 30.10.39
- **Occupation:** Credit manager
- **Social:** Lives with his wife; children have moved out
- **Diagnosis:** Elective total knee replacement on 16.12.96
- **X-ray Report (19.12.96):** L total knee replacement position appears satisfactory

**Past history**
- L knee trouble for many years – osteoarthritis, instability, intermittent locking; painful most of the time; uses a walking stick.
- Was a good soccer player. Years of knee pain L > R.
- Keen sportsman in the past. Previously independent.

**17.12.96**
- **Treatment:** Resting in bed with a Zimmer knee splint
- **Plan:** Continue bed exercises, mobilise when able, aim for home

**18.12.96**
- **Complaining of pain**
- **Treatment:** Continue bed exercises
- **Plan:** To commence ambulating on 20/12

**20.12.96**
- **Pain decreased**
- **Treatment:** Bed exercises as previously – still not able to straight leg raise
  - Quad exercises ++
  - Commence active knee flexion = 30°
  - Commence partial weight bearing with crutches and Zimmer splint – walked 10 metres with difficulty
24.12.96  No change in range of motion or quads strength  
Continue bed exercises and walking  
Encourage ++  

4.1.97  No change; for manipulation under anaesthetic tomorrow  

6.1.97  Having intensive physiotherapy  
Knee flexion = 60°  
Quads lag – 10°  
Walking independently between crutches  
Refer to rehabilitation centre for outpatient physiotherapy  
Review in outpatient clinic: 6.2.97  

Writing Task  
Using the information in the case notes, write a letter of referral to Ms Barbara Blunt, Physiotherapy Department, City Rehabilitation Centre, Bond Street, Newtown.  

In your answer:  
• Expand the relevant case notes into complete sentences.  
• Do not use note form.  
• Use correct letter format.  
The body of the letter should be approximately 180-200 words.
Writing Test – Podiatry

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.
(Assume today’s date is 2 July 2001.)

Patient history
Name: Mrs Emily-Jane Smith
Date of birth: 27.08.1930

Social history
Widow: husband died five years ago
Planning to move across town to live with unmarried daughter

Medical history
Healthy
Recently diagnosed as a non-insulin diabetic i.e., diabetes is being controlled by a combination of diet and medication

21.1.2001
Visit to podiatrist as recommended by doctor
Reason for visit
To check feet due to current medical condition
No problem

2.7.2001
Visit to podiatrist
Patient reported painless swelling on dorsum of right foot
Diagnosis
Ganglion
Treatment
Nil at this time
Recommendation
To visit podiatrist for check-up every three months: to monitor ganglion, possible side effects of diabetes

Writing Task

Mrs Smith plans to move to live with her unmarried daughter in Oldmeadows in one month’s time. Using the information in the case notes, write a letter of referral to Ms Joanne Smythe, Podiatrist, 4 River Arcade, Oldmeadows.

In your answer:

• Expand the relevant case notes into complete sentences.
• Do not use note form.
• Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Radiography

Time allowed: 40 minutes

Read the letter, the X-ray reports and the patient log below, then complete the writing task which follows. (Assume today’s date is 24 July 1997.)

D J Smith
Medical Superintendent
City Hospital
Station Street
Greywalls
23 July 1997

Dear Dr Smith

I am writing to complain about the treatment my son received from a radiographer at your hospital last Saturday, 20/07/97.

My son, Tim, is six years old, and I took him to your casualty section after he had fallen off a swing at the local playground and hurt his arm. By the time I got Tim to your casualty section his elbow had puffed up like a balloon and was very sore. He could not move his arm and he was screaming with pain.

When we came into the casualty section, the nurse at the front desk saw Tim’s arm and called a doctor. This was very helpful as your casualty section was very busy and Tim could have been waiting for hours to see a doctor. When the doctor saw Tim he said that the elbow was broken and out of joint, and he would need an X-ray picture taken before the elbow could be straightened and put back in place.

We then waited from 4.30pm to 6.00pm before Tim was taken to the X-ray section. The casualty sister tried to contact the radiographer three times. However, he would not answer his pager. By this time, the pain in the arm had become worse, spreading down the arm into the fingers. When Tim arrived at the X-ray section he was taken straight into the X-ray room by the radiographer. I found the radiographer very rude and his handling of Tim was very rough. Because of all the pain, Tim was finding it difficult to keep his arm still. After the second X-ray the radiographer became annoyed with Tim and said, ‘You must co-operate and keep your arm still, otherwise you are wasting time and films.’ With that he put some very heavy bags on Tim’s arm and then took another two X-rays. All this made Tim scream even more with pain.

When I got back to casualty the doctor immediately called in a specialist to see Tim. The specialist took Tim to the operating room where he put some wires in to hold the bones together.

Tim has now left hospital, but he was very frightened when he had to have his arm X-rayed the second time before discharge. Thankfully, this radiographer was more patient and kind.

My family has always used your hospital, and this is the first time I have met any rudeness from a member of your staff. Also, I have never had to wait such a long time for an X-ray before, especially with someone in pain. My other son, Roger, broke his arm when he was three, and there was no waiting for his X-ray to be done.

I am bringing this to your attention so that you may investigate the matter.

With regards

John Roberts
X-ray report

Patient: Tim Roberts
Region: Right elbow
MRN: 008 06 69
Date: 20 July 1997

There is a comminuted fracture involving the lower end of the humerus. The proximal humerus is displaced anteriorly by 10mm, with the distal fragment being displaced superiorly and tilted 30 degrees dorsally. On the lateral, there is widening of the proximal radio-ulnar joint. On the AP the fragments are in anatomical alignment. There is widening of the joint between the head of the radius and the capitulum.

Conclusion: A comminuted fracture of the lower end of the humerus with marked angulation and displacement occurring at the fracture site. Damage to the radial artery and entrapment of the radial nerve would have to be considered. A subluxation of the proximal radio-ulnar joint is present.

Dr K Snowgrass
Staff Radiologist

X-ray report

Patient: Tim Roberts
Region: Right elbow
MRN: 008 06 69
Date: 22 July 1997

There is a 5mm displacement of the fragments with no overlapping. There is 20 degrees posterior tilting of the distal fragments. There is less widening of the radio-ulnar joint, consistent with a minor subluxation or a resolving haematoma. Two metallic pins are noted in the lower end of the humerus.

Dr P Phillips
Staff Radiologist

Patient log

Date: Saturday, 20/7/97

<table>
<thead>
<tr>
<th>Time</th>
<th>Examination/Patient Name/Ward/Comments</th>
<th>Notification &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.00</td>
<td>Mobile chest. Urgent. KINNEAR J D6a post cardiac surgery. Left pneumothorax</td>
<td>Pager 3.55</td>
</tr>
<tr>
<td>4.10</td>
<td>Mobile chest. Urgent. ROWLES L D6a re-positioning of subclavian catheter</td>
<td>Pager 3.55</td>
</tr>
<tr>
<td>4.25</td>
<td>Mobile chest. Urgent. HOBBS twin 1 Neonate ICU post insertion of chest tube</td>
<td>Pager 4.15</td>
</tr>
<tr>
<td>4.45</td>
<td>Wrist. SMYTHE W Casualty # mid radius</td>
<td>Phone 4.40</td>
</tr>
<tr>
<td>4.55</td>
<td>Mobile chest. Urgent. KINNEAR J D6a Post insertion of chest tube</td>
<td>Pager 4.50</td>
</tr>
<tr>
<td>5.00</td>
<td>End of shift Radiographer for new shift (Jeff K) has not arrived</td>
<td>None</td>
</tr>
<tr>
<td>5.10</td>
<td>Left leg. RAVEN P Casualty – soccer injury</td>
<td>None</td>
</tr>
<tr>
<td>5.15</td>
<td>Right shoulder. RYAN J Casualty # clavicle</td>
<td>Phone 4.45</td>
</tr>
</tbody>
</table>
Writing Task

You are the radiographer involved in X-raying this patient. Dr Smith has received the letter of complaint and has requested you to write to him with an explanation of the events.

Using the information provided, write a letter to Dr Smith explaining your actions.

In your answer:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Writing Test – Speech Pathology

Time allowed: 40 minutes

Read the case notes below and complete the writing task which follows.

(Assume today’s date is 1 July 1997.)

You are working in a community hospital and have received a medical referral from an affiliated nursing home to re-assess a patient with severe, long-standing swallowing difficulties.

Dysphagia Bedside Assessment

Name: Helen Walsh (Ms)
D.O.B.: 2/12/1965
Aetiology: Motor vehicle accident
No significant L.O.C.
Spinal injury at C2/3 level with dislocation of C2
Aphonia
Dysphagia. G.T. in situ
Onset: 12/4/1997
Physical: Quadraparesis affecting L > R side, arms > legs
Occupation: Bank clerk (previously)

Assessment Results
Alert, co-operative
Hist. of recur. chest infections
↓↓ head control, needs posturing

Oral stage
R weak & invol. movts of tong.
Lips, cheeks, jaw, S.P. – NAD
Drool – sev +++

Pharynx stage
V.F. palsy
No eff’v cough – vol. or invol.
No veloph, ele’n
No gag
Spon. sw. observed but infreq.
Delay init’n of vol. sw. ++
↓↓ laryn. elev’n
Asp’r risk ++++
asst result = sev. impairments L.M.N., signs C.N. damage: C.N. IX, X and XII
NIL MOUTH
Writing Task

Using the information in the assessment summary, write a letter to the referring doctor, Dr A Street, Bayside Nursing Home, Bay City. Give your assessment of the patient’s swallowing skills with a recommendation about the patient’s oral eating status.

In your answer:

• Expand the relevant case notes into complete sentences.
• Do not use note form.
• Use correct letter format.

The body of the letter should be approximately 180-200 words.
Date: 2.1.97
Time of Presentation: 10pm
Owner: Mrs Dee
Animal: ‘Fru-Fru’, a 5-year-old female Terrier cross (10kg)
History: Vomiting and diarrhoea for 3 days. No appetite. Now very weak.
Clinical Findings: Temp 38.5 C
10% dehydration estimated
Demeanour lethargic and depressed
Generalised muscle weakness
Weak pulse
Bradycardia (80bpm)
Other Procedures: Clinical Pathology:
Asostix BUN=20mg/dl PCV 48% TP 7.5mg/dl Glucose 80mg/dl
ECG: very small P waves
tall spiked T waves
prolonged PR interval
Diagnosis: Tentative diagnosis: hypoadrenocorticism (Addison’s disease)
DDx: acute pancreatitis; renal failure. gastroenteritis
Treatment: Pre-treatment blood samples collected for lab analysis tomorrow
IV indwelling catheter placed
Given 1 litre 0.9% isotonic saline, DOCA (desoxycorticosterone acetate) 2mg IM,
Prednisolone Sodium Succinate IV
Advised owner of need for further hospitalisation and monitoring at own vet’s.
Original blood sample to be analysed to confirm diagnosis.
Writing Task

You are a vet at an after-hours clinic and you are referring the client back to their own vet the next morning. Write a letter of referral to Dr Black at Suburbia Veterinary Practice, Suburbia.

In your answer:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- Use correct letter format.

The body of the letter should be approximately 180-200 words.
Dentistry – Letter of Referral

Dr Perry Donal  
10 Carpenter Street  
Newtown

Dear Dr Donal

Re: Ms Rosie Buck

Ms Buck presented at my surgery today, 5/2/97, complaining of pain on and around the upper right central incisor. This tooth has a post crown which was constructed on 19/10/95. Until now the tooth has been non-symptomatic.

My radiograph indicated that the tooth is now split, and I believe that the cause of the pain is an infection in the gum.

Please note that Ms Buck is allergic to penicillin. Also, the last time I gave her a local anaesthetic (Lignocaine) she had a reaction, which I suspect is a sensitivity to adrenaline.

Please would you examine the gum around the tooth and treat appropriately. I have enclosed the radiograph of the tooth.

Thank you for seeing Ms Buck for me.

Yours sincerely

Dentist
Dietetics – Patient Report

Dr J Smith  
765 Main Road  /Newtown

Dear Dr Smith

Re:  Mr James Mann

Thank you for referring your patient Mr James Mann for advice on a low fat diet for cholecystitis.

I first saw the patient today, when he weighed 90 kg.

As Mr Mann is 178cm tall, this gives him a BMI of 28 which is classified as overweight.

Patient’s usual diet is quite high in fat and energy and he also leads a sedentary lifestyle which has contributed to his being overweight. However, he basically has a regular eating pattern and is happy to make changes to his diet.

I have advised Mr Mann on a balanced diet with an emphasis on lowering fat intake to approx 50g/day and I have also advised him to increase his activity in order to allow gradual weight reduction to approximately 79kg which will give him a BMI of 25.

I will be reviewing Mr Mann in two weeks’ time.

In the meantime should you require any further information about this patient please do not hesitate to contact me.

Yours sincerely

Dietitian
Medicine – Letter of Referral

The Registrar
Emergency Department
Newtown City Hospital
Main Road
Newtown

Dear Doctor

Re: Mr Derek Romano

I am writing to refer Mr Romano, a patient of mine, to you. Mr Romano is 46 years old and is an insurance clerk. He is married with one child, and is suffering from his first episode of ischaemic (or cardiac) chest pain. The patient first attended me six months ago. His risk factors include: hypertension, smoking (one packet per day), obesity, strong family history (father died of an acute myocardial infarction aged 48) and hypercholesterolaemia (total cholesterol = 6.4mmol/L). He has no known allergies.

After persistently elevated blood pressure readings around 150/100, patient was commenced on nifedipine and this was recently increased to 20mg twice daily. He also uses Mylanta for reflux oesophagitis. A cardiovascular examination on 23.4.97 was normal.

Today, Mr Romano presented following a minimum of one hour of crushing, retrosternal chest pain. He felt nauseated and sweaty with mild dyspnoea. Examination revealed a distressed and anxious man with a pulse of 64 (sinus rhythm) and blood pressure of 160/100. Crepitations were noted on chest auscultation. Electrocardiography revealed changes consistent with an inferior myocardial infarction.

Oxygen was given and one Anginine sublingually followed by morphine 2.5mg intravenously. His pain has now settled but I consider he requires admission for stabilisation. I will telephone later to check on his condition.

Yours sincerely

Doctor
Dear Ms Hext

Re: Mrs Violetta Ortiz

I am writing to refer Mrs Violetta Ortiz and her baby, Maria, to you. Mrs Ortiz is being discharged today from our hospital after seven days. The baby is progressing quite well, but has only gained a small amount of weight. Her birth weight was 3010g, and on discharge it was 3020g.

The baby is breast fed, but sleepy and reluctant to feed, and Mrs Ortiz is anxious about managing her three children. She has a boy, Sam, who is five years and not yet at school, and a three-year-old girl, Teresa, as well as the new baby. Mrs Ortiz receives little assistance from her husband, Jose, who works at night. The family lives in a two-bedroom rented flat.

Should you require any further information regarding Mrs Ortiz please do not hesitate to contact me.

Yours sincerely

Charge Nurse
Ms Dorothy Ross  
Occupational Therapy Department  
City Rehabilitation Centre  
Marks Street  
Newtown

Dear Ms Ross

Re: Ms Jillian May Jackson

I am writing to refer Ms Jillian May Jackson to you. Ms Jackson, a 38-year-old married woman with a five-year history of multiple sclerosis, was admitted to City Hospital on 06/05/1997 with a one-week history of rapid deterioration in function.

Her husband, Mr Jackson, a bank manager, is very supportive. They have no children.

Patient’s problems were identified as: lower limb spasticity requiring a wheelchair for mobility; upper limb ataxia; loss of bladder control, requiring a permanent indwelling catheter.

Specifically, Ms Jackson demonstrated difficulty in eating, dressing, writing and communication, toileting, transfers, grooming and sexual activity. She has not undertaken domestic chores for the last 12 months. Transport and recreation are also areas of difficulty. A home visit is essential. At discharge on 15/05/1997, Ms Jackson was eating independently with supplied adaptive cutlery and dressing her upper body with adapted clothing. Assistance was required with lower-limb dressing and other personal tasks due to difficulty within transfers and co-ordinated movement.

Please don’t hesitate to contact me if you require any further information about this patient.

Yours sincerely

Occupational Therapist
Dear Mrs Charlton

Dr Goodrich has prescribed Drug X to bring your raised blood pressure under control.

You will need to take one tablet each morning after breakfast. It is important to take the tablets after food so as to prevent stomach upsets.

You may find that this medicine causes dizziness, especially when you stand up quickly. Take extra care to move slowly from lying to sitting or sitting to standing positions, especially when you first start taking these tablets. This effect can be worsened by alcohol.

In addition, report any skin reaction, such as a rash, itch or sun sensitivity to your doctor, and see your doctor if you experience unusual thirst, dryness of the mouth, lethargy or drowsiness.

Do not stop taking the tablets without consulting your doctor.

Please feel free to contact me should you require any further information.

Yours sincerely

Pharmacist
Ms Barbara Blunt
Physiotherapy Department
City Rehabilitation Centre
Bond Street
Newtown

6 January, 1997

Dear Ms Blunt

Thank you for agreeing to take over the physiotherapy management of Mr John Browning.

Mr Browning, a 57-year-old credit manager, was admitted to hospital for an elective left total knee replacement on 16 December 1996, following many years of chronic pain. He has a past history of osteoarthritis, instability and intermittent locking of the left knee following a career as a soccer player. He lives with his wife and was previously independent but walked with a walking stick.

Post-operatively the X-ray report showed a good position.

Mr Browning commenced walking with crutches and a Zimmer splint, partial weight bearing on 20 December, but he had persistently poor quadriceps strength and difficulty gaining knee flexion. A manipulation under anaesthetic was performed on 5 January and he now has 60 degrees knee flexion and a quadriceps lag of 10 degrees. He walks independently with crutches.

Mr Browning has an appointment with the specialist on 6 February 1997.

Please do not hesitate to contact me should you require any further information about this patient.

Yours sincerely

Physiotherapist
2 July 2001

Ms Joanne Smythe
4 River Arcade
Oldmeadows

Dear Ms Smythe

I am writing to refer Mrs Emily-Jane Smith, a patient of mine, to you.

Mrs Smith is a 70-year-old widow who has recently been diagnosed as a non-insulin dependent diabetic. Her diabetes is currently being controlled by a combination of diet and medication.

On her doctor’s recommendation, the patient first visited my rooms on 21 January for me to check her feet. At this time there were no problems.

Then on 2 July the patient visited me again for her six-monthly check-up. During this visit patient reported a painless swelling on the dorsum of her right foot, which I diagnosed as a ganglion. At this time, although no treatment was given I recommended that Mrs Smith visit a podiatrist every three months for the monitoring of this condition and any other side effects resulting from her diabetes.

The reason for this referral is that Mrs Smith intends to move house in a month’s time, to live with her daughter in Oldmeadows.

Should you require any further information about Mrs Smith’s condition please do not hesitate to contact me.

Yours sincerely

Podiatrist
24 July 1997

Dear Dr Smith

I am responding to your request for an explanation concerning Mr Roberts’ letter of complaint. In addition, for your information, I have included a copy of a portion of the patient log for Saturday, 20 July.

In the letter from Mr Roberts there is a statement that his son was kept waiting in Casualty from 4.30pm to 6.00pm because the casualty sister was unable to contact me on the pager. As you can see from the log, the pager was working. I received only one page from Casualty at 5.50pm for the patient. When I have had to X-ray Casualty patients prior to Tim, Casualty either contacted me by phone or sent the patient around to the X-ray department. I cannot explain why the other two pages from Casualty were not received by me.

Mr Roberts states that I was rude and handled Tim roughly. The day was very busy, and this, combined with the next radiographer appearing late for the next shift, may have combined to make me appear rude. Because Tim was in so much pain, I attempted to X-ray his arm without any immobilisation. However, because he was moving so much, I eventually had to use sandbags to keep his arm still. I did place the sandbags carefully because it was obvious that Tim had a ‘nasty’ fracture and I did not wish to worsen his condition. I did ask Tim to keep his arm still and explained that the X-ray would be finished more quickly if he kept still.

I hope this information is helpful in your investigation of this patient’s father’s complaint.

Yours sincerely

Radiographer
Speech Pathology – Letter of Assessment

1 July 1997

Dr A Street
Bayside Nursing Home
Bay City

Dear Dr Street

Re: Ms Helen Walsh

Thank you for your referral for dysphagia assessment of your patient Ms Helen Walsh. Oral-motor evaluation indicated significant lower motor neuron impairments involving cranial nerves IX, X, XII. The oral stage of the patient’s swallowing was mildly impaired, particularly due to reduced tongue mobility and control. Pharyngeal stage of swallowing was severely impaired: no gag reflex, no voluntary or involuntary cough, patient unable to cope with her saliva, infrequent spontaneous swallowing and markedly decayed swallow reflex with minimal laryngeal elevation. Assessment results indicated severely impaired protective mechanisms to cope with any oral intake, and hence she is at great risk of aspiration pneumonia.

It is highly advisable to maintain Ms Helen Walsh nil orally and to continue gastrostomy feeding. Ms Walsh appears to exhibit a very poor prognosis for return to oral feeding.

If you require any further information or have any queries, please do not hesitate to contact me.

Yours sincerely

Speech Pathologist
Dr Black

3 January 1997

Suburbia Veterinary Practice
Suburbia

Dear Dr Black

Mrs Dee’s dog, ‘Fru-Fru’, was presented here at 10pm last evening, with a history of inappetence, vomiting and diarrhoea for the last three days and with weakness tonight.

Clinical examination revealed depression, lethargy, generalised muscle weakness, a normal temperature, a very weak pulse and a bradycardia (HR 80bpm). I estimated 10% dehydration.

Available blood tests were performed confirming dehydration, and revealing a uraemia and mild hypoglycaemia. An ECG demonstrated small P waves, tall spiked T waves and a prolonged PR interval.

A tentative diagnosis includes acute pancreatitis, renal failure and gastroenteritis.

Given the history, ECG changes and the severity of the clinical signs, I elected to begin treatment for Addison’s disease. Base-line blood samples were taken for you to submit to the laboratory.

The dog was admitted, had an IV catheter placed and was given 1 litre of 0.9% isotonic saline. 2mg DOCA was given by IM injection and 200mg Prednisolone Sodium Succinate given IV.

The owner is aware that her dog needs further hospitalisation and monitoring with you. I have indicated that you will discuss the long-term treatment options with her.

Should you require any further information please do not hesitate to contact me.

Yours sincerely

Veterinarian