



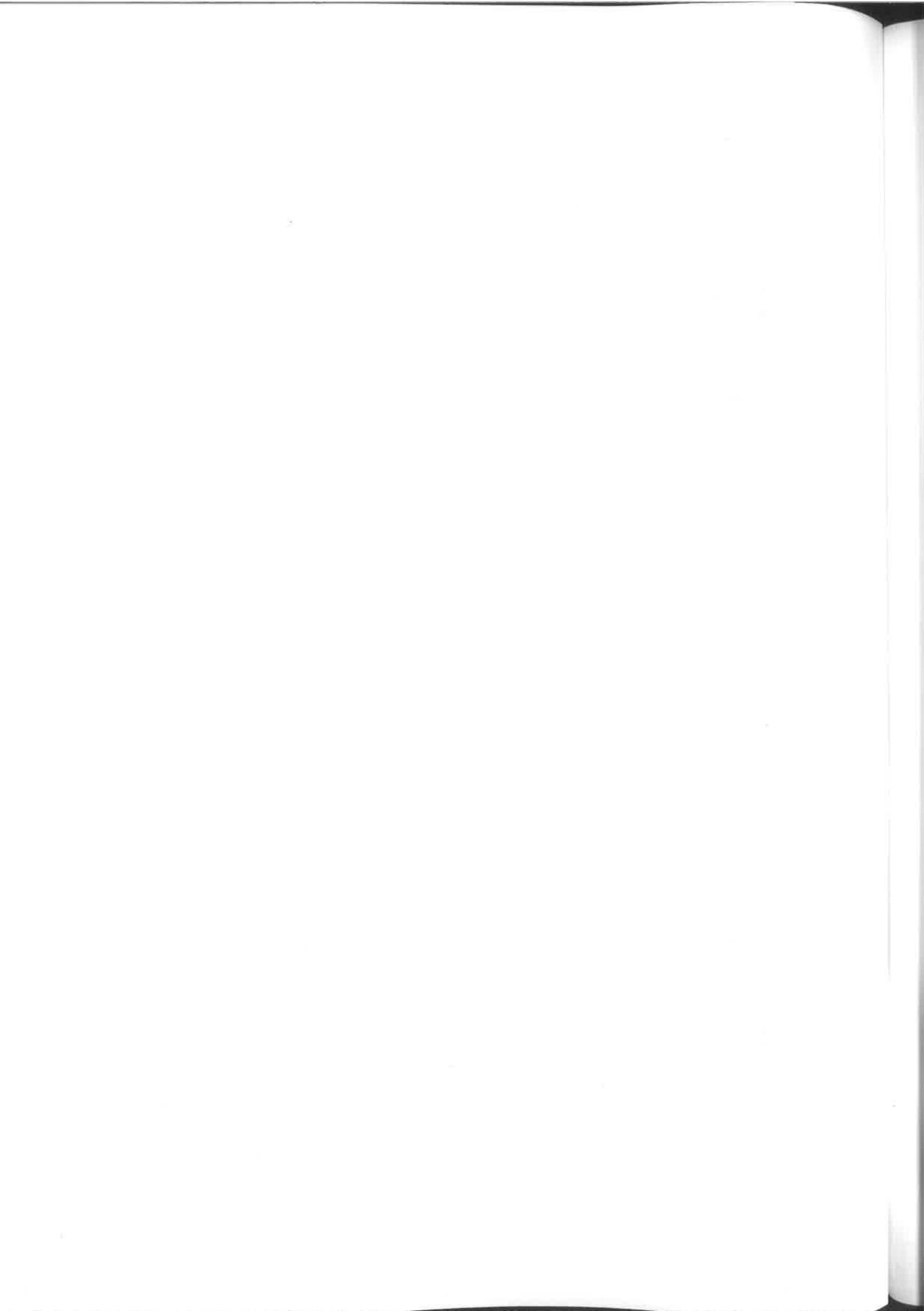
OFFICIAL OET PREPARATION MATERIALS

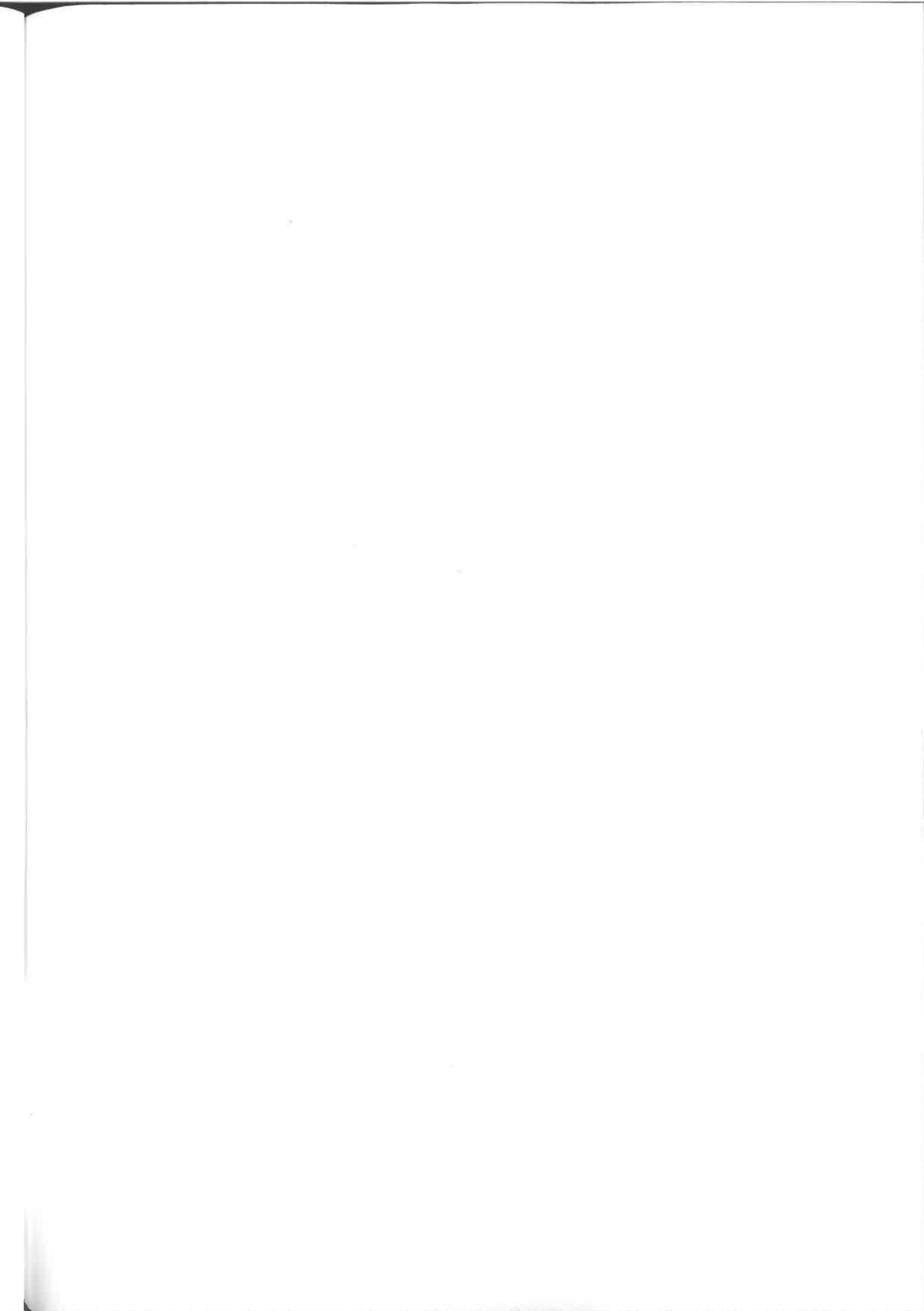


Practice Book
Medicine

WRITING

Set 1







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For information in regards to OET visit the OET website: www.occupationalenglishtest.org

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An overview of OET (Occupational English Test)

OET assesses the language proficiency of healthcare professionals who wish to register and practise in an English-speaking environment. It is designed to meet the specific English language needs of the healthcare sector.

OET tests candidates from the following 12 health professions: Dentistry, Dietetics, Medicine, Nursing, Occupational Therapy, Optometry, Pharmacy, Physiotherapy, Podiatry, Radiography, Speech Pathology and Veterinary Science. Nursing, Medicine and Dentistry currently provide the largest numbers of candidates.

The test is now owned by Cambridge Boxhill Language Assessment Pty Ltd (CBLA), a joint venture between Cambridge English Language Assessment and Box Hill Institute in Australia.

Who recognises OET?

OET is recognised by over 20 regulatory healthcare bodies and councils at state and national level in Australia, New Zealand and Singapore.

OET is one of only two English language tests recognised by the Department of Immigration and Border Protection (DIBP)* for a number of skilled immigration visas.

* This information is accurate as of December 2013. The Department of Immigration and Border Protection (DIBP) used to be the Department of Immigration and Citizenship (DIAC).

Sub-test (duration)	Content	Shows candidates can:
Listening (50 minutes)	2 tasks Common to all 12 professions	follow and understand a range of health-related spoken materials such as patient consultations and lectures.
Reading (60 minutes)	2 tasks Common to all 12 professions	read and understand different types of text on health-related subjects.
Writing (45 minutes)	1 task Specific to each profession	write a letter in a clear and accurate way which is relevant for the reader.
Speaking (20 minutes)	2 tasks Specific to each profession	effectively communicate in a real-life context through the use of role plays.

When and where is OET available?

OET is available up to twelve times a year, at more than 40 test venues in 25 countries.

What is in the test?

OET is an in-depth and thorough assessment of all areas of language ability – with an emphasis on communication in medical and health professional settings.

The test consists of four sub-tests:

- Listening
- Reading
- Writing
- Speaking

The Writing and Speaking sub-tests are specific to each profession, while the Listening and Reading sub-tests are common to all professions.



Results

OET Statements of Results include a separate grade for each sub-test, ranging from A (highest) to E (lowest). There is no overall grade for OET.

High-quality, secure language assessment

CBLA is committed to the highest standards of quality, security and integrity for OET – from test development, test delivery and results processing, through to post-examination review and evaluation.

Fair and consistent delivery of OET is ensured by secure technology and the continual training and monitoring of assessors, as well as test centre management and facilities.

The Writing and Speaking sub-tests are developed in consultation with practising healthcare professionals and educators to ensure test materials simulate real-life clinical situations, such as explaining a diagnosis and writing referral letters.

The Listening and Reading sub-tests are developed by the Language Testing Research Centre (LTRC) at the University of Melbourne.

Assessment

All sub-tests are assessed at the OET Centre by trained expert assessors. Assessment procedures routinely include double marking and statistical analysis to ensure that candidate results are accurate and fair.

Each of the four sub-tests is assessed in a specific way. Read more about OET assessment procedures at:
www.occupationalenglishtest.org

Registration procedures

For registration details visit: www.occupationalenglishtest.org

Here you'll find all the information and instructions you need to apply for OET online for the first time, including test fees, ID, payment and photo guidelines.

Our ID procedures have DIBP approval, ensuring confidence in candidate identity.

Special provision

Candidates with special needs may apply in advance for special provision. CBLA makes all reasonable arrangements to accommodate special visual or auditory needs, including enlargement of print texts and special auditory equipment.

Preparation materials

Resources can be accessed from the OET website, including:

- sample papers
- suggested reading material
- a list of preparation training providers*

* This list is for information only – we do not endorse any particular training program.



History of the test

Occupational English Test was designed by Professor Tim McNamara of the University of Melbourne under contract to the Australian Federal Government.

As part of the annual intake of refugees and immigrants, hundreds of overseas-trained health practitioners were entering Australia by the mid to late 1980s. The majority were medical practitioners, but a number of other health professional groups were also represented.

The process of registration to practise in most health professions in Australia included three stages of assessment: English language proficiency, a multiple choice test of profession-specific clinical knowledge and a performance-based test of clinical competence.

Dissatisfaction with the results of existing language tests led to the development of thoroughly researched specifications for a

communicative, contextualised test. OET has been frequently reviewed and analysed in the literature since the 1980s. McNamara (1996)¹ gives a full account of the development of the test and associated validation research.

The Initial development of the test specifications involved:

- extensive consultation with expert informants, including clinical educators, ESL teachers offering language support in clinical settings, and overseas-trained professionals who were completing or had completed a clinical bridging program.
- literature search.
- direct observation of the workplace.

Stages of Test Development [presentation by Prof Tim McNamara, August 2007]²

STAGES OF TEST DEVELOPMENT

- Analysing target domain via 'job analysis'

Job analysis (1): Consultation with expert informants

- Clinical educators (especially those with experience of overseas-trained health professionals) [via interview]
- ESL teachers offering language support in clinical settings [via interview]
- Overseas-trained health professionals who are in or have completed a clinical bridging programme [via questionnaire]

Job analysis (2 and 3):

- Literature search
- Direct observation of the workplace

Commonalities observed: (1) stages (some optional) of the 'consultation'

- Assessment of the patient ('subjective assessment') including history taking.
- Physical examination.
- Explanation to patient of diagnosis and prognosis and course of treatment.
- Treatment.
- Patient/client/relative education and counselling.

This event provided the basis for specifications for a common format for assessment of speaking and listening skills.

Commonalities observed (2)

- Listening:
 - professional development
- Reading:
 - Professional development
 - Case history notes
- Writing:
 - Letters of referral

STAGES OF TEST DEVELOPMENT

- Identifying resources/constraints:
Needed to maximize both
 - Specificity: plausibility in professional context
- Commonality: limits to affordability of profession-specific materials
- Drafting of test specifications

1. McNamara, T. [1996] Measuring Second Language Performance. London: Longman.
2. McNamara, T. [2007] Stages of Test Development. OET Forum.



Description of OET

Test format

OET assesses listening, reading, writing and speaking.

There is a separate sub-test for each skill area. The Listening and Reading sub-tests are designed to assess the ability to understand spoken and written English in contexts related to general health and medicine. The sub-tests for Listening and Reading are common to all professions.

The Writing and Speaking sub-tests are specific to each profession and are designed to assess the ability to use English appropriately in a relevant professional context.

Listening sub-test

The Listening sub-test consists of two parts: a recorded, simulated professional-patient consultation with note-taking questions (Part A), and a recorded talk or lecture on a health-related topic with short-answer/note-taking questions (Part B), each about 15 minutes of recorded speech. A set of questions is attached to each section and candidates write their answers while listening. The original recording is edited with pauses to allow candidates time to write their answers.

The format for Part A (the consultation) requires candidates to produce case notes under relevant headings and to write as much relevant information as possible. Part B (the lecture) requires candidates to complete a range of open-ended and fixed-choice listening tasks.

Reading sub-test

The Reading sub-test consists of two parts:

Part A is a summary reading task. This requires candidates to skim and scan 3-4 short texts (a total of about 650 words) related to a single topic and to complete a summary paragraph by filling in the missing words. Candidates are required to write responses for 25-35 gaps in total, within a strictly monitored time limit of 15 minutes.

Part A is designed to test the reader's ability to source information from multiple texts, to synthesise information in a meaningful way and to assess skimming and scanning ability within a time limit.

In Part B candidates are required to read two passages (600-800 words each) on general medical topics and answer 8-10 multiple-choice questions for each text (a total of 16-20 questions) – within a time limit of 45 minutes.

Part B is designed to test the reader's ability to read in greater detail general and specific information for comprehension.



WRITING SUB-TEST MEDICINE	
TIME ALLOWED:	READING TIME: 1 MINUTES WRITING TIME: 40 MINUTES
Read the patient notes and complete the writing task which follows.	
NOTE 9	
Patient:	George Whitehead is a 22 year old man who has been a patient of your practice for 6 years. He is a non-smoker and non-drinker. Apart from the usual childhood illnesses such as measles, he has been fit and healthy.
26/9/07	
Subjective:	Nested severe frontal headache last night. Headache causes no vomiting, slightly blurred vision but no aura. Otherwise well normally. No other symptoms. No photophobia, neck stiffness. No past or family history of migraine.
Objective:	Pulse: BP: 125/86. Fundus normal. Cervical spine movement normal. Eyes otherwise normal.
Assessment:	Probable tension headache.
Plan:	Aspirin simple analgesic (paracetamol 500mg).
27/9/07	
Bulletin:	Complaining of ongoing headache as over last two weeks. Frontal and left sided with visual blurring. Today severe left sided throbbing headache now continuous. Occurred three times today, with headache. Complaint of slight photophobia. A headache.
Objective:	Diminished L.P.R. BP: 127/80. Pupil normal. Fundus normal. Normal eye movements. No visual changes or other sensory signs.
Assessment:	? possible severe migraine headache.
Plan:	Skin: Petechiae (10mm) periorbital. Rectal bleeding (normal). Urine: Nitrites. Review 24 hours if not settling.
28/9/07	Urgent home visit.
Bulletin:	Collapse at home after another left-sided severe headache started 31m ago. Now pain, weakness in right arm & leg. Conscious state depressed, speech altered.
Objective:	P: 100. BP: 155/90. Paraparesis - R arm/below 4/5 power, extension 4/5 power, flexion 4/5 power. R leg knee flexion 4/5. R knee/ankle 4/5. R foot dorsiflexion 4/5.
Assessment:	? acute occupying lesion or other intracranial pathology.
Plan:	Urgent admission to Emergency Dept.
WRITING TASK	
Using the above information, write a letter to the neurologist who will see the patient in the Emergency Department of the local hospital.	
In your answer:	
<ul style="list-style-type: none"> • expand the relevant case notes into complete sentences • do not use note form • use full punctuation 	
The body of the letter should be approximately 180-200 words.	

DET	
ROLEPLAYER'S CARD NO. 1 MEDICINE	
SETTING	Obstetrics Clinical Skills Suite
PATIENT	Tracy, pregnant woman, aged 30, 34 weeks gestation, to be seen by O&G Doctor. She is due to give birth in 2 weeks time. She has a history of hypertension and is currently taking antihypertensive medication. She has had a scan and is awaiting results.
TASK	<ul style="list-style-type: none"> • Explain your findings to O&G Doctor. • Explain to O&G Doctor why you have taken a scan and what it shows. • Ask O&G Doctor whether she needs to go to hospital or stay at home. • Ask O&G Doctor whether she needs to take any further action. • Ask O&G Doctor if there is anything else she needs to know.
DET	
CANDIDATE'S CARD NO. 1 MEDICINE	
SETTING	Obstetrics Clinical Skills Suite
DOCTOR	This patient has come to the midwives' office to discuss her condition. She is pregnant and due to give birth in 2 weeks time. She has a history of hypertension and is currently taking antihypertensive medication. She has had a scan and is awaiting results.
TASK	<ul style="list-style-type: none"> • Explain your diagnosis. • Answer the question that the patient has asked about the scan and what it shows. • Ask the patient if she needs to go to hospital or stay at home. • Ask the patient if there is anything else she needs to know.

Writing sub-test

The Writing sub-test usually consists of a scenario presented to the candidate, which requires the production of a letter of referral to another professional. The letter must record treatment offered to date and the issues to be addressed by the other professional. The letter must take account of the stimulus material presented.

The body of the letter must consist of approximately 180-200 words and be set out in an appropriate format. For certain professions, other professional writing tasks of equivalent difficulty may also be set, e.g., responding in writing to a complaint, or providing written information to a specified audience in the form of a letter.

Speaking sub-test

The production of contextualised professional language is achieved by requiring the candidate to engage with an interlocutor who plays the role of a patient or a patient's carer. The candidate must respond as a professional consultant to two different scenarios played out with the interlocutor. These exchanges are recorded for subsequent assessment. The recording also includes a short 'warm-up' that is part of the Speaking sub-test, though this material is not assessed.

WRITING SECTION 2

Test taker's guide to the Writing sub-test

Do

- Take time to understand the task requirements
- Use your own words to paraphrase or summarise longer pieces of information from the case notes
- Make sure you understand the situation described in the case notes
- Think about how best to organise your letter before you start writing
- Use the space provided to plan your letter (though a draft is not compulsory)
- Use the five minutes' reading time effectively to understand the task set
 - » What is your role?
 - » Who is your audience (the intended reader)?
 - » What is the current situation?
 - » How urgent is the current situation?
 - » What is the main point you must communicate to the reader?
 - » What supporting information is necessary to give to the reader?
 - » What background information is useful to the reader?
 - » What information is unnecessary for the reader? Why is it unnecessary?
- Explain the current situation at the start of the letter (e.g., perhaps an emergency situation)
- Use the names and addresses given
- Set out the names, addresses, date and other information to start the letter clearly
- As you write, indicate each new paragraph clearly, perhaps by leaving a blank line

Don't

- Include everything from the case notes – select information relevant to the task
- Simply copy chunks of text from the case notes
- Write notes or numbered points

General

- Have a spare pen and pencil ready, just in case
- Fill in the cover pages for the task booklet and the answer booklet correctly
- Fill in your personal information on the answer sheet correctly
- Take a sample test under test conditions beforehand so you know what it feels like
- Practise writing clearly if you have poor handwriting
- Write clearly and legibly

Checking at the end

- Make sure your letter communicates what you intend
- Make sure you meet the basic task requirements:
 - » length of the body of the text approximately 180-200 words
 - » full sentences, not note form
 - » appropriate letter format
- Check for any simple grammar and spelling errors that you may have made
- If a page is messy, use clear marks (e.g., arrows, numbers) to show the sequence in which the parts of your text should be read
- Cross out clearly anything you do not want the assessors to read

How can I further prepare for the Writing sub-test?

Your letter is assessed against five criteria:

- Overall task fulfilment
including the overall impression of the performance and whether the response is of the required length
- Appropriateness of language
including the use of appropriate register and tone in the response, and whether it is organised appropriately
- Comprehension of stimulus
including whether the response shows you have understood the situation and provided relevant rather than unnecessary information to your reader
- Control of linguistic features (grammar and cohesion)
how effectively you communicate using the grammatical structures and cohesive devices of English
- Control of presentation features (spelling, punctuation and layout)
how these areas affect the message you want to communicate

Overall task fulfilment

Write enough so the assessors have a sufficient sample of your writing – the task requires approximately 180-200 words in the body of the letter.

Don't write too much – you may need to select content carefully to keep to the required word count.

Use your own words as much as possible – don't simply copy sections from the case notes.

Avoid using a 'formulaic' response – if you include elements that do not fit the task, it indicates a lack of flexibility in your writing.

Don't include information that the intended reader clearly knows already (e.g., if you are replying to a colleague who has referred a patient to you).

Appropriateness of language

Organise the information clearly – the sequence of information in the case notes may not be the most appropriate sequence of information for your letter.

Highlight the main purpose of your letter at the start – this provides the context for the information you include.

Be clear about the level of urgency for the communication.

Always keep in mind the reason for writing – don't just summarise the case notes provided.

Focus on important information and minimise incidental detail.

If it will help, be explicit about the organisation of your letter: e.g., 'First I will outline the problems the patient has, then I will make some suggestions for his treatment'.

Consider using dates and other time references (e.g., three months later, last week, a year ago) to give a clear sequence of events where necessary.

Remember that all professional letters are written in a relatively formal style.

Avoid informal language, slang, colloquialisms and spoken idioms unless you are sure this is appropriate (e.g., use 'Thank you' rather than 'Thanks a lot').

Avoid SMS texting abbreviations in a formal letter (e.g., use 'you' ✓ not 'u').

Give the correct salutation: if you are told the recipient's name and title, use them.

Show awareness of your audience by choosing appropriate words and phrases: if you are writing to another professional, you may use technical terms and, possibly, abbreviations; if you are writing to a parent or a group of lay people, use non-technical terms and explain carefully.

Comprehension of stimulus

Demonstrate in your response that you have understood the case notes fully.

Be clear what the most relevant issues for the reader are.

Don't let the main issue become hidden by including too much supporting detail.

Show clearly the connections between information in the case notes if these are made; however, do not add information that is not given in the notes (e.g., a suggested diagnosis), particularly if the reason for the letter is to get an expert opinion.

Take relevant information from the case notes and transform it to fit the task set.

If the stimulus material includes questions that require an answer in your response, be explicit about this – don't 'hide' the relevant information in a general summary of the notes provided.

Control of linguistic features (grammar and cohesion)

Show that you can use language accurately and flexibly in your writing.

Make sure you demonstrate a range of language structures – use complex sentences as well as simple ones.

Split a long sentence into two or three sentences if you feel you are losing control of it.

Review areas of grammar to ensure you convey your intended meaning accurately – particular areas to focus on might include*:

- articles – a/an, the [e.g., 'She had an operation.', 'on the internet']
- countable and uncountable nouns [e.g., some evidence, an opinion, an asthma]
- verb forms used to indicate past time and the relationship between events in the past and now [past simple, present perfect, past perfect]
- adverbs that give time references [e.g., 'two months previously' is different from 'two months ago']
- prepositions following other words [e.g., 'Thank you very much to see for seeing ...', 'sensitivity of to pressure', 'my examination on of the patient', 'diagnosed with cancer']
- passive forms [e.g., 'He involved in an accident.' for 'He was involved in an accident.]

Use connecting words and phrases ('connectives') to link ideas together clearly (e.g., however, therefore, subsequently).

Create a mental checklist of problems that you have with grammar and go through this when you review your response towards the end of the test: particular areas to focus on might include:

- number agreement, e.g. 'The test result shows that ...', 'There is no evidence ...', 'He lives ...', 'one of the side effects'
- complete sentences, i.e., the main clause includes 'subject and verb', e.g., 'On examination showed that ...' should be 'Examination showed that ...' or 'On examination it was found that ...'
- gender agreement, e.g. 'Mr Jones and her his daughter'
- tense agreement, e.g., 'Examination on 15 May 2006 revealed she is was overweight.' [creating confusion over whether she is still overweight at the time of writing]

Control of presentation features (spelling, punctuation and layout)

Take care with the placement of commas and full stops.

Make sure there are enough – separating ideas into sentences.

Make sure there are not too many – keeping elements of the text meaningfully connected together.

Leave a blank line between paragraphs to show clearly the overall structure of the letter.

Don't write on every other line – this does not assist the reader particularly.

Check for spelling mistakes and for spelling consistency through your writing (e.g., with a patient's name).

Remember that many of the words you write are also in the case notes – check that the spelling you use is the same.

Be consistent in your spelling: alternative spelling conventions (e.g., American or British English) are acceptable as long as your use is consistent.

Don't use symbols and abbreviations in formal letters.

Avoid creating any negative impact on your reader through the presentation of the letter.

Use a clear layout to avoid any miscommunication.

Make sure poor handwriting does not confuse the reader over spelling and meaning.

Write legibly so the assessor can grade your response fairly using the set criteria.

Candidates are assessed on their ability to:

- Select, transform and organise information in the case notes into a coherently structured letter
- Include relevant information to
 - » explain the patient's condition, history and reason for referral,
 - » explain a problematic situation, OR
 - » outline drug information
- Use appropriate conventions of letter format (including addressee's details, date, opening and closing moves)
- Use register, tone and vocabulary appropriate to the professional context
- Show adequate control of a range of grammatical structures and cohesive devices
- Show adequate control of spelling and punctuation

* In the following list, a line through text indicates inaccurate grammar.

Writing sub-test

Practice test 1

Please print in BLOCK LETTERS

Candidate number

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Family name

Other name(s)

City

Date of test

Candidate's signature

YOU MUST NOT REMOVE OET MATERIAL FROM THE TEST ROOM

The OET Centre

GPO Box 372
Melbourne VIC 3001
Australia

Telephone: +613 8656 4000
Facsimile: +613 8656 4020
www.occupationalenglishtest.org

Occupational English Test

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: READING TIME: 5 MINUTES

WRITING TIME: 40 MINUTES

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

Notes:

Jamie Brown is a patient in your General Practice. He is a 5-year-old boy accompanied by his mother.

25.02.10

Examination: Sore throat and husky voice, febrile and irritable
Temp = 39
Large, infected tonsils with exudate
Tender enlarged cervical nodes

Assessment: Tonsillitis

Plan: Penicillin V 250mg q.i.d. for 7 days

18.03.10

Examination: Mum noticed that Jamie had brown urine 4 days ago
She says he is tired and lethargic
No history of frequency, dysuria or trauma
ENT – tonsillar hypertrophy
BP – 90/60
Urinalysis – macroscopic haematuria

Assessment: ? Post streptococcal nephritis
? UTI

Plan: Review in 2 days; drink plenty of fluids

Investigations: FBE + diff
Urea + creatinine
Electrolytes
ASOT titre
MSU M/C/S + cell morphology

20.03.10

Examinations: Patient still asymptomatic
↑BP 110/90
Urinalysis – macroscopic haematuria

Results: FBE – normal
Urea + creatinine – sl. elevated
ASOT – elevated +++
MSU – 4 x 10 # RBC of renal origin

Assessment: Post-streptococcal nephritis with early renal failure

Plan: Refer to paediatrician Dr F. Goldman

Writing task:

Using the information in the case notes, write a letter of referral to Dr F. Goldman, 171 Victoria St, Northfield.

In your answer:

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

The body of the letter should be approximately 180 - 200 words.

Occupational English Test

WRITING SUB-TEST: MEDICINE

SAMPLE RESPONSE: LETTER OF REFERRAL

20 March 2010

Dr F Goldman
171 Victoria St
Northfield

Dear Dr Goldman,

Re: Jamie Brown

This 5 year-old boy, Jamie Brown, initially presented with tonsillitis on 25/02/10 for which he was treated with Penicillin V 250mg q.i.d. for 7 days.

Three weeks later Jamie presented with painless macroscopic haematuria after his mother observed urine discolouration. His only other symptom appeared to be lethargy. Examination was unremarkable: he had tonsillar hypertrophy, his BP was 90/60 and urinalysis confirmed significant haematuria. The patient was advised to maintain fluid intake pending review.

On review today, investigations showed a mildly elevated urea and creatinine, a significantly elevated ASOT titre and haematuria of renal origin.

The patient's blood pressure has increased to 110/90.

I believe Jamie has post-streptococcal nephritis and that he is at risk of developing renal failure. I would appreciate your assessment and management of this young man.

Please do not hesitate to contact me for any further clarification.

Yours sincerely,

Doctor

Writing sub-test

Practice test 2

Please print in **BLOCK LETTERS**

Candidate number

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Family name

Other name(s)

City

Date of test

Candidate's signature

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Occupational English Test

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: READING TIME: 5 MINUTES

WRITING TIME: 40 MINUTES

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

Notes:

Emma Johnson is an 11-year-old patient in your general practice.

Patient history

30/11/09

History: Nocturnal cough last 2 wks associated with runny nose and mild fever
Previously well
Family history of asthma – mother & older sister aged 15
Past history – nil
Medications – nil
Allergies – none known

Examination: Slightly flushed, temp 37.8°C
Red pharynx, ears normal
Chest – no obvious wheeze, no focal signs
Peak expiratory flow rate (PEFR) – 250 L/min (expected 350 L/min)

Assessment: Viral upper respiratory infection
Possible associated asthma

Plan: Paracetamol, fluids for infection
Review if worsens

21/12/09

Examination: Patient returns with persistent nocturnal cough. Runny nose and fever now completely resolved. Cough also noted on exercise.
Chest auscultation – faint basal wheeze, PEFR 230 L/min
Ears, nose and throat normal

Assessment: Probable asthma

Plan: Trial inhaled salbutamol – Ventolin puffer 2 puffs t.d.s.
Keep record of morning and evening PEFR readings
Review 3 wks

11/01/10

Examination: Review symptoms slightly improved; exercise tolerance better
Less nocturnal disturbance
Chest auscultation – no wheeze heard
PEFR 280 L/min

Assessment: Improved but asthma still slightly unstable

Plan: Commence inhaled corticosteroid – Becotide 200 2 puffs t.d.s.
Continue Ventolin as required
Continue PEFR monitoring
Review 4 wks

8/02/10

Examination: Much improved; minimal nocturnal & exercise-induced symptoms
Chest auscultation – clear, PEFR 340 L/min

Assessment: Well-controlled asthma

Plan: Maintain on current therapy
Review 2 mths

10/04/10

Examination: Worsening shortness of breath & wheezing over last 48 hrs w. runny nose, fever, loss of appetite
Red throat, ears normal
Obvious difficulty in breathing with use of accessory muscles
Chest auscultation – widespread wheeze, no focal signs
PEFR 140 L/min

Assessment: Severe asthma triggered by viral upper respiratory infection

Plan: Ventolin nebuliser statim – minimal relief
Urgent assessment at hospital

Writing task:

Using the information given in the case notes, write a letter of referral to Dr B Townsend in the Emergency Department at the Newtown Children's Hospital.

In your answer:

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

The body of the letter should be approximately 180 - 200 words.

Occupational English Test

WRITING SUB-TEST: MEDICINE

SAMPLE RESPONSE: LETTER OF REFERRAL

10 April 2010

Dr B Townsend
Emergency Department
Newtown Children's Hospital

Dear Dr Townsend

Re: Emma Johnson

Thank you for assessing this 11-year-old girl with an acute exacerbation of asthma triggered by a viral upper respiratory infection. Apart from a family history of asthma in her mother and 15-year-old sister, she has been otherwise well and has no other significant past medical history.

She initially presented in November with a mild episode of asthma related to a similar viral infection. At that time, her PEFR was 250 L/min (expected value 350 L/min). She developed a persistent nocturnal cough which responded partially to a trial of inhaled Ventolin but improved significantly with the introduction of inhaled Becotide 200 2 puffs t.d.s. After a four-week trial of Becotide her PEFR was 340 L/min. She is currently maintained on this dose of Becotide with additional Ventolin as required.

Today she presented with a 48-hour history of upper respiratory symptoms and worsening shortness of breath; on examination she has widespread wheeze and her PEFR is now 140 L/min. She has had one Ventolin nebuliser here at the surgery, with little relief, and I feel that the severity of this episode warrants admission for further observation and treatment.

Yours sincerely

Doctor

Writing sub-test

Practice test 3

Please print in **BLOCK LETTERS**

Candidate number

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Family name

Other name(s)

City

Date of test

Candidate's signature

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The OET Centre

GPO Box 372
Melbourne VIC 3001
Australia

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Occupational English Test

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: READING TIME: 5 MINUTES

WRITING TIME: 40 MINUTES

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

Notes:

Marjorie Jackson is a 40-year-old patient in your General Practice.

Patient History

Date of birth: 22/7/69

13/1/10

History: Complaining of poor sleep, no energy, loss of weight over past months
Recent bereavement – older sister died (heart attack six weeks ago)
Tearful + depressed
Family history of depressive illness – mother
Past history of post-natal depression

Examination: Thin, quiet
No physical abnormality on examination
Weight 62kg

Assessment: Reactive depression

Plan: Bereavement counselling – liaising with local social worker

22/2/10

Examination: Still very tearful; difficulty engaging in normal daily activities
Attending social worker on weekly basis
Increasingly withdrawn according to relatives
Weight 59.2kg

Assessment: Reactive depression

Plan: Institute anti-depressive drug therapy – doxepin 25mg nocte increasing to 100mg nocte over next 10 days
Continue counselling

16/3/10

Examination: Brought in by family

Very withdrawn; not giving answers to most questions

Relatives report refusing food at home last few days; not taken medication for last six days; muttering to herself at odd times – not seeming to make sense

Mild dehydration

Weight 56kg

Assessment: Depressive psychosis

Plan: Warrants urgent admission to hospital

Phone discussion with Dr J Blackthorne, Admitting Officer, Newtown Psychiatric Hospital – will accept patient

Writing task:

Using the information in the case notes, write a letter of referral to Dr J Blackthorne, the Admitting Officer at Newtown Psychiatric Hospital, Main Road, Newtown.

In your answer:

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

The body of the letter should be approximately 180 - 200 words.

Occupational English Test

WRITING SUB-TEST: MEDICINE

SAMPLE RESPONSE: LETTER OF REFERRAL

16 March 2010

Dr J Blackthorne
Admitting Officer
Newtown Psychiatric Hospital
Main Road
Newtown

Dear Dr Blackthorne

RE: Ms Marjorie Jackson
D.O.B: 22/7/69

Thank you for accepting this 40-year-old woman with a presumptive diagnosis of depressive psychosis. She originally presented on 13/1/10, complaining of sleep disturbance, weight loss and depressed mood, related to the death of her sister from a myocardial infarction six weeks earlier. She has a family history of depressive illness and a known past history of post-natal depression. At this time I felt her problem was reactive depression following the death of her sister and organised counselling with the local social worker.

She returned on 22/2/10 with worsening symptoms and further weight loss and at this stage I instituted treatment with doxepin 100mg nocte in addition to ongoing supportive counselling.

Ms Jackson was brought in by her family again on 16/3/10. She was refusing food and medications and was clinically dehydrated. She had lost a further three kilograms since the visit on 22/2/10. She refused to respond to questions and was noted by the family to be talking softly to herself.

Given this history, I believe her to be suffering from a depressive psychosis and would appreciate your further assessment and management.

Yours sincerely,

Doctor

Further Practice

There are resources for English-language learners on the Web which can help you develop the general writing skills involved (e.g., formal letter writing, general grammar practice). Some possible sources are:

Online Writing Lab at Purdue University

<http://owl.english.purdue.edu/owl/> new homepage

Englishmed.com

<http://www.englishmed.com/> English learning resources with a medical focus

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The Occupational English Test (OET) is designed to meet the specific English language needs of the healthcare sector. It assesses the language proficiency of healthcare professionals who wish to register and practise in an English-speaking environment.

OET is owned by Cambridge Boxhill Language Assessment Trust (CBLA), a venture between Cambridge English and Box Hill Institute. Cambridge English Language Assessment is a not-for-profit department of the University of Cambridge with over 100 years of experience in assessing the English language. Box Hill Institute is a leading Australian vocational and higher education provider, active both in Australia and overseas.

Writing Phrases for Medical Letter

OPENING SALUTATION

Dear Doctor / Registrar / Dr. Smith / Michael,

Re: Patient ... (John Smith) , DOB ... (1.2.1950)

[DOB – Date of birth]

OPENING CLAUSE

[Referral/Admission plus Patient data]

Thank you for (urgently) seeing ... (the above patient/ Mrs. Polanski), [Referral letter]

a 38 year-old ... (worker, profession) **with** ... (cholelithiasis)
for further ... (management) **and possible** ... (operation)

who is currently | in this hospital recovering from ... (a stroke)
| **suffering from** ... (severe acute asthma)
| bedridden/immobile **with possible ... following ... on** ... [combination]
(nerve compression) (heavy lifting) (date)

I am writing to refer | my patient **aged** 45 and **married with** 3 children of school age.

I am pleased to refer | this 45yo lady
↓ Mrs. Smith
| a 45 year-old worker

(This lady of 45years)... was admitted

[Admission letter]

to your facility / this hospital / clinic on ... (4.5.08)

for further (neurological) **assessment and possible treatment of** ... (headaches)
operation ... (of a hernia)
management of ... (her drug substance abuse)

for a fracture of his ... (femur)
for post fracture rehabilitation

I am writing to follow up our conversation earlier today
about ... (your son's management plan)

[Advice letter]

Further to our earlier conversation ... (I am reporting you about ...)

REASON FOR REFERRAL

(Mr. Dubois) ... **presented** to me (today)
at my clinic
to emergency

with signs of a (possible) ... (pulmonary infection)
complaining of ... (left thorax pain)

This 5 yo boy **initially presented with** ... (tonsillitis)
for which he was treated with ... (antibiotics)

He is / **has been suffering his first episode of** ... (poststrept. nephritis/chest pain)

He was admitted to this hospital on ... for a fracture of ...
suffering from ...
with signs for early renal failure / heart attack

PROVISIONAL DIAGNOSIS(PD)

[NYD - not yet diagnosed]

My provisional diagnosis is ... (headaches), possibly ... (stress-related)
Today, I diagnosed .. / he is diagnosed with ...
The complaints may result from ... / caused by ...

I believe he has / may have ... (a urinary tract infection)
I believe that the cause of his complaints is ... (an asthma attack)
and is at risk of developing renal failure

Investigation Diagnosis:

The ECG indicated possible ... (ischemia)
The liver function tests showed possible ... (mild obstruction)
The Xray detected ...

PRESENT ILLNESS

Introduction:

in ... (Nov 2003)
on ... / today / 6 weeks ago
for ... (a check-up)
complaining of... / suffering from...
with symptoms of ... (tonsillitis)

On his first visit to me on he was / has been suffering ... (a sore throat)
On ... Mr Smith presented (at my clinic) complaining of ... **for the previous 10 days**
which was not responding to ... (simple analgesia)

2) His complaints set in 10 days earlier and were related to ... (strong gardening exercise)

SYMPTOMS

The pain **occurs** ... (on exercise)

He **was/felt** + adjective ... (irritable / feverish/ sweaty/ distressed/ nauseated /dehydrated)

He **suffers from** ... irritability
complained of ...
presented with ... an irritable condition
showed... no guarding or rebound on abdominal examination
found it difficult to ...
is unable to ... see clearly

Apart from this,
In addition, he **noticed** *progressively worsening sight*
Furthermore, he **experienced** *a new episode of pain*

**At times,
Occasionally,**

He (initially) had ... (headaches), but has had none since that time until ... (now / 3 weeks ago)

She reported no history of ... (abdominal tenderness)
This causes her stress
He had a decreased range of ... (movement on his right hip)

PAST HISTORY (PH)

[use simple present tense !]

He has a five year history of ... (osteoarthritis)
She has a history of ... hypertension (well controlled by medication)
His (medical) history includes (iron deficiency) **for which he is given ... / treated with ...**
He also suffers from ...

excluding: **She reported no history of** dysuria
There has been no history of **being overweight/ obesity (98kg at 170cm ht)**

He has not suffered from ... (epilepsy) or other significant illness/injuries before ... (accident)

RISK FACTORS / ALLERGY

His (cardiovascular) riskfactors **such as** ... (hypertension)
include ... (hypercholesterol, smoking)
being overweight / obesity
lack of regular exercise / having no regular exercise
a strong family history (father died of ... aged 48)

Smoking: She has smoked 15 cig. a day for the past ... years
He **had cut his smoking to** 10 c. a day [past perfect]

Allergy: **Please note that she is allergic to ... (penicillin)**
He has no known allergies

CURRENT MEDICATION

Abbreviations: stat (latin: statim) – immediately,
BD – twice, t.d.s./t.i.d. - thrice, q.d.s./q.i.d. - four times
p.c. – after food, nocte – at night, s.l. sublingual, s.c. - subcutaneous

**Her current medications include / are ...
She also uses ... (Mylanta) for ... (reflux)**

(No) effect: The pain has(n't) has not **responded to** simple analgesia
was (not) **relieved by** oral medication, Senna, Zantac

**was persistent
resistant to**

Coloxyl, Avapro, Panadol

The was pain **resisted to** ... (Aspirin)
His complaint **usually settles with** NSAID and rest

Side-effect: But the medication **caused significant** ... (dyspepsia)

TREATMENT

Prescription: He was treated here with ... (diuretics)

Combination Treatment !! :

**He was given ... (oxygen) followed by ... (hospital admission)
in addition to ... (adrenalin)
combined with ... (life support)
and advised on ... (losing weight)**

I prescribed ... (Respolin) **combined with ... (the Pulmicort)
in addition to**

Effect: Initially his response to ... (fentanyl) was ... (good), but unfortunately his pain **flared up**.
Therefore, **I commenced him on** ... (morphine)
I changed him on ... (frusemid)
After discussion with Dr. X, I started her on ...

Dosis: After persistently elevated BP readings around x mmHg, he was **commenced/started** on ... (nifedipine), this has **recently been increased** to ... (20mg)

Operation: An arthroplasty was performed.
She underwent/had ... (an appendicectomy) and recovered well/ will be discharged today.

Recovery: She has been able to ... (shower) **with assistance**

She **underwent/had** ... (an appendicectomy) and recovered well/ will be discharged today.

Recovery: She has been able to ... (shower) **with assistance**. Signs of depression have subsided and she is more responsive.

Since the operation her wounds have healed and sutures were removed. Her post operative recovery was successful, uncomplicated and uneventful. She is now normal.

Subsequently

In the following days, he **recovered by taking** ... (Penicillin) for 7 days.
after 7 days treatment with ... (Penicillin)

Complications: **While here, she has (extreme) difficulty using a walking frame / the crutches to walk (with extreme difficulty) to have shower with assistance**

Her short-term memory has worsened while her general condition has deteriorated

EXAMINATION

On neurological physical examination this lady showed cardiovascular I found ... **no abnormalities** she was overweight **with normal vital signs** (P80, BP 120/70, T36)

The examination was **unremarkable** / normal
revealed ... (elevated liver enzymes, no abnormalities)

(Bilateral fine crepitations) ... **were noted on** chest auscultation / examination

Otherwise, examination was normal.

Readings:

The (liver function tests) ... **showed (no)** pathological findings
(FBC, MSU, ASOT) significant abnormalities
were consistent with ... (hepatic failure)

He had **elevated BP readings** around 150/1000
The blood test was normal and Urea, Creatinine were **slightly elevated**

Technical Investigations:

Tests including ...
An Xray/ECG/radiograph **taken here on** ... **revealed** ... NSA (no significant abnormalities)
indicated ...

Test for/on ... (Mr. Smith) **were done and showed** ...
I had test for ... (Mrs. Jones) done which showed ...
I ordered the following test for ... (Michael):

Results:

All tests in summary indicate pathological findings **consistent with** ... (hepatitis)
confirm my provisional diagnosis of ... (poststreptococcal nephritis)

(The urine analysis) ... **showed / confirmed significant** ... (haematuria)
(Her liver function tests) ... **showed possible** ... (mild obstruction)
The ... (CT Scan) **at that time appeared** ... (unremarkable/ normal)

ACTUAL CONSULTATION

[Review, follow-up visit]

On review (Today), ... (Mr. Romano) **reports no further episodes of** ... (headaches)
presented **persisting** complaints
reviewed me due to ... (brown urine) for 4 days.

On review, **investigations showed** ... and haematuria of renal origin.

One month later, he returned today with the symptoms above.

PSYCHOLOGICAL + CONCERNS

was anxious

She showed concerns that she may have ... (cancer), about which I have reassured her.
worried

She is most concerned of ...
She is a widow and has managed alone until now.

He receives support from ... to manage
He needs assistance
He requires

ADVICE

He was **advised to** ... (take antibiotics) **and return in** ... (2 days)
on ... (losing weight)

Mrs. Smith was given advice on ... (quitting smoking)

I advised her (that she may need) to represent to hospital for admission ...

**if she gets any worse
or if she isn't getting better in 2 days.**

To avoid future episodes, he needs ... (to carry medical ID at all times stating he is diabetic)

REQUEST / FUTURE MANAGEMENT

Thank you for continuing the care of ... (this lady)

[discharge letter]

I would appreciate your further assessment and management/treatment
regarding ... (his acute worsening condition).
of the possibility of ... (cancer)
of the suspected/potential cancer

I would appreciate

I would be grateful

(for) your opinion regarding ... (his future management)

if you could please assess this patient

if you could see ... (this lady) **fairly soon** for further management.

if you could **arrange an appointment with**
a physiotherapist
an occupational therapist
a social worker

I would be interested if he would be a suitable candidate for ... (a hip replacement)
I would appreciate if you could keep me informed about his further management.

27/08/10

Mr. and Mrs. Murray

4 Temberton Street

Tarra Hill

Brisbane

Comment: Incorrect spelling: Pemberton

Dear Mr. & Mrs. Murray,

I am writing in regard to your 7 years old daughter Kate, who will need extra attention and care as she has fractured her right lower leg.

She was brought into the hospital by her schoolteacher as both of you were not available when contacted following the incident in the gymnastic class. Her fractured leg has been backslabbed and bandaged along with the supply of crutches on loan. She also has been prescribed with the tablet Panadol 250mg if required.

Comment: Incorrect expression, replace with:

•..7-year-old daughter

✓*For more details, review Year or Years in the Grammar and Vocabulary Clinic*

Comment: Perfect paragraph!

Regarding her fractured right tibia, she must be encouraged to keep her leg elevated to her chest level during the first 48 hours and while resting in order to reduce the swelling. Beside that, her fractured leg should be observed for abnormal sensation such as numbness, tingling or burning or pins and needles as well as swelling in the toes. Please note, if she suffers from any of the symptom, elevate her leg for 20 minutes and if that does not help then ring 0733567853 immediately. In addition, she is scheduled for an appointment for fiberglass cast at 1:30 pm on 3/9/10 at Children's hospital Fracture clinic.

Comment: Use plural form of this word:

•...any of these symptoms

Comment: Capital required for names of institutions such as hospitals. Compare

- 1.I went hospital for a check up (in general so no capital required)
 - 2.I went to Spirit Hospital for a check up
 - 3.I study at university
 - 4.I study at Harvard University
- For more details, review Capitalisation*

In the context of her recovery, her fracture will heal fully without any long-term effect which might take at-least 6-10 weeks. However, heavy activities such as running, skateboarding and gymnastics must be avoided for another month after the removal of the cast. Therefore, to improve muscle strength, mobility and gaining balance, involvement of physiotherapist is recommended.

Please contact me if you have any queries regarding your daughter's health.

Yours sincerely,

Ray Peters

Orthopaedic Nurse

Childrens' Hospital Fracture Clinic

Comments and Feedback

Excellent work this time, and you have made a great improvement from the last task. Your grammatical accuracy is much improved and the paragraphs are very clear and well written and the errors are very minor. What I like most is that you personalised your letter very well with personal expressions such as

- your..daughter Kate
- lot's of her/she
- your daughter's health

This has a big impact on the tone and register of your letter.

However, there are still some errors as noted above so keep working hard.

Grade: This letter is A-

Date- 27.06.2010

The General Practitioner
Aboriginal and Torres Strait Islander Community Health Service
55 Annerley road
Woolongabba
4102

Comment: Capital required
•Road

Dear Doctor,

Re: Gwen Watego DOB 25.03.1967

I am referring this patient, a 33 year old aboriginal widow who requires further investigations for possible Diabetes mellitus .

Comment: Capital not required for names of diseases.

For more details, review Capitalisation in the Grammar and Vocabulary Clinic

Comment: Use verb form of this word : lose

Comment: One word: within

Mrs. Watego was admitted to our emergency department for overnight care following a fall outside the shopping mall. She did not loss her consciousness nor hit her head at the time of injury. Her observation was with in the normal limit during hospitalization.

In terms of her medical and social history, she has no history of any allergies and not taking any medication. She had pneumonia 1 year back. Unfortunately her husband passed away 2 years ago. Therefore, her next of kin is her daughter Cath and sons Vincent and Kevin.

Comment: Missing verb
•she has no history of any allergies and is not taking any medication

During her hospitalization , random blood sugar test was done which showed 11 millimol per liter as she can possibly have diabetes. This patient is a smoker (15 cigarettes per day) and an alcoholic. Therefore, I have discussed the benefits of quitting smoking and have referred her to the Quitline. So, could you please review this patient regarding the above matters.

Comment: Awkward sentence, 2 possible choices are:

•random blood sugar test was done which showed 11 millimol per liter , indicating the possibility of diabetes.

•random blood sugar test was done which showed 11 millimol per liter so she may possibly have diabetes.

Comment: Big error here. Alcoholic means a person who is suffering from alcoholism which means they are a compulsive drinker and addicted to alcohol, which is not the case here. Replace with: moderate to heavy drinker

Comment: This is better expressed as'
•the left and right planter surface of her feet have

Comment: Subject verb agreement is incorrect. Replace with: have *For more details, review Subject-Verb Agreement in the Grammar and Vocabulary Clinic*

On examination, her left and right planter surface of the feet has painful callus and ulcer respectively. So, could you please arrange the podiatrist start new sentence here and the dietician for diabetic diet in your facility' In addition a dietician is required regarding her diet.

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

Yours sincerely,

Karuna Gurung

Registered Nurse

Nanango Hospital

Brisbane

Comments and Feedback

Back to C grade with this task as the error count is too high as noted above. Also one problem is you are trying to put too much information in one sentence, see podiatrist/ dietician above.

The big error is regarding your summary of her alcohol use...but better to make that error now rather than in the exam.

Grade: This letter is C+

13 th September

The Director
Community Child Health Service
41 Vulture Street
West End
Brisbane
4101

Dear Sir / Madam ,

Re : Nicole Smith

I am writing to refer Ms Smith an 18 year old single mother , who was admitted to our hospital on 9 th September . She has emergency caesarean section due to fetal distress and her prolonged labour .

Comment: Incorrect grammar. You have two choices:
1. I am writing to refer Ms Smith, an 18 year old single mother who was admitted to our hospital
2. I am writing to refer Ms Smith who is an 18 year old single mother. She was admitted to our hospital.....

Ms Smith has post partum hemorrhage , which caused her low hemoglobin and she has on fefol and vitamin C. But her wound was healthy . In addition, her son has problem after his birth ,which has treated with oxygen inhalation for a few minutes .However , he has no signs of jaundice and he is feeding well .

Comment: Use past tense & article:
She had an emergency..

Comment: Use adjective form of this word: prolonged

Comment: Again, past tense is preferred here: had

Comment: Incorrect grammar, use simple present : she is currently on fefol

Comment: The linking words but and in addition are not used correctly which disrupts the flow of information. Refer to the model letter for how to group information regarding the mother and son.

Comment: Incorrect grammar: was treated. Please refer to the attached grammar explanation sheet for advice on passive form

Comment: As this is a negative sentence, you need to connect with or

Comment: Wrong word: breast feeding. It would be useful to say why as well: not confident

Comment: Replace with: and

Comment: Verb subject agreement is incorrect : she needs to...

Comment: Incorrect preposition, replace with: of

Comment: Incorrect preposition, replace with: for

Comment: Incorrect spelling: queries

The mother and her child were discharged today, she requires advice for breast feed ,which she would prefer to change to bottle feeding .Also she need assistance for the care to her baby .Could you arrange a home visit and provide appropriate support to her .Should you have any quires , please do not hesitate to phone me .

Yours sincerely
Jaiwei
Charge nurse
Mater Mothers' Hospital
Brisbane

The OET centre uses the assessment criteria below when assessing referral letters

Overall task fulfilment	Word length is much better this time at 179 words. However the letter is difficult to read due to a lack of purpose on behalf of the writer. Refer to the model letter for an example of how to do demonstrate your understanding of the situation.
Comprehension of stimulus	You have identified some of the key points in this letter. However, as in the previous task you have not grouped the information in a logical manner and identified the connection between some of the facts which you report. For example the fact that she has no contact with the father/her parents indicates that she will need support. You need to make this point very clear in your letter, and you can not expect the reader to interpret that.
Appropriateness of language	As stated above, comment U5, at times the information is not organized in a clear and logical manner. So you need to spend more time planning and reading the case notes, and organizing your letter. Overall you have not clearly emphasized the important points in this letter. To do this you need to use phrases such as "my main concern is...." To indicate key points.
Control of linguistic features	Quite a few mistakes in this letter, especially with regard to verb tense. This is an extremely important part of referral letters as it strongly affects the meaning of what you say and the time relationships in the case history.
Control of presentation features	Good, just one spelling mistake

10/06/10

The Registered Nurse

Post- Operative Care Resident

Dear Sir/Madam,

RE: Mr. James Hutton

DOB: 25/03/1920

Comment: When writing to another health professional, it is better to use their title. Use Sir/Madam when unsure what their profession is (i.e if they are a Director)

•♣ . Dear Nurse

For more details, review [Letter Format in the Grammar and Vocabulary Clinic](#)

I am referring this patient, a 90 year old retired widower to your facility for overnight post-operative care as he has undergone right corneal graft.

Comment: Use noun form: widower
✓ For more details, review [Difficult Words in the Grammar and Vocabulary Clinic](#)

He is totally blind by his left eye. His right eye was limitedly functioning until his cornea got distorted for which he underwent for a corneal graft under a full local anesthesia. Mr. Hutton's right eye is sedated and will need an eye patch with the shield to protect from any harm during the night. He is also a hypertensive patient. He is on a range of medications. Please find the attached the medication chart along with the letter.

Comment: Incorrect preposition, replace with: in

Comment: Anesthesia is an uncountable noun so no article is required. For more details, review [Countable & Uncountable Nouns in the Grammar and Vocabulary Clinic](#)

Comment: Incorrect spelling: sedated

He is a gold cardholder and his next to kin is his son Mr. William Hutton with whom he is staying but in separate accommodation.

Comment: Short sentences like this sound awkward, so better to join them.

•He is also a hypertensive patient and he is on a range of medications for both his medical condition and post-operative requirements. Please find the attached...

I am concerned that he will need a full assistance with his showering, mobility and dressing until his vision to his right eye comes back. Moreover, he has an appointment with the doctor for the surgery at 11 am tomorrow for which he should be discharged by 10 am. So, could you please kindly take over this patient and do the necessities.

Comment: This is not a "concern" but more a fact. 2 possible choices are:
•Regarding his care, he will need
•He will need....

Should you have any queries, please don't hesitate to contact me.

Comment: As above, assistance is an uncountable noun so no article is required.

Yours sincerely,

Comment: You do not need to write his twice

Registered Nurse

Comment: Incorrect, the "doctor's surgery" means his clinic or office in this case. (tricky vocabulary, I know)
•..an appointment with his surgeon at....
•.. an appointment with his doctor at....

Karuna Gurung

Comment: Unnecessary and "odd" expression
•Therefore, could you please take over the care of this patient.

Comment: Error
•Yours sincerely

Comments and Feedback

Karuna, there is still a lot of work to do to reach B level, and this letter has exposed many weaknesses. One thing you need to do is learn and follow the "conventions" of formal medical letter writing, especially in the conclusion as noted above. You still have influences of "Indian English" in your writing, so work hard to learn the patterns. Regarding medication, it is fine to write, attached medication chart, but you do need to add a bit more case related information, see above. Apart from that there are a variety of errors so definitely serious review is required this week!

Weaknesses

- Uncountable nouns
- Expression errors
- Vocabulary
- Many small errors

Grade: This letter is mid C

Widow or Widower

- Widow (noun) refers to a woman whose husband has died and who has not remarried.
- Widower (noun) refers to a man whose wife has died and who has not remarried.
- Widowed (adjective) refers either a man or woman whose spouse has died and has not remarried.

Incorrect	Correct
<ul style="list-style-type: none">• I am writing to refer Mrs. Saunders, a 58-year-old widowed who admitted with pain, dehydration and nausea.• I am writing to refer Mr. Saunders, a 60-year-old widow who complained of pain in his upper right second molar.	<ul style="list-style-type: none">• I am writing to refer Mrs. Saunders, a 58-year-old <u>widow</u> who admitted with pain, dehydration and nausea.(noun)• I am writing to refer this patient a 58-year-old <u>widowed woman</u> who admitted with pain, dehydration and nausea.(adjective)• I am writing to refer Mr. Saunders, a 60-year-old widower who complained of pain in his upper right second molar.(noun)

Sample Doctor Model Letter

14.10.10

The Duty Registrar
Emergency Paediatric Unit
Brisbane General Hospital
140 Grange Road
Kelvin Grove, QLD, 4222

Dear Doctor:
Re. Amina Ahmed (8years)

I am writing to refer Amina who is presenting with signs and symptoms of meningococcal meningitis for urgent assessment and management. She is the first child of a family of 5, which includes her parents and two younger siblings. They are immigrants from Somalia, though she and her father understand English.

Initially, accompanied by her parents, she presented to me on 9.10.10 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next two days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.

Regrettably, today Amina became lethargic and listless. She vomited twice last night and had been having severe headaches. On examination, she was severely febrile with a temperature of 40.2 and a pulse rate of 110 beats per minute. There was macula-papular rash over the legs and neck stiffness was present. Blood test showed leucocytosis with a shift to the left.

Based on the above, I believe she needs urgent admission and management. Please note, Penicillin IV has been given as a stat dose.

Yours sincerely,

Dr. Lucy Irving

Kevin Grove Medical Centre
53 Goma Road
Kelvin Grove, Brisbane

Sample: Nurse Model Letter

23 May, 2008

Marcia Devonport
West End Physiotherapy Centre
62 Vulture Street
West End, 4101

Dear Ms Davenport,
Re: Mr. Bob Dawson

I am writing to refer this patient, an 84 year old man, who is under our care with the complaints of a grazed left knee and problems with mobility.

Mr. Dawson has a history of cerebrovascular accident which occurred in 2004. He has had problems with the knee for the last week following an accident when he fell down the stairs.

As per general practitioner's order, we are doing daily home visits and wound dressing and also assisting him with his showers. His wound is healing and is free from infection. He walks slowly with the help of his wife.

Mr. Dawson, who lives with his wife in his own home, is an aged care pensioner. The doctor has advised him to use a walking stick in order to improve his mobility but he is unskilled in using it. It would be greatly appreciated if you could arrange home visits to provide training and assistance to Mr. Dawson

Thank you for agreeing to assist in this matter. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,
Sonya Mathews

Nursing Sister
Blue Nursing Home Care Agency

180 words

Writing Task 1 Doctors

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

16.02.09

Patient History

Miss Cathy Jones - 25 year old single woman
Occupation - receptionist
Family history of deep vein thrombosis
On progesterone-only pill (POP) for contraception
No previous pregnancies

15.02.09

Subjective

Presents to GP surgery at 7 pm, after work
Complains of lower abdominal pain since the evening before, worse in right iliac fossa
Unsure of last menstrual period, has had irregular bleeding since starting
POP 2 months ago, New partner for past 2 months
No bladder or bowel symptoms

Objective

Mild right iliac fossa tenderness, no rebound / guarding

Apyrexial, pulse 88, BP 110/70
Vaginal examination - quite tender in right fornix. No masses

Assessment

Non-specific abdo pain

Plan: Asks her to return in morning for blood test and reassessment

16.02.09

Subjective

Pain has worsened overnight. Now severe constant pain.
Some slight vaginal bleeding overnight also.
Felt faint while waiting in reception.
On questioning, has left shoulder-tip pain also.

Objective

Very tender in the right iliac fossa, with guarding and rebound tenderness
Apyrexial, Pulse 96, BP 110/70
On vaginal examination, has cervical excitation and markedly tender in the right fornix.
Pregnancy test result positive
Urine dipstick clear

Assessment

Suspected ectopic pregnancy

Plan: You ring the on duty Gynaecology Registrar and ask for urgent assessment, and are instructed to send her to the A&E Department with a referral letter.

Writing Task

You are the GP, Dr Sally Brown. Write Referral letter to the Gynaecology Registrar at the Mater Hospital, South Brisbane. Ask to be kept informed of the outcome.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Task 1 Model Letter: Cathy Jones

Gynaecology Registrar
A&E Department
Mater Hospital
South Brisbane

Dear Doctor,

Re: Cathy Jones DOB 1.12.83

Thank you for seeing this 25 year old woman who I suspect has an ectopic pregnancy.

This is her first pregnancy. She presented to the surgery yesterday evening with vague lower abdominal pain. She started the progesterone-only pill for contraception two months ago, when she started a new relationship, and has had some irregular bleeding since then. Therefore she is unsure of her exact last menstrual period. Yesterday, she was mildly tender only and her observations were normal.

However, on review this morning her pain had worsened overnight, she is very tender in the right iliac fossa, with rebound and guarding, and on vaginal examination there is cervical excitation, and marked tenderness in the right fornix. Her pregnancy test is positive.

I am concerned that she may have an ectopic pregnancy, and would appreciate your urgent assessment.

Please keep me informed of the outcome.

Yours sincerely,

Dr Sally Brown (GP)

Task 2 Case Notes: Brendan Cross

Time allowed: 40 minutes

Read the case notes below and complete the writing task that follows:

Today's Date

21/01/10

Patient History

Brendan, 8 years old boy

Has a sister 6 years, brother 3 years

Mother – housewife

Father – Naval Officer currently on active duty in Indonesia

P.M.H- NAD

Brendan is on 50th percentile for height & weight

Allergy to nuts – hospitalised with anaphylaxis 2 years ago following exposure to peanuts

14/01/10

Subjective

Fever, sore throat, lethargy, many crying spells – all for 3 days.

Objective

Temperature - 39.8°C

Enlarged tonsils with exudate

Enlarged cervical L.N.

Ab - NL

CVS – NL

RR – NL

Probable Diagnosis

Tonsillitis (bacterial)

Management

Oral Penicillin 250mg 6/h, 7days

Paracetamol as required.

Review after 5days if no improvement.

19/10

Subjective

Mother concerned – sleepless nights, difficulty coping with husband away – mother-in-law coming to help.

Brendan not eating complaining of fever, right knee joint pain, tiredness, lethargy – for 2 days

Objective

Temperature - 39.2°C

Hypertrophied tonsils

Cervical lymph node – NL

Swollen R. Knee Joint

No effusion

Mid systolic murmur, RR - normal

Investigation

ECG, FBC, ASOT ordered

Treatment

Brufen 100mg tds, review in 2 days with investigation reports

21/10

No change of symptoms

ECG – prolonged P-R interval

ESR – increased

ASOT – Increased

Diagnosis

? Rheumatic fever

Plan

Contact Mater Paediatric Centre to arrange an urgent appointment with Dr Alison Grey, Paediatric Consultant requesting further investigation and treatment.

Writing Task

You are GP, Dr Joseph Watkins, Greenslopes Medical Clinic, 294 Logan Rd, Greenslopes, Brisbane 4122. Write a referral letter to Dr Alison Grey, Mater Paediatric

Centre, Vulture Street, Brisbane 4101.

Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 2 Model Letter: Brendan Cross

21/01/2010

Dr. Joseph Watkins
Greenslopes Medical Clinic
294 Logan Rd
Greenslopes
Brisbane, 4122

Dr. Alison Grey
Mater Paediatric Centre
Vulture Street,
Brisbane, 4101

Dear Dr. Grey,
Re: Brendan Cross

Thank you for seeing this 8 year old boy who has demonstrated features consistent with rheumatic fever. His developmental and past medical history were unremarkable except for an allergy to peanuts . His mother has difficulty in caring for both his illness and two other small children with his father being away due to his work as a naval officer

He presented with symptoms suggestive of acute bacterial tonsillitis on 14/01/10, when fever and sore throat had occurred over the previous 3 days, associated with lethargy and crying spells. High temperature (39.8), enlarged tonsils with exudate and cervical lymphadenopathy were found. Therefore oral penicillin and paracetamol were prescribed.

Regrettably, he returned on 19/01/10 with worsening symptoms. Fever had persisted with right knee joint pain. Also, he appeared restless, and was finding it difficult to eat and sleep. Examination revealed hypertrophied tonsils and a swollen right knee joint without signs of effusion. There was mid-systolic murmur on heart auscultation. Brufen was prescribed but was not effective. Today, blood tests results reported elevated erythrocyte sedimentation rate and anti-streptolysin O titre. An abnormal electrocardiogram indicated prolonged P-R interval.

I consider Brendan needs admission for further investigation and stablization. I would appreciate your urgent attention to his condition.

Yours sincerely,

Dr. Watkins

Word Count 204 words

Task 3 Case Notes: David Taylor

Time allowed: 40 minutes

Read the cases notes below and complete the writing task that follows:

Today's Date

07/11/10

Patient History

Mr David Taylor, 38 years old, married, 3 children

Landscape Gardener

Runs own business.

No personal injury insurance

Active, enjoys sports

Drinks 1-2 beers a day. More on weekends.

Smokes 20-30 cigarettes/day

P.M.H-

Left Inguinal Hernia Operation 2008

12/08/10

Subjective

C/o left knee joint pain and swelling, difficulty in strengthening the leg.

Has history of twisting L/K joint 6 months ago in a game of tennis.

At that time the joint was painful and swollen and responded to pain killers.

Finds injury is inhibiting his ability to work productively.

Worried as needs regular income to support family and home repayments.

Objective

Has limp, slightly swollen L/K joint, tender spot on medial aspect of the joint and no effusion.

Temperature- normal

BP 120/80

Pulse rate -78/min

Investigation - X ray knee joint

Management

Voltarin 50 mg bid for 1/52

Advise to reduce smoking

Review if no improvement.

25/8/10

Subjective

Had experienced intermittent attacks of pain and swelling of the L/K joint

No fever

Unable to complete all aspects of his work and as a result income reduced

Reduced smoking 15/day

Objective

Swelling +

No effusion

Tender on the inner-aspect of the L/K joint

Flexion, extension – normal

Impaired range of power - passive & active

Diagnosis ? Injury of medial cartilage

Investigation – ordered MRI

Management

Voltarin 50mg bid for 1 week

Review after 1 week with investigations

07/11/10

Subjective

Limp still present

Patient anxious as has been unable to maintain full time work.

Desperate to resolve the problem

Weight increase of 5kg

Objective

Pain decreased, swelling – no change

No new complications

MRI report – damaged medial cartilage

Management Plan

Refer to an orthopaedic surgeon, Dr James Brown to remove damaged cartilage in order to prevent future osteoporosis. You have contacted Dr Brown's receptionist and you have

arranged an appointment for Mr Taylor at 8am on 21/11/10

Writing Task

You are the GP, Dr Peter Perfect. Write a referral letter to Orthopaedic Surgeon, Dr. James Brown: 1238 Gympie Road, Chermside, 4352. In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Model Letter 3: Damaged Cartilage

07/11/10

Dr. James Brown
1238 Gympie Rd
Chermside, 4352

Dear Dr. Brown,

Re: David Taylor

Thank you for seeing this patient, a 38-year-old male who has a damaged cartilage in the left knee joint. He is self-employed as a landscape gardener, and is married with 3 children.

Mr. Taylor first presented on 12 August 2010 complaining of pain and swelling in the left knee joint associated with difficulty in strengthening the joint. He initially twisted this joint in a game of tennis 6 months previously, experiencing pain and swelling which had responded to painkillers. Examination revealed a slightly swollen joint and there was a tender spot in the medial aspect of the joint. Voltarin 50mg twice daily was prescribed.

Despite this treatment, he developed intermittent pain and swelling of the joint. The x-ray showed no evidence of osteoarthritis. However, the range and power including passive and active movements was impaired. An MRI scan was therefore ordered and revealed a damaged medial cartilage.

Today, the pain was mild but the swelling has not reduced. Mr Taylor is keen to resolve the issue as it is affecting his ability to work and support his family.

In view of the above I believe he needs an arthroscopy to remove the damaged cartilage to prevent osteoarthritis in the future.

Yours sincerely,

Dr. Peter Perfect
Word Count: 200 words

Writing Task 4 – Karen and William Conway

Time allowed: 40 minutes

Read the cases notes below and complete the writing task that follows:

Today's Date: 15/03/10

Patient History

Mrs Karen Conway has consulted you, her GP, as she and her husband have been trying to conceive for about 18 months without success, and she is becoming concerned that there may be something wrong.

Karen is a 32 year old solicitor.

Her husband, William, is a 33 year old accountant.

Karen: previous pregnancy 10 years ago, terminated. William does not know about this.

William: no previous pregnancies.

15/02/10

Subjective

Karen attends on her own. She reports that neither she or William have any significant medical problems. Neither partner smokes, although she reports that William drinks quite heavily. Also he has to travel regularly with his job.

Married for 3 years, and decided to try for a pregnancy in May 2006, when Karen stopped the pill. Was on Microgynon 30 for the previous 5 years.

Periods are regular

No history of gynaecological problems, or sexually transmitted diseases.

Objective

Karen overweight BMI 28.

Pulse and BP normal.

Abdo exam normal.

As is some time since she last had a smear test, you do a vaginal examination, which is normal, and take a cervical smear.

Assessment

Although the couple have only been trying to conceive for 18 months, Karen is clearly very anxious, and so you decide that further investigation is appropriate.

Plan

Blood tests for Karen required to confirm that her hormone levels are normal and that she

is ovulating. You explain to Karen that it is necessary for you to see her husband, William also, and ask her to make an appointment for him. Karen anxious that you do not reveal her history of a termination of pregnancy to him.

15/03/10

Karen re-attends, accompanied by her husband William Conway.

Subjective

Karen's baseline blood tests are normal, except the test for ovulation is borderline. However Karen informs you that she has used a home ovulation-prediction test which did show positive, so it is likely that she is ovulating. Smear test result negative. As Karen reported, William has no significant medical problems. He says he only drinks 10 units per week, which does not agree with Karen's previous comments that he drinks heavily. He also explains that he works away from home approximately 2 weeks out of 4, so he is not so concerned that Karen has not conceived yet, as he thinks that it is because they haven't been trying long enough. Therefore not keen on being investigated.

Objective

William refuses to be examined as he doesn't think there is a problem.

Assessment

Karen is even more anxious than when first seen and wants to be referred to an infertility specialist, whereas William is quite reluctant. She tells you that her sister has recently had IVF treatment.

Plan

You suggest that William do a semen analysis, to which he agrees reluctantly, under pressure from Karen. You try to reassure Karen that it is not unusual to take up to 2 years to conceive, and there are no obvious risk factors, however at Karen's insistence, you agree to refer them to a specialist, while awaiting the results of the semen analysis. You give them some general advice regarding timing of intercourse, and suggest to Karen that she should try to lose some weight. Lastly you check that Karen is taking folic acid, 400 micrograms daily.

Writing Task

You are her GP, Dr Claire Black. Write the referral letter to Dr John Expert MBBS FRANZCOG, Gynaecologist and IVF Specialist, St Mary's Infertility Centre, Wickham Terrace, Brisbane.

In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 4 Model Letter

15.3.10

Dr John Expert, MBBS, FRANZCOG
St Mary's Infertility Centre
Wickham Terrace
Brisbane

Dear Dr Expert,

Re: Karen Conway, DOB 1.2.78
William Conway, DOB 2.1.77

This couple have requested referral as they have been trying to conceive for approximately 18 months without success. I have tried to reassure them that there is no reason to be concerned yet, particularly as William works away from home regularly and there are no risk factors in their history, however Karen, particularly, was anxious to be referred sooner rather than later.

Karen has regular periods and has no history of gynaecological problems or sexually transmitted diseases. Her hormone tests are all normal, and ovulation confirmed. I did a smear test on 15.2.08 which was negative, and examination then was normal. She is a little overweight, with a Body Mass Index of 28, and I have advised that she lose some weight. Karen is taking folic acid 400 mcg daily.

William also has no significant medical problems and he declined examination. However, he has agreed to do a semen analysis, but I don't as yet have the results. I will forward them on in due course.

Thank you for seeing them and continuing with investigations as you think appropriate. I do wish them success.

Yours sincerely,

Dr Claire Black (GP)

Word length: 184 words

Writing Task 5 Alison Martin

Time allowed: 40 minutes

Read the case notes below and complete the writing task that follows:

Today's Date
10/02/10

Patient History

Alison Martin

Female

28 year old, teacher.

Patient in your clinic for 10 years

Has 2 children, 4 years old and 10 months old, both pregnancies and deliveries were normal. Husband, 30 yr old, manager of a travel agency. Living with husband's parents.

Has a F/H of schizophrenia, symptoms controlled by risperidone

Smoking- nil

Alcohol- nil

Use of recreational drugs – nil

09/01/10

Subjective

c/o poor health, tiredness, low grade temperature, unmotivated at work, not enjoying her work. No stress, loss of appetite or weight.

Objective

Appearance- nearly normal

Mood – not depressed

BP- 120/80

Pulse- 80/min

Ab, CVS, RS, CNS- normal

Management

Advised to relax, start regular exercise, and maintain a temperature chart. If not happy follow up visit required

20/01/10

Subjective

Previous symptoms – no change

Has poor concentration and attention to job activities, finding living with husband's parents difficult. Says her mother-in-law thinks she is lazy and is turning her husband against her. Too tired to do much with her children, mother-in-law takes over. Feels anxiety, poor sleep, frequent headaches.

Objective

Mood- mildly depressed

Little eye contact

Speech- normal

Physical examination normal

Tentative diagnosis

Early depression or schizophrenia

Management plan

Relaxation therapy, counselling

Need to talk to the husband at next visit

Prescribed Diazepam 10mg/nocte and paracetamol as required

Review in 2/52

10/02/10

Subjective

Accompanied by husband and he said that she tries to avoid eye contact with other people, reduced speech output, impaired planning, some visual hallucinations and delusions for 5 days

Objective

Mood – depressed

Little eye contact

Speech – disorganised

Behaviour- bizarre

BP 120/80

Pulse- 80

Ab, CVS, RS, CNS- normal

Probable diagnosis

Schizophrenia and associated disorders

Management plan

Refer to psychiatrist for assessment and further management.

Writing Task

You are the GP, Dr Ivan Henjak. Write a referral letter to Psychiatrist, Dr. Peta Cassimatis: 1414 Logan Rd, Mt Gravatt, 4222. In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 5 Model Letter: Alison Martin

10/02/10

Dr. Peta Cassimatis
1414 Logan Rd,
Mt Gravatt, 4222

Re: Alison Martin

Dear Doctor,

I am writing to refer Mrs. Martin, a 28-year-old married woman, who is presenting with symptoms suggestive of schizophrenia.

Mrs Martin has been a patient at my clinic for the last 10 years and has a family history of schizophrenia. She is a teacher with two children, aged 4 years and 10 months, and lives with her husband's parents.

She first presented at my clinic on 9 January 2010 complaining of tiredness, a lack of motivation at work and a low grade fever. On review after ten days, she did not show any improvement. She displayed symptoms of paranoia and was suffering from poor sleep, anxiety and frequent headaches. In addition, she was mildly depressed with little eye contact. Relaxation therapy and counselling were started and Diazepam 10 mg at night was prescribed based on my provisional diagnosis of early depression or schizophrenia.

She presented today accompanied by her husband in a depressed state, showing little eye contact, bizarre behaviour and disorganised speech. Despite my management, her symptoms have continued to worsen with a 5-day history of reduced speech output, impaired planning ability as well as some visual hallucinations and delusions.

In view of the above, I would appreciate your attention to this patient.

Yours sincerely,

Dr. Ivan Henjak

Word Count: 204 words

Sample Writing Task 1

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

15.08.09

Patient History

Darren Walker

DOB 05.07.69

Regular patient in your General Practice

09.07.09

Subjective

Regular check up, Family man, wife, two sons aged 5 and 3

Parents alive - father age 71 diagnosed with prostate cancer 2002.

Mother age 68 hypertension diagnosed 1999.

Smokes 20 cigarettes per day –trying to give up

Works long hours – no regular exercise

Light drinker 2 –3 beers a week

Objective

BP 165/90 P 80 regular

Cardiovascular and respiratory examination normal

Height 173 cm Weight 85kg

Urinalysis normal

Plan

Advise re weight loss, smoking cessation

Review BP in 1 month

Request PSA test before next visit

14.08.09

Subjective

Reduced smoking to 10 per day

Attends gym twice a week, Weight 77 kg

Complains of discomfort urinating

Objective

BP 145/80 P76

DRE hardening and enlargement of prostate

PSA reading 10

Plan

Review BP, smoking reduction in 2 months
Refer to urologist – possible biopsy prostate

Writing Task

Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001. Asl to be informed of the outcome.

In your answer:

- * Expand the relevant case notes into complete sentences
- * Do not use note form
- * The body of the letter should not be more than 200 words
- * Use correct letter format

Sample Model Letter 1

15/08/2008

Dr. David Brooker (Urologist)
The Urology Department
259 Wickham Tce,
Brisbane, 4001

Dear Doctor,

Re: Mr. Darren Walker

I am writing to refer this patient, a 40 year old married man with two sons aged 3 and 5, who requires screening for prostate cancer.

Initial examination on 09/07/09 revealed a strong family history of related illness as elderly father was diagnosed with prostate cancer and mother was diagnosed as hypertensive. Mr Walker is a smoker and light drinker. He works long hours and does not do any regular exercise. His blood pressure was initially 165/90 mmhg and pulse was 80 and regular. He is 173cm tall and his weight, at that time, was 85 kg. He was advised to reduce weight and stop smoking and a prostate specific antigen test was requested. There were no other remarkable findings.

When he came for the next visit on 14/08/2009, Mr Walker had reduced smoking from 20 to 10 cigarettes per day and was attending gym twice a week. He had lost 8kg of weight. His blood pressure was improved at 165/90mmhg. However digital rectal examination revealed an enlarged prostate and the PSA reading was 10.

In view of the above signs and symptoms, I believe he needs further investigations including a prostate biopsy and surgical management. I would appreciate your urgent attention for his condition.

Yours sincerely,

Dr.X

Word Length: 205 words

Sample Writing task 2

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

03.07.09

Patient History

Margaret Leon 01 .08. 49

Gender: Female

Regular patient in your General Practice .

14.01.09

Subjective

Wants general check up, single, lives with and takes care of elderly mother.

Father died bowel cancer aged 50.

Had colonoscopy 3 years ago. Clear

Does not smoke or drink

Objective

BP 160/90 PR 70 regular

Ht 152cm

Wt 69 kg

On no medication.

No known allergies.

Assessment

Overweight. Advised on exercise & weight reduction.

Borderline hypertension.

Review in 3 months

25.04.09

Subjective

Feeling better in part due to weight loss

Objective

BP 140/85

PR 70 regular

Ht 152cm

Wt 61 kg

Assessment

Making good progress with weight. Blood pressure within normal range

03.07.09

Subjective

Saw blood in the toilet bowl on two occasions after bowel motions. Depressed and very anxious. Believes she has bowel cancer. Trouble sleeping.

Objective

BP 180/95 P 88 regular

Ht 152cm Wt 50 kg

Cardiovascular and respiratory examination normal.

Rectal examination shows no obvious abnormalities.

Assessment

Need to investigate for bowel cancer

Refer to gastroenterologist for assessment /colonoscopy.

Prescribe 15 gram Alepam 1 tablet before bed.

Advise patient this is temporary measure to ease current anxiety/sleeplessness.

Review after BP appointment with gastroenterologist

Writing Task

Write a letter addressed to Dr. William Carlson, 1st Floor, Ballow Chambers, 56 Wickham Terrace, Brisbane, 4001 requesting his opinion.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 2

03/07/2009

Dr. William Carlson
First Floor,
Ballow Chamber
56 Wickham Tce,
Brisbane 4001

Dear Doctor Carlson,

Re: Margaret Leon
DOB 01/08/1949

Thank you for seeing my patient, Margaret Leon, who has been very concerned about blood in her stools. She has seen blood in the toilet bowl on two occasions after bowel motion. She is very anxious and as well as that depressed because her father died of bowel cancer and she feels she may have the same condition.

Margaret has otherwise been quite healthy. She does not drink or smoke and is not taking any medication. She was slightly overweight six months ago with borderline high blood pressure. At that time I advised her to lose weight which she did successfully. Three months later, her weight had dropped from 69kg to 61kg and blood pressure was back within normal range.

On presentation today she was distressed because she believes she has bowel cancer. She has had trouble sleeping and her weight has reduced a further 11 kg. The rectal examination did not show any abnormalities. Her blood pressure was slightly elevated at 180/95 but her cardiovascular and respiratory examination was unremarkable. Alepam, one before bed, was prescribed to control the anxiety and sleeplessness.

I would appreciate it if you could perform a gastroenterology assessment.

Yours sincerely,

Dr X (GP)

Word Length: 194 words

Sample Writing Task 3

Read the cases notes below and complete the writing task which follows:

Time allowed: 40 minutes

Today's Date

08.08.09

Patient History

Dulcie Wood

DOB 15.07.43

New patient in your General Practice. Moved recently to be near family.

03.07.09

Subjective

Widowed January 06, three children, wants regular check up, has noticed uncomfortable feeling in her chest several times in the last few weeks like a heart flutter.
Mother died at 52 of acute myocardial infarction, non smoker, rarely drinks alcohol
Current medication: zocor 20mg daily, calcium caltrate 1 daily
No known allergies

Objective

BP 145/75 P 80 regular

Ht 160cm Wt 61kg

Cardiovascular and respiratory examination normal ECG normal

Plan

Prescribe Noten 50 gm ½ tablet daily in am. Advise to keep record of frequency of fibrillation sensation.

Review in 2 weeks if no increase in frequency.

17.07.09

Subjective

Reports sensations less but woke up twice at night during last 2 weeks

Objective

BP 135/75 P70 regular

Assessment

Increase Noten to 50 gm daily ½ tablet am and ½ tablet pm
Advise review in one month.

08.08.09**Subjective**

Initial improvement but in last 3 days heart seems to be fluttery several times a day and also at night. Very nervous and upset. Wants a referral to a cardiologist Dr.Vincent Raymond who treated her sister for same condition

Objective

BP 180/90 P70

Action

Contact Dr Raymond's receptionist and you are able to arrange an appointment for Mrs Wood at 8am on 14/08/09

Writing Task

Write a letter addressed to Dr. Vincent Raymond, 422 Wickham Tce, Brisbane 4001 describing the situation.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 3

08/08/09
Dr Vincent Raymond
422 Wickham Tce
Brisbane, 4001

Dear Dr Raymond,
Re: Dulcie Wood
DOB: 15/07/43

As arranged with your receptionist, I am referring this patient, a 66 year old widow, who has been demonstrating symptoms suggestive of heart arrhythmia.

Mrs. Woods has seen me on several occasions in the past five months, during which time she has had frequent episodes of heart flutter and her blood pressure has been fluctuating.

The patient initially responded to Noten 50mg ½ tablet daily in the morning, but she still had episodes of disturbed sleep during the night. Therefore the dose of Noten was increased to 50mg ½ tablet in the morning and ½ tablet at night, but unfortunately her heart flutter has increased recently, especially over the last three days. Other current medications are Zocor 20mg and Calcium Caltrate 1 daily.

Today's examination revealed a nervous and upset woman with a pulse rate of 70 and blood pressure of 180/90.

Please note that her mother died of acute myocardial infarction and her sister, who is a patient of yours, has a similar condition.

In view of the above, I would appreciate it if you provide an assessment of Mrs. Wood and advise regarding treatment and management of her condition.

Yours sincerely,

Dr Z

Word Length: 191 words

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

25.08.09

Patient History

James Warden

DOB 05.07.29

Regular patient in your General Practice

09.07.09

Subjective

Wants regular check up, has noticed small swelling in right groin.

Hypertension diagnosed 5 years ago, non smoker, regularly drinks 2 – 4 glasses of wine nightly and 1 - 2 glasses of scotch at weekend.

Widower living on his own ,likes cooking and says he eats well.

Current medication noten 50 mg daily, $\frac{1}{2}$ aspirin daily, normison 10mg nightly when required, fifty plus multivitamin 1 daily, allergic reaction to penicillin.

Objective

BP 155/85 P 80 regular

Cardiovascular and respiratory examination normal

Urinalysis normal

Slight swelling in right groin consistent with inguinal hernia.

Plan

Advised reduction of alcohol to 2 glasses maximum daily and at least one alcohol free day a week.

Discussed options re hernia. Patient wants to avoid surgery.

Advised to avoid any heavy lifting and review BP and hernia in 3 months

25.08.09

Subjective

Had problem lifting heavy wheelbarrow while gardening. Has a regular dull ache in right groin, noticed swelling has increased.

Has reduced alcohol intake as suggested.

Objective

BP 140/80 P70 regular

Marked increase in swelling in right groin and small swelling in left groin.

Assessment

Bilateral inguinal hernia

Advise patient you want to refer him to a surgeon. He agrees but says he wants a local anaesthetic as a friend advised him he will have less after effects than with general anaesthetic.

Writing Task

Write a letter addressed to Dr. Glynn Howard, 249 Wickham Tce, Brisbane, 4001 explaining the patient's current condition.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 4

25/08/2009

Dr. Glynn Howard
Surgical Department,
249 Wickham Tce,
Brisbane 4001

Dear Doctor,

Re: Mr. James Warden
DOB 05/07/29

I am referring this patient, a widower, who is presenting with symptoms consistent with a bilateral inguinal hernia. He has been suffering from hypertension for 5 years for which he takes Noten, Aspirin and multivitamins. He is allergic to penicillin.

Initially Mr Warden presented to me on 09/07/09 for a regular check up. On examination he had a mild swelling of the right groin, his blood pressure was 155/85 and pulse was 80 beats per minute, otherwise his condition was normal. He was diagnosed as having an inguinal hernia. I discussed the possibility of surgery, however he indicated he did not want an operation. Therefore I advised that he avoid heavy lifting and reduce alcohol consumption. A review consultation was scheduled for 3 months later.

Today he returned complaining that his right groin had increased in size with a regular dull ache possibly due to lifting a heavy wheel barrow. The examination revealed a considerable increase in the swelling in the right groin as well as a mild swelling of the left groin.

Based on my provisional diagnosis of a bilateral inguinal hernia, I would like to refer him for surgery as early as possible. Please note that wishes to have the surgery under local anaesthesia.

Yours sincerely,

Dr X (GP)

18 August, 2009

Ms. Jenny Chong
Senior Physiotherapist
St Edwards Cardiac Prevention and
Rehabilitation Centre
22 Thompson Street
West End, 4101

Dear Ms. Chong

Re: Alice Denham
DOB: 14/11/1960

Thank you for continuing the physiotherapy treatment of Ms. Denham.

Ms. Denham, a 49 year old primary school teacher, divorced and living with 3 teenage children. She was diagnosed with coronary artery disease who underwent triple bypass surgery on 10/08/2006. She is very anxious about her recovery and would like to resume her full time teaching work.

Ms. Denham has a past medical history of persistent insomnia, hypertension and has been suffering from increased chest tightness and breathlessness over the last 3 months. She is on anginine one tablet sublingually as required and propranolol 40 mg.

On 10 May, 2006 she was admitted with severe chest pain. Her physiotherapy management consists of deep breathing, coughing and exercises to prevent deep vein thrombosis. Later, triflow incentive deep breathing exerciser was introduced.

Ms. Denham has shown signs of improvement by walking independently and able to ascend and descend stairs without breathlessness. She would like to attend rehabilitation centre to maintain motivation and gain confidence.

I would appreciate if you can continue with her treatment. She is going to have a review at outpatient clinic by Dr O'connor at 10 am.

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

Yours sincerely,

sign
Name
Title

Sample Nurse Model Letter: Nina Sharman

21/03/2012

Dietician
Department of Nutrition and Dietetics
Spirit Hospital
Prayertown
NSW 2176

Dear Dietician,
Re: Ms. Nina Sharman
DOB: 09/02/1951

Thank you for seeing this patient, a 61-year-old single female resident of our Dementia Specific Unit, who had an episode of choking on a piece of food on 20/03/12. She requires an urgent swallowing and nutritional assessment due to a high risk of aspiration and chest infection.

Ms. Sharman's condition has been deteriorating since May, 2011, when she suffered a stroke. Over the last year she has developed advanced dementia and is now confused and disorientated. Apart from this, she is edentulous for both upper and lower teeth and sometimes refuses to wear dentures due to her confusion. Her appetite has increased recently, and she has gained 10kg of weight over the last 5 months. Her current weight is 106kg (BMI of 30). Ms. Sharman also complains of chronic constipation. She has no allergies to medication or food. Her vital signs and blood sugar level were all within normal limits.

In regards to her medical history, Ms Sharman has been living with type 2 diabetes since 2000, which has been managed by a diabetic diet only. She was also diagnosed with ischaemic heart disease in 2005 and has had osteoarthritis for the past 20 years.

If you require any more information, please do not hesitate to contact me.

Yours sincerely,

Registered Nurse
Dementia Specific Unit
Westside Aged Care Facility

The Registrar
Victoria Hospital,
Victoria Rd.,
Melbourne

Date: 22 Feb. 2002

Re: Mrs Fiona Marsden

Dear Dr,

This 30 year-old, mother of 2, housewife, came to my surgery 2 days ago, complaining of mild abdominal pain for a few days. She claimed that her pain was in the lower abdominal area and could be relieved by panadol; however, she denied nausea or vomiting.

Her physical examinations were normal, except a mild tenderness over the right abdominal quadrant with no evidence of hepatosplenomegaly. The possible diagnosis was ovarian cyst enlargement; therefore, FBE, ESR tests and a pelvic ultrasound were requested with a revisit arranged for one week's time.

Mrs Marsden visited my office today as an emergency appointment, complaining that her pain has gradually become worse and severe in intensity since few hours ago. She also reports being weak and fatigued since then.

On examination, she is pale and restless; moreover, there is a severe tenderness with palpable mass in the lower right abdominal quadrant. Based on the evidence, there is a strong possibility that she is suffering from a ruptured ovarian cyst.

Please note that she had a history of tubular ligation two years ago, and a right ovarian cyst (5-6cm) 6 months ago when she was put on 3 months of OCP.

I am referring her to you for admission to your gynaecological ward for further investigation and management regarding her urgent problem.

Thanking you in advance,

Yours sincerely,

Dr X----- (GP)

UNSWIL Medical Centre
22 King Street
Randwick NSW 2031

24/08/2002

Dr. G Brian
Emergency Department Medical Officer
Alfred Hospital
Commercial Road
Prahan Victoria.

Dear Dr. Brian,

Thank you for seeing Mr. Johnson, a 25 year old man suffering from severe abdominal pain.

He first came to see me at 10am yesterday complaining of crampy central abdominal pain, nausea and several loose bowel movements which he had had in the previous 24 hours. On examination I found that he had generalized central abdominal tenderness. All other investigations were normal. I prescribed analgesics and advised him to increase his fluid intake and to rest.

At 9.00am today, Mr. Johnson presented again as his condition had deteriorated. His pain had increased and had vomited several times overnight. He was also slightly flushed and had tenderness on his right side with mild guarding. Other test results were normal. I suspected viral infection and possibly appendicitis and ordered a blood film. I prescribed Maxolon 10gm four hourly for the vomiting.

Mr. Johnson has come to see me again as his condition has worsened. The pain is now severe, constant and localized to right iliac fossa. He is flushed and restless. The blood film shows a white cell count of 18,000. I suspect that he has acute appendicitis.

I would appreciate if you could urgently assess Mr. Johnson and treat him further.

Yours sincerely

J Harris

Dr J Harris

Dr Michaels
St. Patrick Ave,
Melbourne

Date: 30th June 2004

Re: Mrs Patricia Gordon

Dear Dr Michaels,

I am referring Mrs. Patricia Gordon who first visited my surgery two years ago. She had just married and requested contraception pills; however, she did inform me of her intention to have a family in one to two years time.

On examination at the time, all the test results were unremarkable – breast examination, pap- smear, Rubella test. She was subsequently prescribed Microgynon 30 ED 12x12.

On her next visit last year, she reported that she had stopped her contraceptive pills two months earlier, with the intention of getting pregnant but her menstrual cycle had started again. She was rather disappointed at the time that she did not get pregnant. We discussed temperature and cycle measurements to augment her chances of conception.

She visited my office two weeks ago, tearful and depressed, as nothing seemed to have worked. The temperature chart showed definite and appropriate changes. Her pelvic and general examinations were unremarkable as was her pap-smear test. She was asked to return with her spouse a week later for further investigation.

Last week, Mr. Gordon's examination revealed a healthy young man, and consequently a sperm-count test was arranged.

This morning the couple returned for the result of the test, which showed normal count and viable sperms.

As this couple is keen to start a family soon; I am, therefore, referring this couple to you for further investigation, diagnosis and advice.

Thanking you in advance,

Yours sincerely,

Dr X-----

Doctors – Letter of Referral

Dr F Goldman
171 Victoria Parade
East Melbourne

30/01/2005

Re: Jamie Brown
DOB: 10.5.85

Dear Dr Goldman,

This 5 year-old boy Jamie Brown initially presented with tonsillitis on the 20/12/2005 for which he was treated with Penicillin V 250mg qid for 7 days.

Four weeks later Jamie presented with painless macroscopic haematuria. His only other symptom appeared to be lethargy. Examination was unremarkable: he had tonsillar hypertrophy, his BP – 90/60 and urinalysis confirmed significant haematuria.

On review today, investigations showed a mildly elevated urea and creatinine, a significantly elevated ASCOT titre and haematuria of renal origin.

Patient's blood pressure has increased to 110/90.

I believe Jamie has post-streptococcal nephritis and that he is at risk of developing renal failure. I would appreciate your assessment and management.

Yours sincerely,

Dr X

Mr. Lawrence Mitchell, surgeon.
Suite 12,
Cabrini Medical Centre,
Malvern 3127

2nd Feb 2005

Re: Mr Patrick Freeman D.O.B 20.01.57
16 Garden Ave
Brisbane
QLD
Tel: 0413 111 333

Dear Dr Mitchell,

I am writing to refer Mr Patrick Freeman, a 48-year-old sales manager, to you for further management. He presented at my surgery one month ago complaining of pain in the epigastric area which was accompanied by vomiting and tiredness for the past few months. However, there was no Melena at this point and his pain was relieved by eating a meal.

Duodenal ulcer was a possible diagnosis; therefore, a full set of tests were requested which included X-ray Barium meal.

He returned 3 days later for his results. His pain, nausea and vomiting still persisted. His FBE was normal, but there was a slight increase in ALAT. Also, there was no evidence of ulcer in the X-ray. He was advised to improve his diet and give up both cigarettes and coffee. In addition, Tagamet (200mg tid) was prescribed and he was asked to revisit in 6 weeks time.

He, however, came to my surgery today (3 weeks early), complaining of the epigastric pain and black faeces for one week. On examination, he was pale, agitated and preferred to keep his posture upright. The upper abdominal quadrant was tender; although, his bowel sounds were normal.

Please note that Mr Freeman was hypotensive (B.P 80/50; P 110/min) this morning. He is a 2 pack a day smoker and drinks 5-6 cups of coffee per day.

I believe he is suffering from a bleeding duodenal ulcer which requires immediate attention. I would appreciate if you could examine, assess and treat this patient as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr -----

Dr Peter Groves
Paediatric gastroenterologist
Royal Children's Hospital

Date: 21st February 2005

Re: Master Ben Schmidt

Dear Dr Groves,

I am writing to refer Master Ben Schmidt, an 8 year old patient of mine, who was first brought to my office by his parents, David and Sue, 12 days ago. On examination, he was feverish (Temp.40.5 °C) with flu and exhibited symptoms relating to Asthma. Otitis media was also diagnosed; therefore, a course of Amoxicillin was prescribed. In addition, Paracetamol tablets as well as Ventolin (2 puff q.i.d) were included.

Ben was brought back to my surgery five days later by his mother on 14th Feb, complaining of his son vomiting. The examination revealed a lowering of his temperature (39.5) but the Asthma was consistent. At this point only Maxilon injection was prescribed.

Yesterday, his mother brought him to my office again this time complaining of bleeding from his bowels which apparently had started 3 days prior. His previous problems had settled, although he was feeling lethargic due to his flu infection. The physical examination revealed no anal fissure. A full set of blood tests were requested at this point to aid with the diagnosis.

Mrs Schmidt was asked to come to my surgery today with Ben. The results show that he is anemic (Hb - 7), and since the problem still persists, I believe this is a serious problem and calls for a colonoscopy and further internal examination to detect the source and cause of hemorrhage.

I would appreciate if you could examine, diagnose and treat this patient as you think appropriate,

Thank you in advance,

Yours sincerely,

Dr X-----

Dr F Goldman
171 Victoria Parade,
East Melbourne

Date: 30 Jan 2005

Re: Jamie Brown

Dear Dr Goldman,

I would like to refer Master Jamie Brown, a five-year-old boy, who was brought by his mother to my surgery six weeks ago. He had sore throat at the time, with a husky voice, feverish and irritable.

On examination, large infected tonsils with exudates were observed as well as tender and enlarged cervical lymph nodes. Accordingly, tonsillitis was diagnosed and a course of penicillin V250 mg (q.i.d) was prescribed for 7 days.

On his return two days ago, his mother reported Jamie to be tired, lethargic and had passed brownish urine 4 days earlier. On examination, he was hypotensive (BP 90/60), had tonsillar hypertrophy, and his urinalysis revealed macroscopic haematuria. With possible diagnosis of UTI or post-streptococcal nephritis, prescribed a number of tests. Plenty of fluid intakes were recommended and a revisit was arranged for two days time.

Jamie was brought to my surgery today by his mother, still asymptomatic. However, elevated blood pressure was observed. His test results showed elevated urea, creatinine and ASCOT. In addition, his urinalysis indicated a macroscopic haematuria, and his mid-stream urine test revealed 4x10 RBC, attributed to renal origin.

I would like to refer Jamie Brown to you with a diagnosis of post streptococcal nephritis with early renal failure. Could you please assess, investigate and treat him as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X-----(GP)

Dr. William Jones
The medical centre
46 Prince Street
AUBURN NSW 2247

Date: 28 January 2006

Re: Mrs. Trudy McHugh
7 Alfred Street
Sydney NSW 2000

Dear Dr Jones,

This 38-year-old woman came to my surgery yesterday, complaining of a sudden onset of left lower abdominal pain for one day. She claimed that it was sharp and constant which worsened by sitting up, walking or bending. There were no other symptoms; however, she claimed that she had another episode of left abdominal pain one week before.

On examination, there was a great tenderness on the left quadrant of her abdomen, and a vague mass was also palpated in the same region. To exclude pregnancy, β -HCG was requested; in addition, full blood examination and ESR were checked too.

On her visit today, the pain still persisted, but it has become easier. There have not been any bowel motions since two days ago, when she passed a hard stool with bright blood on the outside of it.

Tonight, her pain has worsened - after eating a meal - and she is moderately in distress. There are still no bowel motions or flatus; moreover, her bowel sounds are inaudible. She is febrile ($T = 37.4^\circ\text{C}$); in addition, there is a left shift in the blood test and her Hb was 9.3.

Please note, she had had an ovarian cystectomy and appendectomy. She was also rushed to hospital at the beginning of this month due to hemorrhage, which was diagnosed as spontaneous abortion.

I am referring her to you with the diagnosis of early bowel obstruction due to diverticulitis or carcinoma, and for further management and treatment including surgery.

Yours sincerely,

Dr X -----

Dr William Ammerry
100 Collins St,
Melbourne

22nd Feb 2006

Re: Miss Sally Webster
Aged: 17

Dear Dr Ammerry,

This 17 year old student girl first visited my surgery two months ago complaining of chronic constipation. She claimed that she had been trying everything from bran to laxatives to relieve her once every 4-5 days bowel habits, and yet, this condition still persists.

The physical examination was unremarkable (her weight was 54kg). Her request for the strongest laxative was refused; however, increased intake of fluids and vegetable fibers were recommended to improve her condition.

On her next visit six weeks later, her mother accompanied her. The mother was concerned about her daughter's loss of appetite, loss of weight, and the constant arguing at home regarding Sally's eating habits. When spoken to Sally directly, she claimed that she did not know what all the fuss was about, as she was not hungry.

On examination, she was under weight (47kg), pale and thin. Hence, several tests were prescribed, and she was asked to re-visit me at a later date for one to one assessment.

On her re-visit 6 days later, she was distant with little eye contact. She felt her parents were over-reacting, claiming her ideal weight to be 40kg (current weight 47kg). When asked, she denied vomiting and taking laxatives. After all factors considered, I believe Sally is suffering from Anorexia Nervosa.

I would appreciate if you could examine, diagnose and treat this young lady as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X -----

Dr Michaels
The Registrar,
St Paul's Hospital,
Victoria Rd,
Melbourne

Date: 20 June 2006

Re: Mrs Julie Hobart

Dear Dr Michaels,

This 33 year-old woman came to my surgery about one week ago, complaining of abnormality in her menstrual cycle. She claimed that her menstrual periods had become sparse and eventually ceased completely. She also claimed to have stopped exercising a year ago because of feeling fatigue and weakness. Meanwhile, she began to gain weight, and noticed the development of facial hair and acne.

On examination, she was mildly obese (W- 73kg, H- 1.57m) with thin extremities. There were fullness of the supraclavicular fat pads and generalised muscular weakness, as she was unable to stand from squatting position without help or difficulty standing from a seated position. In addition to a visible increase of facial hair and acne, there were marked striae on her abdomen and buttocks. While other physical examinations were unremarkable, there was a slight measured hypertension (BP 153/98).

With the possible diagnosis of Cushing's syndrome, early morning cortisol level was requested as well as FBE and Urine analysis. Meanwhile, to control the hypertension, Thiazide diuretics were prescribed.

On her visit today, she reported polyuria and nocturia. Her blood pressure was 144/99, while the result of her laboratory tests showed FBE = 136 and serum glycate = 85%. The morning cortisol level was 21 μ g/dl.

I am referring this patient to you with the diagnosis of Cushing's syndrome accompanied with Diabetes Mellitus. I would appreciate if you could examine and manage this patient following further tests to confirm my diagnosis.

Yours sincerely,

Dr X-----(GP)

Dr James Collins
256 South Borough Lane
Brisbane
QLD 4290

Date: 21 July 2006

Re: Mrs Heather Lincoln
17 Highcombe Place
Brisbane
QLD

Dear Dr Collins,

Thank you for seeing Mrs Lincoln, an 85-year-old patient of mine who was first brought to my surgery two months ago by her daughter. She was suffering from urinary incontinence and abdominal pain for a week. The daughter claimed that her mother was more confused than usual. In addition, she had refused to eat at the time.

On examination, there was mild suprapubic tenderness by palpation, and the urine test results confirmed UTI; Amoxicillin was, therefore, prescribed for a week. Confusion was reported to have subsided a week later with the elimination of UTI.

A month later, she was brought back to my surgery, because she was found confused, loitering the streets by her neighbours. The daughter was reassured as she was very much distressed and tearful.

On July 4, her daughter reported a further increase in her vague behaviour, unsteady gait and unbalanced emotions. She was also found lying next to her bed, incontinent.

On examination, she had postural hypotension, and exhibited a general confusion. This was assumed to be due to the high dose of Aldomet; consequently, half reduced the dose.

Today, although her gait has improved but she is still confused. Her daughter claims that she could no longer cope with her mother's condition and is wondering if a nursing home would be a better option.

Please note, this patient has had a history of hypertension (20 years), type II diabetes (15 years), Dementia (10 years) and recurrent UTI. Her current medications are Aldomet (250mg b.d), Indocit (15mg t.d.s) and Daonit (5mg b.d).

I would appreciate if you could assess this patient and give advice to her daughter for the best possible management.

Yours sincerely,

Dr X-----

Dr Frank Adams
Neurological Ward
South Brisbane Hospital
QLD 4101

26th July 2006

Re: Mrs Phillipa King D.O.B: 18.4.38
Unit 7a, Fremantle place
Brisbane
QLD
Ph: 07 3234 3234

Dear Dr Adams,

I am referring Mrs Phillipa King, a 68-year-old woman, with a diagnosis of CVA to you for further investigation and management. She was found two days ago by a neighbour, lying on her kitchen floor conscious and stating that she had fallen two hours previously but was unable to get up by herself. Consequently, she was admitted to R.B.H yesterday.

Initial consultation with Mrs King revealed a loquacious, distractible lady who felt her main problem was the pain in her left knee which was preventing her from walking. She was also worried about her two cats.

On examination, Mrs King is an obese, large, right handed lady who sat slumped to the right on the chair with her head and eyes also leaned the same way. She showed an UMN facial droop (L) and exhibited dribbling on the same side. Her left arm was poorly positioned under the pillow. She had a left homonymous hemianopic vision as her poor eye only followed across midline left.

Please note that she has been suffering from NIDDM, Osteoarthritis in her left knee and C.O.A.D. She is a 30 pack year smoker and is currently on Ventolin and Naprosyn. Mrs King is a pensioner who lives alone (after losing her husband 3 years ago) with no children, in a housing trust unit in Brisbane. However, a neighbour does visit her twice a week for a chat and a cup of tea.

I would appreciate if you assess and manage this patient from this point on.

Yours Sincerely,

Dr X-----

Dr Jensen
Unit 40, Manor House
Ripley Street
Brisbane
QLD 4880

Date: Sep-11- 2006

Re: Mr Paul Nigels D.O.B: 9-2-72
3 Roach Street
Brisbane QLD
Tel: 0434 333444

Dear Dr Jensen,

This thirty five year-old man has come to this hospital today complaining of headaches, which has been occurring about six weeks of the year. It generally lasts about 1-2 hours each time, especially in the mornings and it worsens by straining, coughing and other stress factors, including psychological ones, which he claims causes some visual blurring. These headaches, however, are partially relieved by panadol.

On examination, there were some observable concentration drifts in speech, slightly blurred right disc as seen by Fundoscopy, and minor cerebellar ataxia. The result of the other neurological and physical examinations was unremarkable and there were no observable features of migraine found.

The possible diagnosis at this point was stress related headaches; in addition, there were some elements in the medical history, which suggested raised ICP. Hence, CT-scan was requested, and he was asked to bring his old films for comparison. A revisit was also arranged for two weeks later.

Please note that he had a major head injury because of a car accident two years ago which put him in coma for eight consecutive days in Prince Henry Hospital. There were several post-traumatic problems including amnesia, blurred vision and limb stiffness (with normal tone). I urge you to check for the list of his present medications with Caulfield Hospital.

Meanwhile, I am referring this patient to you for a second opinion and would be grateful if you could re-examine this patient. I will include the results of all the tests with this letter, and will request the CT-scans to be sent to you directly prior to the patient's visit.

Looking forward to your feed back,

Yours sincerely,

Dr X -----

Dr Robert Vaughn
34 Volturen St,
Rewanden

Date: 19 Dec. 2006

Re: Mrs Joanne White

Dear Dr Vaughn,

Mrs White, a 36 year-old mother of two, came to my surgery a week ago, reporting a two months history of fatigue, early satiety and left upper quadrant fullness. She had lost 10 pounds of body weight during this time; however, she denied fever, night sweats, nausea, vomiting and other GI problems. Her menses were normal without excessive bleeding.

On examination, her skin was moist and warm. The spleen was palpable 9 cm below the costal margin. Other physical examinations were otherwise unremarkable. Multivitamins were prescribed, but several tests were requested (FBE, ESR, LFT and peripheral blood smear). She was asked to revisit in a week's time.

On her visit today, she is still symptomatic with the results of her tests suggesting a mild leukocytosis (WBC 12K). Other abnormalities could also be seen in other blood cells. I will include the test results with this letter for your careful examination.

Please note that she does not smoke or drink, and has not had any recent exposures or travel. Her paternal grandfather did suffer from adult onset diabetes.

I believe this matter needs further specialist intervention with a possible bone marrow biopsy to help with the correct diagnosis. I would appreciate if you could treat and manage her regarding her problem.

Thanks in advance,

Yours sincerely,

Dr X -----(GP)

Dr Vaughn
34 Volturen St.
Rewanden

Date: 19th dec 2006

Reg: Mrs Joanne White

Dear Dr Vaughn,

Thank you for visiting Mrs. White, a 36 year-old patient who visited me one week ago. She complained about 2- month fatigue, early satiety, left upper quadrant fullness and 10-pound weight loss. However. she had no history of nausea, vomiting, haematochesia, haematemesis or night sweat.

On examination, her skin was moist and warm. The spleen was palpated 9cm below left costal margin; however, there was no sign of hepatomegaly, lymphadenopathy or thyromegaly. Consequently, a full set of blood tests (FBE, ESR and Peripheral blood smear) as well as biochemical tests including LFT were requested. Furthermore, multivitamins were prescribed and she was asked to come back today.

On her visit today, her problems are still persisting. There was a wide range of results obtained from the laboratory tests. For example. an increase was seen in all kinds of WBCs; however, platelet count and Hb level were normal. In addition, the vitamin B12 level was over 2000 pg/ml, but leukocyte alkaline phosphatase level had decreased.

According to her exhibited symptoms and lab-test results, I believe that her problem is a kind of hematogenous malignancy, which calls for a bone marrow biopsy for a more precise assessment.

I would appreciate if you could provide further management and treatment for this patient from this point on.

Thank you in advance,

Sincerely yours,

Dr. X-----(GP)

Mr Francis Baker
Surgical Registrar,
Victoria Hospital,
Victoria Road,
Melbourne

Date: 14 February 2007

Re: Mr John Webster

Dear Dr Baker,

This 35-year-old mechanic attended my surgery two weeks ago, complaining of six-months of crampy abdominal pain, nausea and severe intermittent diarrhoea. He claimed having seven loose, foul odoured stools per day. He denied any other symptoms; however, the pruritic skin rash developed just before the diarrhoea began.

On examination, the mucous membranes were dry, and there was a diffused abdominal tenderness with no hepatosplenomegaly. Populovesicular lesions were also visible on elbows, knees and buttocks. Other physical examinations were otherwise unremarkable including bowel sounds and sphincter tone. With the possibility of gastroenteritis, diphenoxylate was prescribed and FBE, stool exam and culture were requested.

One week later, his diarrhoea was persisting, which had resulted in a loss of 9kg body weight. Although, WBC, LDH and ALP had increased, a reduction in serum albumin was noted. Prochlorperazine and megestrol were added to his drug requirements, and an abdominal CT-scan was requested. Gluten-intake restriction was also advised based on his skin rash.

Today, he claimed that his diarrhoea had improved, and his skin rash appeared to be healing. Based on the results and observations, I am inclined to celiac sprue as a possible diagnosis.

Please note that he has just stopped smoking tobacco, and drinks only occasionally (mainly beer). He does not have any considerable medical history, though his father died of lymphoma.

I am referring this patient to you for further investigations including colonoscopy and bowel biopsy to confirm my diagnosis.

Yours sincerely,

Dr X-----(GP)

The Registrar
Emergency Department
Royal Melbourne hospital
Flemington Road
Parkville 3052

Dear Doctor,

Re: Mr Derek Romano

I am writing to refer Mr Romano, a patient of mine to you. Mr Romano, is a 46-year-old and is an insurance clerk. He is married with one child who is suffering from his first episode of ischemic (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 hypercholesterolemia (Total cholesterol = 6.4 mmol/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 20 mg 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 and one sublingual anginine were given, followed by intravenous morphine (2.5mg). His pain has now settled down, but I consider that he requires admission to the Coronary Care Unit for stabilization. I will telephone later to check on his condition.

Yours sincerely,

Dr X

Mr Dooley
34 Volturen St.,
Rewanden

Dear Mr. Dooley,

re: Mr Bernard Smith
24 Derid Street
Farfeth

Thanks for seeing Mr. Smith, a 77 year old retired farmer. He first presented to me in November 1991 with a five year history of right hip pain. At this time he had a two month history of severe pain in the right hip which was not responding to simple analgesia. He found it difficult to bear weight and had a decreased range of movement on his right side.

Otherwise, examination was normal. X-Ray at this time showed moderate degeneration of right hip joint consistent with osteoarthritis.

I commenced him on Indomethacin 50mg t.d.s. Initially his response was good but unfortunately he suffered a further flare up in January 1992. Indomethacin was recommenced at this time but caused significant dyspepsia. I therefore commenced Mylanta and changed him on to Tilcotil 25mg two tablets daily. Unfortunately, his hip pain has continued to worsen and the change in therapy has not helped.

I would appreciate your opinion regarding his future management and would be interested to know if he would be a suitable candidate for a hip replacement.

Thanks for your opinion.

Yours sincerely,

Dr X

Mr. B.Dooly
Orthopaedic surgeon
34 Volturen St.,
Rewanden

Date: 16th Feb 1992

Re: Mr Bernard Smith

Dear Dr Dooly,

Mr Bernard Smith is a 77 year old retired farmer with a 5 year hip trouble. When he visited my surgery 3 months ago, he was limping with a 2 months severe pain in his right hip and knee that did not respond to Panadol.

On examination, he was hypertensive (BP 150/85) and had a decreased internal rotation and flexion of right hip. Osteoarthritis was confirmed with the aid of an X-ray; consequently, he was put on a course of Indomethacin tablets (50mg t.d.s).

He visited my surgery last month complaining of the flare up of his pain. The exacerbation of the pain was due to his cessation of the medication 6 weeks before. On examination the range of his right hip movement had further decreased with inability to bear weight. A new course of endomethacin (50mg t.d.s) was recommenced.

He returned again 6 days later with severe dyspepsia. He was consequently prescribed Mylanta as he showed mild epigastric tenderness, and Indomethacin was replaced with Tilcotil (25mg 2 tablets maine.).

Mr Smith has visited my office today and the examination shows little improvement in his right hip condition. I believe, his osteoarthritis is not responding to the normal treatment with the anti-inflammatory medications and he does require further specialist attention.

I am referring this patient to you for an assessment, advice and the possibility of hip replacement if you consider him a suitable candidate.

Yours sincerely,

Dr X-----

Assessment Criteria

Your writing will be rated by at least 2 assessors who will use the criteria below to determine your writing level. Therefore study this information carefully so that you can develop the skills to write at A or B level.

Category	Strategy	Self Assessment
Overall Task Fulfillment	<ul style="list-style-type: none">Always aim to write between 180~200 words. Short letters don't allow you enough sentences to demonstrate your ability. Long letters may mean you have not summarised or focussed on the main issue.Read the task question carefully, and make sure your letter has a clear focus. As a rule, recent case history is more important than older case history.State the purpose of the letter clearly in the introduction and focus on important information and minimise less relevant detail.Make your conclusion specific to the situationUse your own words as much as possible – don't simply copy sections from the case notes.	<ul style="list-style-type: none">Is the letter of the required length?Has your letter responded to the task question?Does your letter focus on the important points such as chief complaint, your main concern, important social factors and reason for writing?Is the language in your letter original?
Comprehension of Stimulus	<ul style="list-style-type: none">Read the information carefully and plan the content of the letter before beginning to write. 15 minutes planning and 25 minutes writing is a good model.Don't let the main issue become hidden by including too much supporting detail.Base your letter from today's perspective. That means, include all the relevant history, but in summary form, eliminate less important detail and focus your attention on the current situation.Show clearly the connections between information in the case notes if these are made; however, do not add information that is not given in the notes.	<ul style="list-style-type: none">Have the key points been mentioned and grouped appropriately?Have you identified and emphasised the reason for writing the letter.Have you selected relevant information and omitted non-relevant information?
Appropriateness of Language	<ul style="list-style-type: none">Organise the information clearly into paragraphs. Remember, the sequence of	<ul style="list-style-type: none">Is the letter organised into paragraphs?

	<p>information in the case notes may not be the most appropriate sequence of information for your letter.</p> <ul style="list-style-type: none"> Always keep in mind the reason for writing – don't just add information randomly. Avoid informal and casual expression and maintain a formal tone. Do not overuse medical terminology including abbreviations and acronyms 	<ul style="list-style-type: none"> Is the information logically presented? Is the expression of suitable formality? Is the vocabulary and expression of a suitable standard? Have the abbreviations and acronyms been written in full?
Control of Linguistic Features	<ul style="list-style-type: none"> Show that you can use language accurately and flexibly in your writing. Ensure you use correct verb tense and form as this is an essential requirement Make sure you demonstrate a range of language structures – use compound and complex sentences as well as simple sentences. Use connecting words and phrases to link ideas together clearly e.g. however, therefore, at that time. 	<ul style="list-style-type: none"> Is your grammar of sufficient standard? Key areas are: <ul style="list-style-type: none"> Verb usage Sentence structure Article usage Word form More than 5~7 errors in the letter will reduce your chance of getting a B grade or higher.
Control of Presentation Features	<ul style="list-style-type: none"> Follow standard letter format for referral letters Use correct punctuation including commas and capital letters appropriately Check for spelling mistakes and for spelling consistency through your writing e.g. misspelling the patient's name is not good! Organise the letter into clear paragraphs and leave a blank line between paragraphs to show the overall structure of the letter. 	<ul style="list-style-type: none"> Is the letter formatted appropriately? Is the punctuation correct? Have you used capitals correctly? Are there a lot of spelling errors?

Writing Sub-Test Overview

The writing sub-test is usually a letter of referral but it may also be a letter requesting or giving advice. Candidates are given patient case notes and sometimes other information along with task instructions. The test procedure is as follows:

1. 5 minutes reading time, during which you can **not** take notes or underline any details
2. 40 minutes to read the task and write your letter in a booklet provided. You can use pen or pencil.

You can expect the stimulus material to be between 2 & 3 pages long and include detailed social & medical history. Most tasks will require you to identify the important aspects of the history and summarize this into letter format. Unlike other professions, most tasks are referral letters between doctors. The important point is to always read the task question carefully and respond appropriately.

Handy Hint

Do not just summarize the medical history. Always consider what the referred to person needs to know and what they will do with information. The social factors are sometimes very significant, hence the need for ongoing care, and are included to make the task more complex and challenging for the candidate.

Task Types

Letter Type	Chief Complaint & Purpose of Writing	Complicating factors in case notes
<ul style="list-style-type: none">• Referral from GP to Duty Registrar in Hospital	<ul style="list-style-type: none">• Meningococcal meningitis	<ul style="list-style-type: none">• Complex social factors including language barrier• Detailed and long medical history
<ul style="list-style-type: none">• Referral from GP to Psychiatrist	<ul style="list-style-type: none">• Schizophrenia	<ul style="list-style-type: none">• Complex social factors• Medical history
<ul style="list-style-type: none">• Referral from GP to Admitting Doctor Emergency Department	<ul style="list-style-type: none">• Peritonitis	<ul style="list-style-type: none">• Significant medical history• Urgent case• Socio-economic situation of patient
<ul style="list-style-type: none">• Referral from GP to Gynaecologist at a Fertility Clinic	<ul style="list-style-type: none">• Fertility problem	<ul style="list-style-type: none">• Confidentiality• Conflicting views of husband and wife and GP• Detailed medical history
<ul style="list-style-type: none">• Referral from GP to Consultant Obstetrician at a Mother's Hospital	<ul style="list-style-type: none">• Antenatal care	<ul style="list-style-type: none">• Only one very detailed consultation
<ul style="list-style-type: none">• Referral from GP to Endocrinologist	<ul style="list-style-type: none">• Diabetes	<ul style="list-style-type: none">• Complex social history• Long medical history
<ul style="list-style-type: none">• Referral from GP to Neurosurgeon	<ul style="list-style-type: none">• Subdural haematoma	<ul style="list-style-type: none">• Urgent situation• Detailed social and medical history
<ul style="list-style-type: none">• Referral from GP to Psychiatrist	<ul style="list-style-type: none">• Anorexia Nervosa	<ul style="list-style-type: none">• Complex social history

• Referral from GP to Urologist	• Severe hydronephrosis	• Detailed medical history • Urgent situation
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How to approach the task

What you need to do is spend time planning your letter carefully before writing. I advise 10~15 minutes of planning, which still allows 25~30 minutes to write the letter. A good strategy is:

1. Read the task question first
2. Read the most recent information to understand patient's current condition/situation. Always focus your writing on the main problem and any connected information. Ignore unrelated information as these have been put in the case notes to distract the reader.
3. Read the history to identify trends in medical condition, treatment, medication, social history etc.
4. Bring a highlight pen on test day and highlight related points with the same colour pen to help you summarize and group the information
5. On test day write with a pencil so that you can erase any mistakes
6. A format which will fit most scenarios is as follows:
 - o Introduction: Including purpose of writing and chief complaint in brief
 - o Body Paragraph 1: Patient past medical history in summary
 - o Body Paragraph 2: Trends in history & medication
 - o Body Paragraph 3: Chief complaint and current situation in detail
 - o Conclusion: Concluding request specific to the task

Planning

Ask yourself the following questions when reading the case notes:

- o Who am I writing to?
- o What information do they need to know?
- o What information do they not need to know?
- o What is the chief complaint/current condition or purpose of the letter?
- o Are there any significant social factors which need to be mentioned?
- o What information can be grouped together?

Introductions

There are a variety of ways to write introductions and with practice you can develop a formula that works for you. For the purpose of this document, the opening salutation and subject will be included as part of the introduction.

Salutation: If the name of the person is included in the case notes then it should be used. This can be followed by either a comma or full colon.

- Dear Dr. Wilson,
- Dear Dr. Wilson:

If the name of person is not mentioned then you can begin with Sir/Madam

- Dear Sir/Madam,

Subject: The subject is a place where information such as the name & age of the patient can be included. This can save you words in the body of the letter, but be careful not include too much information here, and definitely no phrases or sentences. Both Re & RE are acceptable.

- Re: Dylan Charles D.O.B. 04/12/2009
- RE: Dylan Charles D.O.B. 04/12/2009

Handy Tip 1

You can save on word length by adding some detail after Re, such as the patient name and age. However, take care not to write too much here, and always use note form i.e nouns only (no articles, verbs, adjectives).

Basically, the introductory sentence of the letter can contain the following:

1. Background information such as name, age, occupation, marital status and gender of the patient if relevant and not mentioned in the subject line.
2. A brief summary of the chief complaint, purpose of writing or your main concern.

It will usually be only 1 or 2 sentences long and detailed information about the patient's history and condition should go in the main body of the letter.

Important Grammar Rules

The important patterns to learn are as follows:

Example 1

Relative Clauses: A relative clause is a useful sentence structure to use in the introduction. It allows the writer to demonstrate the ability to write a complex sentence, which is a basic necessity to get B grade or higher.

1. I am writing to refer this patient. I suspect **he** has subdural haematoma .
2. I am writing to refer this patient **who I suspect has subdural haematoma**

Example 2

Appositives: This is a noun or a noun phrase that is placed after another noun to explain or identify it, and a comma is required to separate these nouns. It has a very important use in the introductory sentence of referral letters as in the example below.

1. I am writing to refer Mr. Barry Booth. He is 68 years old. He is my patient. He presented with signs and symptoms suggestive of peritonitis.
2. I am writing to refer Mr. Barry Booth, a 68-year-old patient of mine who presented with signs and symptoms suggestive of peritonitis.

Example 3

Age: There are specific rules regarding how to refer to a patient's age. The first is that it must be hyphenated when used before a noun such as man/woman, and the second is that an article is required. For more details refer to [Year Vs Years](#) in the Grammar and Vocabulary Clinic.

Incorrect	Correct
<ul style="list-style-type: none">I am writing to refer this patient, a 63 years old man who lives alone.I am writing to refer this patient, 63 years old man who lives alone.	<ul style="list-style-type: none">I am writing to refer this patient, a 63-year-old man who lives alone.I am writing to refer this patient who is 63 years old and lives alone.

Handy Tip 2

Mastery of the patterns above will ensure that you start your letter on a positive note.

Sample Introductions

Introduction	Analysis
Dear Doctor, Re: Mr. Darren Walker I am writing to refer this patient, a 40 year old married man with two sons aged 3 and 5, who requires screening for prostate cancer.	<ul style="list-style-type: none">Does not include patient name as this is clearly stated in the subject lineUses relative clause and appositive sentence structures which demonstrate ability to use complex sentencesStates purpose of writing clearly
Dear Dr Raymond, Re: Dulcie Wood DOB: 15/07/43 As arranged with your receptionist, I am referring Mrs. Wood, a 66 year old widow who has been demonstrating symptoms suggestive of heart arrhythmia.	<ul style="list-style-type: none">Includes shorter form of patient name as full name stated in the subject lineUses appositive and relative clause sentence structure which demonstrates ability to use complex sentencesStates both purpose of writing and chief complaintIncludes reference to previous communication
Dear Doctor Normal, Re: Catherine Walker DOB 6.12.70 Thank you for your urgent attention to this patient who presented today with severe depression.	<ul style="list-style-type: none">Sometimes a short and concise introduction is all that is needed, and it can help keep your word length within required limits.Summarizes chief complaint
Dear Doctor, Re. Mr John Pike, I am writing to refer Mr Pike, a patient of mine for necessary emergency management of acute peritonitis caused by perforation of peptic ulcers. Mr Pike is forty years old and is a heavy smoker and heavy drinker. He is a contractor in the machinery industry and is suffering from stress.	<ul style="list-style-type: none">Summarizes chief complaint and treatment and current conditionIncludes relevant biographical detail: age, habits & occupationExpresses level of urgency
Dear Doctor: Re. Amina Ahmed (8years) I am writing to refer Amina who is presenting with signs and symptoms indicative of meningococcal meningitis for urgent assessment and management. She is the first child of a family of 5, which includes her parents and two	<ul style="list-style-type: none">Purpose of writing stated clearly in the subject lineSummarizes chief complaintIncludes relevant biographical detail: family, nationality & language concerns

younger siblings. They are immigrants from Somalia, though she and her father understand English.

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> • Thank you for seeing Brendan 8 year old boy, who is signs and symptoms demonstrated perhaps the possibility of Rheumatoid arthritis <p>Explanation: Several errors in this introduction. The important point is to follow the conventions and patterns standard in introductions.</p>	<ul style="list-style-type: none"> • Thank you for seeing Brendan, an 8-year-old boy who is demonstrating signs and symptoms suggestive of rheumatoid arthritis.
<ul style="list-style-type: none"> • I am writing to refer the above named patient, 25 years old, who I worry that she may suffer from ectopic pregnancy. <p>Explanation: As above</p>	<ul style="list-style-type: none"> • I am writing to refer the above named patient, a 25-year-old woman who I suspect may be suffering from ectopic pregnancy. • I am writing to refer this 25-year-old woman who presented with signs and symptoms suggestive of ectopic pregnancy.
<ul style="list-style-type: none"> • I am writing to refer Miss. Cathy Jones, a 25-year-old single receptionist who is presenting with signs and symptoms of ectopic pregnancy to you for urgent assessment. <p>Explanation: ..to you should be omitted as it is too far apart from the verb it is connect to refer</p>	<ul style="list-style-type: none"> • I am writing to refer Miss. Cathy Jones, a 25-year-old single receptionist who is presenting with signs and symptoms of ectopic pregnancy for urgent assessment.
<ul style="list-style-type: none"> • Mr. James Warden is a patient of mine. I am writing to refer him to you for further assessment and management of his bilateral inguinal swelling. <p>Explanation: No grammatical errors but does not display the complexity required to earn a B grade or higher.</p>	<ul style="list-style-type: none"> • I am writing to refer Mr. James Warden, a patient of mine to you for further assessment and management of his bilateral inguinal swelling.
<ul style="list-style-type: none"> • I am writing with regard to this 81 year-old widowed patient presents with a ten-year-history of dementia which has become worse in recent months. <p>Explanation: Requires relative clause structure with <i>who</i></p>	<ul style="list-style-type: none"> • I am writing with regard to this 81-year-old widowed patient who presents with a ten-year-history of dementia which has become worse in recent months.

Study Strategy

When writing introductions, find a style which you like and use it for all tasks. However, take care to understand the basic grammar rules and always remember to include the chief complaint, purpose of writing or your main concern. Practice writing introductions using the sample case notes provided in your course.

Body Paragraphs

Most referral letters will contain 2 or 3 body paragraphs located between the introduction and the conclusion. Each of the paragraphs should have a main idea which the writer needs to convey to the reader. All the sentences with the paragraphs must relate to this main idea. The length of the paragraphs will vary, but an approximate guideline to meet the required word length of 180~200 words in OET is as follows:

- Introduction: 25 words
- Body paragraph 1: 40 words
- Body Paragraph 2: 40 words
- Body Paragraph 3: 70 words
- Conclusion: 25 words

Paragraph Structure

A good paragraph will contain 3 main elements

1. A Topic Sentence which introduces the reader to the main idea of the paragraph. In many cases it will identify and/or summarize an area of concern regarding the patient. Quite often it is written in original words rather than from words in the case notes.
2. Supporting sentences which may contain the detail regarding patient history, descriptions of symptoms, significant aspects from the treatment record, causes and effects, trends and so on. Quite often this information can be taken directly from the case notes, and written as full sentences. However, you will need to paraphrase the information into your own words. This includes:
 - o Changing verbs to nouns: complain=complaint
 - o Changing adjectives to nouns: lethargic=lethargy
 - o Using synonyms
 - o For more details on how to paraphrase, follow this link: [Paraphrase](#)
3. **Signal words** link sentences together so that the information flows smoothly and is easy to read.

Common signal words which can help you present information clearly and logically include:

- o Time: *At that time, On review today, On consultation today, Recently, Over the past 3 weeks...., Two weeks later, On her next visit, During, Since that time, Initial examination..., On 19/08/10...*
- o Location: *During hospitalization, Initial examination at my clinic revealed..., On examination....*
- o More information: *In addition, Moreover, Also, Apart from this..*
- o Contrast: *However, Despite, Although*
- o Result: *Therefore, Consequently, As a result, For this reason...*
- o Emphasis: *Please note, May I remind you, My main concern is...., What concerns me most is.....*
- o Sympathy: *Unfortunately, Regrettably, Fortunately,*
- o Subject: *In terms of her social history..., With regard to her medication...., Based on the blood test results...., Regarding her medical history...., Her dental history shows..., The risk factors include...., Treatment to date includes...*
- o Advice: *It is important to..., I recommend that you....., Please ensure that....*
- o Chronology: *Firstly, Secondly, Finally*

Example 1

Case Notes	Paragraphs	Analysis
<p>Patient History Amina Ahmed aged 8 years – new patient at your clinic Parents – Mother Ayama, house-wife. Father Talan, cab driver Brothers Dalma aged 4 and Roble aged 2 Family refugees from Somali 2005. Have Australian Citizenship Amina and father good understanding of English, mother has basic understanding of slowly spoken English. Amina had appendicectomy 2 years ago No known allergies</p> <p>Assessment Meningococcal Meningitis Penicillin IV given (stat dose)</p> <p>Plan Arrange urgent admission to the Emergency Pediatric Unit, Brisbane General Hospital, for further investigation and treatment.</p>	<p><i>I am writing to refer Amina who is presenting with signs and symptoms of meningococcal meningitis for urgent assessment and management. She is the first child of a family of 5, which includes her parents and two younger siblings. They are immigrants from Somalia, though she and her father understand English.</i></p>	<ul style="list-style-type: none"> In this letter, the writer uses the introduction to include both the chief complaint and the relevant social factors Supporting sentences transform case notes into complete sentences
<p>09/10/10</p> <p>Subjective Fever, runny nose, mild cough, loss of appetite Unable to attend school</p> <p>Objective Pulse 85/min Temperature 39.4 No rash No neck stiffness CVS, RS & abdo – normal</p> <p>Assessment Viral infection</p> <p>Management Keep home from school Rest and paracetamol three times daily Review in 3 days if no improvement</p>	<p><i>Initially, accompanied by her parents, she presented to me on 9.10.10 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next three days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.</i></p>	<ul style="list-style-type: none"> Topic sentence is introduced with the phrase: <i>Initially...she presented to me on 9.10. 10..</i> Supporting sentences transform case notes into complete sentences Second visit is only briefly summarized Signal words express contrast and cause and effect <ul style="list-style-type: none"> Initially, However, Therefore,
<p>12/10/10</p> <p>Subjective Amina not well Cough +, continuous headache, lethargic, loss of appetite Difficult to control temperature with Paracetamol Mother worried</p> <p>Objective Fever 39.8 C No rash or neck stiffness</p> <p>Management Prescribe Brufen 200mg as required FBC & UFR were ordered</p>		

Review in two days with results of reports		
14/10/10 Subjective Both parents very concerned Reported Amina lethargic and listless Vomited twice last night and headaches worse Objective FBC- WBC(18000) and left shift Urinary Function Report Normal Temperature 40.2C Pulse 110/min Macula-papular rash over legs Neck Stiffness+	<i>Regrettably, today Amina became lethargic and listless. She vomited twice last night and had been having severe headaches. On examination, she was severely febrile with a temperature of 40.2 and a pulse rate of 110 beats per minute. There was macula-papular rash over the legs and neck stiffness was present. Blood test showed leucocytosis with a shift to the left..</i>	<ul style="list-style-type: none"> This paragraph explains the current condition in detail Supporting sentences expand the case notes into complete sentences, note the use of verbs, articles and conjunctions (and) Signal word shows empathy <ul style="list-style-type: none"> Regrettably, On examination,

Example 2

Case Notes	Paragraphs	Analysis
Medical History Thyroidism diagnosed Feb 07 High blood pressure June 09 Hip replacement July 09 Medications – thyroxine 1mg daily, Atacand 4mg daily, Fosamax 10mg daily No known allergies 21.02.10 Subjective Complains of inflamed, sticky and weeping eyes. Objective BP 135 /75 P 74 Both eyes – red, watery discharge right eye worse than left	<i>Initially, she presented to me on 21/2/10, complaining of inflamed, sticky and weeping eyes. Both her eyes were reddish with watery discharge. However, her right eye was worse than the left eye. Therefore, she was prescribed chlorisig drops 4 hourly. In terms of her medical history, she has had thyroidism for 3 years, high blood pressure for 1 year and a hip replacement was done in 2005. Her current medications are Thyroxin 1 mg, Atacand 4 mg and Fosamax 10 mg daily. She has no known allergies.</i>	<ul style="list-style-type: none"> The topic sentence begins with the first consultation Supporting sentences transform case notes into complete sentences Includes both medical history and initial consultation Signal words express a time line, contrast and cause and effect. <ul style="list-style-type: none"> Initially, However, Therefore, In terms of... ..current
03.03.10 Subjective No improvement to eyes, blurred vision Objective Odema eye lids ++ Marked conjunctival congestion Plan Chloramphenicol 0.5% sterile 1 drop TID Bion Tears 1 drop each eye 4 hrly Review 2 weeks	<i>On review 2 weeks later, she had made no improvement. In addition, she had blurred vision with oedematous eye lids and conjunctival congestion. Therefore, chloramphenicol was prescribed 0.5% one drop three times daily and Bion tears one drop 4 hourly. A review was scheduled after 2 weeks.</i>	<ul style="list-style-type: none"> Topic sentence is introduced with the phrase: <i>On review 2 weeks later</i> Explains medication details clearly in complete sentences Signal words continue time line <ul style="list-style-type: none"> Two weeks later, In addition, Therefore,
05.06.10 Subjective Accompanied by husband. Very distressed. Has lost most sight in both eyes – can make out light or dark shapes but unable to read or watch TV. Objective Marked oedema upper and lower lids White sticky discharge Unable to read eye chart Plan Refer immediately Emergency Dept,	<i>Unfortunately, today she was accompanied by her husband with complaints of impaired vision in both eyes and an inability to read books or watch television. There was oedema in both eyelids with white discharge. She could not read the eye</i>	<ul style="list-style-type: none"> Summarizes medical condition clearly and concisely with the expression "vision Impairment" Supporting sentences expand case notes into formal sentences Signal words add sympathy <ul style="list-style-type: none"> Unfortunately,

Royal Melbourne Eye Hospital. Husband will drive to hospital		
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Handy Hint

When describing the history, base your letter from today's perspective. That means, include all the relevant past history, but in summary form, eliminating less important detail and focus your attention on the current situation which is usually more important.

Conclusions

The conclusion or final paragraph in the letter should be fairly standard in structure. It should be based on the task question which is found at the end of case notes. It may contain one or two of the following points:

- a polite request of action required
- a summary of your (suspected) diagnosis
- a thank you for ongoing support
- an offer of future assistance if required (this can be useful if you choose to omit some details from the case notes)

It is useful to be familiar with some standard patterns so that you are able to conclude your letter confidently, quickly and most importantly, accurately. However, some degree of originality will impress the assessors. Therefore, where possible try to ensure that your conclusion is related to your task and not simply a memorized ending.

Handy hint

When describing the chief complaint or your diagnosis, try to use different words or sentence structure to what you have said in the introduction.

Important Grammar Rules

Modal Verbs: Some modal verbs & the verb *hope* are used to convey politeness and commonly used for polite requests in the conclusion of formal letters. Compare the patterns below.

Informal	Polite	More polite
<ul style="list-style-type: none"> • I want you to see him as early as possible and advise him on further management. • I will be pleased if you can examine, diagnose and treat the patient as you feel appropriate. • Can you take over her care for appropriate treatment? <p>Explanation: These sentences are fine in spoken English, but not suitable for formal writing. <i>Can</i> and <i>will</i> are considered less polite than <i>could</i> and <i>would</i>.</p>	<ul style="list-style-type: none"> • Please see him as early as possible and advise him on further management.(this sounds like an order so should not be used) • Please examine, diagnose and treat the patient as you feel appropriate. • Please take over her care for appropriate treatment. <p>Explanation: These sentences are acceptable in written English, but can sound quite direct.</p>	<ul style="list-style-type: none"> • I <u>would</u> appreciate it if you <u>could</u> see him as early as possible and advise him on further management. • It <u>would</u> be greatly appreciated if you <u>could</u> see him as early as possible and advise him on further management. (passive and most polite) • I <u>would</u> be grateful if you <u>could</u> examine, diagnose and treat the patient as you feel appropriate. (active) • I <u>would</u> appreciate it if you <u>could</u> examine, diagnose and treat the patient as you feel appropriate. (active) • I <u>would</u> appreciate it if you <u>could</u> take over her care for appropriate treatment.

		<ul style="list-style-type: none"> I would be grateful if you could <u>take over her care</u> for appropriate treatment. <p>Explanation: These sentences are the most suitable for concluding requests in formal letters.</p>
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Conditional Sentences: These sentences are also frequently used in the conclusion of a referral letter and the rules are as follows:

Use a comma when the <i>if clause</i> is at the beginning of the sentence.	Don't use a comma when the <i>if clause</i> is at the end of the sentence.
<ul style="list-style-type: none"> If you could take over her on going care, it would be greatly appreciated. If you have any further questions regarding this patient, please don't hesitate to call me. 	<ul style="list-style-type: none"> It would be greatly appreciated if you could take over her ongoing care. Please don't hesitate to call me if you have any further questions regarding this patient.
<ul style="list-style-type: none"> If <u>you require</u> any more information, please don't hesitate to contact me.(active) If any more information <u>is required</u>, please don't hesitate to contact me.(passive) 	<ul style="list-style-type: none"> Please don't hesitate to contact me if <u>you require</u> any more information.(active) Please don't hesitate to contact me if any more information <u>is required</u>.(passive)
<ul style="list-style-type: none"> Should you have any further queries, please don't hesitate to contact me. <p>Note: Sometimes <i>if</i> is omitted from a conditional sentence. In full the sentence means: If you should have any further questions regarding this patient, please don't hesitate to call me.</p>	<ul style="list-style-type: none"> Please don't hesitate to contact me should you have any further queries.

Closer and signature

Leave a space between the last line of the conclusion and the closer. The closer should be followed by a comma. Then write your signature below the closer, and if you have time, print your name below your signature.

Sample Conclusions

Case Notes	Conclusion	Analysis
<p>Plan Review BP, smoking reduction in 2 months Refer to urologist – possible biopsy prostate</p> <p>Writing Task Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001. Asl to be informed of the outcome.</p> <p>In your answer:</p> <ul style="list-style-type: none"> * Expand the relevant case notes into complete sentences * Do not use note form * The body of the letter should not be more than 200 words * Use correct letter format 	<p><i>In view of the above signs and symptoms, I believe he needs further investigations including a prostate biopsy and surgical management. I would appreciate your urgent attention for his condition.</i></p> <p><i>Yours sincerely,</i> <i>Dr X</i></p>	<ul style="list-style-type: none"> Uses information from the writing task to formulate conclusion Refers back to what was said in the body of the letter: <u>In view of the above signs and symptoms</u> Contains a polite request and maintains polite tone through the use of modal verb: would Includes suspected diagnosis and level of urgency
<p>Assessment Bilateral inguinal hernia Advised patient you want to refer him to a surgeon. He agreed but says he wants a local anesthetic as a friend</p>	<p><i>Based on my provisional diagnosis of a bilateral inguinal hernia, I would like to refer him for surgery as early as possible. Please note, that Mr Warden wishes to have the surgery</i></p>	<ul style="list-style-type: none"> Uses information from the final consultation and writing task to formulate conclusion

<p>advised him he will have less after effects than with general anesthetic.</p> <p>Writing Task</p> <p>Write a letter addressed to Dr. Glynn Howard, 249 Wickham Tce, Brisbane, 4001 explaining the patient's current condition.</p>	<p><i>under local anesthesia.</i></p> <p><i>Yours sincerely,</i></p> <p><i>Dr X (GP)</i></p>	<ul style="list-style-type: none"> • Uses sophisticated vocabulary and expression: <u>Based on my provisional diagnosis of</u> • Adds extra information specific to the task with the expression: <i>Please note,</i>
<p>Plan</p> <p>Suspected angina - refer to cardiologist for cardiovascular assessment.</p> <p>Writing Task</p> <p>Write a referral letter to cardiologist Dr. Ken Wilson. Suite 5, Green slopes Hospital Medical Centre, Brisbane 4121.</p>	<p><i>I believe he needs cardiovascular investigations <u>in order to rule out</u> angina pectoris.</i></p> <p><i>I would appreciate it if you could see him as early as possible and advise him on further management.</i></p> <p><i>Yours sincerely</i></p> <p><i>Dr Z</i></p>	<ul style="list-style-type: none"> • Uses information from the writing task to formulate conclusion • Maintains polite tone through the use of modal verbs would & could • Uses appropriate expression: <u>in order to rule out</u>
<p>Assessment</p> <p>Depression. Severe. ?Bi polar</p> <p>Needs urgent treatment</p> <p>Called to husband</p> <p>Writing Task</p> <p>Write a referral letter to psychiatrist Dr. Abe Normal Brampton St, Mt Gravatt ,4121,QLD.</p>	<p><i>I believe that Catherine needs an urgent psychiatric consultation regarding her acute episode of depression and I would appreciate it if you could take over her care for appropriate treatment.</i></p> <p><i>Yours sincerely,</i></p> <p><i>Dr X (GP)</i></p>	<ul style="list-style-type: none"> • Summarizes chief complaint in original language • Maintains polite tone through the use of modal verbs would & could • Uses polite request for ongoing care
<p>Assessment</p> <p>Diagnosed peritonitis with perforation</p> <p>Writing Task</p> <p>Refer urgently to the Emergency Department Admitting Doctor</p>	<p><i>I would appreciate your assessment and emergency management of this patient's condition. If you need further information, please feel free to contact me.</i></p> <p><i>Yours sincerely,</i></p> <p><i>Dr X</i></p>	<ul style="list-style-type: none"> • Note, sometimes a brief conclusion is all that is required.... or all that you will have time for! Although it is a memorized phrase to some degree, it is grammatically correct, concise, direct and contains a level of urgency • Maintains polite tone through the use of modal verb would • Contains an offer of future support

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> I would very much appreciated your attention regarding further management of Mr. Henderson. <p>Explanation: Incorrect grammar, see above</p>	<ul style="list-style-type: none"> I would very much appreciate your attention regarding further management of Mr. Henderson.(active) Your attention regarding further management of Mr. Henderson would be very much appreciated.(passive)
<ul style="list-style-type: none"> If you have any query, please do not hesitate to contact me. <p>Explanation: Use plural form of query</p>	<ul style="list-style-type: none"> If you have any queries, please do not hesitate to contact me.
<ul style="list-style-type: none"> I will appreciate your further assessment and management In view of the above findings I believe he needs an abdominal CT scan. Therefore, I will greatly appreciate your further assessment for Mr Backo. <p>Explanation: Polite form "would" required instead of would</p>	<ul style="list-style-type: none"> I <u>would</u> appreciate your further assessment and management. In view of the above findings I believe he needs an abdominal CT scan. Therefore, I <u>would</u> greatly appreciate your further assessment for Mr Backo.
<ul style="list-style-type: none"> Kindly investigate this child and do the needful. If you need any more information regarding her situation, please try to contact me without any hesitation. <p>Explanation: Several errors here. Basically it is important that the standard patterns and style conventions are followed in conclusions.</p>	<ul style="list-style-type: none"> I would appreciate it if you could investigate this child's condition and do the necessary management. If you require anymore information, please do not hesitate to contact me.
<ul style="list-style-type: none"> Based on above history and physical findings, I suspect she may have a ruptured rupt. I will appreciate if you would offer your expert assessment to this lady. Please keep me informed of the outcome. <p>Explanation: Two errors: 1. Incorrect use of modal 2. omission of the definite article <u>the</u>. Click here for more details.</p>	<ul style="list-style-type: none"> Based on <u>the</u> above history and physical findings, I suspect she may have a ruptured ectopic pregnancy. I would appreciate it if you could offer your expert assessment to this lady. Please keep me informed of the outcome.
<p>I would be appreciated if you could take over the care of this patient.</p> <p>Explanation: Incorrect grammar</p>	<ul style="list-style-type: none"> <u>It would be appreciated</u> if you could take over the care of this patient. (passive verb) I would be <u>appreciative</u> if you could take over the care of this patient.(be + adjective) I would appreciate it if you could take over the care of this patient. (active verb)

Handy Tip

As with introductions, when writing conclusions, find a style and pattern which you are confident with and use it. However, take care to understand the basic grammar rules and always remember to respond to the task question. Practice writing conclusions using the sample case notes provided in your course.

Dos & Don'ts

Below is a list of simple points to remember on the day of your exam.

Do	Don't
Summarises all the information from the case notes into sections such as: treatment given and obvious trends, medication, medical history. This will be both easier to write and read as well as avoiding repetition	Follow a strict chronological order as your letter may become too long, difficult to read and will not focus on the main problem and related factors.
Try to write somewhere between 180 and 200 words for the body of the letter. This is the requirement of OET and the assessors are quite strict in this area.	Write over 220 words as it will affect your overall result. You being tested on your ability to write a clear concise letter, not a long letter. Don't write under 160 words as there may not be sufficient language to get a B grade.
Omit information which is not directly relevant to your task. This is a big trap for many candidates in that they try to write down all the information from the task sheet. This does not reflect reality.	Try to put all the information from the case notes into the letter. Your letter will be too long and also poorly organized and difficult to read
Expand on all acronyms. For example OPG should be written as orthopantamogram, BP as blood pressure and PR as pulse rate & hx as history	Overuse acronyms. You are being tested on your ability to expand on case notes so make sure you do.
Provide a simple clear summary of the condition so that a lay person could understand	Use too much medical jargon. Remember it is a test of English not Latin!
Spend time reading the case notes and grouping information which are related such as medication, persistent high blood pressure etc etc	Start writing without planning your letter. You should allow 15 minutes reading case notes and planning the letter.
Use synonyms so that you can express the information from the case notes in different ways	Copy directly from the case notes without any changes. You are expected to put the information into your own words.
Allow 5 minutes at the end of the test to proof read your work and fix up any mistakes	Submit the letter without checking for basic mistakes such as grammar/spelling.

Writing

Present Perfect

Present perfect tense is used to describe an event which starts in the past and continues until the present. Mastery of this pattern is an essential for writing successful referral letters. Three common ways to form present perfect when writing referral letters are as follows:

Present Perfect Simple	Present Perfect Progressive	Present Perfect Passive
<p>Form: <i>have/has+ past participle</i></p> <ul style="list-style-type: none">I <u>have treated</u> Mr. Smith at this hospital for 3 years.Dr X <u>has treated</u> Mr. Smith at this hospital for 3 years.	<p>Form: <i>have/has + been +____ing (present participle)</i></p> <ul style="list-style-type: none">I <u>have been treating</u> Mr. Smith at this hospital for 3 years.Dr X <u>has been treating</u> Mr. Smith at this hospital for 3 years.	<p>Form: <i>have/has +been+ past participle</i></p> <ul style="list-style-type: none">Mr. Smith <u>has been treated</u> at this hospital for 3 years(..by Dr X).They <u>have been treated</u> at this hospital for 3 years(..by Dr X).

Present perfect is often combined with **for/since/over**. Compare the usage below and note time markers used.

For	Since	Over
<p><i>For</i> is used to describe a period of time</p> <ul style="list-style-type: none">I have been treating the patient for 3 years.The patient has been on this medication for 6 months.I haven't seen the patient for 1 year.The patient has been in pain for 5 hours.The patient has been waiting for 15 minutes.He has been complaining of back pain for a week.	<p><i>Since</i> is used to refer to the start of period of time</p> <ul style="list-style-type: none">I have been treating the patient since 2007.The patient has been on this medication since January.I haven't seen this patient since December 2009.The patient has been in pain since 10am.The patient has been waiting since 11.45am.He has been complaining of back pain since last week.	<p><i>Over</i> uses similar time markers to <i>for</i> but is used to express a change in condition, or to describe a repeated event.</p> <ul style="list-style-type: none">The patient's condition has deteriorated over the past 3 months.(change in condition)The patient has presented several times over the last year. (repeated event)The patient's back pain has worsened over the last week.(change in condition)He has tried to quit smoking several times over the past 25 years.(repeated event)

<ul style="list-style-type: none"> • He has not had bowel motions for 3 days. • He has been a smoker for a period of 25 years. 	<ul style="list-style-type: none"> • He has not had bowel motions since Saturday. • He has been a smoker since 1985. 	<ul style="list-style-type: none"> • The patient has experienced seizures on 3 occasions over the past year.(repeated event)
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Handy Tip

When using time markers such as ...for the past 20 years, ...for the last 3months, ...for the next 3 months or for the previous 3 months always use the definite article "the" as it its function is to specify a particular period of time.

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> • The patient was diagnosed hypothyroidism since 2007 <p>Explanation: Past tense cannot be used with for or since</p>	<ul style="list-style-type: none"> • The patient <u>has had</u> hypothyroidism <u>since</u> 2007. (present perfect) • The patient <u>was diagnosed</u> with hypothyroidism <u>in</u> 2007. (simple past)
<ul style="list-style-type: none"> • She has been problems with arthritis in her hands. <p>Explanation: <u>Problems</u> in this sentence is a noun so you cannot use "been" with a noun. You must use have or has + noun or been+ <u>ing</u> verb. You can also use been + adjective</p>	<ul style="list-style-type: none"> • She <u>has been having</u> problems with arthritis in her hands since 2007. (present perfect progressive) • She <u>has had</u> problems with arthritis in her hands since 2007.(present perfect simple) • She <u>has been arthritic</u> since 2007. (present perfect simple +adjective) • She <u>has had arthritis</u> since 2007. (present perfect simple +noun)
<ul style="list-style-type: none"> • He is smoking 2 packs of cigarettes a day for the past 25 – 30 years. • Over the past week she remains free from severe pain and has been able to tolerate a fluid diet. • Also, there is an ulcer on the right lower lateral border of the tongue which is present for more than one year. 	<ul style="list-style-type: none"> • He <u>has been smoking</u> two packs of cigarettes a day for the past 25-30 years. (present perfect progressive) • Over the past week she <u>has remained</u> free from severe pain and has been able to tolerate a fluid diet.(present perfect simple) • Also, there is an ulcer on the right lower lateral border of the tongue, which <u>has been</u> present

<ul style="list-style-type: none"> • Mr. Diamond is a patient of mine since 2000 • Mr. Eddy is a known smoker for 25-30 years. <p>Explanation: The verbs in these sentences are in simple present tense. Present perfect needs to be used because you are referring to a time period which started in the past and has continued to the present.</p>	<p>for more than one year. (present perfect passive)</p> <ul style="list-style-type: none"> • Mr Diamond <u>has been</u> a patient of mine since 2000.(present perfect simple) • Mr. Eddy <u>has been</u> a smoker for 25 years. (present perfect simple)
<ul style="list-style-type: none"> • Mrs. Brown has been presenting to me on several occasions over the past few months. <p>Explanation: Progressive form not required.</p>	<ul style="list-style-type: none"> • Mrs. Brown <u>has presented</u> to me on several occasions over the past few months.

Articles Usage with Countable & Uncountable Nouns

Whether an article is required or not depends on the noun that follows. For this purpose nouns can be classified into two types: countable & uncountable nouns. The difference is based on whether the noun can be counted or not. For example complaint is a countable noun as it can be counted. Therefore it is possible to say 1 complaint or 2 complaints. Advice on the other hand cannot be counted so it is not possible to say 1 advice or 2 advices , The correct expression is some/any advice or the expression a piece of advice.

Countable nouns

These nouns have a singular form and plural form.

Singular

In the singular form an article is usually used before the noun. Example: The doctor received a complaint from her patient.

NB. Exceptions: The article can be left out if it is replaced with another determiner such as his/her or this /that or any/each/every. E.g. The doctor listened to each complaint. Her complaint was recorded.

Plural

In the plural form the article is usually not used before the noun. Example: The doctor received complaints from her patients.

 **Remember:** Always use articles when referring a particular job such as:
doctor/dentist/nurse/pharmacist/physiotherapist/teacher etc etc.

Countable nouns	Singular form	Plural form
	<i>Note the use of an article before each noun in singular form, either as a/an/the</i>	<i>Note the absence of the indefinite articles a/an before each noun in singular form, but the definite article</i>
abscess	The patient had an abscess on her gum.	The patient had 3 abscesses on her gum.
ache	The patient reported a dull ache in her abdomen.	The patient suffered from aches and pains.
accountant	Mr. Hagen is an accountant.	Mr. & Mrs. Hagen are both accountants.
appointment	A follow-up appointment was scheduled.	The patient did not attend her follow-up appointments.
cavity	The cavity was exposed.	The cavities were exposed.
check up	The patient attended for a check-up.	Regular check-ups will keep you healthy.
complaint	If you have a complaint, tell your doctor.	If you have any complaints, tell your doctor.
condition	You have a condition known as tuberculosis.	There are 3 conditions which can indicate the presence of cancer.
deposit	A carious deposit was evident on tooth 32.	Carious deposits were evident on teeth 32 & 33.
doctor	The patient has not seen a doctor for several years.	Three doctors were involved in the treatment of the patient.
episode	The patient had an episode of heart flutter.	The patient reported 3 episodes of heart flutter.
examination	An examination is necessary to rule out cancer.	Blood urine examinations revealed no abnormalities.
gum	The gum surrounding tooth 23 was inflamed.	The gums were infected.

increase	There was an increase in the size of the swelling.	The patient presented with numerous swellings.
interpreter	An interpreter is required.	Interpreters will be required.
investigation	An investigation is required to rule out bowel cancer.	Investigations are required to rule out bowel cancer.
limp	The patient walked with a limp.	All the patients had limps.
parasite	The threadworm is a parasite.	Threadworms are parasites.
lip	The patient had a swollen lip. (one lip)	The patient had swollen lips. (both lips)
smoker	She is a smoker.	They are smokers.
operation	An operation is necessary.	Two operations are necessary.
painkiller	The patient requested a painkiller.	Painkillers are not necessary with this procedure.
physiotherapist	An appointment needs to be arranged with a physiotherapist.	Two physiotherapists work at this rehabilitation centre.
result	The patient hoped for a positive result.	The results were positive.
review	A review was scheduled after 2 weeks.	The nurse received positive reviews from her patients.
sensation	The patient reported a tingling sensation in his fingers.	The patient experience tingling sensations in his fingers.
social worker	A social worker has been arranged to offer ongoing care.	Two social workers have been arranged to offer ongoing care.
teacher	Steve is a teacher.	Steve and Chris are teachers.
test	A blood test was ordered.	Blood and urine tests were ordered.
visit	Please organise a visit by a social worker.	Regular visits by a social worker are required.

Uncountable nouns

These nouns cannot take a plural form such as: cancer, anaesthesia and information. For these words no article is required. However, the definite article the as well as quantifiers such as some and any can be used before the noun.

Uncountable nouns	Indefinite articles cannot be used with uncountable nouns. However definite article “the” as well as quantifiers such as some and any can be used.
accommodation	The patient lives in rental accommodation.
advice	Advice on diet is requested.
assistance	The patient will require assistance upon discharge.
attention	The patient requires urgent attention.
behaviour	On examination, the patient's behaviour was abnormal.
cancer	The patient has cancer.
caries	Deep caries were present on several teeth.
concentration	The patient has poor concentration.
damage	The scan confirmed damage to the medial cartilage.
discomfort	If you experience discomfort, please consult your doctor.
information	Should you require further information, please do not hesitate to contact me.
pain	The patient experienced pain on palpation.
progress	The patient has made good progress.
tissue	She has healthy, soft tissue.
treatment	The condition did not respond to treatment.
research	Further research is required.

surgery	The patient chose not to have surgery.
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Common mistakes

Incorrect	Correct
Wound on her left knee has been stitched.	A wound on her left hand has been stitched.
I am writing to refer Marvin, 7 year old boy who was admitted to hospital on 21/11/10.	I am writing to refer Marvin, a 7 year old boy who was admitted to hospital on 21/11/09.
Mr Brown has been patient of mine for 7 years.	Mr Brown has been a patient of mine for 7 years.
Please note, the patient has had prosthetic heart valve for year.	Please note, the patient has had a prosthetic heart valve for a year.
Examination revealed abscess on her gum.	Examination revealed an abscess on her gum.
Apart from bruises to her body, X-rays reveal that she has fracture of the right ankle.	Apart from bruises to her body, X-rays reveal that she has a fracture of the right ankle.
Mr Jones had a heart surgery in 2009.	Mr Jones had heart surgery in 2009.
The patient has a cancer.	The patient has cancer.
She had a healthy soft tissue.	She had healthy soft tissue.
He had lacerated lip and swollen gum.	He had a lacerated lip and swollen gums.
The patient has pollen allergy.	The patient has a pollen allergy.
The patient has tender right elbow joint.	The patient has a tender right elbow joint.
The patient presented for regular check-up on 12/2/10.	The patient presented for a regular check-up on 12/2/10.

Referring to Something Specific

The definite article is used when referring to something specific. It is very important to include this article to signify the information is specific.

Note: These articles are usually omitted in the case notes. This is because the case notes are in short note form and standard grammar rules do not apply. However, for referral letters it is necessary to apply and adhere to standard grammar rules.

Incorrect	Correct
<ul style="list-style-type: none">• She was on Microgynon 30 for previous 5 years.• He has been a smoker for last 12 years.• Mr. Roberts has been a resident at our nursing home for past 2 years.• This medication needs to be taken twice a day for next 3 days. <p>Explanation: All the expressions above are referring to a specific period of time so a definite article is required.</p>	<ul style="list-style-type: none">• She was on Microgynon 30 for <u>the</u> previous 5 years• He has been a smoker for <u>the</u> last 12 years.• Mr. Roberts has been a resident at our nursing home for <u>the</u> past 2 years.• This medication needs to be taken twice a day for <u>the</u> next 3 days.
<ul style="list-style-type: none">• Mrs Sangean is currently on following medication: karvea 150mg daily, oroxinen 0.1 daily. <p>Explanation: In this case, the writer is referring to specific medication. i.e that which follows.</p>	<ul style="list-style-type: none">• Mrs Sangean is currently on <u>the</u> following medication: karvea 150mg daily, oroxinen 0.1 daily
<ul style="list-style-type: none">• The patient reported pain in left ankle. <p>Explanation: Here the writer is referring to a specific side, i.e not the right side but the left side.</p>	<ul style="list-style-type: none">• The patient reported pain in <u>the</u> left ankle.
<ul style="list-style-type: none">• Patient complained of chest pain. <p>Explanation: Patient requires an article to indicate which patient the writer is referring to.</p>	<ul style="list-style-type: none">• <u>The</u> patient complained of chest pain.
<ul style="list-style-type: none">• Examination revealed a slightly swollen joint and a tender spot on medial aspect of it.	<ul style="list-style-type: none">• Examination revealed a slightly swollen joint and a tender spot on <u>the</u> medial aspect of it.

<p>Explanation: Here the writer is referring to a specific region, i.e not the anterior aspect but the medial aspect.</p>	
<ul style="list-style-type: none"> Based on above information, I believe the patient needs urgent admission to hospital. <p>Explanation: Here the writer is referring to a specific information, i.e not the information on the medical chart but the information written above.</p>	<ul style="list-style-type: none"> Based on <u>the</u> above information, I believe the patient needs urgent admission to hospital.
<ul style="list-style-type: none"> Thank you for seeing this patient who presented at my surgery regarding tooth 54 which has been temporary filled by school dental service. <p>Explanation: Here the writer is referring to a specific dental service, i.e not the community dental service but the school dental service.</p>	<ul style="list-style-type: none"> Thank you for seeing this patient who presented at my surgery regarding tooth 54 which has been temporary filled by <u>the</u> school dental service.

Special Usage of Articles

There are some situations where you should always use the definite article and there are some situations where the indefinite article is required. Understanding these rules can greatly reduce the number of "minor" errors in your writing so please study these rules carefully.

Handy Hint!

Articles are usually omitted in the case notes. This is because the case notes are in short note form and standard grammar rules do not apply. However for referral letters it is necessary to apply and adhere to standard grammar rules including article usage.

Body Parts

The definite article "the" should be used when referring to parts of the body.

Incorrect	Correct
<ul style="list-style-type: none"> Pain in left groin. Pain in stomach. I suspect it to be adenoma of parotid gland. Mr. Smith had an operation on a left knee. 	<ul style="list-style-type: none"> Pain in <u>the</u> left groin. Pain in <u>the</u> stomach. I suspect it to be adenoma of <u>the</u> parotid gland. Mr. Smith had an operation on <u>the</u> left knee.

Names of Diseases

Do not use an article for names of diseases or conditions.

Incorrect	Correct
<ul style="list-style-type: none">• The patient is suffering from the high blood pressure.• Recently, the patient has complained of the headache.• The patient was diagnosed with the arthritis.• The patient has had the influenza for three days.	<ul style="list-style-type: none">• The patient is suffering from high blood pressure.• Recently, the patient has complained of headache.• The patient was diagnosed with arthritis.• The patient has had influenza for three days.

Same

Always use the definite article with this word.

Incorrect	Correct
<ul style="list-style-type: none">• She has a family history of same disease that had been controlled by Risperidone.• The children were treated by same dentist.• The medication is same as last time.	<ul style="list-style-type: none">• She has a family history of <u>the</u> same disease that had been controlled by Risperidone.• The children were treated by <u>the</u> same dentist.• The medication is <u>the</u> same as last time.

Articles with Gerunds

A gerund is the ...ing form of a verb which takes on the grammatical function of a noun. It can be the subject or object in a sentence. Usually no article is required with gerunds.

Incorrect	Correct
<ul style="list-style-type: none">• On review today, Mr Walker has reduced the smoking from 20 to 10 cigarettes per day.• The patient was advised to stop the drinking.	<ul style="list-style-type: none">• On review today, Mr Walker has reduced smoking from 20 to 10 cigarettes per day.• The patient was advised to stop drinking.

Articles and Nominalization

Nominalization is a process where verbs can be turned into a "noun phrase". For example: The patient sucked his thumb until he was five becomes The patient had a habit of thumb sucking until the age of five.

Often in medical English, it is necessary to use nominalization such as: The excessive drinking of alcohol will adversely affect your health. The reduction of weight has led to improved health. It is common in these cases to use an article before the nominalized expression.

The other benefit of using the style of writing is that it creates a formal tone and allows you to summarize details from the case notes.

Incorrect	Correct
<ul style="list-style-type: none">• The patient is complaining of discomfort during passing of urine.	<ul style="list-style-type: none">• The patient is complaining of discomfort during the passing of urine.

Capitalization

Correct use of capitals is an important area to master when writing referral letters. Study the rules of usage below to ensure you meet the standard conventions.

Rules of Usage

1. Medications and Diseases

- Capitals are required for proper nouns. Proper nouns include the brand name of a drug or registered trademark of the manufacturer.
 - **Ritalin**
 - **Voltaren**
 - **Zocor**
- The chemical constituent should be written in lower case.
 - **penicillin**
 - **amoxicillin**
- Names of diseases should always be lower case.

- **bowel cancer**
 - **high blood pressure**
 - **diabetes**
 - **epilepsy**
- Eponyms: Some medical conditions are named after the person who discovered it. In this case the first word should be capitalised.
 - **Parkinson's disease**
 - **Bell's palsy**
- Names of medical procedures do not require capitals.
 - **orthopantomogram**
 - **x-ray**
 - **caesarian section**
- Body parts should always be lower case
 - **heart**
 - **adrenal gland**
 - **knee**

2. Proper Nouns: Proper nouns name something specific as in the examples below. These words must always be capitalised.

- Job titles
 - The Lactation Consultant, Mater Hospital
 - The Veterinary Eye Specialist, University of Queensland
- Institutions
 - Mary Jones was admitted to Spirit Hospital.
 - Dr. Bloomfield works at Weller Point Medical Centre.
- Places including addresses
 - 168 Wickham Terrace, Spring Hill
 - 12 Logan Road, Mt Gravatt
 - 36 Barmore Street, Holland Park
- Titles when they precede the name of a person

- The patient was seen by Doctor Smith.
- Nurse Jones is in charge of the patient's care.

3. Common Nouns: Common nouns do not name any specific institution, place, person or profession. These words do not need to be capitalised.

- The patient was admitted to hospital.
- The patient does not have a family doctor.
- Steve is a teacher.
- Yoshiro is a doctor.
- Reza is a dentist.

4. Holidays, months, days of the week all need to be capitalised. However seasons do not.

- The baby was born on Christmas Day.
- The patient was admitted to hospital on January 12.
- Please come and see me on Wednesday.
- The vaccination will be available in spring.

5. The pronoun "I" must always be capitalised.

- It was I who treated the patient.

6. Capitalise the first word of a salutation and the first word of a complimentary close.

- Dear Dr. Jameson:
- Yours sincerely,

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> • His medical history shows that he is Epileptic. • Also, I have given Dycal base on 1.1 and dressed it with Glass Ionomer Cement. • The patient was diagnosed with Type 2 Diabetes. • Mrs. Marsh has a history of Hyperthyroidism, Hypertension and Glaucoma. 	<ul style="list-style-type: none"> • His medical history shows that he is <u>epileptic</u>. • Also, I have given <u>dycal</u> base on 1.1 and dressed it with <u>glass ionomer cement</u>. • The patient was diagnosed with <u>type 2 diabetes</u>. • Mrs. Marsh has a history of <u>hyperthyroidism</u>, <u>hypertension</u> and <u>glaucoma</u>.

<ul style="list-style-type: none"> The patient is allergic to Penicillin. The patient suffered from severe Abdominal pain. <p>Refer to rule 1 above.</p>	<ul style="list-style-type: none"> The patient is allergic to <u>penicillin</u>. The patient suffered from severe <u>abdominal</u> pain.
<ul style="list-style-type: none"> Mr. duane thomson presented at my clinic today with the complaint of a broken posterior tooth. The director of nursing emergency department Mater hospital 84 Monash road The patient was seen by doctor Jones. <p>The above words are all proper nouns. Refer to rule 2 above.</p>	<ul style="list-style-type: none"> Mr. <u>Duane Thomson</u> presented at my clinic today with the complaint of a broken posterior tooth. <u>The Director of Nursing</u> <u>Emergency Department</u> <u>Mater Hospital</u> <u>84 Monash Road</u> The patient was seen by <u>Doctor Jones</u>.
<ul style="list-style-type: none"> As per the General Practitioner's order, we are doing daily home visits and wound dressing and also assisting him with his showers. Please see your Pharmacist for advice. Ms. Gatsby is a University student. <p>The above words are all common nouns. Refer to rule 3 above.</p>	<ul style="list-style-type: none"> As per the <u>general practitioner's</u> order, we are doing daily home visits and wound dressing and also assisting him with his showers. Please see your <u>pharmacist</u> for advice. Ms. Gatsby is a <u>university</u> student.
<ul style="list-style-type: none"> The patient first visited my surgery in march, 2008. Mrs. Green will be discharged from hospital on wednesday. Symptoms of hay fever are worse in Spring. <p>Refer to rule 4 above.</p>	<ul style="list-style-type: none"> The patient first visited my surgery in <u>March</u>, 2008. Mrs. Green will be discharged from hospital on <u>Wednesday</u>. Symptoms of hay fever are worse in <u>spring</u>.
<ul style="list-style-type: none"> The patient requested that i prescribe antibiotics for the virus. <p>Refer to rule 5 above.</p>	<ul style="list-style-type: none"> The patient requested that<u>I</u> prescribe antibiotics for the virus.

- dear Dr. Roberts:
- yours sincerely,

Refer to rule 6 above.

- Dear Dr. Roberts:
- Yours sincerely,

Common Mistakes Regarding Physical Description

Incorrect	Correct
<p>Advice was given to reduce her weight.</p> <p>After the verb reduce it is not necessary to follow with a pronoun. So <u>you</u> is not required. Simply say:</p> <p>I advised him to reduce weight, or, you need to reduce weight.</p>	<ol style="list-style-type: none"> 1. Advice was given to reduce weight. 2. The patient was advised to reduce weight. 3. A reduction of weight was advised.
<p>In addition, she had lost her weight.</p> <p>After the verb <u>lose</u> it is not correct to follow with a pronoun.</p>	<ol style="list-style-type: none"> 1. In addition, she had lost weight. 2. In addition, she has lost a further 11 kg of weight over the past 2 months. 3. In addition, the patient's weight has significantly reduced from 61 kg to 50 kg over the past 2 months.
<p>He is now obese with a 99kilos weight and a 170cm height.</p> <p>The use of the correct verb & noun form and associated grammar is difficult. Refer opposite for correct usage.</p>	<ol style="list-style-type: none"> 1. He is now obese with a weight of 99 kg and a height of 170cm. (noun form) 2. He weighs 99 kg and is 170cm tall. (verb form) 3. He weighs 99kg and is 170cm in height. (verb form)
<ol style="list-style-type: none"> 1. Today's examination revealed multiple missing teeth, various carious lesions and a periodontal pocket of depth 4-9mm. 2. There are several periodontal pockets with about 4-9 mm in depth. <p>Correct word order is:</p> <p>Depth of 4-9mm</p> <p>Height of 173cm</p>	<ol style="list-style-type: none"> 1. Today's examination revealed multiple missing teeth, various carious lesions and a periodontal pocket depth of 4-9mm. 2. There are several periodontal pockets which are about 4'9 mm in depth <u>or</u> 3. There are several periodontal pockets with a depth of about 4-9 mm. 4. His height is 173cm.

<p>Length of 20 m</p> <p>Weight of 78kg</p> <p>3. His height was 173cm. Weight can change but height can not so don't use past tense.</p>	
<p>1. He was overweight 85 Kg with respect to his height 173 cm.</p> <p>This sentence is a shortened version similar to the case notes. It is important to write in full sentences.</p>	<p>1. He was overweight at 85 kg with respect to his height of 173 cm.</p>

Introductions

There are a variety of ways to write introductions and with practice you can develop a formula that works for you. For the purpose of this document, the opening salutation and subject will be included as part of the introduction.

Salutation: If the name of the person is included in the case notes then it should be used. This can be followed by either a comma or full colon.

- Dear Dr. Wilson,
- Dear Dr. Wilson:

If the name of person is not mentioned then you can begin with Sir/Madam

- Dear Sir/Madam,

Subject: The subject is a place where information such as the name & age of the patient can be included. This can save you words in the body of the letter, but be careful not include too much information here, and definitely no phrases or sentences. Both Re & RE are acceptable.

- Re: Dylan Charles D.O.B. 04/12/2009
- RE: Dylan Charles D.O.B. 04/12/2009

Handy Tip 1

You can save on word length by added some detail after Re, such as the patient name and age. However, take care not to write too much here, and always use note form i.e nouns only (no articles, verbs, adjectives)

Basically, the introductory sentence of the letter can contain the following:

1. Background information such as name, age, occupation, marital status and gender of the patient if relevant and not mentioned in the subject line
2. A brief summary of the chief complaint, purpose of writing or your main concern

It will usually be only 1 or 2 sentences long and detailed information about the patient's history and condition should go in the main body of the letter.

Important Grammar Rules

The important patterns to learn are as follows:

Example 1

Relative Clauses: A relative clause is a useful sentence structure to use in the introduction. It allows the writer to demonstrate the ability to write a complex sentence, which is a basic necessity to get B grade or higher.

1. I am writing to refer this patient. **He** is due to be discharged today. **He has made a full recovery.**

2. I am writing to refer this patient **who** is due to be discharged today **after making** a full recovery.

Example 2

Appositives: This is a noun or a noun phrase that is placed after another noun to explain or identify it, and a comma is required to separate these nouns. It has a very important use in the introductory sentence of referral letters as in the example below.

1. I am writing to refer **Mr. Barry Booth**. He is 68 years old. He is a pensioner. He is a widower. He requires dietary advice after undergoing heart surgery.
2. I am writing to refer **Mr. Barry Booth, a 68-year-old widowed pensioner** who requires dietary advice after undergoing heart surgery.

Example 3

Age: There are specific rules regarding how to refer to a patient's age. The first is that it must be hyphenated when used before a noun such as man/woman, and the second is that an article is required. For more details refer to [Year Vs Years](#) in the Grammar and Vocabulary Clinic.

Incorrect	Correct
<ul style="list-style-type: none">• I am writing to refer this patient, a 63 years old man who lives alone.• I am writing to refer this patient, 63 years old man who lives alone.	<ul style="list-style-type: none">• I am writing to refer this patient, a 63-year-old man who lives alone.• I am writing to refer this patient who is 63 years old and lives alone.

Handy Tip 2

Mastery of the patterns above will ensure that you start your letter on a positive note.

Sample Introductions

Introduction	Analysis
Dear Ms. Attard, Re: Ms. Robyn Harwood DOB: 04/02/1948 I am writing to request daily home visits by the Blue Nurses to provide care and support for this patient, a 61-year-old widow who lives on her own.	<ul style="list-style-type: none">• Does not include patient name as this is clearly stated in the subject line• Uses relative clause and appositive sentence structures which demonstrate ability to use complex sentences• States purpose of writing clearly
Dear Sir/Madam, Re: Mr. Henry O'Keefe I am writing to request aged care assistance for Mr. O'Keefe, an 83-year-old man who is recovering from a malignant melanoma in his left shoulder.	<ul style="list-style-type: none">• Includes shorter for a patient name as full name stated in the subject line• Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences• States both purpose of writing and chief complaint
Dear Sir/Madam, Re: Mr. Bill O' Riley I am writing with regard to Mr. O'Riley, a 53-year-old man who was admitted the hospital on the 2nd of September and diagnosed with obstructive coronary artery disease. He underwent a coronary artery bypass graft on the 4th of September.	<ul style="list-style-type: none">• Includes shorter for a patient name as full name stated in the subject line• Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences• Summarises chief complaint and treatment

<p>Dear Sir/Madam,</p> <p>Re: Mrs. Carol Bradley</p> <p>I am writing to request a respite admission for this patient, a 41-year-old married mother of two who has been receiving personal care from our organisation over the last two months.</p>	<ul style="list-style-type: none"> • Does not include patient name as this is clearly stated in the subject line • Includes relevant biographical detail: age, marital status, mother • Uses relative clause and appositive sentence structures which demonstrate ability to use complex sentences • States purpose of writing clearly and summarises recent history
<p>Dear Parents:</p> <p>Re: Outbreak of headlice</p> <p>I am writing to inform you of a recent outbreak of headlice at Mt Gravatt Primary School. Although headlice spread easily and cause several symptoms of itchiness and discomfort, they are easy to diagnose and treat.</p>	<ul style="list-style-type: none"> • Purpose of writing stated clearly in the subject line • Informs parents of main problem • Summarises symptoms and treatment briefly
<p>Dear Mrs. MacDonald,</p> <p>Re: Nasser Ali DOB: 04/02/62</p> <p>I am writing to refer this patient who was admitted to our Coronary Care Unit ten days ago with the diagnosis of myocardial infarction. A cardiac artery bypass graft was done, followed by post-operative treatment and physiotherapy. Mr. Ali's condition has now stabilized and he is being discharged today.</p>	<ul style="list-style-type: none"> • Does not include patient name or age as this is clearly stated in the subject line • States purpose of writing clearly and summarises recent history • Summarises chief complaint and treatment and current condition • Uses relative clause structure which demonstrate ability to use complex sentences
<p>Dear Dr. Thompson,</p> <p>Re: Ms. Amber Watson DOB: 25/03/1991</p> <p>I am writing to request further testing and contraceptive advice for this patient, an 18-year-old single woman who presented to our clinic for a Pap test on 16th May.</p>	<ul style="list-style-type: none"> • Does not include patient name or age as this is clearly stated in the subject line • States purpose of writing clearly • Uses relative clause and appositive structures which demonstrate ability to use complex sentences

Common Errors

Incorrect	Correct
<p>Dear Ms. Jones,</p> <p>Re: Mr. Adrian Lamp DOB: 10/10/1949</p> <p>I am writing to refer Mr Adrian Lamp to you, an 61-year-old widower. He is due to be discharged today. He has made a full recovery from chest congestion.</p> <p>Explanation: No grammatical errors, but it lacks sophistication in the use of simple sentences. Also, it repeats the patient name in full which is not necessary and repetitive since it was written directly above in the subject line.</p>	<p>Dear Ms. Jones,</p> <p>Re: Mr. Adrian Lamp DOB: 10/10/1949</p> <p>I am writing to refer this patient to you, a 61-year-old widower who is due to be discharged today after making a full recovery from chest congestion.</p>
<p>Dear Sir/Madam,</p> <p>Re: Beryl Saunders</p>	<p>Dear Sir/Madam,</p> <p>Re: Beryl Saunders</p>

<p>Thank you for admitting Mrs. Saunders, an 80-year-old dementia patient, requires respite care for a period of two months.</p> <p>Explanation: Relative pronoun required.</p>	<p>Thank you for admitting Mrs. Saunders, an 80-year-old dementia patient <u>who</u> requires respite care for a period of two months.</p>
<p>Dear Mrs. Smith,</p> <p>I am writing in regards of Annette MacNamara , single, age pensioner, requesting your assistance when she discharged from this hospital today.</p> <p>Explanation: Several errors in terms of sentence structure and grammar.</p>	<p>Dear Mrs. Smith,</p> <p>I am writing in regards of Annette MacNamara , a single age pensioner who will require your assistance when she discharges from hospital today.</p> <p>or</p> <p>I am writing to request assistance for Annette MacNamara , a single age pensioner who is due to be discharged from this hospital today.</p>
<p>Dear Doctor,</p> <p>Re: Mrs Diana Atherton</p> <p>I am writing to refer Mrs Atherton, an 77 year old woman who is a resident at the Sandy Beach Retirement Village, who needs urgent admission to your hospital due to chest pain.</p> <p>Explanation: Incorrect sentence structure with two relative clauses.</p>	<p>Dear Sir/Madam,</p> <p>Re: Mrs Diana Atherton</p> <p>I am writing to refer Mrs Atherton, a 77-year-old woman who is a resident at the Sandy Beach Retirement Village. She needs urgent admission to your hospital due to chest pain.</p> <p>or</p> <p>I am writing to refer Mrs Atherton, a 77-year-old female resident at the Sandy Beach Retirement Village who needs urgent admission to your hospital due to chest pain.</p>
<p>Dear Sir/Madam,</p> <p>Re: Aiden Cooper</p> <p>I am writing to refer Cooper a 12-year-old boy, who is a year 6 student at Wellers Hill State School.</p> <p>Explanation: Two errors 1. Use first name when referring to a child. Click here for more details. 2. Incorrect comma placement</p>	<p>Dear Sir/Madam,</p> <p>Re: Aiden Cooper</p> <p>I am writing to refer Aiden, a 12-year-old boy who is a year 6 student at Wellers Hill State School.</p>

Study Strategy

When writing introductions, find a style which you like and use it for all tasks. However, take care to understand the basic grammar rules and always remember to include the chief complaint, purpose of writing or your main concern. Practice writing introductions using the sample case notes provided in your course.

Most referral letters will contain 2 or 3 body paragraphs located between the introduction and the conclusion. Each of the paragraphs should have a main idea which the writer needs to convey to the reader. All the sentences with the paragraphs must relate to this main idea. The length of the paragraphs will vary, but an approximate guideline to meet the required word length of 180~200 words in OET is as follows:

- Introduction: 25 words
- Body paragraph 1: 40 words
- Body Paragraph 2: 40 words
- Body Paragraph 3: 70 words
- Conclusion: 25 words

Paragraph Structure

A good paragraph will contain 3 main elements

1. A Topic Sentence which introduces the reader to the main idea of the paragraph. In many cases it will identify and/or summarise an area of concern regarding the patient. Quite often it is written in original words rather than from words in the case notes.

- Supporting sentences which may contain the detail regarding patient history, descriptions of symptoms, significant aspects from the treatment record, causes and effects, trends and so on. Quite often this information can be taken directly from the case notes, and written as full sentences. However, you will need to paraphrase the information into your own words. This includes:
 - Changing verbs to nouns: complain=complaint
 - Changing adjectives to nouns: lethargic=lethargy
 - Using synonyms
 - For more details on how to paraphrase, follow this link: [Paraphrase](#)
- Signal words** link sentences together so that the information flows smoothly and is easy to read.

Common signal words which can help you present information clearly and logically include:

- Time: *At that time, On review today, On consultation today, Recently, Over the past 3 weeks..., Two weeks later, On her next visit, During, Since that time, Initial examination..., On 19/08/10...*
- Location: *During hospitalisation, Initial examination at my clinic revealed..., On examination....*
- More information: *In addition, Moreover, Also, Apart from this..*
- Contrast: *However, Despite, Although*
- Result: *Therefore, Consequently, As a result, For this reason...*
- Emphasis: *Please note, May I remind you, My main concern is..., What concerns me most is.....*
- Sympathy: *Unfortunately, Regrettably, Fortunately,*
- Subject: *In terms of her social history..., With regard to her medication..., Based on the blood test results....., Regarding her medical history....., Her dental history shows..., The risk factors include....., Treatment to date includes...*
- Advice: *It is important to..., I recommend that you....., Please ensure that....*
- Chronology: *Firstly, Secondly, Finally*

Example 1

Case Notes	Paragraphs	Analysis
Diagnosis Right partial rotator cuff tear Presented to Mater hospital with pain and weakness in the right shoulder, especially when lifting arm overhead. Descending stairs at home and slipped, falling onto outstretched arm. Xray and MRI showed a partial rotator cuff tear. Orthopaedic surgeon discussed surgery. Patient prefers to try non-surgical treatment. Date of admission: 30-10-2008 Date of discharge: 01-11-2008	<i>Ms. Harwood was admitted to our hospital on the 30th of October with a diagnosis of right rotator cuff tear following a fall while descending stairs. Therefore, surgery has been suggested, however, she prefers non-surgical treatment. She has received ibuprofen and cortisone as prescribed and also daily visits by a physiotherapist.</i>	<ul style="list-style-type: none"> Topic sentence is introduced with the phrase: <i>Ms. Harwood was admitted to our hospital on....</i> Supporting sentences transform case notes into complete sentences Signal words express cause and effect and express contrast <ul style="list-style-type: none"> Therefore, However
Treatment Ibuprofen orally QID Cortisone injections Daily physiotherapy		
Medical History Diabetes Mellitus Type 2 Metformin 500mg mane	<i>In terms of her medical history, she suffers from type 2 diabetes mellitus for which she is taking metformine 500mg. However, following her discharge, she will need a regular monitoring on the blood glucose level which may become elevated due to administration of cortisone during hospitalisation. She will also require assistance in showering and home help. As well as this, she</i>	<ul style="list-style-type: none"> Topic sentence is introduced with the phrase: <i>In terms of medical history,</i> Supporting sentences transform case notes into complete sentences Signal words connect ideas and express contrast <ul style="list-style-type: none"> However, due to
Nursing Care Needs Needs blood glucose level monitoring 4 hourly May be elevated because of cortisone Needs assistance with shower and		

housework Orthopaedic review on 19th November	<i>needs to review her condition with an orthopaedic surgeon on the 19th of November.</i>	<ul style="list-style-type: none"> ○ also ○ As well as this,
Social Background Marital status: Widow. No children. Lives alone Next of kin: Megan Mack (Niece) Niece lives with husband in Sydney who works as software engineer for Google Australia. Sister died recently. No other relatives.	<i>Ms. Harwood lives alone and has no children. Her next of kin is her niece, Megan Mack who lives in Sydney. <u>Regrettably</u>, she has no relatives or friends to support her.</i>	<ul style="list-style-type: none"> • There is no topic sentence, but the main idea of social history is clear • Supporting sentences expand the case notes into complete sentences, note the use of verbs, articles and conjunctions (and) • Signal word shows empathy <ul style="list-style-type: none"> ○ Regrettably,

Example 2

Case Notes	Paragraphs	Analysis
<p>Birth History Normal vaginal birth at term Birth weight: 3400gm Apgar score at 5min: 9 No antenatal or postnatal complications</p> <p>Feeding Breast fed for first three weeks after birth.</p> <p>Baby became unsettled during heatwave at Christmas. Mother got sick and had a fever for a few days. Mother-in-law came to visit and advised changing baby to formula feeds. Mother-in-law advised extra powder in formula feeds to improve weight gain. Mother-in-law says her son (Ray Charles) also had feeding problems and difficulty gaining weight as a baby.</p> <p>Mother says she is worried she does not have enough breast milk and now gives extra formula feeds as well as breast feeding. She wishes she could breast feed properly as she believes it would be the best thing for her son. He hasn't taken to the bottle.</p>	<p><i>The patient was born via vaginal birth at term with a birth weight of 3400 grams. During a heatwave at Christmas, the baby became unsettled, due to lack of fluids. When the mother became sick for a few days, her mother-in-law visited to help out but has advised her to change to formula feeds and to put more powder in the bottle to improve weight gain. However, the mother believes that breast milk is the best for her baby and would like to breast feed full-time but is worried that she doesn't have enough breast milk for the baby. Therefore, she has been giving extra formula feeds to the baby.</i></p>	<ul style="list-style-type: none"> • The topic sentence begins with the baby's birth. • Supporting sentences transform case notes into complete sentences • Displays understanding of the long case notes by summarising the main idea. Explains conflicting views of mother and mother-in-law. • Signal words express a time line, contrast and cause and effect. <ul style="list-style-type: none"> ○ During a heatwave ○ When... ○ However,.... ○ Therefore,....
15/01/10 Subjective Mother and baby attended for routine 6 week check-up. Mother says she is concerned about constipation: once every three days, hard stool. Mother is asking about stool softener or prune juice for baby.	<i>At the 6 week check-up, the baby's weight is 4200 grams and his vital signs are in normal limits. However, the baby is suffering from mild constipation, dehydration and lethargy.</i>	<ul style="list-style-type: none"> • Topic sentence is introduced with the phrase: <i>At the 6 week check up</i>, • Focuses on objective information and final assessment. Omits less relevant detail.

<p>Objective</p> <p>Reflexes normal Lethargic No abdominal tenderness Heart Rate: 174 Respirations: 56 Temperature: 37.1 Weight: 4200gms 3 wet nappies in last 24 hours. Urine dark.</p> <p>Assessment</p> <p>Mild constipation and dehydration</p>		<ul style="list-style-type: none"> Summarises objective details concisely into "vital signs in normal limits" Paraphrases adjectives into nouns i.e lethargic=lethargy
<p>Plan</p> <p>Increase breast feeds. Refer to breast feeding support service. Check formula is correctly prepared. If continuing formula feeds, advise to supplement with water (boiled and cooled). Advise on keeping baby cool in hot weather. Return for review in 48 hours.</p>	<p><i>Could you please support and advise the mother regarding breastfeeding and correct preparation of formula feeds if required. In addition, advice on how to keep the baby cool in hot weather is necessary. Please note, the patient is due for review on 17/01/2010.</i></p>	<ul style="list-style-type: none"> Topic sentence is a request of support Supporting sentences expand case notes into formal sentences Signal words add cohesion <ul style="list-style-type: none"> In addition, Please note,

Conclusions

The conclusion or final paragraph in the letter should be fairly standard in structure. It should be based on the task question which is found at the end of case notes. It may contain one or two of the following points:

- a polite request of action required
- a thank you for ongoing support
- an offer of future assistance if required (this can be useful if you choose to omit some details from the case notes)

It is useful to be familiar with some standard patterns so that you are able to conclude your letter confidently, quickly and most importantly, accurately. However, some degree of originality will impress the assessors. Therefore, where possible try to ensure that your conclusion is related to your task and not simply a memorised ending.

Important Grammar Rules

Modal Verbs : Some modal verbs & the verb *hope* are used to convey politeness and commonly used for polite requests in the conclusion of formal letters. Compare the patterns below.

Informal	Polite	More polite
<ul style="list-style-type: none"> Can you examine and treat the patient as you feel appropriate I will be pleased if you can examine, diagnose and treat the patient as you feel appropriate. Can you arrange someone to help this family and provide proper medical support. 	<ul style="list-style-type: none"> Please examine and treat the patient as you feel appropriate. Please examine, diagnose and treat the patient as you feel appropriate. Please arrange someone to help this family and provide proper medical support. 	<ul style="list-style-type: none"> <u>Could</u> you please examine and treat the patient as you feel appropriate I <u>would</u> be grateful if you <u>could</u> examine, diagnose and treat the patient as you feel appropriate. (active) I <u>would</u> appreciate it if you <u>could</u> examine, diagnose and treat the patient as you feel appropriate. (active)

<p>Explanation: These sentences are fine in spoken English, but not suitable for formal writing. <i>Can</i> and <i>will</i> are considered less polite than <i>could</i> and <i>would</i>.</p>	<p>Explanation: These sentences are acceptable in written English, but can sound quite direct.</p>	<ul style="list-style-type: none"> • It <u>would</u> be greatly appreciated if you <u>could</u> examine, diagnose and treat the patient as you feel appropriate. (passive and most polite) • I <u>hope you can</u> arrange someone to help this family and provide proper medical support. <p>Explanation: These sentences are the most suitable for concluding requests in formal letters.</p>
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Conditional Sentences: These sentences are also frequently used in the conclusion of a referral letter and the rules are as follows:

Use a comma when the <i>if clause</i> is at the beginning of the sentence.	Don't use a comma when the <i>if clause</i> is at the end of the sentence.
<ul style="list-style-type: none"> • If you could take over her on going care, it would be greatly appreciated. • If you have any further questions regarding this patient, please don't hesitate to call me. 	<ul style="list-style-type: none"> • It would be greatly appreciated if you could take over her ongoing care. • Please don't hesitate to call me if you have any further questions regarding this patient.
<ul style="list-style-type: none"> • If <u>you require</u> any more information, please don't hesitate to contact me.(active) • If any more information <u>is required</u>, please don't hesitate to contact me.(passive) 	<ul style="list-style-type: none"> • Please don't hesitate to contact me if <u>you require</u> any more information.(active) • Please don't hesitate to contact me if any more information <u>is required</u>.(passive)
<ul style="list-style-type: none"> • Should you have any further queries, please don't hesitate to contact me. <p>Note: Sometimes <i>if</i> is omitted from a conditional sentence. In full the sentence means: If you should have any further questions regarding this patient, please don't hesitate to call me.</p>	<ul style="list-style-type: none"> • Please don't hesitate to contact me should you have any further queries.

Closer and signature

Leave a space between the last line of the conclusion and the closer. The closer should be followed by a comma. Then write your signature below the closer, and if you have time, print your name below your signature.

Sample Conclusions

Case Notes	Conclusion	Analysis
<p>Writing Task Mr O'Riley has requested advice on low fat dietary guidelines and healthy simple recipes. Write a letter to the Community Information Section of the Heart Foundation, Gregory Terrace, Brisbane on the patient's behalf. Use the relevant case notes to explain Mr O'Riley's situation and the information he needs. Include Medical History, Body Mass Index and lifestyle. Information should be sent to his home address.</p>	<p><i>In order to maintain a good health condition, Mr. O'Riley has requested advice on low fat dietary guidelines and healthy simple recipes. It <u>would</u> be greatly appreciated if you <u>could</u> send the above mentioned information to Mr. O'Riley at his home address, 9476 Old Dam Road, Goondiwindi, QLD, 4390.</i></p> <p><i>Yours sincerely,</i></p> <p><i>Lee Wong Charge Nurse</i></p>	<ul style="list-style-type: none"> • Uses information from the writing task to formulate conclusion • Contains a polite request • Maintains polite tone through the use of modal verbs would and could • Contains information specific to the task

<p>Writing Task Using the information in the case notes, write a letter to The Director, Community Child Health Service, 15 Pauline Street, Kuraby, requesting follow-up of this family.</p>	<p><i>I hope you will be able to arrange someone who can help this family and provide proper medical support. Please do not hesitate to contact me if you require any further information about this family.</i></p> <p><i>Yours sincerely,</i> <i>Nurse</i></p>	<ul style="list-style-type: none"> • Uses information from the writing task to formulate conclusion • Contains a request using the polite expression: <i>I hope you will be able to..</i> • Contains information specific to the task • Offers future assistance
<p>Writing Task Write a letter for the admitting doctor of the Medivale Hospital Emergency Department. Give the recent history of events and also the patient's past medical history and condition.</p>	<p><i>I would appreciate your assessment and emergency management of this patient's condition.</i></p> <p><i>Yours sincerely,</i> <i>Night Nurse Sandy Beach Retirement Village</i></p>	<ul style="list-style-type: none"> • Uses information from the writing task to formulate conclusion • Maintains polite tone through the use of modal verb would • Maintains level of urgency appropriate to the situation
<p>Writing Task Write a referral letter to the Dr Jane Thompson, Medical Practitioner at the North Fitzroy General Practice, requesting assessment of your patient' condition. Give the recent history of events and also the patient's past medical history and condition.</p>	<p><i>It would be greatly appreciated if you could assess the patient's condition and treat as you feel appropriate.</i></p> <p><i>Yours sincerely,</i> <i>Charge Nurse</i></p>	<ul style="list-style-type: none"> • Contains a very polite request using conditional "if" plus passive form • Polite tone through the use of modal verbs would & could • Note, sometimes a brief conclusion is all that is required,... or all that you will have time for! Although it is a memorised phrase, it is grammatically correct, concise and direct.
<p>Discharge Plan Organise social worker and Meals on Wheels. (niece will visit at weekend to help with housework and shopping) Stitches to be removed and situation to be reviewed at Out Patient Department appointment - 10.30 am 31-05-09</p> <p>Writing Task Using the information in the case notes, write a letter to the Director, Blue Nursing Service, 207 Sydney Street, West End.</p>	<p><i>It would be greatly appreciated if you could do daily home visits and provide support and reassurance for Mrs. Butler. In addition, please organize Meals on Wheels and a social worker for home help. Please note, the patient has an appointment at the Out Patient Department at 10.30 am 31-05-09 for the removal of stitches . Thank you for your ongoing care.</i></p> <p><i>Yours sincerely,</i> <i>Charge Nurse</i></p>	<ul style="list-style-type: none"> • This is a long conclusion, but incorporates discharge plan into the conclusion which is an effective strategy • Emphasises a future appointment • Maintains polite tone through the use of modal verb would & could • Contains a polite thank you

Common Errors

Incorrect

Correct

<ul style="list-style-type: none"> I would very much appreciated your attention regarding further management of Mr. Henderson. <p>Explanation: Incorrect grammar, see above</p>	<ul style="list-style-type: none"> I would very much appreciate your attention regarding further management of Mr. Henderson.(active) Your attention regarding further management of Mr. Henderson would be very much appreciated.(passive)
<ul style="list-style-type: none"> If you have any query, please do not hesitate to contact me. <p>Explanation: Use plural form of query</p>	<ul style="list-style-type: none"> If you have any queries, please do not hesitate to contact me.
<ul style="list-style-type: none"> I will appreciate your further assessment and management <p>Explanation: Polite form "would" required</p>	<ul style="list-style-type: none"> I would appreciate your further assessment and management.
<ul style="list-style-type: none"> Kindly investigate this child and do the needful. If you need any more information regarding her situation, please try to contact me without any hesitation. <p>Explanation: Several errors here. Basically it is important that the standard patterns and style conventions are followed in conclusions.</p>	<ul style="list-style-type: none"> I would appreciate it if you could investigate this child's condition and do the necessary management. If you require anymore information, please do not hesitate to contact me.
<ul style="list-style-type: none"> Thanks to review and arrange a home visit for this patient, if you have any further questions, please be free to ask me. <p>Explanation: As above, several errors here. The style is casual and therefore an inappropriate way to conclude a letter</p>	<ul style="list-style-type: none"> I would appreciate it if you could review and arrange a home visit for this patient. If you have any further questions, please do not hesitate to contact me. It would be appreciated if you could review and arrange a home visit for this patient. Please do not hesitate to contact me if you have any further questions.
<p>I would be appreciated if you could take over the care of this patient.</p> <p>Explanation: Incorrect grammar</p>	<ul style="list-style-type: none"> <u>It would be appreciated</u> if you could take over the care of this patient. (passive verb) I would be <u>appreciative</u> if you could take over the care of this patient.(be + adjective) I would appreciate it if you could take over the care of this patient. (active verb)



Handy Tip

As with introductions, when writing conclusions, find a style and pattern which you are confident with and use it. However, take care to understand the basic grammar rules and always remember to respond to the task question. Practice writing conclusions using the sample case notes provided in your course.

205 words before correction, after correction 206 words.

Dr. XXXXXX	
General Practice	
40 high Street	
Penrith	
VIC 1234	
19 January 2007	
Dr. Isaacson	
45 Inkerman Street	
Canfield 3162	
VIC 4567	
Dear Dr. Isaacson,	
Re: Mr. Jing Zu, 72, married, retired school teacher	
Thank you for seeing Mr. Zu who is suffering from deteriorating coronary heart disease.	
Mr. Zu's medical history includes hypertension for 18 years and ischemic heart disease for 10 years. He had an acute myocardial infarction in 1999 and has had chronic cardiac failure (CCF) for five years. His current medications are as follows: Lasix 80 mg and Enalapril 10 mg daily, slow-released potassium twice daily, nifedipine 10 mg three times a day and Anginine when necessary.	Medical history
The patient initially presented on 3 January 2007 with exertion-induced angina, which improved with rest and Anginine. In addition, he had the typical manifestations of chronic heart failure and postural BP drop. Thus, he was observed for stable CCF and angina.	Recent medical history of disease being referred for. (in this case over a number of visits – starting with first of this series)
Mr. Zu also experienced an episode of exacerbation of his CCF on 15 th of January and consequently was treated with increased dose of the Lasix at 80 mg daily.	The next phase – could go with previous?
On review today, although his dyspnea has responded to Lasix, the patient reported a 10-minute- attack of angina (OR a 10-minute angina attack) yesterday. The ECG revealed suspicious anterolateral ischemic changes.	On day of referral.
Given Mr. Zu's history of acute myocardial infarction and the atypical ischemic changes of his ECG, I would appreciate your further assessment and management regarding his angina. Please do not hesitate to contact me if you require further information.	Request for help + offer of further information.
Yours sincerely	
XXXXXX	

(words 205)

Writing

180 - 200 words

45 minutes

→ Only a referral letter

25% for formatting

Letter format

Dr Sara Adams
Psychiatrist
177 Main Road
Newtown

- ① The doctor's name
- ② Speciality
- ③ Address.

"No Commas nor full stops"

→
17/01/2016

"leave alone"

→ ④ Date

Dear Dr Adams,
Re: Adam Sandler

D.O.B. 07/03/1986

→ In case you do not have the doctor's name

Admitting officer
123 Second Avenue
Newtown

→
17/01/2016

Dear Sir/Madam,
Re: Adam Sandler

• 30 years of age

Yours sincerely

in case there's no pen

All these are not counted

All

• The ideal letter must have 5 parts"

- ① [Introductory Paragraph]"
 - Mainly ② sentences.
 - " 25 ~ 30 words "
- ② [Body①]
 - ↓ 45 ~ 50
 - Social and Medical history
 - Mainly Present tense"
- ③ [Body②]
 - ↓ 45 ~ 50
 - "in-between Visits"
 - Mainly Past tense"
- ④ [Body③]
 - ↓ 45 ~ 50
 - Final visit = Today's Visits.
 - "present or past"
- ⑤ Conclusion Paragraph.
 - ↓ 25 ~ 30 words
 - "Mainly ③ sentences"

Notice

- ① A paragraph must have more than one sentence.
- ② Capital letters after full stops, not Commas.
- ③ Introduction and Conclusion must not have any details.

②

"The Introduction"

① I am writing "this letter" to refer you Ms Adams, a 30-year-old Sales person, who is presenting with signs and symptoms suggestive or patient of gout.

① Thank you for seeing Ms. Adams, a 30-year-old,

② Her Condition is getting progressively worse.

- Her Condition is getting much better.

- Her Condition needs your further management.

- Your further management is highly-appreciated.

- I would be glad if you could manage her Condition as you think appropriate.

"The Conclusion"

My provisional diagnosis is gout. Therefore, I am referring this patient for further management of her condition. For further queries, please do not hesitate to contact me.

Yours sincerely,

Doctor

| Example for Body ① |

Ms. Adams is married with three children. However she does not smoke, she is a heavy drinker. Regarding her medical history, she is -

Example for Body ②

On 07/03/2013, the patient initially presented complaining of ___. Consequently, blood tests were ordered which unfortunately revealed ___. A month later, she attended the clinic for ___. Later on, ___.

Example for Body ③

Today, the patient "Ms Adam" came reporting that ___.

Thus, ___ -

* Please watch Out:
→ Avoid too long sentences.
→ Avoid mixing tenses "past with present" in one paragraph.

- have a line between each paragraph and the other.
- Use Passive:

Ex. Blood tests were ordered.

She was instructed to start Commence.

④

- Use formal Vocab. (Ex. tell → inform | start → commence)

Use Conjunctions and Adverbs

well

Avoid and, but, so, because.

and = Moreover, In addition, Furthermore, Apart from this, Besides,

But = However, Nevertheless, Although, Despite

So = Therefore, Thus, Consequently, As a result, That's why,

because = The reason why — is ↗ Due to, Because of.

(Also) → Never start with / Use it before main verbs.

(Ex.) I also prescribed —

Adverbs

- Fortunately, luckily,

- Unfortunately, Unluckily, Regrettably, —

- Surprisingly, Unexpectedly, —

Important Expressions

- Please note, — / It is important to —. Please ensure that

- Firstly / Secondly / Finally

- Use relative clauses (Who, which, when, —

Please record your answer on this page.

(Only answers on Page 3 and Page 4 will be marked.)

diagnosis of unstable angina. Should you have any further information please do not hesitate to contact me, and I would be grateful if you would do the needed as soon as possible.

Yours sincerely

Dr Alaa

Please record your answer on this page.

(Only answers on Page 3 and Page 4 will be marked.)

Resting ECG was performed as well and it appeared to be normal. The patient was anxious together with believing to have a heart attack. Consequently, hospital admission for assessing the condition was advised; furthermore, the patient was counselled for the risk of myocardial infarction.

My provisional diagnosis is unstable Angina. Therefore, I am referring this patient for further management. For more queries, please contact me.

Yours Sincerely,
Doctor.

Please record your answer on this page.
(Only answers on Page 3 and Page 4 will be marked.)

Dr John McLennan

Psychiatrist

Royal Mental Health Clinic
177, Park Avenue
Newtown

21/08/2016

Dear Dr McLennan

Re: Ms Dolores Hoffman

D.O.B 22/06/1986

I am writing to refer Ms Hoffman, a 30-year-old sales assistant, who is presenting with signs and symptoms suggestive of depression and anxiety.

Ms Hoffman is single and has no family in Australia, living with her boyfriend. Please note that the patient is allergic to penicillin.

On 11/12/2013, the patient initially presented of short loss of consciousness after drinking alcohol. On clinical examination, she was slightly pale with normal vital signs. Blood test were ordered and fortunately were normal. Therefore, she was given one day off work. Nine months later, Ms Hoffman came reporting symptoms of upper respiratory tract infection. Luckily, her blood tests showed no abnormalities. I gave her erythromycin and two days rest.

One year later, Ms Hoffman came complaining of nightmares, insomnia, loss of appetite and low libido. Her symptoms were severe to

and to be reviewed later. Two days later, Ms. McConville reported increasing fever and chest symptoms; consequently, amoxicillin and prednisolone were commenced.

On today's visit, Ms. McConville experienced more shortness of breath at rest and feeling feverish despite the medications. Examination showed using her accessory muscles along with widespread wheezes and bilateral basal crepitations. These findings increased the possibility of having an acute asthma exacerbation or pneumonia. Accordingly, Ventolin nebuliser and a review were advised. Unfortunately, the review (follow-up) showed no improvement after fifteen minutes.

My provisional diagnosis is acute asthma or pneumonia. Therefore, I am referring Ms. McConville for further assessment, investigations and management. If you have any further queries, please do not hesitate to contact me.

Yours sincerely,
Doctor,

Please record your answer on this page.
(Only answers on Page 3 and Page 4 will be marked.)

Dr David Smith

Cardiologist

Emergency Department

Main Hospital

Coast city

35 minutes
207 words

09/06/2016

Dear Dr. Smith,
Re.: Mrs. Lucy Clarke

D.O.B.: 11/03/1951

I am writing to refer Mrs. Clarke, a 64-year-old retired office clerk, who is presenting with symptoms and signs suggestive of unstable angina. Your further assessment is highly appreciated.

Mrs. Clarke is married, living with her husband. She does not smoke; however, she is a social drinker. Regarding her medical history, she had diabetes mellitus type II which is currently stable on insulin. She also has hypertension since 2005 in addition to hyperlipidemia. As for her current medications, she is on Januvia, Lipitor and Avapro.

Today, she came complaining of a central crushing chest pain on exertion of one week duration. This described pain radiated down to her left arm and was relieved by rest. She reported having associated dyspnoea; nevertheless, she had no palpitations, no orthopnoea or paroxysmal nocturnal dyspnoea. Her examination revealed regular heart rate and no peripheral oedema.

Admitting Officer
Emergency Department
Newtown Hospital

13/09/2014

Dear Sir,

RE: Ms. Sally McConville, 38 years of age

I am writing you this letter to refer Ms. McConville, a 38-year-old administrator, who had symptoms suggestive of acute asthma or pneumonia. Your further assessment is highly appreciated.

Ms. McConville is single. Although the patient is non-smoker, she is asthmatic and hypertensive. Thus, she is on ramipril, fluticasone and ventolin. Unluckily, the patient is on paroxetine for (her) depression.

On 10/09/2014, Ms. McConville presented with symptoms of chest infection; however, asthma was well-controlled. The patient was suspected to have (an) infective asthma exacerbation or viral upper respiratory tract infection. Accordingly, she was encouraged to continue ventolin

Xolamol™

TYMER

Please record your answer on this page.
(Only answers on Page 3 and Page 4 will be marked.)

Today, Mr Foster came reporting that he had shortness of breath when playing sport; furthermore, he got wheeze and cough which waking him at night. I increased the dose of inhaler hopefully to control his worsening symptoms.

My provisional diagnosis is asthma. Therefore I am referring this patient for further management of his condition. For further queries please do not hesitate to contact me.

Yours sincerely
Doctor

Later, I decreased the dose of Warfarin to 4mg due to high INR.

Today, Mr Johnson discharged home with nursing assistance; Moreover she was put on Warfarin 4mg ofenlab 150mg, paracetamol 1g and oxy codone 5-10mg. Please note the patient had appointment with rehab after two weeks. Repeating FBE and INR is highly recommended after one week.

In view of the above, your further follow up is appreciated. For further queries, please feel free to contact me.

Yours Sincerely,
Doctor

Cardiologist
Emergency Department
Main Hospital
Coast City

September 20, 2015

Dear Dr Smita,
RE Mrs Lucy Clarke

DOB: March 11, 1951.

I am referring Mrs Clarke, a 74-year-old lady, that has been diagnosed as a case of unstable angina for admission and urgent evaluation.

Mrs Clarke is a retired office clerk, who live at home with her husband. She is known with long standing Diabetes that is controlled with insulin and sitagliptin. In addition, she is hypertensive and hyperlipidemic on medications since about 10 years. It is worthy to mention that she has a strong family history of cardiovascular disease; her mother had had an acute myocardial infarction at the age of 57 and died of Ischemic stroke at 59 years old.

My patient presented today with one week history of cramping chest pain that is aggravated by exertion and radiating down to left arm. She is worried about having heart attack despite of absence of palpitation, orthopnea, paroxysmal or nocturnal dyspnea. On examination, she is mildly overweight with stable vitals. Her ECG showed no abnormality.

Please be kind enough to see my patient, admit her to your unit and investigate her further to confirm or exclude your provisional

Please record your answer on this page.

(Only answers on Page 3 and Page 4 will be marked.)

make her broke up with her boyfriend. My impression was that the patient had reactive depression; consequently, I commenced her on temazepam and advised her to see a psychiatrist.

My provisional diagnosis is depression. Therefore I am referring this patient for further management. Please note that Ms Hoffmann was initially refused to see a psychiatrist and was noncompliant to temazepam.

Yours sincerely,
Doctor

Please record your answer on this page.
(Only answers on Page 3 and Page 4 will be marked.)

Dr Tanya Williams
Respiratory specialist
Bayview Private Hospital
81 Canyon Road
Bayview

26/8/2016

Dear Dr Williams,
Re: Mr Zach Foster

D.O.B 25/10/1991

I am writing to refer Mr Foster, a 25-year-old builder, who is presenting with signs and symptoms suggestive of asthma. Your further management is highly appreciated.

Mr Foster is single and he is a heavy smoker. He has been asthmatic since age of three years with a history of two hospital admissions. The patient was commenced on Ventolin and Pulmicort to control his asthma. Please note, Mr Foster is allergic to cats and hayfever.

On 11.10.2014, the patient initially presented complaining of burning sensation in his chest after meals. Thus, CXR and FBE were ordered which fortunately revealed no abnormalities. I commenced him on Pantoprazole in addition, I advised him to quit smoking and to take his medications regularly. One week later, he attended my clinic for reassessment. His chest symptoms improved; however, he still smoking and non-compliant to Pulmicort.

Please record your answer on this page.
(Only answers on Page 3 and Page 4 will be marked.)

Dr Tony Jones
Private Practice
12 New Street
Stillwater

30/08/2016

Dear Dr Jones,

Re: Ms Betty Johnson, a 81 year old op.

I am writing to update you regarding Ms Johnson, a 81-year-old patient, who underwent right total knee replacement. Your further follow up is highly appreciated.

Ms Johnson is a widow with three children and lives alone. She is known to have osteoarthritis since 2011; in addition, she underwent aortic valve replacement along with pacemaker in 2010.

right

On 25/02/2015, the patient underwent total knee replacement. Luckily, she was stable after the surgery and shifted back to the ward and was started on PCA. On second day, warfarin and Clexan were commenced; however, her blood tests revealed low Hb, so I added iron sulphate to her medication. She started to walk on crutches 3 days after surgery. On 02/03/2015, INR was found high; consequently, clexan was ceased. Four days later, all the clips were removed and I referred her to rehab unit.

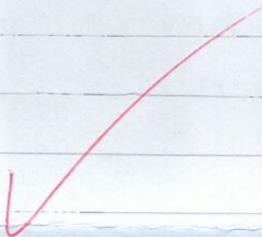
Ms Johnson was admitted to rehab unit on 07/03/2015 where she started to do gentle exercises to enhance her mobility. Seven days

On review today, he reported non-compliance with his medications besides continuing smoking. His investigations were unremarkable. However, symptoms ~~were~~ are still present. Therefore he agreed on referral to a respiratory specialist for further assessment.

My provisional diagnosis is uncontrolled asthma. Therefore, I am referring this patient for further management. For further queries, do not hesitate to contact me.

Yours sincerely,

Doctor



24
39
01
52

Dr Malcolm Still
Rheumatologist
5 Grant Street
Fairmont

DATE

03/05/2014

Dear Dr. Still,
Re: Mr James Seymour

D.O.B. 19/09/1953

I am writing this letter to refer you MR Seymour, a 60 year-old retired patient, who is presenting with signs and symptoms suggestive of gout. Your further management of his condition is much appreciated.

Mr Seymour is divorced and live by himself. However, he stopped smoking twenty years ago, he is a heavy drinker. Please note that his father had been suffered from rheumatoid arthritis for the last thirty five years in his life. There is no relevant medical history apart from recurrent attacks of inflammation in his first toe. Thus, he was commenced on colchicine, Indomethacin in addition to Allopurinol.

On 28/04/2014 Mr Seymour presented at clinic complaining of acute pain and swelling in his first left toe. Nevertheless, he was irritable. Because of his father's medical history and wants to exclude rheumatoid arthritis. Consequently, X-ray foot was arranged in addition to the same treatment and advised to use paracetamol on a regular base. Moreover, he was advised regarding his diet and alcohol intake, as well as use of oxycodone if needed.

One week later, his x-ray revealed degenerative changes of first left metatarsophalangeal joint. It is worth mentioning that his urea 0.48 mmol/L, CRP 6.0 mg/L and MCH 32.3 pg. Luckily, he has no side effect from his treatment apart from brief diarrhoea.

My provisional diagnosis is gout. Therefore, I am referring this patient due to his insistence for further management. For any more queries, please do not hesitate to contact me.

Yours sincerely,
Doctor

Ty

Dr Tanya Williams
Respiratory Specialist
Bayview Private Hospital
81 Canyon Road
Bayview

18/10/2014

Dear Dr. Williams,
Re: Mr Zach Foster

A

DOB: 25/10/1991

I am writing to refer you Mr Foster, a 22-year-builder, whose symptoms and signs are suggestive of bronchial asthma. Your further management of his condition is much appreciated.

Mr Foster is a single smoker who has known allergy to cats, eczema, in addition to Hay fever. He is an asthmatic patient whose medical records reported two previous hospital admissions. Moreover, he is on Ventolin and Pulmicort spray for asthma treatment. Please note that his 18-year-old sister also suffers from asthma.

s2 ✓

The patient initially presented at clinic complaining of respiratory symptoms, that increased with exercise and wake him at night.

Therefore, he was advised to increase the dose of Ventolin according to his symptoms. Last week, he presented with additional burning sensation in ^{his} lower part of the chest aggravated by meals. Therefore, Pantaprazole was added to his medications. He was also advised to quit smoking. CXR and FBE were ordered as well.

A to Z of Phrasal Verbs and Useful Vocabulary

Letter	Expression	Example sentences
a.	<ul style="list-style-type: none"> • admitted to • associated with • advised to • advice on • allergies • allergic to • arrived at • arrived in 	<ul style="list-style-type: none"> • The patient was <u>admitted to</u> the first time. • Mr. Booth first came to see me with shortness of breath which was <u>worse down</u>. It was <u>associated with</u> coughing. • She was <u>advised to</u> return the following day for a follow up consultation. (verb) • For both children <u>advice on</u> recommended medication was <u>necessary</u>. (noun) • She is not on any medication <u>at present</u>. • Please note, the patient is <u>allergic to</u> shellfish. • The patient <u>arrived at</u> my surgery this morning. • The family <u>arrived in</u> Australia yesterday.
b.	<ul style="list-style-type: none"> • believe • borderline 	<ul style="list-style-type: none"> • I <u>believe</u> the patient <u>needs</u> urgent admission. • She <u>was noted to be</u> overweight and had hypertension.
c.	<ul style="list-style-type: none"> • consistent with • commence • commence on • confidence in 	<ul style="list-style-type: none"> • I am writing to refer Mr. Walker's <u>patient</u>, presenting with significant <u>urinary difficulties</u> due to <u>prostatic enlargement</u>. • IV fluids <u>were commenced</u> in the <u>outpatient clinic</u>. • Therefore, I <u>commenced him on</u> a course of antibiotics. I <u>strongly advised</u> him to stop drinking alcohol. (<u>active</u>) • <u>She was commenced on</u> 15gr of diazepam <u>as required</u> for her current anxiety and sleep problems. • She lacks <u>confidence in</u> caring for herself and bathing.
d.	<ul style="list-style-type: none"> • discharge on • deteriorate • deny • difficulty in • diagnosed with 	<ul style="list-style-type: none"> • He will be <u>discharged on</u> the <u>28th of July</u>. • Since <u>28th of July</u>, her condition has <u>deteriorated</u> and she has developed occasional disorientation. • She <u>denied</u> vomiting and she has been taking <u>laxatives</u>.

	<ul style="list-style-type: none"> diagnosis of 	<ul style="list-style-type: none"> Mr. MacIntosh presented to me with difficulty in passing urine. I am writing to refer my patient, a 5-year-old Labrador cross dog who is diagnosed with lymphoma. (verb) Histological results confirmed the diagnosis of lymphoma. (noun)
e.	<ul style="list-style-type: none"> evidence of enclosed 	<ul style="list-style-type: none"> Examination findings revealed a lump in the prostate. I have enclosed the radiograph.
f.	<ul style="list-style-type: none"> to follow 	<ul style="list-style-type: none"> The patient was advised to follow up in one month.
h.	<ul style="list-style-type: none"> history 	<ul style="list-style-type: none"> The patient first attended our clinic in January with a one day history of lower abdominal pain. Mr. Abraham has a positive family history of heart disease.
i.	<ul style="list-style-type: none"> indicate indicative of inconspicuous 	<ul style="list-style-type: none"> The family has indicated that they speak Farsi or Arabic during their consultations. However, there was slight swelling in the right inguinal hernia. His family and social history is non contributory.
k.	<ul style="list-style-type: none"> known 	<ul style="list-style-type: none"> She is a known asthmatic since childhood and uses a Budesonide inhaler for the same.
m.	<ul style="list-style-type: none"> to make an appointment 	<ul style="list-style-type: none"> I have made an appointment with the receptionist.
n.	<ul style="list-style-type: none"> on examination 	<ul style="list-style-type: none"> On examination, her blood pressure was 120/80 mmHg with a regular pulse of 70 beats per minute.
o.	<ul style="list-style-type: none"> occasions 	<ul style="list-style-type: none"> Today, she presents very anxious and agitated. She has noted some blood in her mouth.
p.	<ul style="list-style-type: none"> provisional present at present to 	<ul style="list-style-type: none"> Provisional diagnosis suggests a brain tumor. Mr Gates presented at my clinic with a complaint of lower back pain and numbness in the legs. Today, he presented to me with a lump in the groin.
q.	<ul style="list-style-type: none"> queries 	<ul style="list-style-type: none"> If you have any further queries, please do not hesitate to contact me.
r.	<ul style="list-style-type: none"> reveal risk factors a routine recovery reluctant to rule out remarkable findings 	<ul style="list-style-type: none"> Examination today revealed a lump in the right inguinal lymph node. His risk factors include smoking, hypertension, and a sedentary lifestyle. He has made a routine recovery without any complications.

		<ul style="list-style-type: none"> • He is <u>reluctant to</u> seek treatment • I believe she needs <u>an urgent</u> assessment for bipolar disorder • There were no other remarkable findings.
S.	<ul style="list-style-type: none"> • suggestive of ectopic pregnancy • suspicious of bowel obstruction • suffering from abdominal pain • signs and symptoms of hypoglycaemia 	<ul style="list-style-type: none"> • Miss Jones is suffering from <u>suggestive of</u> ectopic pregnancy • I am writing to refer this patient to you as she has <u>suspicious of</u> bowel obstruction • Ms.Tylor has been <u>suffering from</u> abdominal pain after administering insulin injection • He is a 40-year-old man who has been <u>suffering from</u> abdominal pain and <u>symptoms suggestive of</u> peritonitis and peptic ulcer.
t.	<ul style="list-style-type: none"> • treated with Atenolol 50 mg 	<ul style="list-style-type: none"> • He also has been suffering from hypertension and is currently being treated with Atenolol 50 mg
u.	<ul style="list-style-type: none"> • underlying cause • under control • uneventful • urgent • unremarkable • to undergo treatment/surgery/an operation 	<ul style="list-style-type: none"> • I would appreciate your assessment of whether he has any underlying cause • Currently, her pain is <u>under control</u> and she is tolerating fluids. • Her second pregnancy and delivery was <u>uneventful</u>. • I would appreciate if you could provide details about her Woods' problem. • Cardiovascular examination was normal. The <u>electrocardiogram</u> was normal. • She <u>underwent</u> colonoscopy which was <u>normal</u>. (<i>simple past</i>) • During hospitalization, the patient had <u>normal electromyogram</u> and X-ray. (past tense)
v.	<ul style="list-style-type: none"> • vital signs 	<ul style="list-style-type: none"> • Her <u>vital signs</u> were normal, <u>therefore</u> she was advised to undergo <u>colonoscopy</u>.
w.	<ul style="list-style-type: none"> • with a complaint of lower back pain 	<ul style="list-style-type: none"> • Mr Gates presented at my clinic with <u>a complaint of</u> lower back pain.

Active and Passive Verb Formation

In writing a referral letter it is necessary to use a variety of verb forms including both active and passive verbs. Using active verbs is good when you wish to create a personal tone or impart subjective information. However, passive verbs and sentence structures enable the writer to be more objective and focus attention on what is most important in a sentence such as the patient, procedures and treatment rather than on themselves.

Compare

1. I advised the patient to stop smoking.
2. **The patient was advised** to stop smoking (*focus on the patient*)

1. I advised her to do bed exercises to prevent further complications such as deep vein thrombosis.
2. Bed exercises **were advised** to prevent further complications such as deep vein thrombosis. (*focus on the treatment*)

1. You need to take Flucloxacillin capsules twice a day for a duration of 2 weeks.
2. **Flucloxacillin capsules need to be taken** twice a day for a duration of 2 weeks. (*focus on the medication*)

To form the passive, use the be verb (be, is/ are; was/were; has been/have been) + past participle as described in the table below.

Active	Passive
Present simple <ul style="list-style-type: none">• The patient <u>takes</u> aspirin daily.	Present simple <ul style="list-style-type: none">• Aspirin <u>is taken</u> daily.
Present simple continuous <ul style="list-style-type: none">• The patient <u>is taking</u> aspirin daily.	Present simple continuous <ul style="list-style-type: none">• Aspirin <u>is being taken</u> daily.
Past simple <ul style="list-style-type: none">• The patient <u>took</u> aspirin daily.• The patient <u>took</u> 3 tablets daily.	Past simple <ul style="list-style-type: none">• Aspirin <u>was taken</u> daily.• 3 tablets <u>were taken</u> daily.
Past simple continuous	Past simple continuous

<ul style="list-style-type: none"> The patient <u>was taking</u> aspirin daily. 	<ul style="list-style-type: none"> Aspirin <u>was being taken</u> daily.
Present perfect <ul style="list-style-type: none"> The patient <u>has taken</u> aspirin daily for a period of one year. The patient <u>has taken</u> aspirin, noten and normison for a period of one year. 	Present perfect <ul style="list-style-type: none"> Aspirin <u>has been taken</u> daily for a period of one year. Aspirin, noten and normison <u>have been taken</u> for a period of one year.
Present perfect continuous <ul style="list-style-type: none"> The patient <u>has been taking</u> aspirin daily. 	Present perfect continuous <ul style="list-style-type: none"> Nil: This form is rarely used in the passive.
Past perfect <ul style="list-style-type: none"> The patient <u>had taken</u> aspirin daily for a period of one year. The patient <u>had taken</u> aspirin, noten and normison for a period of one year. 	Past perfect <ul style="list-style-type: none"> Aspirin <u>had been taken</u> daily for a period of one year. Aspirin, noten and normison <u>had been taken</u> for a period of one year.
Past perfect continuous <ul style="list-style-type: none"> The patient <u>had been taking</u> aspirin daily. 	Past perfect continuous <ul style="list-style-type: none"> Nil: This form is rarely used in the passive.
Future <ul style="list-style-type: none"> The patient <u>will take</u> aspirin in the evening 	Future <ul style="list-style-type: none"> Aspirin <u>will be taken</u> in the evening.
Modal form <ul style="list-style-type: none"> The patient <u>should have taken</u> 	Modal form <ul style="list-style-type: none"> Aspirin <u>should have been</u> taken in

aspirin in the evening.

the evening.

Please review the list of common mistakes below.

Incorrect	Correct
<ul style="list-style-type: none"> She was performed a colostomy accompanied with a partial bowel resection. 	<ul style="list-style-type: none"> A colostomy <u>was performed</u> with a partial bowel resection. A colostomy <u>was performed</u> on the patient by the doctor with a partial bowel resection. <p><i>The first example is better as it more concise and also it is obvious the roles of patient and doctor so it is unnecessary to state them.</i></p>
<ul style="list-style-type: none"> As per the doctor's order, we were organized daily home visits. 	<ul style="list-style-type: none"> As per the doctor's order, <u>daily home visits were organized</u>. (passive) As per the doctor's order, <u>we organised</u> daily home visits. (active) <p><i>Both sentences are grammatically correct but the first example is preferred because it focuses attention on the procedure.</i></p>
<ul style="list-style-type: none"> On 9.7.06 he was presented to me for his regular check up. 	<ul style="list-style-type: none"> On 9.7.06, <u>he presented</u> to me for his regular check up. (active) <p><i>Active voice is preferred here as <u>the patient is the subject</u> and most likely presented himself.</i></p>
<ul style="list-style-type: none"> On the subsequent visit the treatment options was discussed. 	<ul style="list-style-type: none"> On the subsequent visit, the treatment options <u>were discussed</u>. <p><i>Because the noun is plural the plural verb "were" is required.</i></p>
<ul style="list-style-type: none"> She had done colonoscopy 3 years ago. 	<ul style="list-style-type: none"> A colonoscopy <u>was done</u> 3 years ago. She <u>had</u> a colonoscopy done 3 years ago. <p><i>In these sentences it is unimportant who performed the</i></p>

	<i>colonoscopy so passive voice is used.</i>
<ul style="list-style-type: none"> Initially, she came to me on 14/01/2006 for a general check up and was found her blood pressure 160/90. 	<ul style="list-style-type: none"> Initially, she came to me on 14/01/2006 for a general check up and her blood pressure <u>was found</u> to be 160/90. <p>After the conjunction and a subject is required.</p>
<ul style="list-style-type: none"> In addition, her baby will need to monitor his growth and general health condition 	<ul style="list-style-type: none"> In addition, the baby's growth and general health condition <u>will need to be monitored</u> <p><i>Future form of the passive.</i></p>
<ul style="list-style-type: none"> Noten 50mg 1/2 tablet daily was prescribed while Zocor and Calcium Caltrate were continued taking. 	<ul style="list-style-type: none"> Noten 50mg 1/2 tablet daily was prescribed while Zocor and Calcium Caltrate <u>were continued to be taken</u>
<ul style="list-style-type: none"> Today at my surgery attended Mr. Attard complaining of pain in his upper left molar. 	<ul style="list-style-type: none"> Today, Mr. Attard attended surgery complaining of pain in his upper left molar. <p><i>Use active form here as you need to focus on your patient, not your surgery</i></p>

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Capitalisation

Correct use of capitals is an important area to master when writing referral letters. Study the rules of usage below to ensure you meet the standard conventions.

Rules of Usage

1. Medications and Diseases

- Capitals are required for proper nouns. Proper nouns include the brand name of a drug or registered trademark of the manufacturer.
 - Ritalin
 - Voltaren
 - Zocor
- The chemical constituent should be written in lower case.
 - penicillin
 - amoxicillin
- Names of diseases should always be lower case.
 - bowel cancer
 - high blood pressure
 - diabetes
 - epilepsy
- Eponyms: Some medical conditions are named after the person who discovered it. In this case the first word should be capitalised.
 - Parkinson's disease
 - Bell's palsy
- Names of medical equipment do not require capitals.
 - orthopantomogram
 - x-ray
- Body parts should always be lower case

- heart
- adrenal gland
- knee

2. Proper Nouns: Proper nouns name something specific as in the examples below. These words must always be capitalised.

- Job titles
 - The Lactation Consultant, Mater Hospital
 - The Veterinary Eye Specialist, University of Queensland
- Institutions
 - Mary Jones was admitted to Spirit Hospital.
 - Dr. Bloomfield works at Weller Point Medical Centre.
- Places including addresses
 - 168 Wickham Terrace, Spring Hill
 - 12 Logan Road, Mt Gravatt
 - 36 Barmore Street, Holland Park
- Titles when they precede the name of a person
 - The patient was seen by Doctor Smith.
 - Nurse Jones is in charge of the patient's care.

3. Common Nouns: Common nouns do not name any specific institution, place, person or profession. These words do not need to be capitalised.

- The patient was admitted to hospital.
- The patient does not have a family doctor.
- Steve is a teacher.
- Yoshiro is a doctor.
- Reza is a dentist.

4. Holidays, months, days of the week all need to be capitalised. However seasons do not.

- The baby was born on Christmas Day.
- The patient was admitted to hospital on January 12.
- Please come and see me on Wednesday.
- The vaccination will be available in spring.

5. The pronoun "I" must always be capitalised.

- It was I who treated the patient.

6. Capitalise the first word of a salutation and the first word of a complimentary close.

- Dear Dr. Jameson:
- Yours sincerely,

Common Errors

Incorrect	Correct
<ul style="list-style-type: none">• His medical history shows that he is Epileptic.• Also, I have given Dycal base on 1.1 and dressed it with Glass Ionomer Cement.• The patient was diagnosed with Type 2 Diabetes.• Mrs. Marsh has a history of Hyperthyroidism, Hypertension and Glaucoma.• The patient is allergic to Penicillin.• The patient suffered from severe Abdominal pain.	<ul style="list-style-type: none">• His medical history shows that he is <u>epileptic</u>.• Also, I have given <u>dycal</u> base on <u>1.1</u> and dressed it with <u>glass ionomer cement</u>.• The patient was diagnosed with <u>type 2 diabetes</u>.• Mrs. Marsh has a history of <u>hyperthyroidism</u>, <u>hypertension</u> and <u>glaucoma</u>.• The patient is allergic to <u>penicillin</u>.• The patient suffered from severe <u>abdominal</u> pain.
Refer to rule 1 above.	<ul style="list-style-type: none">• Mr. duane thomson presented at my

clinic today with the complaint of a broken posterior tooth.

- The director of nursing
- emergency department
- Mater hospital
- 84 Monash road
- The patient was seen by doctor Jones.

The above words are all proper nouns. Refer to rule 2 above.

clinic today with the complaint of a broken posterior tooth.

- The Director of Nursing
- Emergency Department
- Mater Hospital
- 84 Monash Road
- The patient was seen by Doctor Jones.

- As per the General Practitioner's order, we are doing daily home visits and wound dressing and also assisting him with his showers.
- Please see your Pharmacist for advice.
- Ms. Gatsby is a University student.

The above words are all common nouns. Refer to rule 3 above.

- As per the general practitioner's order, we are doing daily home visits and wound dressing and also assisting him with his showers.
- Please see your pharmacist for advice.
- Ms. Gatsby is a university student.

- The patient first visited my surgery in march, 2008.
- Mrs. Green will be discharged from hospital on wednesday.
- Symptoms of hay fever are worse in Spring.

Refer to rule 4 above.

- The patient first visited my surgery in March, 2008.
- Mrs. Green will be discharged from hospital on Wednesday.
- Symptoms of hay fever are worse in spring.

- The patient requested that i prescribe antibiotics for the virus.

Refer to rule 5 above.

- The patient requested that I prescribe antibiotics for the virus.

- dear Dr. Roberts:

- Dear Dr. Roberts:

- yours sincerely,

Refer to rule 6 above.

- Yours sincerely,

Clauses of Contrast

Contrast can be expressed by joining two clauses with the following linking words: although/but/despite/despite the fact that/even though/however/in spite of/on the other hand/whereas/while. A comma is used to separate the two clauses as illustrated below.

- *Although* her condition has improved, she is still very weak.
- Her condition has improved, *but* she is still very weak.
- *Despite* an improvement in her condition, she is still very weak.
- *Despite the fact that* there has been an improvement in her condition, she is still very weak.
- *Even though* her condition has improved, she is still very weak.
- Her condition has improved. *However*, she is still very weak.
- *Inspite of* an improvement in her condition, she is still very weak
- *While* her condition has improved, she is still very weak.

Rules for linking words

- **Although/Even Though + clause (underlined below)**

e.g. *Although* + her condition has improved, she is still very weak.

- **Despite/Inspite of + noun or gerund (underlined below)**

e.g. *Despite* an improvement in her condition, she is still very weak.

Despite overcoming her illness, she is still very weak

- **Despite the fact that/Inspite of the fact that + clause (underlined below)**

e.g. *Despite the fact that* there has been an improvement in her condition, she is still very weak.

Despite the fact that her condition has improved, she is still very weak.

- **However** : A comma is required after however

e.g. Her condition has improved. *However*, she is still very weak

Common Mistakes

Incorrect	Correct
<ul style="list-style-type: none"> Inspite of providing with exercises and compensatory techniques she was unable to cope with training due to an increase in pain. <p>Explanation: providing is incorrect, as it was the patient who was provided exercise, in such cases you have 2 choices</p> <ol style="list-style-type: none"> 1. Use a noun phrase In spite of our provision of exercises 2. Use passive voice In spite of being provided with exercise 	<ul style="list-style-type: none"> Inspite of our provision of exercise she was unable to cope with training due to an increase in pain. Inspite of being provided with techniques, she was unable to cope with an increase in pain.
<ul style="list-style-type: none"> Although she has improved, but she is still very weak <p>Explanation: This sentence has two linking words so one must be omitted.</p>	<ul style="list-style-type: none"> Although she has improved, she is still very weak. She has improved, but she is still very weak.
<ul style="list-style-type: none"> Despite of regular follow up, plaque and tartar were detected over cervical and bucal surfaces of the denture teeth. <p>Explanation: There is no linking expression “despite of”</p>	<ul style="list-style-type: none"> Despite regular follow up, plaque and tartar were detected over cervical and bucal surfaces of the denture teeth. Inspite of regular follow up, plaque and tartar were detected over cervical and bucal surfaces of the denture teeth.
<ul style="list-style-type: none"> Despite of this advice, he regularly drinks 2~4 glasses of wine every night as well as 1~2 glasses of scotch at weekends. <p>Explanation: As above</p>	<ul style="list-style-type: none"> Despite this advice, he regularly drinks 2~4 glasses of wine every night as well as 1~2 glasses of scotch at weekends. Inspite of this advice, he regularly drinks 2~4 glasses of wine every night as well as 1~2 glasses of scotch at weekends.

Clauses of Purpose

Purpose clauses allow the writer to express why a certain action was taken in the past or why a certain action needs to be taken in the future. It can be expressed by joining two clauses with the following linking words: *in order to*; *so that*. A comma is required when the subordinate clause comes before the independent clause.

- *In order to* reduce weight, a low fat diet has been recommended. (quite formal and suitable for referral letters)
- A low fat diet has been recommended *in order to* lose weight.
- A low fat diet has been recommended *so that* the patient can lose weight. (casual expression and used more in informal writing or spoken English)

Rules

- *in order to* + infinitive: Further investigation is required in order to rule out bowel cancer.
- *so that* + past reference: A general anaesthetic **was given** so that the patient **would** not feel pain.
- *so that* + future reference: A general anaesthetic **needs** to be given so that the patient **will** not feel any pain.

😊 Handy Tip: *in order to rule out* + disease name is a useful phrase for introductions or conclusions.

- In order to rule out ectopic pregnancy, I would appreciate your urgent assessment.
- The patient wants to have a scan for nuchal translucency in order to rule out Down's Syndrome.

Incorrect	Correct
<ul style="list-style-type: none">• In order for alleviation of pain, the patient was prescribed paracetamol.	<ul style="list-style-type: none">• In order to alleviate of pain, the patient was prescribed paracetamol.

Explanation: In order must be followed by to + infinitive verb, not for + noun

😊 This page is under construction, more examples coming soon.

Clauses of Reason

In referral letters it is often necessary to state why a certain action was taken and clauses of reason allow the writer to do this in a clear manner. It can be expressed by joining two clauses with the following linking words: due to/due to the fact that; for this reason; because/because of.

Examples

- *Due to* failure to progress and fetal stress, an emergency caesarean section was performed.
- *Due to the fact that there was* failure to progress and fetal stress, an emergency caesarean section was performed. (formal)
- There was evidence of poor progress and fetal stress. *For this reason*, an emergency caesarean section was performed.
- *Because* there was evidence of poor progress and fetal stress, an emergency caesarean section was performed.
- *Because of* failure to progress and fetal stress, an emergency caesarean section was performed.

Rules

- due to/because of + noun (underlined below)

Example: Due to a low fat diet, the patient's health improved.

The patient's health improved due to a low fat diet.

Because of a low fat diet, the patient's health improved.

The patient's health improved because of a low fat diet.

- due to + gerund (----ing form)

Example: Due to losing weight, the patient's health improved.

- for this reason+ clause (underlined below)

Example: The patient was placed on a low fat diet. For this reason, her health improved.

- because + clause

Example: Mrs Healy's health improved because she was on a low fat diet.

Because she was on a low fat diet, Mrs Healy's health improved .

- due to the fact that + clause

Example: The patient's health improved due to the fact that she was on a low fat diet.

Due to the fact that Mrs Healy was on a low fat diet, her health improved.

 **Handy Tip:** due to + ing form allows the writer to express meaning clearly and concisely so it is useful in referral letters.

Comma placement

@@ A comma is required when the subordinate clause comes before the independent clause. However, if the independent clause comes first, no comma is required. Click [here](#) for more details.

Incorrect	Correct
<ul style="list-style-type: none"> The patient is feeling lonely and isolated due to lose her usual social contacts. <p>Explanation: Incorrect word form and sentence structure after due to</p>	<ul style="list-style-type: none"> The patient is feeling lonely and isolated due to <u>losing</u> her social contacts. (clear and concise) The patient is feeling lonely and isolated due to the fact that <u>she lost her social contacts</u>. (formal and a bit wordy)
<ul style="list-style-type: none"> His mother had difficulty in caring for both her son's illness and looking after two other small children due to sick. <p>Explanation: Incorrect word form and sentence structure after due to</p>	<ul style="list-style-type: none"> His mother had difficulty in caring for both her son's illness and looking after two other small children due to <u>her sickness</u>. His mother had difficulty in caring for both her son's illness and looking after two other small children due to <u>being sick</u>.
<ul style="list-style-type: none"> Recently, the Mr Hutton stopped playing sport because muscle soreness. <p>Explanation: Incorrect word form and sentence structure after because of</p>	<ul style="list-style-type: none"> Recently, the Mr Hutton stopped playing sport because of <u>muscle soreness</u>. Recently, the Mr Hutton stopped playing sport because <u>he had muscle soreness</u>.

Clauses of Time

A very important part of referral letters is summarising the patient history and order of events in the case notes. The use of time conjunctions help the writer express these relationships clearly. Commonly used conjunctions include: ago, during, when, while, since, first, on the next visit, at that time, after, later, in time etc. etc.

Example sentences

- The patient first saw me three months *ago* complaining of painful wisdom teeth.
- *During* hospitalisation, the patient had surgery to remove a suspicious lesion on his lip.
- *When* Mr. Matthews is discharged, he will need assistance with showering and general household chores.
- *While* you are on this medication, please do not drive or consume alcohol.
- **Since being** admitted 3 weeks ago, the patient has steadily improved and is due to be discharged today.
- The patient first attended me yesterday evening
- *On the next visit*, Peter's condition had worsened and he was very anxious.
- Mr. Hauritz initially presented at my clinic on 20/11/09. *At that time*, examination revealed carious lesions on several teeth along with poor dental hygiene.
- On review *after* three months, she had made good progress with her weight reduction.
- The patient was advised to reduce alcohol consumption, avoid heavy lifting and review *in three months time*.
- A review consultation was scheduled *for one month later*.

Example paragraph

Six months ago, Mr. Roberts twisted his right ankle while playing golf. During the following months, the patient experienced intermittent attacks of pain which hindered his ability to work effectively. On review after three months, the right ankle joint was x-rayed and the result appeared to be satisfactory. However, when the swelling, pain and impaired improvement persisted, an MRI was ordered which revealed a detached cartilage. Currently, Mr. Roberts does not have full mobility, and is no longer capable of full-time employment on which, financially, his family depends.

Rules

- During + noun (underlined below)

Example: During his stay in hospital, Mr Mason's condition has improved.

- When + time clause (underlined below)

Example: When Ms. Song returned today, she was pale and distressed.

- While + clause (underlined below)

Example: While waiting in reception, the patient fainted.

- Ago + past tense (underlined below)

The patient had a liver transplant 12 months ago.

Comma Placement

💡 A comma is required when the time clause comes before the independent clause.

💡 Handy Tip

Correct verb tense is an important point to consider when writing time clauses. The important points to remember are as follows:

- When the **verb** of the time clause is in present form, the verb in the main clause must also be present or future form.

Example: While you display symptoms of fever and rash, you are still infectious.

- When the verb of the time clause is in past form, the verb in the main clause must also be in past form.

Example: When the patient received his results, he fainted.

- When the verb in the main clause is in present perfect form, the verb of the time clause must be in present perfect form.

Example: While the patient has been in hospital, his condition has steadily improved.

Incorrect	Correct
<ul style="list-style-type: none">• Today, the couple presented at my clinic. Mrs. Conway informed me that her home ovulation prediction test showed positive. <p>Explanation: To demonstrate a higher level of English proficiency this information should be expressed in a complex sentence rather</p>	<ul style="list-style-type: none">• <u>When</u> the couple presented at my clinic today, Mrs. Conway informed me that her home ovulation prediction test showed positive.• Today, <u>when</u> the couple presented at my clinic, Mrs. Conway informed me that her home ovulation prediction test

than two simple sentences.	showed positive.
<ul style="list-style-type: none"> The patient has had placement of a prosthetic heart valve 12 months ago. <p>Explanation: <i>has had</i> is present perfect, but simple past is required with the time marker <i>ago</i>.</p>	<ul style="list-style-type: none"> The patient <u>had</u> placement of a prosthetic heart valve 12 months ago.
<ul style="list-style-type: none"> I first saw Mrs. Smythe at my clinic last week , she urgently needed a new partial denture. <p>Explanation: An adverb of time such as when required to connect these two independent clauses</p>	<ul style="list-style-type: none"> <u>When</u> I first saw Mrs. Smythe at my clinic last week , she urgently needed a new partial denture. (best choice) I first saw Mrs. Smythe at my clinic last week <u>and</u> she urgently needed a new partial denture.

Articles Usage with Countable & Uncountable Nouns

Whether an article is required or not depends on the noun that follows. For this purpose nouns can be classified into two types: countable & uncountable nouns. The difference is based on whether the noun can be counted or not. For example, **complaint** is a countable noun as it can be counted. Therefore, it is possible to say 1 complaint or 2 complaints. Advice on the other hand cannot be counted so it is not possible to say 1 advice or 2 advices , The correct expression is some/any advice or the expression a piece of advice.

Countable nouns

These nouns have a singular form and plural form.

Singular

In the singular form an article is usually used before the noun. Example: The doctor received a complaint from her patient.

NB. Exceptions: The article can be left out if it is replaced with another determiner such as his/her or this /that or any/each/every. E.g. The doctor listened to each complaint. Her complaint was recorded.

Plural

In the plural form the article is usually **not** used before the noun. Example: The doctor received complaints from her patients.

Remember: Always use articles when referring a particular job such as:
doctor/dentist/nurse/pharmacist/physiotherapist/teacher etc etc.

Countable nouns	Singular form <i>Note the use of an article before each noun in singular form, either as a/an/the</i>	Plural form <i>Note the absence of the indefinite articles a/an before each noun in singular form, but the definite article</i>
abscess	The patient had an abscess on her gum.	The patient had 3 abscesses on her gum.
ache	The patient reported a dull ache in her abdomen.	The patient suffered from aches and pains.
accountant	Mr. Hagen is an accountant.	Mr. & Mrs. Hagen are both accountants.
appointment	A follow-up appointment was scheduled.	The patient did not attend her follow-up appointments.
cavity	The cavity was exposed.	The cavities were exposed.
check up	The patient attended for a check-up.	Regular check-ups will keep you healthy.

complaint	If you have a complaint, tell your doctor.	If you have any complaints, tell your doctor.
condition	You have a condition known as tuberculosis.	There are 3 conditions which can indicate the presence of cancer.
deposit	A carious deposit was evident on tooth 32.	Carious deposits were evident on teeth 32 & 33.
doctor	The patient has not seen a doctor for several years.	Three doctors were involved in the treatment of the patient.
episode	The patient had an episode of heart flutter.	The patient reported 3 episodes of heart flutter.
examination	An examination is necessary to rule out cancer.	Blood urine examinations revealed no abnormalities
gum	The gum surrounding tooth 23 was inflamed.	The gums were infected.
increase	There was an increase in the size of the swelling.	The patient presented with numerous swellings.
interpreter	An interpreter is required.	Interpreters will be required.
investigation	An investigation is required to rule out bowel cancer.	Investigations are required to rule out bowel cancer.
limp	The patient walked with a limp.	All the patients had limps.
parasite	The threadworm is a parasite	Threadworms are parasites.
lip	The patient had a swollen lip. (one lip)	The patient had swollen lips. (both lips)
smoker	She is a smoker.	They are smokers.
operation	An operation is necessary.	Two operations are necessary.
painkiller	The patient requested a painkiller.	Painkillers are not necessary with this procedure.
physiotherapist	An appointment needs to be arranged with a physiotherapist.	Two physiotherapists work at this rehabilitation centre.
result	The patient hoped for a positive result.	The results were positive.
review	A review was scheduled after 2 weeks.	The nurse received positive reviews from her patients.
sensation	The patient reported a tingling sensation in his fingers.	The patient experience tingling sensations in his fingers.
social worker	A social worker has been arranged to offer ongoing care.	Two social workers have been arranged to offer ongoing care.
teacher	Steve is a teacher.	Steve and Chris are teachers.

test	A blood test was ordered.	Blood and urine tests were ordered.
visit	Please organise a visit by a social worker.	Regular visits by a social worker is required.

Uncountable nouns

These nouns cannot take a plural form such as: cancer, anaesthesia and information. For these words no article is required. However, *the definite article the as well as quantifiers such as some and any can be used before the noun.*

Uncountable nouns	Indefinite articles cannot be used with uncountable nouns. However definite article “the” as well as quantifiers such as some and any can be used.
accommodation	The patient lives in rental accommodation.
advice	Advice on diet is requested.
assistance	The patient will require assistance upon discharge.
attention	The patient requires urgent attention.
behaviour	On examination, the patient's behaviour was abnormal.
cancer	The patient has cancer.
caries	Deep caries were present on several teeth.
concentration	The patient has poor concentration.
damage	The scan confirmed damage to the medial cartilage.
discomfort	If you experience discomfort, please consult your doctor.
information	Should you require further information, please do not hesitate to contact me.
pain	The patient experienced pain on palpation.
progress	The patient has made good progress.
tissue	She has healthy, soft tissue.
treatment	The condition did not respond to treatment.
research	Further research is required.
surgery	The patient chose not to have surgery.

Common mistakes

Incorrect

Wound on her left knee has been stitched.

I am writing to refer Marvin, 7 year old boy who was admitted to hospital on 21/11/10.

Mr Brown has been patient of mine for 7 years.

Please note, the patient has had prosthetic heart valve for year.

Examination revealed abscess on her gum.

Apart from bruises to her body, X-rays reveal that she has fracture of the right ankle.

Mr Jones had a heart surgery in 2009.

The patient has a cancer.

She had a healthy soft tissue.

He had lacerated lip and swollen gum.

The patient has **pollen** allergy.

The patient has tender right elbow joint.

The patient presented for regular check-up on 12/2/10.

Last modified: Tuesday, 20 July 2010, 06:48 AM

A wound on her left hand has been stitched.

I am writing to refer Marvin, a 7 year old boy who was admitted to hospital on 21/11/09.

Mr Brown has been a patient of mine for 7 years.

Please note, the patient has had a prosthetic heart valve for a year

Examination revealed an abscess on her gum.

Apart from bruises to her body, X-rays reveal that she has a fracture of the right ankle.

Mr Jones had heart surgery in 2009.

The patient has cancer.

She had healthy soft tissue.

He had a lacerated lip and swollen gums.

The patient has a pollen allergy

The patient has a tender right elbow joint.

The patient presented for a regular check-up on 12/2/10.

Compound sentences and Coordinating Conjunctions

When writing referral letters it is necessary to take information from the case notes and write it in complete sentences. The most basic way to do this is as a simple sentence. Simple sentences commonly contain a subject, verb and object and are known as independent clauses.

Example: **The patient is allergic to penicillin.**

This method is suitable for information which is not connected to other information in the case notes. However, it is more common to group information which is related into compound sentences. In the sentence below, two ideas are joined by the conjunction **and**. Note that the subject for each clause is different and each clause can function as a complete sentence

Example: **I prescribed Panadol for his hand pain and he was advised to reduce weight and do exercise.**

Compound sentences are joined by conjunctions and they show the relationship between the ideas. The most common conjunctions are:

and = the second clause contains a similar idea as the first

Example: **She does not smoke and (she)drinks alcohol rarely.**

but = the second clause contains an contrasting idea

Example: **She does not smoke but (she) is a heavy alcohol drinker.**

so=the second clause expresses a result or outcome

Example: **She does not smoke or drink alcohol so her health is good.**

One important decision for the writer to make is whether to include a subject in the second clause. Basically, the rule is you need to add a subject after a conjunction if the subject of the second clause is different to that of the first clause. Or if the sentence is very long.

- **I prescribed Panadol for his hand pain and he was advised to reduce weight and do exercise.** (In this case **you must add a subject after and as the subject is different** in the second clause)

- **I prescribed Panadol for his hand pain and advised for weight reduction and exercise.** (in this case you can omit the subject **I** as it is the same as the subject for the first part of the sentence)

- Iprescribed Panadol for his hand pain and Iadvised for weight reduction and exercise.

(this is grammatically correct, but in terms of style not very good as it is clear the subject remains the same, so **need to repeat it**)

Common Mistakes

Incorrect	Correct
<ul style="list-style-type: none"> • Nicole is a non-smoker and no drink alcohol or other drugs. <p>Explanation: The sentence is not balanced and there is no verb after the conjunction and</p>	<ul style="list-style-type: none"> • Nicole is a non-smoker and she drinks alcohol or other drugs.
<ul style="list-style-type: none"> • The parents say that immunizations were given at birth to both their children, but no record to prove that. <p>Explanation: No subject or verb after the conjunction but</p> <ul style="list-style-type: none"> • The wound has healed and free of infection <p>Explanation: Omission of subject and verb</p>	<ul style="list-style-type: none"> • The parents say that immunizations were given at birth to both their children, but they have no records to prove that. <ul style="list-style-type: none"> • The parents say that immunizations were given at birth to both their children, but there are no records to prove that. <ul style="list-style-type: none"> • The wound has healed and (it) is free of infection
<ul style="list-style-type: none"> • Mr. Smith's activities were restricted since last year by grinding pain in the left hip and had difficulty in climbing and descending stairs. <p>Explanation: No subject after the conjunction and, and note the subject for each clause is different. In the first clause the subject is Mr Smith's activities and in the second clause the subject is Mr Smith (not his activities)</p> <ul style="list-style-type: none"> • Her blood pressure was 175/95 and took normison 1 tablet and 2 panadol at 10 pm. <p>Explanation: You must add a new subject here as it is different to the subject of the first clause Her BP Vs She</p>	<ul style="list-style-type: none"> • Mr. Smith's activities were restricted since last year by grinding pain in his left hip and he had difficulty in climbing and descending stairs. <ul style="list-style-type: none"> • Her blood pressure was 175/95 and she took normison 1 tablet and 2 panadol at 10 pm
<ul style="list-style-type: none"> • She is a widow and a resident at Golden Pond Retirement Village, has a son in Warwick. <p>Explanation: This error is called a comma splice. A comma splice is incorrect because two sentences cannot be joined with a comma</p>	<ul style="list-style-type: none"> • She is a widow and a resident at Golden Pond Retirement Village, who has a son in Warwick.

alone. In this case you can join the sentences with **and**.

- Mr. Jones has been a patient of mine since 1999 and attending my clinic on a regular basis for scaling and cleaning.

Explanation: incomplete verb formation after **and**

- Mr. Jones has been a patient of mine s attending my clinic on a regular bas

Parallel Structures & Balanced Sentences

The information in the case notes is usually written in note form, and therefore does not follow conventional grammatical rules. However, when this information is organised into complete sentences in the referral letter it is necessary to follow standard conventions of grammar and sentence structure. This worksheet explains how to group information using parallel structures to ensure that the sentences you write are grammatically balanced. This can be achieved by making sure that verbs, adjectives, nouns, prepositions, phrases and clauses are parallel. Parallel structures within a sentence are joined with coordinating conjunctions such as and/or as well as with commas. Here are some examples:

With active verbs

- He is now worried about his condition because he is overweight, lacks exercise and smokes regularly

With passive verbs

- During hospitalization, IV fluids were commenced and a transdermal patch was used for her pain.

With nouns & noun phrases

- He is now worried about his condition because of his increased weight, lack of exercise and his habit of smoking.
- He will require information about how and when to take his medication, how to stop smoking and the necessity of doing regular exercise.

With gerunds

- In order to handle the above mentioned effects be cautious when driving a car, operating machinery or performing any hazardous activities especially after taking your regular dose.

With prepositions

- Threadworms resemble pieces of 1.5 cm cotton thread which is normally detectable at the surface of the feces or around the anus at night.

With verbs in the conclusion

- I am worried about Miss Jones and would appreciate your urgent assessment and treatment as you think appropriate.

The important point to remember is that the structures must be balanced.

Common Mistakes

Incorrect	Correct
<ul style="list-style-type: none"> Sally initially presented alone to my clinic on 27/12/07 with a 3-month-history of constipation and associated using laxatives <p>Explanation: The sentence is not balanced as noun phrases</p>	<ul style="list-style-type: none"> Sally initially presented alone to my clinic on 27/12/07 with <u>a 3-month-history of constipation</u> and associated using laxatives
<ul style="list-style-type: none"> He has a family history of stroke and diabetic. <p>Explanation: This sentence is not balanced as stroke is a noun and diabetic is an adjective</p>	<ul style="list-style-type: none"> He has a family history of <u>stroke</u> and <u>diabetic</u>.
<ul style="list-style-type: none"> Good hygiene should be maintained by taking a morning shower, using individual towels, washing clothes daily and to vacuum regularly. <p>Explanation: the final verb is out of balance</p>	<ul style="list-style-type: none"> Good hygiene should be maintained by taking a morning shower, using <u>individual towels</u>, <u>washing</u> clothes daily and to vacuum regularly.
<ul style="list-style-type: none"> I am writing to refer this patient, a 26 year old computer programmer, who is displaying sign and symptoms consistent with subdural haematoma. <p>Explanation: Both nouns should be in plural form</p>	<ul style="list-style-type: none"> I am writing to refer this patient, a <u>26</u> year old computer programmer, who is displaying <u>signs</u> and <u>symptoms</u> consistent with subdural haematoma.
<ul style="list-style-type: none"> His height is 170cm and weighing 99kg. <p>Explanation: unbalanced word form, height is a noun, weight is a gerund</p>	<ul style="list-style-type: none"> His <u>height</u> is 170cm and <u>weight</u> is 99kg.
<ul style="list-style-type: none"> On subsequent visits, impressions for full upper and lower dentures were made, bite registered and complete upper and lower dentures were delivered . <p>Explanation: Passive form required for all verbs</p>	<ul style="list-style-type: none"> On subsequent visits, impressions for <u>full upper and lower dentures were made</u>, bite registration <u>was taken</u> and <u>complete upper and lower dentures were delivered</u>.
<ul style="list-style-type: none"> She diagnosed with hyperthyroidism in 1997, hypertension in 2003 and Glaucoma since 2004. <p>Explanation: Time markers need to be balanced.</p>	<ul style="list-style-type: none"> She was diagnosed with hyperthyroidism in 1997, hypertension in 2003 and Glaucoma <u>in</u> 2004. She <u>has had</u> hyperthyroidism since 1997, hypertension since 2003 and Glaucoma <u>since</u> 2004.

<ul style="list-style-type: none"> During hospitalization, IV fluids were commenced and used a transdermal patch for her pain. <p>Explanation: Passive form required for all verbs</p>	<ul style="list-style-type: none"> During hospitalization, IV fluids <u>were commenced</u> and a <u>transdermal patch was used</u> for her pain.
<ul style="list-style-type: none"> Further examination revealed dry mouth, dentures were worn out on occlusal surfaces and a heavy calculus deposit was seen on the dentures. <p>Explanation: In example 1, by adding in addition, you can change the structure and keep the sentence balanced. In example 2 the sentence is balanced as the verbs have been replaced with noun phrases.</p>	<ul style="list-style-type: none"> Further examination revealed dry mouth <u>worn out</u> on occlusal surfaces and a <u>heavy calculus deposit</u>.
<ul style="list-style-type: none"> She is feeling loneliness and isolated due to losing her social contacts <p>Explanation: Loneliness is a noun whereas isolated is an adjective so the word forms are not balanced.</p>	<ul style="list-style-type: none"> She is suffering from <u>loneliness</u> and <u>isolated</u> due to <u>losing</u> her social contacts. (nouns) She is feeling <u>lonely</u> and <u>isolated</u> due to <u>losing</u> her social contacts. (adjectives)

Last modified: Tuesday, 13 April 20

Present Perfect

Present perfect tense is used to describe an event which starts in the past and continues until the present.

Mastery of this pattern is an essential for writing successful referral letters. Three common ways to form present perfect when writing referral letters are as follows:

Present Perfect Simple	Present Perfect Progressive	Present Perfect Passive
<p>Form: <i>have/has + past participle</i></p> <ul style="list-style-type: none"> • I <u>have treated</u> Mr. Smith at this hospital for 3 years. • Dr X <u>has treated</u> Mr. Smith at this hospital for 3 years. 	<p>Form: <i>have/has+been+__ing (present participle)</i></p> <ul style="list-style-type: none"> • I <u>have been treating</u> Mr. Smith at this hospital for 3 years. • Dr X <u>has been treating</u> Mr. Smith at this hospital for 3 years. 	<p>Form: <i>have/has +been+ past participle</i></p> <ul style="list-style-type: none"> • Mr. Smith <u>has been treated</u> at this hospital for 3 years(..by Dr X). • They <u>have been treated</u> at this hospital for 3 years(..by Dr X).

Present perfect is often combined with *for/since/over*. Compare the usage below and note time markers used.

For	Since	Over
<p><i>For</i> is used to describe a period of time</p> <ul style="list-style-type: none"> • I have been treating the patient for 3 years. • The patient has been on this medication for 6 months. • I haven't seen the patient for 1 year. • The patient has been in pain for 5 hours. • The patient has been waiting for 15 minutes. • He has been 	<p><i>Since</i> is used to refer to the start of period of time</p> <ul style="list-style-type: none"> • I have been treating the patient since 2007. • The patient has been on this medication since January. • I haven't seen this patient since December 2009. • The patient has been in pain since 10am. • The patient has been waiting since 11.45am. • He has been 	<p><i>Over</i> uses similar time markers to <i>for</i> but is used to express a change in condition, or to describe a repeated event.</p> <ul style="list-style-type: none"> • The patient's condition has deteriorated over the past 3 months. (change in condition) • The patient has presented several times over the last year. (repeated event) • The patient's back pain has worsened over the last week.(change in condition) • He has tried to quit

complaining of back pain for a week.	complaining of back pain since last week.	smoking several times over the past 25 years. (repeated event)
<ul style="list-style-type: none"> • He has not had bowel motions for 3 days. • He has been a smoker for a period of 25 years. 	<ul style="list-style-type: none"> • He has not had bowel motions since Saturday. • He has been a smoker since 1985. 	<ul style="list-style-type: none"> • The patient has experienced seizures on 3 occasions over the past year.(repeated event)

💡 Handy Tip

When using time markers such as ...for the past 20 years, ...for the last 3months, ...for the next 3 months or for the previous 3 months always use the definite article "the" as its function is to specify a particular period of time.

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> • The patient was diagnosed hypothyroidism since 2007 <p>Explanation: Past tense cannot be used with for or since</p>	<ul style="list-style-type: none"> • The patient <u>has had</u> hypothyroidism since 2007. (present perfect) • The patient <u>was diagnosed</u> with hypothyroidism <u>in</u> 2007. (simple past)
<ul style="list-style-type: none"> • She <u>has been</u> problems with arthritis in her hands. <p>Explanation: <u>Problems</u> in this sentence is a noun so you can not use "been" with a noun. You must use have or has + noun or been+<u>ing</u> verb. You can also use been + adjective</p>	<ul style="list-style-type: none"> • She <u>has been having</u> problems with arthritis in her hands since 2007. (present perfect progressive) • She <u>has had</u> problems with arthritis in her hands since 2007.(present perfect simple) • She <u>has been</u> arthritic since 2007. (present perfect simple +adjective) • She <u>has had</u> arthritis since 2007. (present perfect simple +noun)
<ul style="list-style-type: none"> • He <u>is smoking</u> 2 packs of cigarettes a 	<ul style="list-style-type: none"> • He <u>has been smoking</u> two packs of cigarettes a day for the past 25-30

day for the past 25 – 30 years.

- Over the past week she remains free from severe pain and has been able to tolerate a fluid diet.
- Also, there is an ulcer on the right lower lateral border of the tongue which is present for more than one year.
- Mr. Diamond is a patient of mine since 2000
- Mr. Eddy is a known smoker for 25-30 years.

Explanation: The verbs in these sentences are in simple present tense. Present perfect needs to be used because you are referring to a time period which started in the past and has continued to the present.

years. (present perfect progressive)

- Over the past week she has remained free from severe pain and has been able to tolerate a fluid diet.(present perfect simple)
- Also, there is an ulcer on the right lower lateral border of the tongue, which has been present for more than one year. (present perfect passive)
- Mr Diamond has been a patient of mine since 2000.(present perfect simple)
- Mr. Eddy has been a smoker for 25 years. (present perfect simple)

- Mrs. Brown has been presenting to me on several occasions over the past few months.

- Mrs. Brown has presented to me on several occasions over the past few months.

Explanation: Progressive form not required.

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Past Perfect

Past Perfect is an important tense in referral letters. The main functions of this tense are:

- When used with simple past it allows the writer to distinguish the order of events:
 - *She had not been able to conceive over the previous four months and as a result she was suffering from depression.* This means: first she could not conceive, then she became depressed.
- When used in reported speech. The case notes may describe the patient's condition at a time in the past, i.e *patient found blood in toilet bowl 2 times*. This can be written in the referral letter as follows:
 - At today's consultation, Ms. Leon reported that there had been blood in the toilet bowl on 2 occasions.

So the main benefits of using past perfect is that it allows the writer to express the order in which certain health events occurred logically and clearly.

😊 Handy Hint 1

Do not use past perfect when describing one past event as it is not necessary.

Compare

- The patient had been feeling unwell last week. (incorrect if 1 past event described)
- The patient was feeling unwell last week. (correct)
- The patient had been feeling unwell last week and was admitted to hospital for observation. (correct as 2 past events need to be distinguished)

😊 Handy Hint 2

Past perfect is often used with the word **previous** instead of **ago** to demonstrate that you are referring to a time before a particular date in the past, not the date you are writing the letter. See below for examples.

Incorrect	Correct
<ul style="list-style-type: none">• She presented to me on 03/07/2010 for a regular check up because she experienced several episode of heart flutter over the past few weeks.<ul style="list-style-type: none">○ <i>Past perfect tense is necessary here (had experienced) to differentiate what happened prior to the check up, which is also in the past.</i>○ <i>As your meaning is prior to 03/07/10 and not the day of writing the letter, you should use the word previous</i>	<ul style="list-style-type: none">• She presented to me on 03/07/2010 for a regular check up because <u>she had experienced</u> several episodes of heart flutter over the <u>previous</u> few weeks.

<p><i>instead of past.</i></p>	
<ul style="list-style-type: none"> • On review two weeks later, the frequency of headache decreased. <ul style="list-style-type: none"> ○ Use past perfect to indicate that frequency of headache <u>had decreased</u> prior to the consultation. 	<ul style="list-style-type: none"> • On review two weeks later, the frequency of headache <u>had decreased</u>.
<ul style="list-style-type: none"> • A review on 25/04/10 showed the patient's general health improved and her blood pressure dropped to 140/85 and she lost 4 kg. <ul style="list-style-type: none"> ○ Past perfect is used when describing a condition that was true at a certain time in the past. 	<ul style="list-style-type: none"> • A review on 25/04/10 showed the patient's general health <u>had improved</u> and her blood pressure <u>had dropped</u> to 140/85 and she <u>had lost</u> 4kg.
<ul style="list-style-type: none"> • She presented to me yesterday evening with abdominal pain, mostly on the left iliac fossa, and was since 24 hours. <ul style="list-style-type: none"> ○ Note that in the correct version 3 different times need to be considered ○ The present i. e today: time of writing ○ Yesterday evenings consultation ○ Symptoms which occurred before yesterday's consultation. 	<ul style="list-style-type: none"> • She presented to me yesterday evening with abdominal pain, mostly on the left iliac fossa, which <u>had been</u> occurring for the previous 24 hours.
<ul style="list-style-type: none"> • She was admitted in Royal Brisbane and Women's Hospital on 24/07/08 because she collapsed at home. <ul style="list-style-type: none"> ○ Use past perfect tense to create a time line, so past perfect indicates the collapse occurred before the 	<ul style="list-style-type: none"> • She was admitted in Royal Brisbane and Women's Hospital on 24/07/08 because she <u>had collapsed</u> at home.

<p><i>admission.</i></p>	
<ul style="list-style-type: none"> • Initially she presented to me in July 2010 with a complaint of chest discomfort for three weeks. <ul style="list-style-type: none"> ○ <i>If you use this time expression: <u>for a few weeks</u> then you must either use a relative clause and past perfect verb tense, or the very concise and useful expression: <u>of _____ duration</u>.</i> 	<ul style="list-style-type: none"> • Initially she presented to me in July 2010 with a complaint of chest discomfort which <u>had been present for</u> three weeks. • Initially she presented to me in July 2006 with a complaint of chest discomfort <u>of 3 week duration</u>.
<ul style="list-style-type: none"> • Mrs. Jones had taken Microgynon 30 for the previous 5 years but had stopped in May 2009. <ul style="list-style-type: none"> ○ <i>There is no need to use past perfect twice.</i> 	<ul style="list-style-type: none"> • Mrs. Jones <u>had taken</u> Microgynon 30 for the previous 5 years but <u>stopped</u> in May 2009.
<ul style="list-style-type: none"> • On rechecking at 10.45pm, her condition has further deteriorated and an ambulance was arranged for transfer to hospital. <ul style="list-style-type: none"> ○ <i>Use past perfect and simple past together to distinguish the order of events i.e her condition deteriorated then an ambulance was called.</i> 	<ul style="list-style-type: none"> • On rechecking at 10.45pm, her condition <u>had further deteriorated</u> and an ambulance <u>was arranged</u> for transfer to hospital.

Simple Past or Present Perfect

There is often confusion of whether to use simple past or present perfect tense. The basic rule to remember is if you are referring a particular time in the past then you must use simple past tense. If you are referring to a period of time that starts in the past and continues up to now use present perfect tense.

There are some common time markers used with simple past and present perfect. It is important to study, learn and use these tenses correctly when writing referral letters as you must refer to both past events and periods of time leading to the present.

Time Markers with Simple Past	Time markers with Present Perfect
<ul style="list-style-type: none">• He sucked his thumb <u>until he was 5.</u>• Mrs. Kelly had diverticulitis <u>when she was a teenager.</u>• He first came to see me <u>in 2004.</u>• The patient didn't respond to treatment.• The patient was diagnosed with cancer <u>3 months ago.</u>• The patient stopped taking medication <u>yesterday.</u>	<ul style="list-style-type: none">• He has been sucking his thumb for five years.• Mrs. Kelly has had diverticulitis <u>for the last 12 years.</u>• He <u>has been seeing me since 2004.</u>• The patient hasn't responded to treatment <u>yet.</u>• The patient <u>has shown</u> no signs of improvement <u>up to now.</u>• The patient has stopped taking medication <u>recently.</u>

Common Errors

Incorrect	Correct
<ul style="list-style-type: none">• She <u>has underwent</u> triple coronary bypass surgery on 10.08.09	<ul style="list-style-type: none">• She <u>underwent</u> triple coronary bypass surgery on 10.08.09

⚠ This page is still under construction
Last modified: Saturday, 24 July 2010, 06:09 AM

Prepositions

Prepositions are a difficult area of language to fully master as their usage is not governed by strict rules. The best way to learn prepositions is by regular reading so that you can slowly absorb and become comfortable with their correct use. However, it is possible to memorise the correct use of a selection of prepositions in order to use them accurately in writing the referral letter.

Prepositions of Time

In: In is used for longer periods of time	On: On is used for days and dates and some time expressions	At: At is used for the time of day and for some expressions	Some words require no preposition
<ul style="list-style-type: none"> • In November • In Spring • In 2006 • In the past • In the future • In the morning • In the afternoon • In her childhood • In his twenties 	<ul style="list-style-type: none"> • On Monday • On 20 November • On Christmas day • On his birthday • On review • On examination • On investigation • On presentation • On two occasions 	<ul style="list-style-type: none"> • At 6 o'clock • At night • At lunchtime • At that time • At the moment • At the age of 45 • At birth 	<ul style="list-style-type: none"> • Yesterday • Today • Tomorrow • Last week • This week • Next week

Prepositions of Place

In: In is used for inside of something	On: is used for the surface area of something	At: At is used for a place of activity
<ul style="list-style-type: none"> • In Australia 	<ul style="list-style-type: none"> • On the skin 	<ul style="list-style-type: none"> • At home

<ul style="list-style-type: none"> • In hospital • In surgery • In the stomach 	<ul style="list-style-type: none"> • On the ground floor 	<ul style="list-style-type: none"> • At work • At the wound site • At the clinic
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Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> • His father died of cancer during the age of 50. 	<ul style="list-style-type: none"> • His father died of cancer at the age of 50.
<ul style="list-style-type: none"> • In examination today, the patient was anxious and distressed. 	<ul style="list-style-type: none"> • On examination today, the patient was anxious and distressed.
<ul style="list-style-type: none"> • Initial examination on today revealed inflammed gums. 	<ul style="list-style-type: none"> • Initial examination today revealed inflammed gums.
<ul style="list-style-type: none"> • On December 2006, the patient had his wisdom teeth removed. 	<ul style="list-style-type: none"> • In December 2006, the patient had his wisdom teeth removed.
<ul style="list-style-type: none"> • The patient's family arrived at Australia in last year. 	<ul style="list-style-type: none"> • The patient's family arrived in Australia last year.

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Relative Clauses

In the introduction of a referral letter it is common practice to introduce the patient and provide some relevant details relating to their situation or condition. The relative clause allows writers to do this in a clear and concise manner.

Definition: A relative clause is the part of the sentence which provides information about the patient. They can be divided into two types, defining and non-defining. Defining clauses provide details about the noun being referred to. Commas are not required.

Non-defining clauses provide extra information about the noun being referred to but do not define it. Commas are required.

Defining	Non-defining
<ul style="list-style-type: none">I am writing to refer this patient who is due to be discharged today. <p>Explanation: The relative clause defines the object of the main clause i.e Which patient? The patient who is being discharged.</p>	<ul style="list-style-type: none">I am writing to refer this patient, who is due to be discharged today, for ongoing physiotherapy treatment. <p>Explanation: The relative clause provides extra information (patient is due to be discharged) about the <u>object</u> of the main clause but does not define it. It could be removed from the sentence and the meaning would still be clear: I am writing to refer this patient for ongoing physiotherapy treatment.</p>
<ul style="list-style-type: none">I am writing to refer Mrs. Patterson, a 36-year-old married woman who is suffering from mild depression. <p>Explanation: The relative clause defines the object of the main clause i.e Who? Mrs. Patterson, a 36-year-old woman. <i>n.b. In this sentence, the first comma allows extra information to be added about Mrs. Patterson.</i></p>	<ul style="list-style-type: none">Mrs. Patterson, who is a 36-year-old married woman, is suffering from mild depression. <p>Explanation: The relative clause provides extra information (Mrs. Patterson is a 36 year old woman) about the <u>subject</u> of the main clause but does not define it. It could be removed from the sentence and the meaning would still be clear: Mrs Patterson is suffering from mild depression.</p>

😊 Handy Tip

No name=no comma

In example 1 below, no comma is required as the relative clause is defining the person being referred to. In example 2, the relative clause does not define the person being referred to because it is already known. Therefore, If you include the patient's name, commas are required.

1. The doctor who performed the operation is from Iraq.

2. Doctor Yousif, who is from Iraq, performed the operation.

Incorrect	Correct
<ul style="list-style-type: none"> Mr. Holmes who lives with his wife in a government flat, is an aged care pensioner. <p>Explanation: Commas required as it is a non-defining relative clause. You can also express this information in a compound sentence.</p>	<ul style="list-style-type: none"> Mr. Holmes, who lives with his wife in a government flat, is an aged care pensioner. Mr. Holmes lives with his wife in a government flat <u>and</u> is an aged care pensioner.
<ul style="list-style-type: none"> Mr. O'Riley, who lives alone in his own home, and works as a fencing contractor and has only one brother. <p>Explanation: After the second comma a verb is required. i.e Mr O'Riley <u>works</u>.</p>	<ul style="list-style-type: none"> Mr. O'Riley, who lives alone in his own home, <u>works</u> as a fencing contractor and has only one brother.
<ul style="list-style-type: none"> Mrs. Peterson who recently moved to our retirement village following her husband's death. <p>Explanation: No relative pronoun needed here as it is a simple sentence.</p>	<ul style="list-style-type: none"> Mrs. Peterson recently moved to our retirement village following her husband's death. Mrs. Peterson, who recently moved to our retirement village following her husband's death, has a history of hypertension.
<ul style="list-style-type: none"> Mr. Brown presented at my clinic today with a complaint of fractured front teeth in a traumatic car accident. <p>Explanation: A relative clause is required to define how the teeth were fractured. Alternatively it can be written as two separate sentences.</p>	<ul style="list-style-type: none"> Mr. Brown presented at my clinic today with a complaint of fractured front teeth <u>which</u> occurred in a traumatic car accident. Mr. Brown presented at my clinic today with a complaint of fractured front teeth. This occurred in a traumatic car accident.
<ul style="list-style-type: none"> I am writing regarding Mr. Jones, a 35 year-old-male, who was recently diagnosed with tuberculosis. <p>Explanation: Second comma not required as it is a defining relative clause, i.e it defines Mr.</p>	<ul style="list-style-type: none"> I am writing regarding Mr. Jones, a 35 year-old-male who was recently diagnosed with tuberculosis.

Jones	
<ul style="list-style-type: none"> I am writing to refer Mrs. Margaret Green, a 66 year old widow with three children, with complaints of chest pain. <p>Explanation: Relative clause required here as two prepositional phrases is confusing.</p>	<ul style="list-style-type: none"> I am writing to refer Mrs. Margaret Green, a 66 year old widow with three children who is complaining of chest pain.
<ul style="list-style-type: none"> I am writing to refer, Ms. Abbot, a 58 year old widow admitted with pain, dehydration and nausea. <p>Explanation: Incorrect comma placement and relative clause required.</p>	<ul style="list-style-type: none"> I am writing to refer Ms. Abbot, a 58 year old widow who was admitted with pain, dehydration and nausea.
<ul style="list-style-type: none"> Mr. Fisher was admitted to hospital with the diagnosis of obstructive artery disease and end with quadruple artery bi-pass grafts. <p>Explanation: A relative clause is required to define the treatment.</p>	<ul style="list-style-type: none"> Mr. Fisher was admitted to hospital with the diagnosis of obstructive artery disease which required quadruple artery bi-pass grafts.
<ul style="list-style-type: none"> I am writing to refer this 14-year-old boy to you who came to me complaining of a sprained ankle. <p>Explanation: The relative pronoun must follow the noun it is referring to.</p>	<ul style="list-style-type: none"> I am writing to refer this 14-year-old boy who came to me complaining of a sprained ankle.
<ul style="list-style-type: none"> I am writing to refer this patient, a 39 year old widowed woman, who is under our care after being injured in a car accident. <p>Explanation: No comma required as it is a defining relative clause.</p>	<ul style="list-style-type: none"> I am writing to refer this patient, a 39 year old widowed woman who is under our care after being injured in a car accident.
<ul style="list-style-type: none"> Mr. Roberts who is a 72-year-old retired gentleman was admitted to hospital for acute cerebral infarction on 08/03/10. <p>Explanation: Commas required as it is a non-defining relative clause and provides extra</p>	<ul style="list-style-type: none"> Mr. Roberts, who is a 72-year-old retired gentleman, was admitted to hospital for acute cerebral infarction on 08/03/10.

information about Mr. Roberts.

- I am writing to explain Mr. Clarke's current situation, who has been a patient of mine for a long time.

Explanation: The relative pronoun must be added directly after the person you are referring to.

- I am writing to explain Mr. Clarke's current situation. He has been a patient of mine for a long time.

- I am writing to refer Mr. Clarke, who has been a patient of mine for a long time. Currently, he is suffering from.....

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The Comma

The comma is the most frequently used punctuation mark within sentences. Used correctly it allows the writer to separate a group of words or phrase from other parts of a sentence. This is necessary in order to add useful information in a sentence. The information can be added at the beginning, the middle or the end. However, if commas are not used or overused, the meaning can be affected and the flow of information disrupted. By understanding the basic rules presented in this section you should be able to develop a good understanding of how and when to use commas in referral letters.

Rules of Usage

1. The Adverbial Phrase: The adverbial phrase can be used in referral letters to provide information such as a time, place, context, emphasis or mood in the sentence which is to follow and it is commonly separated by a comma

- **Context:** On examination, there was slight tenderness in the right fornix.
- **Date:** On today's visit, the patient was pale and sweaty.
- **Emphasis:** Please note, the patient is allergic to penicillin.
- **Mood:** Unfortunately, the patient's condition has worsened. *Note, mood or comment adverbs, such as unfortunately or regrettably convey the health professionals concern toward the patient's condition and are therefore effective ways of displaying empathy.*
- **Contrast:** The patient's condition has improved. However, a follow up visit is required.

Sentence Structure

	Adverbial Phrase	Subject	Verb	Object/Compliment
	Blank	I	suspect	the patient has developed ectopic pregnancy.
Comma preferred	Unfortunately,	I	suspect	the patient has developed ectopic pregnancy.
	Blank	Abdominal examination	revealed	slight right iliac fossa tenderness.
Comma preferred	On examination,	slight right iliac fossa tenderness	was revealed.	blank
	Blank	Clinical examination of hard tissues	revealed	a large mesioincisal fracture.
Comma	On examination,	a large	was revealed.	blank

preferred		mesioincisal fracture		
Comma preferred	Regarding her medical history,	she	has been suffering from	asthma for which she uses a ventolin inhaler.
Comma preferred	On review today,	there	was	no improvement in her condition.
Comma preferred	In terms of his medical history,	he	is	a heavy smoker and a heavy to moderate drinker.
Comma preferred	Please note,	the patient	has	an appointment with his physiotherapist at 10 o'clock on Monday.
Comma preferred	In addition,	there	are	composite and amalgam restorations on several teeth.

 **Handy Hint:** Do not put a comma between a subject and a verb or a verb and an object.

2. Appositives: This is a noun or a noun phrase that is placed after another noun to explain or identify it. It has a very important use in the introductory sentence of referral letters as follows.

- *Mr Smith, an 80 year old widow, was admitted to hospital with complaints of heart palpitations.*
- *Thank you for seeing Jordan, a 10 year old boy who presented at my clinic today with a main concern of pain in tooth 54.*
- *I am writing to refer Mrs. Bradley, a 42 year old married woman who is suffering from cancer.*

3. Conditional Sentences: These sentences are frequently used in the conclusion of a referral letter and the rules are as follows:

- Use a comma if the if clause is at the beginning of the sentence.
 - *If you could take over her antenatal care, it would be much appreciated.*
 - *If you have any further questions regarding this patient, please don't hesitate to call me.*
- Don't use a comma if the if clause is at the end of the sentence.

- *It would be greatly appreciated if you could take over her antenatal care.*
- *Please don't hesitate to call me if you have any further questions regarding this patient.*

4. Complex sentences:

- Use a comma if the dependent clause is at the beginning of the sentence.
 - *In case of irritation, redness or swelling, please consult your doctor.*
 - *When the results become available, I will forward them to you.*
 - *Because of her deteriorating condition, the patient was admitted to hospital.*
- Don't use a comma if the dependent clause is at the end of the sentence.
 - *Please consult your doctor in case of irritation, redness or swelling.*
 - *I will forward the results to you when they become available.*
 - *The patient was admitted to hospital because of her deteriorating condition.*

5. Comma Splices: A comma splice is two sentences joined together with a comma, but no conjunction. This is an error as the information must be either joined with a [coordinating conjunction](#) such as *and/but/or* or a new sentence must be started.

- *He does not have any dental experience, he is worried about the pain.* (incorrect)
- *He does not have any dental experience and he is worried about the pain.* (correct)
- *He does not have any dental experience. Therefore, he is worried about the pain.* (correct)

6. Noun Clauses beginning with *that* should not be separated by a comma.

- *It is also important to know, that a re-check is organised for the 31.5.2009 at 10:30 in order to remove the suture.* (incorrect)
- *It is also important to know that a re-check is organised for the 31.5.2009 at 10:30 in order to remove the suture.* (correct)

7. Use commas to separate three or more words, phrases, or clauses written in a series. The final word does not require a comma and it should be separated by a conjunction such as and or or

- Mrs. Olsen has a history of hypertension, hypothyroidism, glaucoma for which she is on regular medication. (incorrect)
- Mrs. Olsen has a history of hypertension, hypothyroidism and glaucoma which is on regular medication. (correct)

Common Errors

Incorrect	Correct
<p>1. On review today Mr Walker has reduced smoking from 20 to 10 cigarettes per day.</p> <p>2. On examination today there was a soft fluctuant swelling palpable on the left cheek</p> <p>3. Regrettably she has problems with breast feeding and caring for the baby.</p> <p>4. Please note he has a prosthetic heart valve.</p>	<p>1. On review today, Mr Walker has reduced smoking from 20 to 10 cigarettes per day.</p> <p>2. On examination today, there was a soft fluctuant swelling palpable on the left cheek</p> <p>3. Regrettably, she has problems with breast feeding and caring for the baby.</p> <p>4. Please note, he has a prosthetic heart valve.</p>
Comma preferred for adverbial phrases. Refer to rule 1 above.	
<p>1. I am writing to refer Mr. Jones a 57 year old man who was admitted to hospital on the 18th of July, diagnosed with myasthenia gravis.</p> <p>2. Mr Jones, a 57 year old man was admitted to hospital on the 18th of July, diagnosed with myasthenia gravis.</p>	<p>1. I am writing to refer Mr. Jones, a 57 year old man who was admitted to hospital on the 18th of July, diagnosed with myasthenia gravis.</p> <p>2. Mr Jones, a 57 year old man, was admitted to hospital on the 18th of July, diagnosed with myasthenia gravis.</p>
Comma required for appositives. Refer to rule 2 above.	
Apply the comma rule for conditional sentences. Refer to rule 3 above.	
Apply the comma rule for complex sentences. Refer to rule 4 above.	

<ul style="list-style-type: none"> He has an allergy to nuts, once he was hospitalised for severe anaphylactic reaction. <p>Refer to rule 6 above.</p>	<ul style="list-style-type: none"> He has an allergy to nuts <u>and</u> was once hospitalised for severe anaphylactic reaction.
<ul style="list-style-type: none"> Please note that, Daniel has an allergy to peanuts. <p>Apply the comma rule for comma splices. Refer to rule 5 above.</p>	<ul style="list-style-type: none"> Please note that Daniel has an allergy to peanuts.
<ul style="list-style-type: none"> Mr.Farrah, presented at my surgery today complaining of pain radiating from his left ear to his front teeth. <p>Do place a comma between the subject and verb of a sentence.</p>	<ul style="list-style-type: none"> Mr.Farrah presented at my surgery today complaining of pain radiating from his left ear to his front teeth.
<ul style="list-style-type: none"> Initial examination revealed, complete edentulous upper and lower jaws with healthy soft tissue. I am writing to request, visits for this family. <p>Do place a comma between the verb and object of a sentence.</p>	<ul style="list-style-type: none"> Initial examination revealed complete edentulous upper and lower jaws with healthy soft tissue. I am writing to request visits for this family.

For more information on comma usage, follow this [link](#).

Useful signal markers

Letter	Signal Marker	Example
a.	<ul style="list-style-type: none"> • _____as well as_____ • as a result of • as a result • along with • apart from this • at that time 	<ul style="list-style-type: none"> • She suffers from oedema and only tolerates fluids. • This child was admitted <u>as a result of</u> a complication. • Let me inform you that the patient was uncooperative during his history. I would recommend the use of a general anaesthetic. • On vaginal examination there was <u>along with</u> tenderness in the adnexa. • She looked very anxious and distressed. <u>Apart from this</u>, no abnormalities were detected in the cardiovascular and respiratory systems. • Initially, I saw the patient six months ago. He complained of constipation. <u>At that time</u> he was found to be normal.
b.	<ul style="list-style-type: none"> • besides that • because of this • based on 	<ul style="list-style-type: none"> • The patient has smoked 20 cigarettes a day for the last 10 years. <u>Besides that</u> he has been drinking heavily. • He smokes 20 cigarettes a day. <u>Because of this</u>, he has been advised to reduce alcohol. • Furthermore, a fine needle aspiration biopsy was investigated. <u>Based on the results</u> of the biopsy, he developed lymphoma.
c.	<ul style="list-style-type: none"> • consequently 	<ul style="list-style-type: none"> • The depth of periodontal pockets was measured to be 3.4mm. <u>Consequently</u>; he was referred to a dentist for treatment for carious lesions and dental plaque maintenance.
d.	<ul style="list-style-type: none"> • during _____ • duration • despite 	<ul style="list-style-type: none"> • <u>During hospitalization</u>, his blood pressure was found to be raised and he has been assisted by the medical team. • On 15/2/08, she presented to the emergency department with abdominal pain <u>of 1 day duration</u>. • <u>Despite</u> various dental treatments and regular dental cleaning, his general gum health has been poor.
f.	<ul style="list-style-type: none"> • for this reason 	<ul style="list-style-type: none"> • Mr. Fox's blood pressure was found to be raised. <u>For this reason</u>, he was advised to take regular exercise and follow a healthy diet.
h.	<ul style="list-style-type: none"> • hence 	<ul style="list-style-type: none"> • The carious lesions on 65 were removed and the tooth was filled.

	<ul style="list-style-type: none"> however 	<p>the tooth has to be extracted.</p> <ul style="list-style-type: none"> The patient regularly visits the dentist. His oral hygiene status is good. He has no caries.
i.	<ul style="list-style-type: none"> in terms of _____ in order to in addition in the meantime in case of 	<ul style="list-style-type: none"> <u>In terms of her medical history</u>, she has a history of thumb sucking until the age of 5 years. She is epileptic and uses dylantoin. I have prescribed agleam. Regarding the medical history, she has a history of thumb sucking until the age of 5 years. She is epileptic and uses dylantoin. I have planned to review her blood pressure and smoking status. <u>meantime</u>, I believe he needs to continue the treatment as per the prescription. <u>In case of</u> any irritation, redness or pain, she should discontinue the treatment and consult me.
m.	<ul style="list-style-type: none"> may I remind you that.... my main concern is that..... 	<ul style="list-style-type: none"> <u>May I remind you that</u> before the canal treatment and crowns were placed, she was able to breastfeed and confident. <u>My main concern is that</u> she is able to communicate in English.
n.	<ul style="list-style-type: none"> It should <u>be noted</u> 	<ul style="list-style-type: none"> <u>It should be noted that</u> the patient is able to communicate in English.
o.	<ul style="list-style-type: none"> over..... on review today, 	<ul style="list-style-type: none"> <u>Over the past week</u>, she has been experiencing pain and has been tolerating it well. She first presented to me with a history of heart flutter <u>over the past month</u>. <u>On review today</u>, the patient reported smoking 20 cigarettes a day, attending social events and so far.
p.	<ul style="list-style-type: none"> please note 	<ul style="list-style-type: none"> <u>Please note</u>, he has an alergy to penicillin.
r.	<ul style="list-style-type: none"> regarding regrettably recently 	<ul style="list-style-type: none"> <u>Regarding his medical history</u>, he has a history of hypertension and asthma for which he takes inhalers. <u>Regrettably</u>, she complains of palpitations and weakness. <u>Recently</u>, she has been presenting with palpitations. She is taking Oroxine 0.1mg per day, Tabex 100mg per day and Normison 10mg at night.
s.	<ul style="list-style-type: none"> since then 	<ul style="list-style-type: none"> His urinalysis and examination results are pending.

		obesity and borderline hypertension. She has been doing regular exercise and maintaining her weight.
t.	<ul style="list-style-type: none"> • therefore • the reason for 	<ul style="list-style-type: none"> • Her vital signs were normal (BP 120/78 mmHg, HR 68 bpm, RR 18 breaths/min, weight 75 kg). <u>Therefore</u> she was admitted to hospital for further investigation. • <u>The reason for the referral</u> was a positive prostate biopsy regarding prostate cancer.
u.	<ul style="list-style-type: none"> • up until now, • unfortunately 	<ul style="list-style-type: none"> • <u>Up until now</u>, Mr. Hutton has been well. • <u>Unfortunately</u>, he is not able to work for the last few months.
w.	<ul style="list-style-type: none"> • with regard to 	<ul style="list-style-type: none"> • I am writing <u>with regard to</u> myasthenia gravis.

Years Vs Year

Incorrect	Correct
<p>I am writing to refer this patient, 63 years old man who lives alone.</p> <p>In this sentence there are two mistakes:</p> <ol style="list-style-type: none"> 1. the expression is a phrase and therefore requires an article “a” to precede the phrase a 63-year-old man. An article is required because the noun man is singular. Compare with: There are two 63-year-old men in the waiting room. 2. Years is an adjective in this sentence (it describes the age of the man) and adjectives are uncountable. 	<ol style="list-style-type: none"> 1. I am writing to refer this patient, a 63-year-old man who lives alone. 2. There are two 63-year-old men in the waiting room.
<p>This patient is 63 year old.</p> <p>In this sentence the word <u>years</u> is a noun preceding an adjective <u>old</u>. Nouns can be countable so <u>in this case you must make it plural.</u></p>	<p>This patient is 63 years old.</p>
<p>Her father died at 50 year old of bowel cancer</p> <p>In this case <u>at</u> is a preposition and needs to be followed by a noun or noun phrase, rather than the adjective “old”. See column on the right for possible correct choices. Year is a noun in this case so it should be written in plural form.</p>	<ol style="list-style-type: none"> 1. Her father died at 50 years old of bowel cancer. 2. Her father died at the age of 50 of bowel cancer. 3. Her father died when he was 50 years old of bowel cancer.
Other examples	
<ol style="list-style-type: none"> 1. In addition, he had a habit of thumb sucking until age of five years. 2. In addition he had a habit of thumb sucking until he was five years age. 3. Regarding the medical history, Alfie has a history of thumb sucking until the age of 5 years, 	<ol style="list-style-type: none"> 1. In addition, he had a habit of thumb sucking until the age of five years. 2. In addition, he had a habit of thumb sucking until he was five years of age. 3. In addition, he had a history of thumb sucking until he was five years old.
<p>Years is an adjective in this sentence (it describes the age of the denture) and adjectives are uncountable.</p>	<ol style="list-style-type: none"> 1. In addition she has fillings, crowns, good dental hygiene and a 13 years old chrome /cobalt removable partial denture.

Subject-Verb Agreement

Subject verb agreement is an area where accuracy is important. Below are some important rules which you should remember.

Singular subject & verb	Plural subject & verb	Explanation
<ul style="list-style-type: none"> The <u>suture</u> <u>has</u> been removed. 	<ul style="list-style-type: none"> The <u>sutures</u> <u>have</u> been removed. 	
<ul style="list-style-type: none"> <u>One</u> of the medications <u>is</u> unavailable. 	<ul style="list-style-type: none"> <u>All</u> of the medications <u>are</u> unavailable. 	The verb agrees with the subject which in this case is either singular in <u>one</u> or plural in <u>all</u> .
<ul style="list-style-type: none"> <u>One</u> of the medications <u>has</u> side effects. 	<ul style="list-style-type: none"> <u>All</u> of the medications <u>have</u> side effects 	The verb agrees with the subject which in this case is either singular in <u>one</u> or plural in <u>all</u> .
<ul style="list-style-type: none"> <u>Mrs. Pratt</u> <u>lives</u> in rental accommodation. 	<ul style="list-style-type: none"> <u>Mr. & Mrs. Pratt</u> <u>live</u> in rental accommodation. 	
<ul style="list-style-type: none"> <u>He</u> <u>needs</u> to be assisted with activities of daily living. 	<ul style="list-style-type: none"> <u>They</u> <u>need</u> to be assisted with activities of daily living. 	

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> Alison's school medical record reveals that her attendance have been declining in recent past. 	<ul style="list-style-type: none"> Alison's school medical record reveals that <u>her attendance</u> <u>has</u> been declining in recent past.
<ul style="list-style-type: none"> All these findings has been confirmed with bite-wing radiographs. 	<ul style="list-style-type: none"> All these findings <u>have</u> been confirmed with bite-wing radiographs.
<ul style="list-style-type: none"> I am writing to refer this patient who I suspect is suffering from rheumatic 	<ul style="list-style-type: none"> I am writing to refer this patient who <u>I</u> suspect is suffering from rheumatic

fever and need urgent admission.	fever and <u>needs</u> urgent admission.
<ul style="list-style-type: none"> I believe that the teeth 65 and 54 needs to be extracted followed by space maintainer. 	<ul style="list-style-type: none"> I believe that the teeth 65 and 54 <u>need</u> to be extracted followed by space maintainer.
<ul style="list-style-type: none"> Threadworms looks like fine pieces of cotton thread that can grow up to 1.5 cm long. 	<ul style="list-style-type: none"> Threadworms <u>look</u> like fine pieces of cotton thread that can grow up to 1.5 cm long. A threadworm <u>looks</u> like fine pieces of cotton thread that can grow up to 1.5 cm long.

For more details follow these links:

- [The Writing Centre](#)
- [The Owl](#)

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Special Usage of Articles

There are some situations where you should always use the definite article and there are some situations where the indefinite article is required. Understanding these rules can greatly reduce the number of "minor" errors in your writing so please study these rules carefully.

😊 Handy Hint!

Articles are usually omitted in the case notes. This is because the case notes are in short note form and standard grammar rules do not apply. However for referral letters it is necessary to apply and adhere to standard grammar rules including article usage.

Body Parts

The definite article "the" should be used when referring to parts of the body.

Incorrect	Correct
<ul style="list-style-type: none">Pain in left groin.Pain in stomach.I suspect it to be adenoma of parotid gland.Mr. Smith had an operation on a left knee.	<ul style="list-style-type: none">Pain in the <u>left</u> groin.Pain in <u>the</u> stomach.I suspect it to be adenoma <u>of the</u> parotid gland.Mr. Smith had an operation <u>on the</u> left knee.

Names of Diseases

Do not use an article for names of diseases or conditions.

Incorrect	Correct
<ul style="list-style-type: none">The patient is suffering from the high blood pressure.Recently, the patient has complained of the headache.The patient was diagnosed with the arthritis.The patient has had the influenza for three days.	<ul style="list-style-type: none">The patient is suffering from high blood pressure.Recently, the patient has complained of headache.The patient was diagnosed with arthritis.The patient has had influenza for three days.

Same

Always use the definite article with this word.

Incorrect	Correct
<ul style="list-style-type: none">• She has a family history of same disease that had been controlled by Risperidone.• The children were treated by same dentist.• The medication is same as last time.	<ul style="list-style-type: none">• She has a family history of <u>the same</u> disease that had been controlled by Risperidone.• The children were treated by <u>the same</u> dentist.• The medication is <u>the same</u> as last time.

Articles with Gerunds

A gerund is the ...ing form of a verb which takes on the grammatical function of a noun. It can be the subject or object in a sentence. Usually no article is required with gerunds.

Incorrect	Correct
<ul style="list-style-type: none">• On review today, Mr Walker has reduced the smoking from 20 to 10 cigarettes per day.• The patient was advised to stop the drinking.	<ul style="list-style-type: none">• On review today, Mr Walker has reduced smoking from 20 to 10 cigarettes per day.• The patient was advised to stop drinking.

Articles and Nominalisation

Nominalisation is a process where verbs can be turned into a "noun phrase". For example: The patient sucked his thumb until he was five becomes The patient had a habit of thumb sucking until the age of five.

Often in medical English it necessary to use nominalisation such as: The excessive drinking of alcohol will adversely affect your health. The reduction of weight has led to improved health. It is common in these cases to use an article before the nominalised expression.

The other benefit of using the style of writing is that it creates a formal tone and allows you to summarise details from the case notes.

Incorrect	Correct
<ul style="list-style-type: none">• The patient is complaining of discomfort during passing of urine.	<ul style="list-style-type: none">• The patient is complaining of <u>discomfort during the passing of urine</u>.

Example Cohesive Paragraphs

Doctors

Initially, I saw Mr. Jones last month when he came for check-up. At this time his blood pressure showed a mild elevation (165/90). Also his weight was above the normal limit (85 kg while his height is 173 cm). However, the cardiovascular examination and the urinalysis were normal. Therefore I advised him to lose weight, to stop smoking cigarettes and to come for a review visit within one month. A prostate specific antigen test was requested to be done before the next visit.

Dentists

Initial examination on 20/ 02/ 2008 revealed that 54 has a temporary filling with a cavity extending through the furcation. Based on the bitewing radiological findings, I advised both 54 and 65 be extracted along with the construction of a space maintainer. Moreover I advised the filling of carious 55 and fissure sealant for all 6's. In my view, general anaesthesia is the proper sedation as the patient is known to be uncooperative in a dentist chair.

Nurses

When admitted to this hospital, Mr. Jagger complained of haemetemesis, anorexia, dizziness associated with weight loss and anaemia. He also was suffering from severe epigastric pain after meals. Therefore, his stool was examined and an endoscopy has been performed.

New Information Vs Previously Mentioned Information

Indefinite Article: A or An

When you mention something for the first time the indefinite article a/an is required. This signifies to the reader that it hasn't been mentioned before.

Definite Article: The

When you mention something for the second and subsequent times that we mention it the definite article the is required because we are referring to something which has been mentioned before.

Example: Initially, she came to me on 03/07/06 for a blood test. The results of the blood test were negative.

Correct application of this rule creates cohesion in your letter as you are able to connect ideas, as in the example above, where the reader knows which blood test is being referred. Conversely, incorrect use can confuse the reader.

Example: Initially, she came to me on 03/07/06 for the blood test. The results of a blood test were negative.

In the example above the ideas are not connected and the reader will be confused.

Incorrect	Correct
<ul style="list-style-type: none">The patient has <u>the</u> family history of diabetes. <p>Explanation: If it is the first time to give this information then the indefinite article is required for countable nouns.</p>	<ul style="list-style-type: none">The patient has <u>a</u> family history of diabetes.
<ul style="list-style-type: none">In addition, <u>the</u> pain in the right knee joint has appeared over the last 2 days.Thank you for seeing, Mr and Mrs Conway, who have presented to me for fertility advice. <p>Explanation: If it is the first time to give this information and the word is an uncountable noun, such as pain or advice, then no article is required. Note, this error has a big effect on meaning: <u>the</u> in this case implies that this subject has been mentioned previously, which of course it hasn't.</p> <p>For more details on countable & uncountable nouns click here</p>	<ul style="list-style-type: none">In addition, <u>pain</u> in the right knee joint has appeared over the last 2 days.Thank you for seeing, Mr and Mrs Conway, who have presented to me for fertility advice.

- | | |
|---|---|
| <ul style="list-style-type: none">• Thank you for seeing this patient ,an eight year old girl who presented today with the broken left arm following the accident at his school play ground.It has been forty minutes since accident. | <ul style="list-style-type: none">• Thank you for seeing this patient ,an eight year old girl who presented today with <u>a</u> broken left arm following <u>an</u> accident at his school play ground.It has been forty minutes since <u>the accident</u>. |
|---|---|

Last modified: Tuesday, 20 July 2010, 05:27 AM

Referring to a Patient

There are certain conventions which need to be followed when referring to a patient in a formal letter. This worksheet will explain what you need to know so that you can conform to these conventions.

The basic rules regarding titles are as follows:

- Mr. is used for adult men, married or single
- Mrs. is used for married women including widows
- Ms. is used to refer to both married or unmarried women
- Miss is used for young girls or unmarried women
- Master is used for young boys, but is rare nowadays as it has become old fashioned. It is still commonly used on an envelope, but not in the body of the letter.

nb Both miss & master are not abbreviations so no punctuation is required.

 **Handy Tip 1:** Definitely do not use titles with first names only, i.e Mr Thomas or Mrs. Carol as this is not acceptable. See below for correct usage.

These titles can be used in the following ways

- I am writing to refer Mr. Hacker (standard)
- I am writing to refer Mr. Thomas Hacker (very formal, usually used above the address or after Re: but not on the body of the letter.)
- I am writing to refer Thomas (informal and commonly used for children)
- I am writing to refer this patient (commonly used in the opening sentence if patient's name has been mentioned above as in Re: Mr. Thomas Hacker)

Question: When and how often should I use the patient's name in the letter?

Answer: The standard way is to write the patient's name in full below the opening salutation. Then, use the patient's name once per paragraph as illustrated below ,after which you can use pronouns. Also, be consistent in how you refer to the patient. Do not mix up your use of first names and surnames in the letter as this will only confuse the reader.

💡 Handy Tip 2: There is no need to write the patient's name out in full in the introduction if you have stated it below the salutation i.e Re: Mrs. Carol Brady as it is very clear who you are writing about. In such cases use "this patient" or title and surname "Mrs. Brady". If you do this you will be following standard conventions.

Example Letter

31 July 2009

The Director
Redeemer Palliative Care Hospital
32 Nelson Drive
St Lucia
Queensland, 4050

Dear Sir/Madam,

Re: Mrs. Carol Brady
DOB 4 February 1968

I am writing to refer this patient, a 42 year old married woman who was diagnosed with stage 4 ovarian cancer on 22 May 2009. I would appreciate it if you could provide respite care for her.

I have been supporting Mrs. Brady and her family for the past 2 months, and she is on palliative care and now only expected to live for four months. Her husband Mr. Mike Brady is her primary carer, and he has reduced his work hours to look after her and their children aged 10 and 12. He usually feels that he is exhausted, emotionally stressed and isolated because he finds it difficult to cope with all the work at home.

Mrs. Brady is depressed and withdrawn and she does not want any visitors. In addition, she has not been eating much recently. Regarding medication, she takes oxycontin and stemitel twice daily and is on a regular panadol. However, her pain is still increasing.

Could you please do a reassessment of Mrs. Brady's pain medication as it may need to be increased. Thank you for looking after this patient and please do not hesitate to contact me if you have any further questions.

Yours sincerely,

Community Nurse

Common Mistakes

Mr. Langer is an only child.

Alfie is an only child.

<p>Explanation: Mr. is only used for adult men, so if the patient is a child you should use their first name.</p>	
<p>Thank you for seeing my patient, Master Alfie Langer, a 7 year old boy.</p> <p>Explanation: Master is somewhat old fashioned and does not sound "familiar" if used in the body of the letter.</p>	<p>Thank you for seeing my patient, <u>Alfie Langer, a 7 year old boy.</u></p>
<p>Mr. Peter, a 23 year old young man, presented at my surgery today complaining of painful wisdom teeth.</p> <p>Explanation: You can not use titles with first names only.</p>	<p><u>Mr Holmes, a 23 year old young man,</u> presented at my surgery today complaining of painful wisdom teeth.</p>
<p>I am writing to refer Miss. Green for surgical assessment.</p> <p>Explanation: Miss is not an abbreviation so no punctuation required.</p>	<p>I am writing to refer <u>Miss Green</u> for surgical assessment.</p>
<p>Dear Dr., I am writing this letter...</p> <p>Explanation: Do not use short forms without the surname of the person.</p>	<p>Dear Doctor, <u>I am writing this letter....</u></p>

Common Mistakes Regarding Physical Description

Incorrect	Correct
<p>Advice was given to reduce her weight. After the verb reduce it is not necessary to follow with a pronoun. So you is not required. Simply say: I advised him to reduce weight, or, you need to reduce weight.</p> <p>In addition, she had lost her weight. After the verb lose it is not correct to follow with a pronoun.</p>	<ol style="list-style-type: none"> 1. Advice was given to reduce her weight. 2. The patient was advised to lose weight. 3. A reduction of weight was advised. <ol style="list-style-type: none"> 1. In addition, she had lost weight. 2. In addition, she has lost weight over the past 2 months. 3. In addition, the patient has reduced weight from 61 kg to 55kg.
<p>He is now obese with a 99kilos weight and a 170cm height. The use of the correct verb & noun form and associated grammar is difficult. Refer opposite for correct usage.</p>	<ol style="list-style-type: none"> 1. He is now obese with a weight of 99kilos and a height of 170cm. (noun form) 2. He weighs 99 kg and is 170cm tall. 3. He weighs 99kg and is 170cm tall.
<p>1. Today's examination revealed multiple missing teeth, various carious lesions and a periodontal pocket of depth 4-9mm. 2. There are several periodontal pockets with about 4-9 mm in depth. Correct word order is: Depth of 4-9mm Height of 173cm Length of 20 m Weight of 78kg 3. His height was 173cm. Weight can change but height can not so don't use past tense.</p>	<ol style="list-style-type: none"> 1. Today's examination revealed multiple missing teeth, various carious lesions and a periodontal pocket of depth 4-9mm. 2. There are several periodontal pockets with a depth of 4-9 mm or more. 3. There are several periodontal pockets with a depth of about 4-9 mm. 4. His height is 173cm.
<p>1. He was overweight 85 Kg with respect to his height 173 cm. This sentence is a shortened version similar to the case notes. It is important to write in full sentences.</p>	<ol style="list-style-type: none"> 1. He was overweight of 85 Kg with respect to his height of 173 cm.

Difficult Words

The English language is governed by rules. However, there are also many exceptions to these rules and words, which do not follow the normal or expected pattern are those which often cause problems. Study this list carefully so that you can improve your grammatical accuracy and knowledge.

Complain Vs Complaint

Complain is a verb

- The patient complained of severe abdominal pain.

Complaint is a noun

- The patient presented with a complaint of severe abdominal pain.

Note 1: Complaint is a countable noun. so it can be used in the plural form or singular with an article.

Note 2: The two main prepositions used with complain are: complain of & complain about.

- Mr. Cochrane presented with complaints of nausea, headache and fever. (plural)
- Mr. Cochrane presented with a complaint of nausea. (singular with article)

Incorrect	Correct
<ul style="list-style-type: none">• The patient complaints of chest pain and her blood pressure is high.• The patient presented with a complain of chest pain.• The patient presented with complaint of chest pain.• He presented to my office on 23/03/2008 complaining on severe pain associated with the lower left first molar.	<ul style="list-style-type: none">• The patient <u>complains</u> of chest pain and her blood pressure is high.(verb)• The patient presented with a <u>complaint</u> of chest pain.(noun)• The patient presented with a <u>complaint</u> of chest pain. (article required)• He presented to my office on 23/03/2008 <u>complaining</u> of severe pain associated with the lower left first molar.

Suggest & Recommend Vs Advise

Suggest, recommend and advise are all words commonly used in referral letters to report information were given to the patient. However their rules of use differ and result in errors. Here are some examples of their correct and incorrect usage.

Incorrect	Correct
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- I have suggested him to see you next week.
- I suggested her to return in morning as she required further blood test and assessment.
- I recommended him to rest for 3 days.

Explanation: The words suggest & recommend cannot be followed by an object pronoun such as him/her whereas advise can.

- I suggested (that) he see you next week.
- I advised him to see you next week
- I suggested (that) she return in morning as she required further blood test and assessment.
- I advised her to return in morning as she required further blood test and assessment.
- I recommended (that) he rest for 3 days.

Explain Vs Tell

Explain and tell also have different rules which cause confusion

Incorrect	Correct
<ul style="list-style-type: none"> • I explained them that unsuccessful conception was not unusual in their case. • I have already explained the couple the basic advice regarding conception. <p>Explanation: The word explain cannot be followed by a pronoun or noun without the preposition to whereas tell can.</p>	<ul style="list-style-type: none"> • I explained to them that unsuccessful conception was not unusual in their case. • I told them that unsuccessful conception was not unusual in their case. • I have already explained to the couple basic advice regarding conception. • I have already told the couple basic advice regarding conception.

Advise Vs Advice

Advise is a verb

- We advise patients on how to take their medication.

Advice is a noun

- We give advice or provide advice to patients on how to take their medication.

Note 1: The noun advice is uncountable so it can not be used in plural form. i.e. advices is incorrect as is an advice.

- I gave some advice to the patient regarding her medication.

Note 2: The pronunciation is different: advise advice

Incorrect	Correct
<ul style="list-style-type: none"> • It would be greatly appreciated if you could make a visit to this family and advice his parents regarding the recommended vaccines for both children. • I am writing to refer this patient to you for an advice regarding the management of his bilateral inguinal hernia. • I gave an advice to the patient regarding her medication. • I gave advices to the patient regarding her medication. • Please advice the patient on how and when to take their medication. 	<ul style="list-style-type: none"> • It would be greatly appreciated if you could make a visit to this family and <u>advise</u> his parents regarding the recommended vaccines for both children. (verb) • I am writing to refer this patient to you for <u>advice</u> regarding the management of his bilateral inguinal hernia(noun) • I gave <u>some advice</u> to the patient regarding her medication.(noun) • I gave <u>advice</u> to the patient regarding her medication.(noun) • Please <u>advise</u> the patient on how and when to take their medication. (verb)

Request

Request can be both a verb and noun.

Request as a verb

- The patient requested painkillers. (verb form)

Request as a noun

- The patient **made** a request for painkillers. (noun form: request+for)

Incorrect	Correct
<ul style="list-style-type: none"> • The patient requested for new dentures. • Ms. Green requested about IVF treatment. <p>Explanation: The common mistake is to use the verb form plus preposition which is incorrect.</p>	<ul style="list-style-type: none"> • The patient <u>requested</u> new dentures. (verb) • The patient <u>made a request</u> for new dentures. (noun) • Ms. Green <u>requested</u> IVF treatment. (verb)

	<ul style="list-style-type: none"> • Ms.Green <u>made a request</u> for IVF treatment. (noun)
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Affect Vs Effect

Affect is a verb

- The patient has not been affected by the treatment.

Effect is a noun

- The treatment has had no effect.

Note: The pronunciation is the same.

Incorrect	Correct
<ul style="list-style-type: none"> • She has also been effected by glaucoma for the past 4 years. • The side affects of this medication are unknown. 	<ul style="list-style-type: none"> • She has also been <u>affected</u> by glaucoma for the past 4 years. (verb) • The side <u>effects</u> of this medication are unknown. (noun)

Widow or Widower

- Widow (noun) refers to a woman whose husband has died and who has not remarried.
- Widower (noun) refers to a man whose wife has died and who has not remarried.
- Widowed (adjective) refers either a man or woman whose spouse has died and has not remarried.

Incorrect	Correct
<ul style="list-style-type: none"> • I am writing to refer Mrs. Saunders, a 58-year-old widowed who admitted with pain, dehydration and nausea. • I am writing to refer Mr. Saunders, a 60-year-old widow who complained of pain in his upper right second molar. 	<ul style="list-style-type: none"> • I am writing to refer Mrs. Saunders, a 58-year-old <u>widow</u> who admitted with pain, dehydration and nausea.(noun) • I am writing to refer this patient a 58-year-old <u>widowed woman</u> who admitted with pain, dehydration and nausea.(adjective)

	<ul style="list-style-type: none"> I am writing to refer Mr. Saunders, a 60-year-old widower who complained of pain in his upper right second molar.(noun)
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History

History **is always present, never past because you can't erase it!** Therefore you need to use simple present tense not past tense when using this expression.

Incorrect	Correct
<ul style="list-style-type: none"> Mrs. McGowan had a history of heart palpitation of 3 day duration. 	<ul style="list-style-type: none"> Mrs. McGowan has a history of heart palpitation of 3 day duration.

Allergy Vs Allergic

Allergy is a countable noun

- Michael has no known allergies.(plural)
- Michael has a peanut allergy. (singular)

Allergic is an adjective

- Michael is allergic to peanuts.

Incorrect	Correct
<ul style="list-style-type: none"> In addition, he is known allergic to nuts for which he was admitted to hospital with anaphylaxis 2 years ago. Regarding his medical history he is allergy to sulphur containing drugs. 	<ul style="list-style-type: none"> In addition, he has <u>a</u> known <u>allergy to</u> nuts for which he was admitted to hospital with anaphylaxis 2 years ago. (noun) In addition, he is known <u>to be allergic to</u> nuts for which he had been admitted in the hospital with anaphylaxis 2 years ago.(adjective) Regarding his medical history he <u>has an allergy to</u> sulphur containing drugs. (noun) Regarding his medical history he <u>is allergic to</u> sulphur containing drugs.

	(adjective)
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Confident Vs Confidence

Confident is an adjective

- The patient is not confident in her ability as a mother.

Confidence is a noun

- The patient lacks confidence in her ability as a mother.

Incorrect	Correct
<ul style="list-style-type: none"> • The patient has not confident social situations. • The patient is not confidence in social situations. 	<ul style="list-style-type: none"> • The patient has no <u>confidence</u> in social situations. (noun form) • The patient is not <u>confident</u> in social situations. (adjective form)

a few/few & a little/little

Few and a few is used with plural nouns, and little and a little is used with uncountable nouns. Little and few have **negative connotations** and are similar in many to not much/ not many. A little and a few have **positive connotations** and are similar in meaning to some. Mixing up these words therefore will completely change the meaning of the sentence.

Incorrect	Correct
<ul style="list-style-type: none"> • The patient has reduced speech output and a little eye contact. • There are few ways to help identify the possibility of threadworms such as checking the anus of your children at night and frequent scratching. 	<ul style="list-style-type: none"> • The patient has reduced speech output and <i>little</i> eye contact.(negative connotation required here) • There are <u>a few</u> ways to help identify the possibility of threadworms such as checking the anus of your children at night and frequent scratching.(positive connotation required)

during/while

During is followed by a noun

- During hospitalisation, the patient made a full recovery.
- The patient had many visitors during his stay in hospital.

While is followed by a phrase or gerund: ____ ing

- While in hospital, the patient made a full recovery.
- The patient had many visitors while recovering in hospital.

Incorrect	Correct
<ul style="list-style-type: none">• He twisted his ankle during playing squash 3 months ago.	<ul style="list-style-type: none">• He twisted his ankle <u>during a game of squash</u> 3 months ago.• He twisted his ankle <u>while playing squash</u> 3 months ago.

following/followed by

Incorrect	Correct
<ul style="list-style-type: none">• She was admitted to our hospital followed by a collapse at home with dehydration, nausea and severe pain. <p>Incorrect as it means the patient was admitted to hospital first, then collapsed.</p>	<ul style="list-style-type: none">• She was admitted to our hospital following a collapse at home with dehydration, nausea and severe pain. <p>Correct as it means the collapse occurred before being admitted to hospital.</p>

Informal & Casual Expressions

The written language of English is different to the spoken language in that it is quite formal whereas the spoken form is more casual. If spoken language expressions are used in formal letters it affects the “tone and register” of the letter. Therefore, **it is important to maintain a formal tone and use standard expressions.** Below is a list of inappropriate casual expressions with more formal appropriate expressions.

Example Words

Casual	Formal	Casual	Formal	Casual	Formal	Casual	Formal	Casual	Formal	Casual	Casual	Formal
asks for	requests	think	believe	get	became	so	very	but	however	kids	children	
say	state	get	receive	got	become	about	regarding	really	greatly	sad	depressed	
said	stated	got	received	So	Therefore	a bit	slightly	kid	child	till	until	
like	include	like	such as	don't	do not	Thanks	Thank-you	kids	children	lots	a lot of	

Example Sentences

Inappropriate Casual or Spoken Expression	Appropriate Formal Expression
<ul style="list-style-type: none"> She refuses to eat solids and prefers fluids only like apple juice and lemonade. There are several measures which can be taken to reduce the risk of infection like taking a shower in morning, using separate towel for everyone, changing underwear and bed sheets regularly, vacuuming carpets, keeping the nails short and washing hand thoroughly. She was given general advise for softening her stool, like changing her dietary habit but she was non compliant. 	<ul style="list-style-type: none"> She refuses to eat solids and prefers fluids <u>such as</u> apple juice and lemonade. There are several measures which can be taken to reduce the risk of infection <u>including</u> taking a shower in morning, using separate towel for everyone, changing underwear and bed sheets regularly, vacuuming carpets, keeping the nails short and washing hand thoroughly. She was given her general advise for softening her stool <u>such as</u> changing her dietary habit but she was non

<p>Explanation: <i>Like</i> is a casual expression, and the two commonly used formal expressions with the same meaning are <i>such as</i> & <i>including</i>.</p>	<p>compliant.</p>
<ul style="list-style-type: none"> • Thanks for seeing Mr. Brown. • Thanks for arranging a home visit for this patient. If you have any further questions, please feel free to ask me. <p>Explanation: <i>Thanks</i> is a casual expression and should be written in full.</p>	<ul style="list-style-type: none"> • <u>Thank you</u> for seeing Mr. Brown. • <u>Thank you</u> for arranging a home visit for this patient. If you have any further questions, please be free to ask me.
<ul style="list-style-type: none"> • In view of the above signs and symptoms I think she is suffering from schizophrenia. • The patient's family is thinking about a reduction in her medication. <p>Explanation: <i>think</i> is informal and preferable expression is either <i>believe</i> or <i>consider</i>, depending on the context.</p>	<ul style="list-style-type: none"> • In view of the above signs and symptoms I <u>believe</u> she is suffering from schizophrenia • The patient's family is <u>considering</u> a reduction in her medication.
<ul style="list-style-type: none"> • I would really appreciate your attention regarding further management of this patient. <p>Explanation: <i>Really</i> is spoken language and should be avoided in formal writing.</p>	<ul style="list-style-type: none"> • I would <u>very much</u> appreciate your attention regarding further management of this patient. • I would <u>greatly</u> appreciate your attention regarding further management of this patient.
<ul style="list-style-type: none"> • About his dietary habits, he eats a large amount of oily and sweet food. • If you require any other information about her 	<ul style="list-style-type: none"> • <u>Regarding</u> his dietary habits, he eats a large amount of oily and sweet food. • If you require any other information <u>regarding</u> her

<p>condition, please do not hesitate to contact me.</p> <p>Explanation: <i>About</i> is a casual expression, <i>regarding</i> is more suitable. <i>Lots of</i> is also casual. “A large amount of” is more formal.</p>	<p>condition, please do not hesitate to contact me.</p>
<ul style="list-style-type: none"> • She had lots of pain. • He eats lots of oily food. <p>Explanation: <i>Lots</i> is a spoken expression</p>	<ul style="list-style-type: none"> • She had <u>a lot of</u> pain. • He eats <u>large amounts of</u> oily food.
<ul style="list-style-type: none"> • There was nothing significant in his social history. <p>Explanation: <i>Nothing</i> is more commonly a spoken expression which is not suitable for writing.</p>	<ul style="list-style-type: none"> • There were <u>no significant findings</u> in his social history.
<ul style="list-style-type: none"> • Please do not hesitate to contact me if u need additional information. <p>Explanation: Definitely no <i>text or SMS language</i> in formal letters. Replace with: you</p>	<ul style="list-style-type: none"> • Please do not hesitate to contact me if <u>you</u> need additional information.
<ul style="list-style-type: none"> • She has got maternal postpartum haemorrhage of 800mls. • Mr O' Riley got an appointment for a follow up visit with his general practitioner, Dr. Avril Jensen. • The mother got sick for a few days. <p>Explanation: <i>Got/Get</i> are casual expressions and should generally be avoided in formal letters.</p>	<ul style="list-style-type: none"> • She <u>has had</u> maternal postpartum haemorrhage of 800mls. • Mr O' Riley <u>has</u> an appointment for a follow up visit with his general practitioner, Dr. Avril Jensen. • The mother <u>became</u> sick for a few days

- Should you have any concerns regarding them, please do not hesitate to contact me.

Explanation: The pronoun *them* sounds casual here. It is much better to use the patient's name, especially in the final sentence of the letter.

- Should you have any concerns regarding Mary and her child, please do not hesitate to contact me.

- At the moment, she is weak and disorientated sometimes but severe pain has been alleviated.

Explanation: Sometimes is a casual expression. More formal expressions include: at times or on occasions

- At the moment, she is weak and disorientated at times but severe pain has been alleviated.
- At the moment, she is weak and disorientated on occasions but severe pain has been alleviated.

- This pain was exaggerated to cold and hot things

Explanation: *Things* is a casual expression and should be avoided

- This pain was exaggerated to hot and cold stimuli.

- A repeat vaginal examination revealed a very tender right vaginal fornix. But her blood pressure pulse is within normal range.

Explanation: It is not good English to begin a sentence with the conjunction *but* In this case use *However*, as it is more formal

- A repeat vaginal examination revealed a very tender right vaginal fornix. However, her blood pressure pulse is within normal range.

- Her temperature and blood pressure were normal while pulse was elevated at 88. So I recommended that she return today for a blood test and reassessment.

- Her temperature and blood pressure were normal while pulse was elevated at 88. Therefore, I recommended that she return today for a blood test and reassessment.

<p>Explanation: So is a casual word, you can use it within a sentence, but not to start a sentence in formal writing. Replace with: Therefore,</p>	
<ul style="list-style-type: none"> There was evidence of poor oral hygiene, carious lesions and active periodontal disease <i>too</i>. <p>Explanation: <i>too</i> is informal, a more formal expression is <i>as well</i>.</p>	<ul style="list-style-type: none"> There was evidence of poor oral hygiene, carious lesions and active periodontal disease <u>as well</u>.
<ul style="list-style-type: none"> Her husband was upset because, she was not showing interest towards the <i>kids</i>. Mark's dad also suffers from this condition. The teacher spoke to her <i>mum</i> regarding the regular absences from school. <p>Explanation: <i>kids</i>, <i>dad</i>, <i>mum</i> are all spoken expressions which are inappropriate in formal letters.</p>	<ul style="list-style-type: none"> Her husband was upset because, she was not showing interest towards the <u>children</u>. Mark's <u>father</u> also suffers from this condition. The teacher spoke to her <u>mother</u> regarding the regular absences from school.
<ul style="list-style-type: none"> She had had termination of pregnancy <i>10 years back</i>. He is a regular smoker and drinker with the only relevant past history of left inguinal hernia operation <i>2 years back</i>. <p>Explanation: Back is used as a spoken expression not a written expression.</p>	<ul style="list-style-type: none"> She had had termination of pregnancy <u>10 years ago</u>. He is a regular smoker and drinker with the only relevant past history of left inguinal hernia operation <u>2 years previously</u>.
<ul style="list-style-type: none"> He had a habit of thumb sucking till the age of 5. <p>Explanation: Till is casual, until is formal</p>	<ul style="list-style-type: none"> He had a habit of thumb sucking <u>until</u> the age of 5.
<ul style="list-style-type: none"> She was so anxious. <p>Explanation: <i>So</i> is informal and subjective, whereas <i>very</i> is more formal and objective.</p>	<ul style="list-style-type: none"> She was <u>very</u> anxious.

<ul style="list-style-type: none"> Owen has big tonsils. <p>Explanation: big is informal and does not sound professional.</p>	<ul style="list-style-type: none"> Owen has <u>enlarged</u> tonsils
<ul style="list-style-type: none"> I am writing to request a follow-up for this patient. Examination revealed that his vitals were stable and left knee was swollen without effusion. Examination revealed normal vitals. <p>Explanation: Vitals and follow up are incomplete expressions, commonly used in spoken English, but not suitable for formal writing.</p>	<ul style="list-style-type: none"> I am writing to request a <u>follow-up visit</u> for this patient. Examination revealed that his <u>vital signs</u> were stable and left knee was swollen without effusion. Examination revealed that his <u>vital signs</u> were normal.
<ul style="list-style-type: none"> Mrs. Jones is a widow who complained of persistent chest pain at roughly 1.45pm. Miss Roberts started smoking around 6 months ago. <p>Roughly and around are casual or vague expressions.</p>	<ul style="list-style-type: none"> Mrs. Jones is a widow who complained of persistent chest pain at <u>approximately</u> 1.45pm. Miss Roberts started smoking <u>approximately</u> 6 months ago.
<ul style="list-style-type: none"> I recommend some investigations to rule out cancer. I requested some blood tests. <p>Explanation: Some is vague and does not sound professional.</p>	<ul style="list-style-type: none"> I recommend <u>further</u> investigations to rule out cancer. I requested <u>additional</u> blood tests.
<ul style="list-style-type: none"> Her BMI was 28 and all the rest of the examinations were normal. <p>Explanation: <i>all the rest of</i> sounds informal.</p>	<ul style="list-style-type: none"> Her BMI was 28 and <u>the remainder of</u> the examinations were normal.
<ul style="list-style-type: none"> Abdominal examination revealed a small right groin swelling that's consistent with inguinal hernia. 	<ul style="list-style-type: none"> Abdominal examination revealed a small right groin swelling <u>that is</u> consistent with inguinal hernia.

- Thank you for your expert care and please don't hesitate to contact us if you require further information.

Explanation: It is best to **avoid contractions** in formal letters as these are used more in spoken English.

- Thank you for your expert care and please do not hesitate to contact us if you require further information.

- In addition, she is just able to tolerate fluids.

Explanation: Just can sound informal at times.

- In addition, she is only able to tolerate fluids.

Medical Terminology

The medical case notes for the OET exam often contain abbreviations, medical acronyms and technical language. The task for the writer is to expand these into full words and sentences. There are 3 reasons why this is important.

1. As the OET is a test of English, you need to demonstrate your ability to transfer technical language in the case notes into Standard English.
2. For some letters you may have to write to someone who is not a health professional such as a social worker or family member.
3. A referral letter is not a report so the standard conventions of letter writing require a formal style which includes using complete words and sentences.

 **Handy Hint:** It is a test of English not Latin, so where possible avoid the use of Latin based acronyms and words.

Here is a list of common abbreviations used in Australia.

Acronym/Short Form	Full Expression	Acronym/Short Form	Full Expression
Abdo	Abdomen	mane	in the morning
AC	before meals	min	minute
ADL	activities of daily living	NAD	no abnormality detected
&	And	nocte	in the evening
BD/bid	2 times a day	OPG	orthopantomogram
BP	blood pressure	P/PR	Pulse/Pulse Rate
BW x-rays	bite wing x-rays	PMH	past medical history
C/O	complains of	PRN	as required
cap	Capsule	QID	4 times a day
DOB	Date of Birth	R	right
ECG	electrocardiograph	tab	tablet
F/-	fluoride application	sid	once a day
FBC	full Blood Count	TDS/tid	3 times a day
FTA	failed to Attend	w/o	without
IV	intravenous	y/yrs	year
h	Hour	? rheumatic fever	possibility of something
hx	History	6/h	6 hourly
L	left	+	Positive
lab	laboratory	3/12	3 months

Exceptions to this rule include abbreviations of measurement. Therefore it is acceptable to use the following in short form:

Acronym/Short Form	Full Expression	Acronym/Short Form	Full Expression
cm	centimeter	ml	Millilitre
g	Gram	mg	Milligram
kg	Kilogram	mm hg	milligram of mercury

Common Errors

Incorrect	Correct
<ul style="list-style-type: none"> Her current medications include sid Metformin 500 mg. mane and nocte, Glycosamine 5mg.mane and Candesartan 10mg. nocte. 	<ul style="list-style-type: none"> Her current medications include <u>a daily dose of Metformin 500 mg. in the morning and at night</u>, Glycosamine 5mg.in the morning and Candesartan 10mg. <u>at night</u>.
<ul style="list-style-type: none"> After discharge from hospital, Mrs.Jones has been told to take Aperients (PRN) and Aldomet (250 mg bid). 	<ul style="list-style-type: none"> After discharge from hospital, Mrs.Jones has been told to take Aperients <u>when required</u> and Aldomet <u>twice a day</u>.
<ul style="list-style-type: none"> I treated Claudia with prednisolone5mg 1t/sid for seven days. 	<ul style="list-style-type: none"> I treated Claudia with prednisolone 5mg <u>tablet once a day</u> for seven days.
<ul style="list-style-type: none"> On examination, there was tenderness and rebound tenderness over the R. iliac fossa. 	<ul style="list-style-type: none"> On examination, there was tenderness and rebound tenderness over the <u>right</u> iliac fossa.
<ul style="list-style-type: none"> I am writing to refer Mrs. Wilson, a 45yr old woman who is suffering from signs and symptoms suggestive of advanced English. 	<ul style="list-style-type: none"> I am writing to refer Mrs. Wilson, a <u>45-year-old</u> woman who is suffering from signs and symptoms suggestive of advanced English.

<ul style="list-style-type: none"> She presented to me yesterday evening with abdominal pain mostly in the left iliac fossa which had been present for the last 24 hrs. 	<ul style="list-style-type: none"> She presented to me yesterday evening with abdominal pain mostly in the left iliac fossa which had been present for the last 24 <u>hours</u>.
<ul style="list-style-type: none"> Her mother died of MI 	<ul style="list-style-type: none"> Her mother died of <u>myocardial infarction</u>
<ul style="list-style-type: none"> On examination she was found to have PR 88/min 	<ul style="list-style-type: none"> On examination she was found to have <u>a pulse rate of 88 beats per minute</u>. On examination she was found to have <u>a pulse of 88</u>.
<ul style="list-style-type: none"> Mr Duane Eddy 57/m is an urgent referral regarding an ulcer in R. lateral border of tongue. 	<ul style="list-style-type: none"> Mr Duane Eddy, a <u>57 year old male</u> is an urgent referral regarding an ulcer in the <u>right</u> lateral border of tongue
<ul style="list-style-type: none"> I would appreciate if you could inform me about her treatment & progress over the next few days. 	<ul style="list-style-type: none"> I would appreciate if you could inform me about her treatment <u>and</u> progress over the next few days.
<ul style="list-style-type: none"> The patient was discharged on Dec. 30 2009. 	<ul style="list-style-type: none"> The patient was discharged on <u>December 30 2009</u>. The patient was discharged on <u>30/12/09</u>.
<ul style="list-style-type: none"> Lab work and review was planned for the next morning. 	<ul style="list-style-type: none"> <u>Laboratory</u> work and review was planned for the next morning.

- For more abbreviations click [here](#)

Model Letter Conjunctivitis

The Emergency Department
Royal Melbourne Eye Hospital
Alexandra Parade
Fitzroy

Dear Doctor
Re. Mrs Constance Markwell

I am writing to refer Mrs Markwell, a 72 year old married mother of 3 adult children who is presenting with a visual impairment.

Initially, she presented to me on 21/2/06, complaining of inflamed, sticky and weeping eyes. Both her eyes were reddish with watery discharge. However, her right eye was worse than the left eye. Therefore she was prescribed chlorisig drops 4 hourly. She has had thyroidism for 3 years, high blood pressure for 1 year and a hip replacement was done in 2005. Her current medications are Thyroxin 1 mg, Atacand 4 mg and Fosamax 10 mg daily. She has no known allergies.

On review after 2 weeks, she had made no improvement. In addition she had blurred vision with oedematous eye lids and conjunctival congestion., so chloramphenicol was prescribed 0.5% one drop three times daily and Bion tears one drop 4 hourly.

Unfortunately, today she was accompanied by her husband with complaints of impaired vision in both eyes and an inability to read books or watch television. There was oedema in both eyelids with white discharge. She could not read the eye chart.

In view of the above signs and symptoms I believe she needs immediate eye care facilities. I would appreciate your urgent attention to her condition.

Yours sincerely

Dr X

Sample Doctor Writing Task

Time allowed: 40 minutes

Read the case notes below and complete the writing task that follows:

Today's Date

14.10.10

Patient History

Amina Ahmed aged 8 years – new patient at your clinic Parents – Mother Ayama, house-wife. Father Talan, cab driver Brothers Dalma aged 4 and Roble aged 2 Family refugees from Somali 2005. Have Australian Citizenship Amina and father good understanding of English, mother has basic understanding of slowly spoken English. Amina had appendicectomy 2 years ago
No known allergies

09/10/10

Subjective

Fever, runny nose, mild cough, loss of appetite

Unable to attend school

Objective

Pulse 85/min

Temperature 39.4

No rash

No neck stiffness

CVS, RS & abdo – normal

Assessment

Viral infection

Management

Keep home from school

Rest and paracetamol three times daily

Review in 3 days if no improvement

12/10/10

Subjective

Amina not well

Cough +, continuous headache, lethargic, loss of appetite

Difficult to control temperature with Paracetamol

Mother worried

Objective

Fever 39.8 C

No rash or neck stiffness

Management

Prescribe Brufen 200mg as required

FBC & UFR were ordered

Review in two days with results of reports

14/10/10

Subjective

Both parents very concerned

Reported Amina lethargic and listless

Vomited twice last night and headaches worse

Objective

FBC- WBC(18000) and left shift

Urinary Function Report Normal

Temperature 40.2C

Pulse 110/min

Macula-papular rash over legs

Neck Stiffness+

Assessment

Meningococcal Meningitis Penicillin IV given (stat dose)

Plan

Arrange urgent admission to the Emergency Paediatric Unit, Brisbane General Hospital, for further investigation and treatment.

Writing Task

You are GP, Dr Lucy Irving, Kelvin Grove Medical Centre, 53 Goma Rd, Kelvin Grove, Brisbane. Write a referral letter to the Duty Registrar, Emergency Paediatric Unit, Brisbane General Hospital, 140 Grange Road, Kelvin Grove, QLD, 4222.

In your letter:

- Expand the relevant case notes into complete sentences.
- Do not use note form.
- The body of your letter should be approximately 200 words.
- Use correct letter format.

Sample Doctor Model Letter

14.10.10

The Duty Registrar
Emergency Paediatric Unit
Brisbane General Hospital
140 Grange Road
Kelvin Grove, QLD, 4222

Dear Doctor:
Re. Amina Ahmed (8years)

I am writing to refer Amina who is presenting with signs and symptoms of meningococcal meningitis for urgent assessment and management. She is the first child of a family of 5, which includes her parents and two younger siblings. They are immigrants from Somalia, though she and her father understand English.

Initially, accompanied by her parents, she presented to me on 9.10.10 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next two days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.

Regrettably, today Amina became lethargic and listless. She vomited twice last night and had been having severe headaches. On examination, she was severely febrile with a temperature of 40.2 and a pulse rate of 110 beats per minute. There was macula-papular rash over the legs and neck stiffness was present. Blood test showed leucocytosis with a shift to the left.

Based on the above, I believe she needs urgent admission and management. Please note, Penicillin IV has been given as a stat dose.

Yours sincerely,

Dr. Lucy Irving

Kevin Grove Medical Centre
53 Goma Road
Kelvin Grove, Brisbane

Angelika

Some notes on my feedback.

The highlighted colours in the feedback (right) column refer to those parts of your letter highlighted with the same colour; where I have crossed out your text, I am suggesting that that text is unnecessary; where I have added text in parentheses/brackets I am suggesting that additional text is needed to improve your original. **Please note that my comments will very often focus in some detail on the finer points of grammar and vocabulary. This is intended as language teaching—if there are many comments, it could simply be that there is a repetition of a minor error that might not unduly affect your test score.**

	196 words in the original This is a very strong letter indeed. Key information is well identified and clearly organised. The underlying grammar and vocabulary are accurate and complex. The comments I have made are quite minor, but the issues they identify might be enough to prevent the letter being at an A standard.
Dr. Haldun Tristan (Endocrinologist) Melbourne Endocrinology Centre 99 Brick Road East Melbourne, 3004	This would not lead to many lost marks, but I think this would more commonly be included on the following line without parentheses.
DATE??	
Dear Dr. Tristan,	
Re: Ms. Toula Athena	

<p>I am writing to refer this patient to you in order to rule out diabetes. Ms. Athena is a 47-year-old housewife. She is married and has 2 children. Her risk factors include: hypertension, obesity, strong family history (her mother was diagnosed with diabetes and died of stroke 10 (ten) years ago), elevated blood sugar and albuminuria.</p>	<p>I'm not sure this is really the main purpose of the letter—it seems more likely to be to refer for more specialised assessment and possible treatment.</p> <p>This information might be relevant to the particular case in some general way, but it is not directly relevant and, if used, would be better placed in the Re: section before the main part of the letter. (See the model letter for a possible treatment of this information.)</p> <p>As a general rule, write out numbers up to, and including, ten in full (this is an editing norm)—I have seen examples of letters where this is not the case, but we recommend writing in full to ‘be safe’.</p>
<p>Initially, she came to see me two months ago. She had been suffering from thirst, bulimia, nocturia and dizziness during the previous four months. In addition, she had been lethargic for the previous 7 (seven) weeks. Her blood pressure was elevated at 160/95 mm hg and pulse rate was 84 beats per minute. She was advised to</p>	<p>The insertion of the linking word, <i>and</i>, here is necessary to prevent a grammatical confusion—without it, it initially seems like blood and urine are a continuation of a list of things that the diet aims to reduce. The addition of <i>and</i> makes it clearer that you are introducing a separate item of advice.</p>

<p>keep on diet in order to reduce weight, (and) blood and urine tests were ordered.</p>	
<p>One month later, her condition did (had) not improve(d) and her weight was unchanged. Due to her symptoms and test results(,) antidiabetic and antihypertensive medications were prescribed.</p>	<p>The past perfect tense (had + past participle) is needed here to refer to a period of time leading up to a point in the past—in this case, the period from the initial consultation up to the one a month later.</p> <p>Some examiners pick up on missing commas apparently—it's a good idea to remember them to distinguish parts of the sentence (in this case and in the next paragraph, after the dependent clause introducing the main, independent clause).</p>
<p>Regrettably, today Ms. Athena's condition deteriorated. She complained of blurred vision and sight spots. Despite treatment(,) her blood pressure also was elevated at 165/90 mmhg.</p>	<p>This borders on being a little 'emotive' for a formal, 'objective' letter—it should not cost too many marks here, but could be deleted without sacrificing meaning.</p>
<p>I believe she requires admission to the Endocrinology Centre for treatment and stabilization. Please keep me informed of her condition.</p>	

Yours sincerely,	
Dr, Svetlana Starodubtseva	

Angelika

Some notes on my feedback.

The highlighted colours in the feedback (right) column refer to those parts of your letter highlighted with the same colour; where I have crossed out your text, I am suggesting that that text is unnecessary; where I have added text in parentheses/brackets I am suggesting that additional text is needed to improve your original. **Please note that my comments will very often focus in some detail on the finer points of grammar and vocabulary. This is intended as language teaching—if there are many comments, it could simply be that there is a repetition of a minor error that might not unduly affect your test score.**

Dr. Xavier Flannery Paediatrician 567 Church Street Springvale, 3171	140 words in the original Once again, nearly faultless. Key ideas are well identified and organised into concise, clearly delineated paragraphs. Some marks lost, but a solid pass.
18 January 2008	
Dear Dr. Flannery,	
Re: Peter Ludovic, 8 years old	
Thank you for seeing Peter who I suspect has post-streptococcal nephritis with early renal failure.	
Initially, Peter presented on 22 December 2006 with symptoms suggestive of acute bacterial tonsillitis. According to his mother, he had been suffering	

<p>from sore throat, associated with fever (39.5), hoarse voice and irritable mood. Enlarged tonsils with exudate and cervical lymphadenopathy were found, and oral penicillin was prescribed.</p>	
<p>On the second examination 15 January 2007, the patient reported blood in urine over the previous four days, as well as lethargy. Examination revealed hypertrophied tonsils, and urine analysis showed macroscopic haematuria. Blood pressure was normal.</p>	<p>I think this misrepresents the case notes slightly (but significantly). The case notes say Peter's mother: ...<i>reported son's urine brown 4 days previously</i>. This suggests that the urine was brown four days prior to the consultation, but it doesn't say that it continued up to the time of the consultation (as would be clear if the notes said something like: ...<i>urine brown for four days previous</i>). It's about the only problem here, so I wouldn't worry too much about it (and I'm willing to change my mind if my 'grammatical' interpretation goes against common medical knowledge).</p>
<p>Today, blood test results reported (revealed/showed) elevated urea and creatinin, antistreptolysin-O titre, and mid-stream urine showed red blood</p>	<p>The original was not quite the right word—a <i>report</i> is provided by a person.</p>

cells of renal origin (4x10).	
In view of the above signs and symptoms, I would appreciate your urgent assessment and treatment of this patient.	
Yours sincerely,	
Dr. Angelika Borozdina	

Angelika

Some notes on my feedback.

The highlighted colours in the feedback (right) column refer to those parts of your letter highlighted with the same colour; where I have crossed out your text, I am suggesting that that text is unnecessary; where I have added text in parentheses/brackets I am suggesting that additional text is needed to improve your original. **Please note that my comments will very often focus in some detail on the finer points of grammar and vocabulary. This is intended as language teaching—if there are many comments, it could simply be that there is a repetition of a minor error that might not unduly affect your test score.**

	201 words in the original Minor issues only—a strong pass.
Dr. Elvira Sterinberg Gynaecologist 123 Church Street Richmond, 3121	
02 February 2007	

Dear Dr. Sterinberg,	
Re: Mrs. Larissa Zanetta, a 38-year(s)-old woman, marketing manager, married, has one child (a four-year-old boy) and Mr. Zanetta, her husband	<p>The <i>Re:</i> section generally includes brief personal information such as age (or DOB) and perhaps some family information—it doesn't require the same attention to grammatical correctness as in the body of the letter.</p> <p>Some problems here:</p> <ul style="list-style-type: none"> • the reader already knows she's a woman (from her title and possibly from her name) • her particular job is not relevant to the particular problem • focus just needs to be on the

key nouns

- I think it is clear by the end of the letter, by which time Mr Zaneeta has been examined and found 'normal', that the medical 'problem' is Mrs Zaneeta's (even though it is more generally a problem for them both of course)

Thank you for seeing my patients who have been trying to conceive for 10 months without any success.

Initially, Mrs. Zanetta came to see me on 11/07/05 complaining of tiredness and difficulty

This would not lose many marks (particularly given the general strength of the

sleeping for the previous 2 months due to work stress. She was on (the) oral contraceptive pill at that time and was planning another pregnancy in 12 months. Her medical history was unremarkable. The patient demonstrated signs of anxiety, such as paleness, tiredness and slightly elevated blood pressure (140/80mmhg). Accordingly, relaxation techniques, reducing work hours and sleeping tablets were recommended.

letter) but, as a general rule, write out numbers up to, and including, ten in full (this is an editing norm)—I have seen examples of letters where this is not the case, but we recommend writing in full to ‘be safe’. The definite article *the* is generally used with *oral contraceptive pill* because the reference is to a particular thing—in this case, a particular type of pill.

One year later, Mrs. Zanetta visited me again complaining of failure to conceive since

she had stopped the pill. Sleeping problem(s) and work-related stress persist. Therefore, reassurance was given and advice regarding nature of conception was provided.

However, on review six months later the patient had not managed to conceive and her anxiety had increased. As a result, Valium was prescribed 1-2 tablets at night. Pelvic examination was normal and Pap smear was taken. Next consultation with her husband was organized the following week.

Examination of Mr.

Zanetta was unremarkable and sperm count was normal.

I would be grateful if you could take over the further management of this couple.

Yours faithfully,

Dr. Angelika Borozdina

Angelika

Some notes on my feedback.

The highlighted colours in the feedback (right) column refer to those parts of your letter highlighted with the same colour; where I have crossed out your text, I am suggesting that that text is unnecessary; where I have added text in parentheses/brackets I am suggesting that additional text is needed to improve your original. **Please note that my comments will very often focus in some detail on the finer points of grammar and vocabulary. This is intended as language teaching—if there are many comments, it could simply be that there is a repetition of a minor error that might not unduly affect your test score.**

	200 words in the original Almost faultless Angelika.
Dr. George Isaacson Cardiologist 45 Inkerman Street Caulfield, 3162	
19 January 2007	
Dear Dr. Isaacson,	

Re: Mr. Jing Zu	
I am writing to refer Mr. Zu, a 72-years-old retired school teacher, to you. Mr. Zu has been suffering from ischemic heart disease for ten years, hypertension for 18 years and has had congestive cardiac failure for five years. He was diagnosed with acute myocardial infarction in 1999. He takes t(L)asix (40(80)mg), Enalapril (10 mg), Nifedepin (10 mg) and Anginine (as necessary).	Because these linked words are acting as an adjective, they do not take the plural s. Lasix is a product name rather than the name of a drug and so requires a capital letter. The simple present tense here indicates that you are referring to his current medications rather than past ones (and you point out later that it has been increased to 80mg).
The patient first came to see me on 03/01/07 complaining of pain in his chest while gardening and mild	

postural dizziness. The pain was easily relieved with rest and Anginine. Stable congestive cardiac failure with angina was diagnosed, and watchful monitoring was recommended.

On the second examination (15/02/2007) his condition had deteriorated. The patient reported increased dyspnoea with orthopnoea. The oedema on his ankle had worsened. The examination revealed slightly increased blood pressure (140/90mmhg), chest crepitation to mid zones, and jugular venous pressure was

doubled (+6cm) compared to the previous visit. Therefore, electrocardiogram was requested, a higher dose of lasix was prescribed (80mg) and another review was scheduled two days later.

Today (19/01/2007) the patient's condition has improved, however, electrocardiogram shows some ischemic changes anterolaterally.

In view of the above, I appreciate your taking over of this patient.

Yours sincerely,

Dr. Angelika Borozdina

Sample Writing Task 1

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

15.08.09

Patient History
Darren Walker

DOB 05.07.69

Regular patient in your General Practice

09.07.09

Subjective

Regular check up, Family man, wife, two sons aged 5 and 3
Parents alive - father age 71 diagnosed with prostate cancer 2002.
Mother age 68 hypertension diagnosed 1999.
Smokes 20 cigarettes per day –trying to give up
Works long hours – no regular exercise
Light drinker 2 –3 beers a week

Objective

BP 165/90 P 80 regular
Cardiovascular and respiratory examination normal
Height 173 cm Weight 85kg
Urinalysis normal

Plan

Advise re weight loss, smoking cessation
Review BP in 1 month
Request PSA test before next visit

14.08.09

Subjective

Reduced smoking to 10 per day
Attends gym twice a week, Weight 77 kg
Complains of discomfort urinating

Objective

BP 145/80 P76
DRE hardening and enlargement of prostate

PSA reading 10

Plan

Review BP, smoking reduction in 2 months
Refer to urologist – possible biopsy prostate

Writing Task

Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001. Asl to be informed of the outcome.

In your answer:

- * Expand the relevant case notes into complete sentences
- * Do not use note form
- * The body of the letter should not be more than 200 words
- * Use correct letter format

Sample Model Letter 1

15/08/2008

Dr. David Brooker (Urologist)
The Urology Department
259 Wickham Tce,
Brisbane, 4001

Dear Doctor,

Re: Mr. Darren Walker

I am writing to refer this patient, a 40 year old married man with two sons aged 3 and 5, who requires screening for prostate cancer.

Initial examination on 09/07/09 revealed a strong family history of related illness as elderly father was diagnosed with prostate cancer and mother was diagnosed as hypertensive. Mr Walker is a smoker and light drinker. He works long hours and does not do any regular exercise. His blood pressure was initially 165/90 mmhg and pulse was 80 and regular. He is 173cm tall and his weight, at that time, was 85 kg. He was advised to reduce weight and stop smoking and a prostate specific antigen test was requested. There were no other remarkable findings.

When he came for the next visit on 14/08/2009, Mr Walker had reduced smoking from 20 to 10 cigarettes per day and was attending gym twice a week. He had lost 8kg of weight. His blood pressure was improved at 165/90mmhg. However digital rectal examination revealed an enlarged prostate and the PSA reading was 10.

In view of the above signs and symptoms, I believe he needs further investigations including a prostate biopsy and surgical management. I would appreciate your urgent attention for his condition.

Yours sincerely,

Dr.X

Word Length: 205 words

Sample Writing task 2

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

03.07.09

Patient History

Margaret Leon 01 .08. 49

Gender: Female

Regular patient in your General Practice .

14.01.09

Subjective

Wants general check up, single, lives with and takes care of elderly mother.

Father died bowel cancer aged 50.

Had colonoscopy 3 years ago. Clear

Does not smoke or drink

Objective

BP 160/90 PR 70 regular

Ht 152cm

Wt 69 kg

On no medication.

No known allergies.

Assessment

Overweight. Advised on exercise & weight reduction.

Borderline hypertension.

Review in 3 months

25.04.09

Subjective

Feeling better in part due to weight loss

Objective

BP 140/85

PR 70 regular

Ht 152cm

Wt 61 kg

Assessment

Making good progress with weight. Blood pressure within normal range

03.07.09

Subjective

Saw blood in the toilet bowl on two occasions after bowel motions. Depressed and very anxious. Believes she has bowel cancer. Trouble sleeping.

Objective

BP 180/95 P 88 regular

Ht 152cm Wt 50 kg

Cardiovascular and respiratory examination normal.

Rectal examination shows no obvious abnormalities.

Assessment

Need to investigate for bowel cancer

Refer to gastroenterologist for assessment /colonoscopy.

Prescribe 15 gram Alepam 1 tablet before bed.

Advise patient this is temporary measure to ease current anxiety/sleeplessness.

Review after BP appointment with gastroenterologist

Writing Task

Write a letter addressed to Dr. William Carlson, 1st Floor, Ballow Chambers, 56 Wickham Terrace, Brisbane, 4001 requesting his opinion.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 2

03/07/2009

Dr. William Carlson
First Floor,
Ballow Chamber
56 Wickham Tce,
Brisbane 4001

Dear Doctor Carlson,

Re: Margaret Leon
DOB 01/08/1949

Thank you for seeing my patient, Margaret Leon, who has been very concerned about blood in her stools. She has seen blood in the toilet bowl on two occasions after bowel motion. She is very anxious and as well as that depressed because her father died of bowel cancer and she feels she may have the same condition.

Margaret has otherwise been quite healthy. She does not drink or smoke and is not taking any medication. She was slightly overweight six months ago with borderline high blood pressure. At that time I advised her to lose weight which she did successfully. Three months later, her weight had dropped from 69kg to 61kg and blood pressure was back within normal range.

On presentation today she was distressed because she believes she has bowel cancer. She has had trouble sleeping and her weight has reduced a further 11 kg. The rectal examination did not show any abnormalities. Her blood pressure was slightly elevated at 180/95 but her cardiovascular and respiratory examination was unremarkable. Alepam, one before bed, was prescribed to control the anxiety and sleeplessness.

I would appreciate it if you could perform a gastroenterology assessment.

Yours sincerely,

Dr X (GP)

Word Length: 194 words

Sample Writing Task 3

Read the cases notes below and complete the writing task which follows:

Time allowed: 40 minutes

Today's Date

08.08.09

Patient History

Dulcie Wood

DOB 15.07.43

New patient in your General Practice. Moved recently to be near family.

03.07.09

Subjective

Widowed January 06, three children, wants regular check up, has noticed uncomfortable feeling in her chest several times in the last few weeks like a heart flutter.
Mother died at 52 of acute myocardial infarction, non smoker, rarely drinks alcohol
Current medication: zocor 20mg daily, calcium caltrate 1 daily
No known allergies

Objective

BP 145/75 P 80 regular

Ht 160cm Wt 61kg

Cardiovascular and respiratory examination normal ECG normal

Plan

Prescribe Noten 50 gm ½ tablet daily in am. Advise to keep record of frequency of fibrillation sensation.

Review in 2 weeks if no increase in frequency.

17.07.09

Subjective

Reports sensations less but woke up twice at night during last 2 weeks

Objective

BP 135/75 P70 regular

Assessment

Increase Noten to 50 gm daily ½ tablet am and ½ tablet pm
Advise review in one month.

08.08.09**Subjective**

Initial improvement but in last 3 days heart seems to be fluttery several times a day and also at night. Very nervous and upset. Wants a referral to a cardiologist Dr.Vincent Raymond who treated her sister for same condition

Objective

BP 180/90 P70

Action

Contact Dr Raymond's receptionist and you are able to arrange an appointment for Mrs Wood at 8am on 14/08/09

Writing Task

Write a letter addressed to Dr. Vincent Raymond, 422 Wickham Tce, Brisbane 4001 describing the situation.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 3

08/08/09
Dr Vincent Raymond
422 Wickham Tce
Brisbane, 4001

Dear Dr Raymond,
Re: Dulcie Wood
DOB: 15/07/43

As arranged with your receptionist, I am referring this patient, a 66 year old widow, who has been demonstrating symptoms suggestive of heart arrhythmia.

Mrs. Woods has seen me on several occasions in the past five months, during which time she has had frequent episodes of heart flutter and her blood pressure has been fluctuating.

The patient initially responded to Noten 50mg ½ tablet daily in the morning, but she still had episodes of disturbed sleep during the night. Therefore the dose of Noten was increased to 50mg ½ tablet in the morning and ½ tablet at night, but unfortunately her heart flutter has increased recently, especially over the last three days. Other current medications are Zocor 20mg and Calcium Caltrate 1 daily.

Today's examination revealed a nervous and upset woman with a pulse rate of 70 and blood pressure of 180/90.

Please note that her mother died of acute myocardial infarction and her sister, who is a patient of yours, has a similar condition.

In view of the above, I would appreciate it if you provide an assessment of Mrs. Wood and advise regarding treatment and management of her condition.

Yours sincerely,

Dr Z

Word Length: 191 words

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

25.08.09

Patient History

James Warden

DOB 05.07.29

Regular patient in your General Practice

09.07.09

Subjective

Wants regular check up, has noticed small swelling in right groin.

Hypertension diagnosed 5 years ago, non smoker, regularly drinks 2 – 4 glasses of wine nightly and 1 - 2 glasses of scotch at weekend.

Widower living on his own ,likes cooking and says he eats well.

Current medication noten 50 mg daily, $\frac{1}{2}$ aspirin daily, normison 10mg nightly when required, fifty plus multivitamin 1 daily, allergic reaction to penicillin.

Objective

BP 155/85 P 80 regular

Cardiovascular and respiratory examination normal

Urinalysis normal

Slight swelling in right groin consistent with inguinal hernia.

Plan

Advised reduction of alcohol to 2 glasses maximum daily and at least one alcohol free day a week.

Discussed options re hernia. Patient wants to avoid surgery.

Advised to avoid any heavy lifting and review BP and hernia in 3 months

25.08.09

Subjective

Had problem lifting heavy wheelbarrow while gardening. Has a regular dull ache in right groin, noticed swelling has increased.

Has reduced alcohol intake as suggested.

Objective

BP 140/80 P70 regular

Marked increase in swelling in right groin and small swelling in left groin.

Assessment

Bilateral inguinal hernia

Advise patient you want to refer him to a surgeon. He agrees but says he wants a local anaesthetic as a friend advised him he will have less after effects than with general anaesthetic.

Writing Task

Write a letter addressed to Dr. Glynn Howard, 249 Wickham Tce, Brisbane, 4001 explaining the patient's current condition.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Sample Model Letter 4

25/08/2009

Dr. Glynn Howard
Surgical Department,
249 Wickham Tce,
Brisbane 4001

Dear Doctor,

Re: Mr. James Warden
DOB 05/07/29

I am referring this patient, a widower, who is presenting with symptoms consistent with a bilateral inguinal hernia. He has been suffering from hypertension for 5 years for which he takes Noten, Aspirin and multivitamins. He is allergic to penicillin.

Initially Mr Warden presented to me on 09/07/09 for a regular check up. On examination he had a mild swelling of the right groin, his blood pressure was 155/85 and pulse was 80 beats per minute, otherwise his condition was normal. He was diagnosed as having an inguinal hernia. I discussed the possibility of surgery, however he indicated he did not want an operation. Therefore I advised that he avoid heavy lifting and reduce alcohol consumption. A review consultation was scheduled for 3 months later.

Today he returned complaining that his right groin had increased in size with a regular dull ache possibly due to lifting a heavy wheel barrow. The examination revealed a considerable increase in the swelling in the right groin as well as a mild swelling of the left groin.

Based on my provisional diagnosis of a bilateral inguinal hernia, I would like to refer him for surgery as early as possible. Please note that wishes to have the surgery under local anaesthesia.

Yours sincerely,

Dr X (GP)

The Registrar
Victoria Hospital,
Victoria Rd.,
Melbourne

Date: 22 Feb. 2002

Re: Mrs Fiona Marsden

Dear Dr,

This 30 year-old, mother of 2, housewife, came to my surgery 2 days ago, complaining of mild abdominal pain for a few days. She claimed that her pain was in the lower abdominal area and could be relieved by panadol; however, she denied nausea or vomiting.

Her physical examinations were normal, except a mild tenderness over the right abdominal quadrant with no evidence of hepatosplenomegaly. The possible diagnosis was ovarian cyst enlargement; therefore, FBE, ESR tests and a pelvic ultrasound were requested with a revisit arranged for one week's time.

Mrs Marsden visited my office today as an emergency appointment, complaining that her pain has gradually become worse and severe in intensity since few hours ago. She also reports being weak and fatigued since then.

On examination, she is pale and restless; moreover, there is a severe tenderness with palpable mass in the lower right abdominal quadrant. Based on the evidence, there is a strong possibility that she is suffering from a ruptured ovarian cyst.

Please note that she had a history of tubular ligation two years ago, and a right ovarian cyst (5-6cm) 6 months ago when she was put on 3 months of OCP.

I am referring her to you for admission to your gynaecological ward for further investigation and management regarding her urgent problem.

Thanking you in advance,

Yours sincerely,

Dr X----- (GP)

UNSWIL Medical Centre
22 King Street
Randwick NSW 2031

24/08/2002

Dr. G Brian
Emergency Department Medical Officer
Alfred Hospital
Commercial Road
Prahan Victoria.

Dear Dr. Brian,

Thank you for seeing Mr. Johnson, a 25 year old man suffering from severe abdominal pain.

He first came to see me at 10am yesterday complaining of crampy central abdominal pain, nausea and several loose bowel movements which he had had in the previous 24 hours. On examination I found that he had generalized central abdominal tenderness. All other investigations were normal. I prescribed analgesics and advised him to increase his fluid intake and to rest.

At 9.00am today, Mr. Johnson presented again as his condition had deteriorated. His pain had increased and had vomited several times overnight. He was also slightly flushed and had tenderness on his right side with mild guarding. Other test results were normal. I suspected viral infection and possibly appendicitis and ordered a blood film. I prescribed Maxolon 10gm four hourly for the vomiting.

Mr. Johnson has come to see me again as his condition has worsened. The pain is now severe, constant and localized to right iliac fossa. He is flushed and restless. The blood film shows a white cell count of 18,000. I suspect that he has acute appendicitis.

I would appreciate if you could urgently assess Mr. Johnson and treat him further.

Yours sincerely

J Harris

Dr J Harris

Dr Michaels
St. Patrick Ave,
Melbourne

Date: 30th June 2004

Re: Mrs Patricia Gordon

Dear Dr Michaels,

I am referring Mrs. Patricia Gordon who first visited my surgery two years ago. She had just married and requested contraception pills; however, she did inform me of her intention to have a family in one to two years time.

On examination at the time, all the test results were unremarkable – breast examination, pap- smear, Rubella test. She was subsequently prescribed Microgynon 30 ED 12x12.

On her next visit last year, she reported that she had stopped her contraceptive pills two months earlier, with the intention of getting pregnant but her menstrual cycle had started again. She was rather disappointed at the time that she did not get pregnant. We discussed temperature and cycle measurements to augment her chances of conception.

She visited my office two weeks ago, tearful and depressed, as nothing seemed to have worked. The temperature chart showed definite and appropriate changes. Her pelvic and general examinations were unremarkable as was her pap-smear test. She was asked to return with her spouse a week later for further investigation.

Last week, Mr. Gordon's examination revealed a healthy young man, and consequently a sperm-count test was arranged.

This morning the couple returned for the result of the test, which showed normal count and viable sperms.

As this couple is keen to start a family soon; I am, therefore, referring this couple to you for further investigation, diagnosis and advice.

Thanking you in advance,

Yours sincerely,

Dr X-----

Doctors – Letter of Referral

Dr F Goldman
171 Victoria Parade
East Melbourne

30/01/2005

Re: Jamie Brown
DOB: 10.5.85

Dear Dr Goldman,

This 5 year-old boy Jamie Brown initially presented with tonsillitis on the 20/12/2005 for which he was treated with Penicillin V 250mg qid for 7 days.

Four weeks later Jamie presented with painless macroscopic haematuria. His only other symptom appeared to be lethargy. Examination was unremarkable: he had tonsillar hypertrophy, his BP – 90/60 and urinalysis confirmed significant haematuria.

On review today, investigations showed a mildly elevated urea and creatinine, a significantly elevated ASCOT titre and haematuria of renal origin.

Patient's blood pressure has increased to 110/90.

I believe Jamie has post-streptococcal nephritis and that he is at risk of developing renal failure. I would appreciate your assessment and management.

Yours sincerely,

Dr X

Mr. Lawrence Mitchell, surgeon.
Suite 12,
Cabrini Medical Centre,
Malvern 3127

2nd Feb 2005

Re: Mr Patrick Freeman D.O.B 20.01.57
16 Garden Ave
Brisbane
QLD
Tel: 0413 111 333

Dear Dr Mitchell,

I am writing to refer Mr Patrick Freeman, a 48-year-old sales manager, to you for further management. He presented at my surgery one month ago complaining of pain in the epigastric area which was accompanied by vomiting and tiredness for the past few months. However, there was no Melena at this point and his pain was relieved by eating a meal.

Duodenal ulcer was a possible diagnosis; therefore, a full set of tests were requested which included X-ray Barium meal.

He returned 3 days later for his results. His pain, nausea and vomiting still persisted. His FBE was normal, but there was a slight increase in ALAT. Also, there was no evidence of ulcer in the X-ray. He was advised to improve his diet and give up both cigarettes and coffee. In addition, Tagamet (200mg tid) was prescribed and he was asked to revisit in 6 weeks time.

He, however, came to my surgery today (3 weeks early), complaining of the epigastric pain and black faeces for one week. On examination, he was pale, agitated and preferred to keep his posture upright. The upper abdominal quadrant was tender; although, his bowel sounds were normal.

Please note that Mr Freeman was hypotensive (B.P 80/50; P 110/min) this morning. He is a 2 pack a day smoker and drinks 5-6 cups of coffee per day.

I believe he is suffering from a bleeding duodenal ulcer which requires immediate attention. I would appreciate if you could examine, assess and treat this patient as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr -----

Dr Peter Groves
Paediatric gastroenterologist
Royal Children's Hospital

Date: 21st February 2005

Re: Master Ben Schmidt

Dear Dr Groves,

I am writing to refer Master Ben Schmidt, an 8 year old patient of mine, who was first brought to my office by his parents, David and Sue, 12 days ago. On examination, he was feverish (Temp.40.5 °C) with flu and exhibited symptoms relating to Asthma. Otitis media was also diagnosed; therefore, a course of Amoxicillin was prescribed. In addition, Paracetamol tablets as well as Ventolin (2 puff q.i.d) were included.

Ben was brought back to my surgery five days later by his mother on 14th Feb, complaining of his son vomiting. The examination revealed a lowering of his temperature (39.5) but the Asthma was consistent. At this point only Maxilon injection was prescribed.

Yesterday, his mother brought him to my office again this time complaining of bleeding from his bowels which apparently had started 3 days prior. His previous problems had settled, although he was feeling lethargic due to his flu infection. The physical examination revealed no anal fissure. A full set of blood tests were requested at this point to aid with the diagnosis.

Mrs Schmidt was asked to come to my surgery today with Ben. The results show that he is anemic (Hb - 7), and since the problem still persists, I believe this is a serious problem and calls for a colonoscopy and further internal examination to detect the source and cause of hemorrhage.

I would appreciate if you could examine, diagnose and treat this patient as you think appropriate,

Thank you in advance,

Yours sincerely,

Dr X-----

Dr F Goldman
171 Victoria Parade,
East Melbourne

Date: 30 Jan 2005

Re: Jamie Brown

Dear Dr Goldman,

I would like to refer Master Jamie Brown, a five-year-old boy, who was brought by his mother to my surgery six weeks ago. He had sore throat at the time, with a husky voice, feverish and irritable.

On examination, large infected tonsils with exudates were observed as well as tender and enlarged cervical lymph nodes. Accordingly, tonsillitis was diagnosed and a course of penicillin V250 mg (q.i.d) was prescribed for 7 days.

On his return two days ago, his mother reported Jamie to be tired, lethargic and had passed brownish urine 4 days earlier. On examination, he was hypotensive (BP 90/60), had tonsillar hypertrophy, and his urinalysis revealed macroscopic haematuria. With possible diagnosis of UTI or post-streptococcal nephritis, prescribed a number of tests. Plenty of fluid intakes were recommended and a revisit was arranged for two days time.

Jamie was brought to my surgery today by his mother, still asymptomatic. However, elevated blood pressure was observed. His test results showed elevated urea, creatinine and ASCOT. In addition, his urinalysis indicated a macroscopic haematuria, and his mid-stream urine test revealed 4x10 RBC, attributed to renal origin.

I would like to refer Jamie Brown to you with a diagnosis of post streptococcal nephritis with early renal failure. Could you please assess, investigate and treat him as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X-----(GP)

Dr. William Jones
The medical centre
46 Prince Street
AUBURN NSW 2247

Date: 28 January 2006

Re: Mrs. Trudy McHugh
7 Alfred Street
Sydney NSW 2000

Dear Dr Jones,

This 38-year-old woman came to my surgery yesterday, complaining of a sudden onset of left lower abdominal pain for one day. She claimed that it was sharp and constant which worsened by sitting up, walking or bending. There were no other symptoms; however, she claimed that she had another episode of left abdominal pain one week before.

On examination, there was a great tenderness on the left quadrant of her abdomen, and a vague mass was also palpated in the same region. To exclude pregnancy, β -HCG was requested; in addition, full blood examination and ESR were checked too.

On her visit today, the pain still persisted, but it has become easier. There have not been any bowel motions since two days ago, when she passed a hard stool with bright blood on the outside of it.

Tonight, her pain has worsened - after eating a meal - and she is moderately in distress. There are still no bowel motions or flatus; moreover, her bowel sounds are inaudible. She is febrile ($T = 37.4^{\circ}\text{C}$); in addition, there is a left shift in the blood test and her Hb was 9.3.

Please note, she had had an ovarian cystectomy and appendectomy. She was also rushed to hospital at the beginning of this month due to hemorrhage, which was diagnosed as spontaneous abortion.

I am referring her to you with the diagnosis of early bowel obstruction due to diverticulitis or carcinoma, and for further management and treatment including surgery.

Yours sincerely,

Dr X -----

Dr William Ammerry
100 Collins St,
Melbourne

22nd Feb 2006

Re: Miss Sally Webster
Aged: 17

Dear Dr Ammerry,

This 17 year old student girl first visited my surgery two months ago complaining of chronic constipation. She claimed that she had been trying everything from bran to laxatives to relieve her once every 4-5 days bowel habits, and yet, this condition still persists.

The physical examination was unremarkable (her weight was 54kg). Her request for the strongest laxative was refused; however, increased intake of fluids and vegetable fibers were recommended to improve her condition.

On her next visit six weeks later, her mother accompanied her. The mother was concerned about her daughter's loss of appetite, loss of weight, and the constant arguing at home regarding Sally's eating habits. When spoken to Sally directly, she claimed that she did not know what all the fuss was about, as she was not hungry.

On examination, she was under weight (47kg), pale and thin. Hence, several tests were prescribed, and she was asked to re-visit me at a later date for one to one assessment.

On her re-visit 6 days later, she was distant with little eye contact. She felt her parents were over-reacting, claiming her ideal weight to be 40kg (current weight 47kg). When asked, she denied vomiting and taking laxatives. After all factors considered, I believe Sally is suffering from Anorexia Nervosa.

I would appreciate if you could examine, diagnose and treat this young lady as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X -----

Dr Michaels
The Registrar,
St Paul's Hospital,
Victoria Rd,
Melbourne

Date: 20 June 2006

Re: Mrs Julie Hobart

Dear Dr Michaels,

This 33 year-old woman came to my surgery about one week ago, complaining of abnormality in her menstrual cycle. She claimed that her menstrual periods had become sparse and eventually ceased completely. She also claimed to have stopped exercising a year ago because of feeling fatigue and weakness. Meanwhile, she began to gain weight, and noticed the development of facial hair and acne.

On examination, she was mildly obese (W- 73kg, H- 1.57m) with thin extremities. There were fullness of the supraclavicular fat pads and generalised muscular weakness, as she was unable to stand from squatting position without help or difficulty standing from a seated position. In addition to a visible increase of facial hair and acne, there were marked striae on her abdomen and buttocks. While other physical examinations were unremarkable, there was a slight measured hypertension (BP 153/98).

With the possible diagnosis of Cushing's syndrome, early morning cortisol level was requested as well as FBE and Urine analysis. Meanwhile, to control the hypertension, Thiazide diuretics were prescribed.

On her visit today, she reported polyuria and nocturia. Her blood pressure was 144/99, while the result of her laboratory tests showed FBE = 136 and serum glycate = 85%. The morning cortisol level was 21 μ g/dl.

I am referring this patient to you with the diagnosis of Cushing's syndrome accompanied with Diabetes Mellitus. I would appreciate if you could examine and manage this patient following further tests to confirm my diagnosis.

Yours sincerely,

Dr X-----(GP)

Dr James Collins
256 South Borough Lane
Brisbane
QLD 4290

Date: 21 July 2006

Re: Mrs Heather Lincoln
17 Highcombe Place
Brisbane
QLD

Dear Dr Collins,

Thank you for seeing Mrs Lincoln, an 85-year-old patient of mine who was first brought to my surgery two months ago by her daughter. She was suffering from urinary incontinence and abdominal pain for a week. The daughter claimed that her mother was more confused than usual. In addition, she had refused to eat at the time.

On examination, there was mild suprapubic tenderness by palpation, and the urine test results confirmed UTI; Amoxicillin was, therefore, prescribed for a week. Confusion was reported to have subsided a week later with the elimination of UTI.

A month later, she was brought back to my surgery, because she was found confused, loitering the streets by her neighbours. The daughter was reassured as she was very much distressed and tearful.

On July 4, her daughter reported a further increase in her vague behaviour, unsteady gait and unbalanced emotions. She was also found lying next to her bed, incontinent.

On examination, she had postural hypotension, and exhibited a general confusion. This was assumed to be due to the high dose of Aldomet; consequently, half reduced the dose.

Today, although her gait has improved but she is still confused. Her daughter claims that she could no longer cope with her mother's condition and is wondering if a nursing home would be a better option.

Please note, this patient has had a history of hypertension (20 years), type II diabetes (15 years), Dementia (10 years) and recurrent UTI. Her current medications are Aldomet (250mg b.d), Indocit (15mg t.d.s) and Daonit (5mg b.d).

I would appreciate if you could assess this patient and give advice to her daughter for the best possible management.

Yours sincerely,

Dr X-----

Dr Frank Adams
Neurological Ward
South Brisbane Hospital
QLD 4101

26th July 2006

Re: Mrs Phillipa King D.O.B: 18.4.38
Unit 7a, Fremantle place
Brisbane
QLD
Ph: 07 3234 3234

Dear Dr Adams,

I am referring Mrs Phillipa King, a 68-year-old woman, with a diagnosis of CVA to you for further investigation and management. She was found two days ago by a neighbour, lying on her kitchen floor conscious and stating that she had fallen two hours previously but was unable to get up by herself. Consequently, she was admitted to R.B.H yesterday.

Initial consultation with Mrs King revealed a loquacious, distractible lady who felt her main problem was the pain in her left knee which was preventing her from walking. She was also worried about her two cats.

On examination, Mrs King is an obese, large, right handed lady who sat slumped to the right on the chair with her head and eyes also leaned the same way. She showed an UMN facial droop (L) and exhibited dribbling on the same side. Her left arm was poorly positioned under the pillow. She had a left homonymous hemianopic vision as her poor eye only followed across midline left.

Please note that she has been suffering from NIDDM, Osteoarthritis in her left knee and C.O.A.D. She is a 30 pack year smoker and is currently on Ventolin and Naprosyn. Mrs King is a pensioner who lives alone (after losing her husband 3 years ago) with no children, in a housing trust unit in Brisbane. However, a neighbour does visit her twice a week for a chat and a cup of tea.

I would appreciate if you assess and manage this patient from this point on.

Yours Sincerely,

Dr X-----

Dr Jensen
Unit 40, Manor House
Ripley Street
Brisbane
QLD 4880

Date: Sep-11- 2006

Re: Mr Paul Nigels D.O.B: 9-2-72
3 Roach Street
Brisbane QLD
Tel: 0434 333444

Dear Dr Jensen,

This thirty five year-old man has come to this hospital today complaining of headaches, which has been occurring about six weeks of the year. It generally lasts about 1-2 hours each time, especially in the mornings and it worsens by straining, coughing and other stress factors, including psychological ones, which he claims causes some visual blurring. These headaches, however, are partially relieved by panadol.

On examination, there were some observable concentration drifts in speech, slightly blurred right disc as seen by Fundoscopy, and minor cerebellar ataxia. The result of the other neurological and physical examinations was unremarkable and there were no observable features of migraine found.

The possible diagnosis at this point was stress related headaches; in addition, there were some elements in the medical history, which suggested raised ICP. Hence, CT-scan was requested, and he was asked to bring his old films for comparison. A revisit was also arranged for two weeks later.

Please note that he had a major head injury because of a car accident two years ago which put him in coma for eight consecutive days in Prince Henry Hospital. There were several post-traumatic problems including amnesia, blurred vision and limb stiffness (with normal tone). I urge you to check for the list of his present medications with Caulfield Hospital.

Meanwhile, I am referring this patient to you for a second opinion and would be grateful if you could re-examine this patient. I will include the results of all the tests with this letter, and will request the CT-scans to be sent to you directly prior to the patient's visit.

Looking forward to your feed back,

Yours sincerely,

Dr X -----

Dr Robert Vaughn
34 Volturen St,
Rewanden

Date: 19 Dec. 2006

Re: Mrs Joanne White

Dear Dr Vaughn,

Mrs White, a 36 year-old mother of two, came to my surgery a week ago, reporting a two months history of fatigue, early satiety and left upper quadrant fullness. She had lost 10 pounds of body weight during this time; however, she denied fever, night sweats, nausea, vomiting and other GI problems. Her menses were normal without excessive bleeding.

On examination, her skin was moist and warm. The spleen was palpable 9 cm below the costal margin. Other physical examinations were otherwise unremarkable. Multivitamins were prescribed, but several tests were requested (FBE, ESR, LFT and peripheral blood smear). She was asked to revisit in a week's time.

On her visit today, she is still symptomatic with the results of her tests suggesting a mild leukocytosis (WBC 12K). Other abnormalities could also be seen in other blood cells. I will include the test results with this letter for your careful examination.

Please note that she does not smoke or drink, and has not had any recent exposures or travel. Her paternal grandfather did suffer from adult onset diabetes.

I believe this matter needs further specialist intervention with a possible bone marrow biopsy to help with the correct diagnosis. I would appreciate if you could treat and manage her regarding her problem.

Thanks in advance,

Yours sincerely,

Dr X -----(GP)

Dr Vaughn
34 Volturen St.
Rewanden

Date: 19th dec 2006

Reg: Mrs Joanne White

Dear Dr Vaughn,

Thank you for visiting Mrs. White, a 36 year-old patient who visited me one week ago. She complained about 2- month fatigue, early satiety, left upper quadrant fullness and 10-pound weight loss. However. she had no history of nausea, vomiting, haematochesia, haematemesis or night sweat.

On examination, her skin was moist and warm. The spleen was palpated 9cm below left costal margin; however, there was no sign of hepatomegaly, lymphadenopathy or thyromegaly. Consequently, a full set of blood tests (FBE, ESR and Peripheral blood smear) as well as biochemical tests including LFT were requested. Furthermore, multivitamins were prescribed and she was asked to come back today.

On her visit today, her problems are still persisting. There was a wide range of results obtained from the laboratory tests. For example. an increase was seen in all kinds of WBCs; however, platelet count and Hb level were normal. In addition, the vitamin B12 level was over 2000 pg/ml, but leukocyte alkaline phosphatase level had decreased.

According to her exhibited symptoms and lab-test results, I believe that her problem is a kind of hematogenous malignancy, which calls for a bone marrow biopsy for a more precise assessment.

I would appreciate if you could provide further management and treatment for this patient from this point on.

Thank you in advance,

Sincerely yours,

Dr. X-----(GP)

Mr Francis Baker
Surgical Registrar,
Victoria Hospital,
Victoria Road,
Melbourne

Date: 14 February 2007

Re: Mr John Webster

Dear Dr Baker,

This 35-year-old mechanic attended my surgery two weeks ago, complaining of six-months of crampy abdominal pain, nausea and severe intermittent diarrhoea. He claimed having seven loose, foul odoured stools per day. He denied any other symptoms; however, the pruritic skin rash developed just before the diarrhoea began.

On examination, the mucous membranes were dry, and there was a diffused abdominal tenderness with no hepatosplenomegaly. Populovesicular lesions were also visible on elbows, knees and buttocks. Other physical examinations were otherwise unremarkable including bowel sounds and sphincter tone. With the possibility of gastroenteritis, diphenoxylate was prescribed and FBE, stool exam and culture were requested.

One week later, his diarrhoea was persisting, which had resulted in a loss of 9kg body weight. Although, WBC, LDH and ALP had increased, a reduction in serum albumin was noted. Prochlorperazine and megestrol were added to his drug requirements, and an abdominal CT-scan was requested. Gluten-intake restriction was also advised based on his skin rash.

Today, he claimed that his diarrhoea had improved, and his skin rash appeared to be healing. Based on the results and observations, I am inclined to celiac sprue as a possible diagnosis.

Please note that he has just stopped smoking tobacco, and drinks only occasionally (mainly beer). He does not have any considerable medical history, though his father died of lymphoma.

I am referring this patient to you for further investigations including colonoscopy and bowel biopsy to confirm my diagnosis.

Yours sincerely,

Dr X-----(GP)

The Registrar
Emergency Department
Royal Melbourne hospital
Flemington Road
Parkville 3052

Dear Doctor,

Re: Mr Derek Romano

I am writing to refer Mr Romano, a patient of mine to you. Mr Romano, is a 46-year-old and is an insurance clerk. He is married with one child who is suffering from his first episode of ischemic (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 hypercholesterolemia (Total cholesterol = 6.4 mmol/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 20 mg 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 and one sublingual anginine were given, followed by intravenous morphine (2.5mg). His pain has now settled down, but I consider that he requires admission to the Coronary Care Unit for stabilization. I will telephone later to check on his condition.

Yours sincerely,

Dr X

Mr Dooley
34 Volturen St.,
Rewanden

Dear Mr. Dooley,

re: Mr Bernard Smith
24 Derid Street
Farfeth

Thanks for seeing Mr. Smith, a 77 year old retired farmer. He first presented to me in November 1991 with a five year history of right hip pain. At this time he had a two month history of severe pain in the right hip which was not responding to simple analgesia. He found it difficult to bear weight and had a decreased range of movement on his right side.

Otherwise, examination was normal. X-Ray at this time showed moderate degeneration of right hip joint consistent with osteoarthritis.

I commenced him on Indomethacin 50mg t.d.s. Initially his response was good but unfortunately he suffered a further flare up in January 1992. Indomethacin was recommenced at this time but caused significant dyspepsia. I therefore commenced Mylanta and changed him on to Tilcotil 25mg two tablets daily. Unfortunately, his hip pain has continued to worsen and the change in therapy has not helped.

I would appreciate your opinion regarding his future management and would be interested to know if he would be a suitable candidate for a hip replacement.

Thanks for your opinion.

Yours sincerely,

Dr X

Mr. B.Dooly
Orthopaedic surgeon
34 Volturen St.,
Rewanden

Date: 16th Feb 1992

Re: Mr Bernard Smith

Dear Dr Dooly,

Mr Bernard Smith is a 77 year old retired farmer with a 5 year hip trouble. When he visited my surgery 3 months ago, he was limping with a 2 months severe pain in his right hip and knee that did not respond to Panadol.

On examination, he was hypertensive (BP 150/85) and had a decreased internal rotation and flexion of right hip. Osteoarthritis was confirmed with the aid of an X-ray; consequently, he was put on a course of Indomethacin tablets (50mg t.d.s).

He visited my surgery last month complaining of the flare up of his pain. The exacerbation of the pain was due to his cessation of the medication 6 weeks before. On examination the range of his right hip movement had further decreased with inability to bear weight. A new course of endomethacin (50mg t.d.s) was recommenced.

He returned again 6 days later with severe dyspepsia. He was consequently prescribed Mylanta as he showed mild epigastric tenderness, and Indomethacin was replaced with Tilcotil (25mg 2 tablets maine.).

Mr Smith has visited my office today and the examination shows little improvement in his right hip condition. I believe, his osteoarthritis is not responding to the normal treatment with the anti-inflammatory medications and he does require further specialist attention.

I am referring this patient to you for an assessment, advice and the possibility of hip replacement if you consider him a suitable candidate.

Yours sincerely,

Dr X-----

Sample Model Letter 1

15/08/2008

Dr. David Brooker (Urologist)
The Urology Department
259 Wickham Tce,
Brisbane, 4001

Dear Doctor,

Re: Mr. Darren Walker

I am writing to refer this patient, a 40 year old married man with two sons aged 3 and 5, who requires screening for prostate cancer.

Initial examination on 09/07/09 revealed a strong family history of related illness as elderly father was diagnosed with prostate cancer and mother was diagnosed as hypertensive. Mr Walker is a smoker and light drinker. He works long hours and does not do any regular exercise. His blood pressure was initially 165/90 mmhg and pulse was 80 and regular. He is 173cm tall and his weight, at that time, was 85 kg. He was advised to reduce weight and stop smoking and a prostate specific antigen test was requested. There were no other remarkable findings.

When he came for the next visit on 14/08/2009, Mr Walker had reduced smoking from 20 to 10 cigarettes per day and was attending gym twice a week. He had lost 8kg of weight. His blood pressure was improved at 165/90mmhg. However digital rectal examination revealed an enlarged prostate and the PSA reading was 10.

In view of the above signs and symptoms, I believe he needs further investigations including a prostate biopsy and surgical management. I would appreciate your urgent attention for his condition.

Yours sincerely,

Dr.X

Sample Model Letter 2

03/07/2009

Dr. William Carlson
First Floor,
Ballow Chamber
56 Wickham Tce,
Brisbane 4001

Dear Doctor Carlson,

Re: Margaret Leon
DOB 01/08/1949

Thank you for seeing my patient, Margaret Leon, who has been very concerned about blood in her stools. She has seen blood in the toilet bowl on two occasions after bowel motion. She is very anxious and as well as that depressed because her father died of bowel cancer and she feels she may have the same condition.

Margaret has otherwise been quite healthy. She does not drink or smoke and is not taking any medication. She was slightly overweight six months ago with borderline high blood pressure. At that time I advised her to lose weight which she did successfully. Three months later, her weight had dropped from 69kg to 61kg and blood pressure was back within normal range.

On presentation today she was distressed because she believes she has bowel cancer. She has had trouble sleeping and her weight has reduced a further 11 kg. The rectal examination did not show any abnormalities. Her blood pressure was slightly elevated at 180/95 but her cardiovascular and respiratory examination was unremarkable. Alepam, one before bed, was prescribed to control the anxiety and sleeplessness.

I would appreciate it if you could perform a gastroenterology assessment.

Yours sincerely,

Dr X (GP)

Word Length: 194 words

Last modified: Tuesday, 12 January 2010, 09:11 AM

Sample Model Letter 3

08/08/09
Dr Vincent Raymond
422 Wickham Tce
Brisbane, 4001

Dear Dr Raymond,
Re: Dulcie Wood
DOB: 15/07/43

As arranged with your receptionist, I am referring this patient a 66 year old widow, who has been demonstrating symptoms suggestive of heart arrhythmia.

Mrs. Woods has seen me on several occasions in the past five months, during which time she has had frequent episodes of heart flutter and her blood pressure has been fluctuating.

The patient initially responded to Noten 50mg ½ tablet daily in the morning, but she still had episodes of disturbed sleep during the night. Therefore the dose of Noten was increased to 50mg ½ tablet in the morning and ½ tablet at night, but unfortunately her heart flutter has increased recently, especially over the last three days. Other current medications are Zocor 20mg and Calcium Caltrate 1 daily.

Today's examination revealed a nervous and upset woman with a pulse rate of 70 and blood pressure of 180/90.

Please note that her mother died of acute myocardial infarction and her sister, who is a patient of yours, has a similar condition.

In view of the above, I would appreciate it if you provide an assessment of Mrs. Wood and advise regarding treatment and management of her condition.

Yours sincerely,

Dr Z

Word Length: 191 words

Last modified: Friday, 20 August 2010, 11:26 AM

Sample Model Letter 4

25/08/2009

Dr. Glynn Howard
Surgical Department,
249 Wickham Tce,
Brisbane 4001

Dear Doctor,

Re: Mr. James Warden
DOB 05/07/29

I am referring this patient, a widower who is presenting with symptoms consistent with a bilateral inguinal hernia. He has been suffering from hypertension for 5 years for which he takes Noten, Aspirin and multivitamins. He is allergic to penicillin.

Initially Mr Warden presented to me on 09/07/09 for a regular check up. On examination he had a mild swelling of the right groin, his blood pressure was 155/85 and pulse was 80 beats per minute, otherwise his condition was normal. He was diagnosed as having an inguinal hernia. I discussed the possibility of surgery, however he indicated he did not want an operation. Therefore I advised that he avoid heavy lifting and reduce alcohol consumption. A review consultation was scheduled for 3 months later.

Today he returned complaining that his right groin had increased in size with a regular dull ache possibly due to lifting a heavy wheel barrow. The examination revealed a considerable increase in the swelling in the right groin as well as a mild swelling of the left groin.

Based on my provisional diagnosis of a bilateral inguinal hernia, I would like to refer him for surgery as early as possible. Please note that Mr Warden wishes to have the surgery under local anaesthesia.

Yours sincerely,

Dr X (GP)

Last modified: Sunday, 22 August 2010, 08:10 AM

Sample Model Letter 5: Amina Ahmed

Kevin Grove Medical Centre
53 Goma Road
Kelvin Grove, Brisbane
14.10.09

The Duty Registrar
Emergency Paediatric Unit
Brisbane General Hospital
140 Grange Road
Kelvin Grove, QLD, 4222

Dear Doctor:
Re. Amina Ahmed (8years)

I am writing to refer Amina who is presenting with signs and symptoms of meningococcal meningitis for urgent assessment and management. She is the first child of a family of 5, which includes her parents and two younger siblings. They are immigrants from Somalia, though she and her father understand English.

Initially, accompanied by her parents, she presented to me on 9.10.10 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next two days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.

Regrettably, today Amina became lethargic and listless. She vomited twice last night and had been having severe headaches. On examination, she was severely febrile with a temperature of 40.2 and a pulse rate of 110 beats per minute. There was macula-papular rash over the legs and neck stiffness was present. Blood test showed leucocytosis with a shift to the left.

Based on the above, I believe she needs urgent admission and management. Please note, Penicillin IV has been given as a stat dose.

Yours sincerely,

Dr. Lucy Irving

208 words

Last modified: Wednesday, 24 March 2010, 02:28 AM

Sample Writing Task 1

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

15.08.09

Patient History
Darren Walker

DOB 05.07.69

Regular patient in your General Practice

09.07. 09

Subjective

Regular check up, Family man, wife, two sons aged 5 and 3
Parents alive - father age 71 diagnosed with prostate cancer 2002.
Mother age 68 hypertension diagnosed 1999.
Smokes 20 cigarettes per day –trying to give up
Works long hours – no regular exercise
Light drinker 2 –3 beers a week

Objective

BP 165/90 P 80 regular
Cardiovascular and respiratory examination normal
Height 173 cm Weight 85kg
Urinalysis normal

Plan

Advise re weight loss, smoking cessation
Review BP in 1 month
Request PSA test before next visit

14.08.09

Subjective

Reduced smoking to 10 per day
Attends gym twice a week, Weight 77 kg
Complains of discomfort urinating

Objective

BP 145/80 P76
DRE hardening and enlargement of prostate
PSA reading 10

Plan

Review BP, smoking reduction in 2 months
Refer to urologist – possible biopsy prostate

Writing Task

Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001. Ask to be informed of the outcome.

In your answer:

- * Expand the relevant case notes into complete sentences
- * Do not use note form
- * The body of the letter should not be more than 200 words
- * Use correct letter format

Sample Writing task 2

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

03.07.09

Patient History

Margaret Leon 01 .08. 49

Gender: Female

Regular patient in your General Practice .

14.01.09

Subjective

Wants general check up, single, lives with and takes care of elderly mother.

Father died bowel cancer aged 50.

Had colonoscopy 3 years ago. Clear

Does not smoke or drink

Objective

BP 160/90 PR 70 regular

Ht 152cm

Wt 69 kg

On no medication.

No known allergies.

Assessment

Overweight. Advised on exercise & weight reduction.

Borderline hypertension.

Review in 3 months

25.04.09

Subjective

Feeling better in part due to weight loss

Objective

BP 140/85

PR 70 regular

Ht 152cm
Wt 61 kg

Assessment

Making good progress with weight. Blood pressure within normal range

03.07.09

Subjective

Saw blood in the toilet bowl on two occasions after bowel motions.
Depressed and very anxious. Believes she has bowel cancer. Trouble sleeping.

Objective

BP 180/95 P 88 regular

Ht 152cm Wt 50 kg

Cardiovascular and respiratory examination normal.

Rectal examination shows no obvious abnormalities.

Assessment

Need to investigate for bowel cancer

Refer to gastroenterologist for assessment /colonoscopy.

Prescribe 15 gram Alepam 1 tablet before bed.

Advise patient this is temporary measure to ease current anxiety/sleeplessness.

Review after BP appointment with gastroenterologist

Writing Task

Write a letter addressed to Dr. William Carlson, 1st Floor, Ballow Chambers, 56 Wickham Terrace, Brisbane, 4001 requesting his opinion.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Last modified: Tuesday, 12 January 2010, 09:08 AM