

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**January 2014**

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

**notes:**

**Patient:** Joshua Vance

**Gender:** Male

**DOB:** 17/11/13

Normal vaginal delivery at 38 weeks' gestation

No perinatal or neonatal complications

Birth weight 3250g

**Parents:** Pamela Vance (mother) - first child

Stewart Vance (father)

**31/12/13**

**Routine 6-week baby check**

**History:**

Mother concerned regarding bowel actions: only one bowel action every 3 days; stools a little hard. Is breastfed. Making wet nappies, feeding well, demand feeding, sleeping through the night.

**Examination:**

6-week check - good tone, hands & feet normal, hips normal, genitalia male, no herniae, no evidence of spina bifida occulta. abdominal/chest/heart exam normal.

fontanelles normal, red reflex present. nose & ears normal, palate intact.

Perianal examination normal, no fissures. Weight 3900g.

**Assessment:** Mild constipation in breastfed baby; otherwise normal 6-week check.

**Plan:** Reassurance - bowel habit variable in infants & can often settle. Try expressing milk from one feed a day & giving it in a bottle with some water (boiled & cooled to body temp).

Review 2/52

**13/01/14**

**History:**

Still hard stools every 3 days. Now waking up crying, pulling legs up to chest every half hour throughout the night. Pulls away from breast halfway through feeds. No vomiting. No fevers.

No respiratory symptoms. Making wet nappies.

**Examination:**

Hydration status normal.

Abdominal examination: hard faeces.

Perianal examination normal, no fissures.

Weight 4200g.

**Assessment:** Constipation no better. Has put on weight.

**Plan:**

Trial of Coloxyl drops daily. Express milk from two feeds a day & give it in a bottle with some water (boiled & cooled to body temp).

Review 1/52.

**18/01/14**

**History:**

Has not passed a bowel action for last 5 days. Refusing feeds. No wet nappies today. Vomit x 1. No fevers.

**Examination:**

Irritable ½ week-old.

Mildly dehydrated: dry mucous membranes, tissue turgor & capillary return normal: P 120; RR 30.

Abdominal examination: mild generalised tenderness, no guarding or rebound tenderness.

Weight 4100g.

**Assessment** Constipation & mild dehydration. Refusing feeds.

**Plan:**

Needs review at Children's Hospital ED for rehydration & further assessment regarding constipation.

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to the Admitting Officer at the Emergency Department, Children's Hospital, 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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**February 2014**

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

**notes:**

Mr Daniel McCrae is a patient in your general practice.

**History:**

**DOB:** 17 October 1962

**Height:** 180cm

**Weight:** 91kg

**BMI:** 28.1

**Social background:**

Smoker

Married, 4 children (23, 20, 10, Byrs)

Barrister

**Hobbies:** Reading, cooking, art, music

19/09/13: Pt fever, sore throat, cough, headache, body aching

Wants antibiotics so no need for time off work - v busy

**O/E:**

BP 120/75

Heart rate 76bpm

Chest clear

Wt 91kg

BMI 28.1

Temp 38.9°C

**Tests:** None

**Assessment:** Viral infection

**Plan:**

Rest 1-3 days until fever subsides, symptoms weaken Paracetamol

R/V if symptoms persist >5 days

**08/02/14:**

**O/E:**

Pt feeling tired. 'ott-colour', as if never fully recovered from infection (Sep 2013). Complains of 'unsettled system' for several weeks - abdominal discomfort, gas, diarrhoea/constipation; feels fatigued. Still under some stress from workload. No family history of colorectal carcinoma, colonic polyps or inflammatory bowel disease.

BP 115/80

Heart rate 77bpm

Wt 92kg

BMI 28.4

Temp 31.1°C

Abdomen soft, lax, no masses, no guarding or rebound

Normal bowel sounds

**Assessment:**

? Irritable bowel syndrome

? Crohn's disease, ulcerative colitis, inflammatory bowel disease

? Unfit, Overweight

**Plan:**

Investigations: CBC

Faecal occult blood test (FOBT)

Colonoscopy

R/V in 2 weeks for test results

**22/02/14:**

O/E: Pt still feeling unwell

BP 120/85

Heart rate 74bpm

Chest clear

Temp 37°C

No abdominal mass

**Results:**

CBC: normal, WBC (8.5), Hb (91), t Hct (34%)

FOBT: positive

Colonoscopy: abnormal. Malignancy detected in ascending colon; biopsy taken and adenocarcinoma diagnosed

**Assessment:**

Adenocarcinoma of the ascending colon

**Plan:** Refer to colorectal surgeon for assessment ASAP

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to: Associate Professor Simon Anderson, Surgeon, Suite 65, City Hospital, 25-29 Main Road, Centreville.*

**In your answer:**

- Expand the relevant notes into complete sentences
- Do or use note form
- Use letter format

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

TIME ALLOWED:

READING TIME: 5 MINUTES

March 2014

WRITING TIME: 40 MINUTES

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

**Notes:**

Patient History	Tracy Bowen (Ms)
DOB	22/7/88
PMH	Childhood asthma - worse with dust, exercise, smoke, cat hair, change in temperature. Recurrent bronchitis. Father heavy smoker - house smoky.
Medications	Salbutamol inhaler, beclomethasone pm
28/06/04	
Subjective	Irregular menstrual periods since menarche. Very infrequent, up to 90-day intermenstrual interval. Frequently with dysmenorrhoea. Stress related to parents' divorce (2002). Adolescent acne since 3/12 ("pus-filled").
Objective	Abdominal exam - NAD Rectal exam - NAD FHx - no genetic anomalies Breast development normal
Assessment	Idiopathic oligomenorrhoea, primary dysmenorrhoea
Treatment	Oral contraceptive pill (Diane-35, 2mg - low dose) Analgesia (naproxen) Reassurance
21/09/05	
Subjective	Acne - facial + upper back, shoulders and neck.
Objective	OE: deep, inflamed nodules and pus-filled cysts with scarring on face, neck, upper back and shoulders.
Assessment	Deep acne
Treatment	Antibiotic therapy: tetracycline 250mg qid; tetracycline ointment 1% 5g, apply liberally bd
24/11/05	
Subjective	Acne - unchanged. Cyst-like, leaves scars. C/o diarrhoea, vaginal candidiasis and sore tongue since 4/52.
Assessment	Cystic acne
Treatment	Refer to dermatologist for Roaccutane (isotretinoin) capsules 30mg bd. Isotrex gel 0.05% - apply at night. R/V 2/52.

*Notes for intervening period omitted for clarity.*

28/03/14

Subjective	Patient married; discontinued OCP January 2013. Difficulty conceiving. Amenorrhoea; depression; weight gain.
Objective	BMI 28 (overweight) BP 100/60  Hirsutism (has had cosmetic therapy: electrolysis)  ★ Oral GTT (fasting) 6.5mmol/L (Ref range <5.5mmol/L) Serum testosterone 2.1nmol/L (Ref range 0.4-2.7) ★ SHBG 19nmol/L (Ref range 20-100) ★ Free Androgen Index (TE/SHBG ratio) 11.1% (Ref range <8.0) Serum oestradiol 325pmol/L (Follicular phase 70-670; Luteal phase 200-600) FSH 5.1IU/L (Follicular phase 2.5-10; Luteal phase 1.5-9) LH 9.0 (Follicular phase <15.0; Luteal phase <15.0) ★ Prolactin 115.3µg/L (Ref range <25.0) TSH 2.8 (Ref range 0.35-5.50mIU/L) Haematology NAD ★ Vitamin D 57nmol/L (Ref range 60-160) Iron studies Normal
Assessment	?PCOS (polycystic ovary syndrome)
Treatment	Climen (cyproterone with oestradiol) 10mg qd Patient requests referral to endocrinologist Pelvic US ordered; copy of results to be sent to endocrinologist

### Writing Task:

Using the information given in the case notes, write a letter of referral to Dr Susan Clayton, endocrinologist at the Women's Health Centre, 11-13 Bell Street, 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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**May 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mr James Seymour is a 60-year-old man presenting in your general practice with a swollen left large toe.

**Patient details:**

**Name:** James Seymour

**Residence:** 4 Pawlet Drive, Clayfield

**DOB:** 19/09/53 (Age 60)

**Social history:**

Retired academic (computer science)

Divorced, no children, lives alone

Non-smoker since 1994

Heavy drinker 5-6 beers and 3 wines/day

**Observations:** BP 115/70mmHg, HR 68, RR 18, T 37.4°C

**Allergies:** Nil known

**FHx:**

Father - rheumatoid arthritis (RA)~ 28 yrs old. Died 75yrs.

Mother - smoker, died chest infection aged 71 yrs.

Grandparents' history unknown, died when old.

**PMHx:**

Appendectomy 1963

Childhood - recurrent bronchitis

Annual influenza vaccine

Regular episodes of inflammation (?gout 1st toe) since 2010 – consulted several doctors

**Medication:**

Colchicine (Lengout) - 500mcg 2 tabs (stat on attack) then 1 tab each 2/24 until relief. Total dose~ 6mg in 4 days.

Indomethacin (Indocid) - 25mg 2 tabs, twice/day.

On allopurinol after last acute attack - after several mths w/o symptoms ceased meds (a couple of mths before current episode).

**Treatment record:**

**25/04/14** ~4 wks into current bout of gout.

Colchicine started 2 wks into bout, only taken at sub-therapeutic levels.

Indocid taken erratically.

3rd bout in 8 mths.

No allopurinol for a couple of mths.

Modifies diet to decrease purines. Sometimes wakes at night.

Given father's Hx Pt wants referral to rheumatologist to exclude RA.

Pt thinks gout meds not working (unlikely).

**On examination:**

Moderately inflamed, red first L toe. V painful - Pt irritated. No evidence of involvement of other joints.

pt V insistent on possibility of RA; poor compliance with gout management much more likely.

**Treatment:**

- Encouraged to comply with gout meds:
  - resume full dose colchicine.
  - resume full dose indomethacin. Cease either if gastrointestinal (GI) side effects (diarrhoea from colchicine; upper GI upset from indomethacin).
- Regular paracetamol (4g/day for 3 days, then prn).
- Take oxycodone 5mg bedtime only if sore and can't sleep; try to cease ASAP.
- Improve dietary compliance and • alcohol intake.
- X-ray L foot, FBE, ESR, LFT, U&E, SUA, CRP.
- Rev. 1/52 to discuss results & referral.

**03/05/14**

X-ray - minor degenerative changes of L first metatarsophalangeal joint.

FBE: MCH 32.3pg (Ref Range: 27.0 - 32.0). All other NAO.

urate 0.48mmol/L (Ref Range: 0.18 - 0.47mmol/L).

CRP 6.0mg/L (Ref Range:< 3.0).

Gout episode subsiding.

No drug side effects apart from brief diarrhoea.

Only needed night time oxycodone 3 nights.

**Provisional Diagnosis:** Gout.

**Treatment:**

Discussed ?synovial fluid sample stat next episode.

Start allopurinol now, long term; reinforce messages re: diet & alcohol.

Referral to Rheumatologist on patient's insistence with copy of pathology results.

**Writing Task:**

*Using the information given in the case notes, write a letter to Dr Malcolm Still, Rheumatologist at 5 Grant St, Fairmont, for further treatment or investigations.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**June 2014**

**WRITING TIME: 40 MINUTES**

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

**Notes:**

You are a doctor at Bayview Private Practice. You are examining a 24-year-old woman who has been losing a lot of weight.

**Name:** Ms Lola Duval

**DOB:** 27.05.90

**Address:** 1087 Feather St  
Bayview

**Medical history:** Laryngitis – 2012

Anxiety

Insomnia

**Medications:** Occasional sleeping pill

**Family history:** Mother – depression

**Social history:** Student at Bayview University (engineering)

**Presenting complaint:** Pt complaining of unexplained weight loss – 10kg over the last 2/12

Pt eating well, has good appetite

**Treatment Record**

31.05.14

**Subjective:** Upon questioning, Pt experienced tremors, episodic palpitations, sweating, heat intolerance for last 2/12. Associated fatigue in last month.

Pt does describe feeling anxious currently – concerned about weight loss, being unwell

**Objective:** HR – 90

BP – 130/70

Weight – 55kg

Height – 160cm

Temp – afebrile

Slightly enlarged non-tender thyroid gland, tremor in both hands

**Eye examination:** Eye movements testing – some exophthalmos with lid lag

**Diagnosis:** Given history, probable hyperthyroidism with overtly anxiety

**Treatment:** Routine blood tests, ECG, thyroid function tests

**01.06.14**

<b>Test results:</b>	ECG: Sinus tachycardia, no other abnormalities
	Blood test: Normal FBE, UEC
	Thyroid Function: TSH < 0.05mU/L (0.4-5mU/L)
	Elevated T4 and T3: Free T3 15pmol/L (3.5-6.5pmol/L) Free T4 40pmol/L (9-26pmol/L)
<b>Treatment:</b>	Discuss results with Pt – likely hyperthyroidism due to Grave's disease Order thyroid auto-antibody tests & thyroid scan Refer to Dr White, thyroid specialist – request early review as Pt anxious

### **Writing Task:**

Using the information given in the case notes, write a letter of referral to the thyroid specialist, Dr White, at Bayview Private Hospital. Address the letter to Dr Charles White, Bayview Private Hospital, 81 Canyon Road, Bayview.

#### **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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**July 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient:**

Mr George Poulos is a 45-year-old man who has hurt his back. He presented at your general practice surgery for the first time in late June.

**21/06/14**

**Subjective:**

Severe lower back pain of 2 days duration:

2 days ago at home lifting logs (approx. weight each 20-30kg) from ground into wheelbarrow.

Action: bending, lifting and rotation.

Sudden severe pain - mid lower back. Thought he felt a click.

Was locked in semi-flexed position, almost impossible to walk.

Wife helped him into house and bed.

Took 2x Panadeine Forte, repeated 4 hours later.

Disturbed sleep.

Pain only low back, no radiation to thighs.

Yesterday pain less severe, able to ambulate around house.

Today again pain less severe.

**Patient History:**

Stockbroker - 45 y.o.

Married - 3 children secondary school, 1 primary school.

App: Good. Diet irregular.

Bowels: Normal. Diarrhoea if stressed.

Mict: Normal.

Wt: Varies - BMI 27.

Sex: Often too tired.

Exercise: Nil.

Tobacco: 25/day.

Alcohol: Frequently 10+ to 15+ std drinks/day.

**Allergies:** Pethidine, penicillins, radiographic contrast agent (unspecified) ?? iodine.

**Family History:**

No Ca bowel, no diabetes, no cardiovascular.

HPI: Head injury (football) approx 15yrs ago. MRI brain. NAO.

Reacted to contrast medium.

**Objective:****Full examination.**

CVS, RS, RES, CNS: NAD.

P 68 bpm reg. BP 135/80.

Musculo-skeletal: Stands erect. No scoliosis.

Loss of lumbar lordosis.

Lumbar spine: Flexion fingertips to patella. Expression of pain.

Extension limited by pain.

Lateral flexion: L & R full.

Rotation: L & R full.

No sensory loss.

Reflexes: Patellar & Ankle L+ R+.

SLR (straight leg raise): L 90 R 90.

**Plan:**

Take time off work. Analgesia: paracetamol 500mg 2x 4hrly max 8 in 24hrs or Panadeine Forte, or 1 of each.

Warned - risk of constipation with Codeine.

Review 1 week.

**28/06/14** : Has now developed pain which extends down back of R thigh, lateral calf and into dorsum of foot.

**Objective:**

Examination. As before except that now lumbar flexion limited to fingers to mid thigh and SLR: L 85 R 60.

Review 1 week.

**05/07/14**

Pain worse. Almost immobile. Severe pain down R leg. Tingling in R calf.

**Objective:**

Examination. Lumbar flexion almost nil. Other movts more restricted by pain. SLR: L 70 R 50.

Loss of light touch sensation lateral distal calf & plantar aspect of foot.

Loss of R ankle reflex.

Diagnosis: Low back pain, probably discogenic, with radiculopathy.

Refer to neurosurgeon & request that the neurosurgeon order an MRI and provide advice regarding the possibility of surgery.

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to Dr™ White, Neurosurgeon, City Hospital, 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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**August 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Michael Weir is a patient in your general practice.

**Name:** Mr Michael Weir (**DOB:** 20 Sep 1970)

**Height:** 183cm

**Background:**

Smoker

Overweight - long term

Depression - sertraline hydrochloride (Zoloft) since Sep 2012

Married - 3 children (13, 10 & 8yrs)

Real estate agent - reports no time for exercise/relaxation

Active member of local church congregation

**Patient History:**

**29.06.14**

**Subjective:** Here for general check-up. Reports feeling 'run down': tired, stressed, 'sluggish'.

**Examination:** BP: 96/83, Heart rate (HR): 70bpm

BMI: 27.8 (Wt: 93.1kg)

Chest clear

Skin check - no suspicious lesions found

**Tests:** CBC, cholesterol/lipids

**Plan:** R/v in 1wk (discuss test results)

**07.07.14**

**Subjective:** Here to receive results of blood tests (cholesterol, CBC)

Still tired, feeling 'down'.

Reports weakness in L leg.

**Examination:** BP: 90/80, HR: 79 bpm

Chest clear

**Test results:**

Sertraline hydrochloride - ongoing

BMI: 28.5 (Wt: 95.5kg)

Cholesterol: 6.37mmol/L

CBC - low WBC; low RBC, low Hb & Hct; other results in normal range

**Assessment:**

Repeat assessment of hypercholesterolaemia in 3mths.

**Plan:**

Monitor general health - tiredness, depressed feelings.

Pt should make lifestyle changes (smoking, diet, exercise, recreation).

Pt to decrease dietary saturated fat, incorporate regular exercise to decrease Weight & cholesterol levels; stop smoking.

R/V in approx 1mth to assess general health, feelings of tiredness & being 'down'.

**09.08.14**

**Subjective:** Complains of dizziness and reports two recent 'blackouts' (a few minutes each).

Feels stressed - busy at work. Mood up and down since last visit. Reports tingling in hands. L leg still feels weak. Breathless, occasional constipation, short of energy.

Has been trying to eat better & exercise more - walks (30mins) x2-3/week.

Still smoking.

**Examination:** BP: 88/70, HR: 76bpm

BMI: 28 (Wt: 93.7kg)

Chest clear

**Tests:**

Loss of sensation on L & R hands (sharp/blunt)

Reflexes - diminished L patellar reflex

Order head & lumbar spinal CT to try to determine cause(s) of leg weakness and associated objective hyporeflexia (?central or spinal - check for spinal cysts/ tumours, etc.).

**Assessment:** ?multiple sclerosis

**Plan:** Order CT

Refer to neurologist: a full neurological assessment; ?order MRI

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to Dr M McLaren, Neurologist, Suite 3, 67 The Crescent, 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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**September 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient:** Sally Mcconville (Ms), aged 38

**Occupation:** Administrator

**Marital Status:** Single

**Patient History:**

- Past history: asthma, hypertension, cholecystectomy, ankle fracture, depression, non-smoker
- Medications: ramipril - 2.5mg daily, paroxetine - 20mg daily, fluticasone 250 – 2 puffs daily, Ventolin (salbutamol) - 2 puffs if required
- Allergies: nil

**10/9/14**

**History:** 2-day history of runny nose, cough productive of yellow sputum, slight fever, wheezy, but not short of breath. Asthma usually well-controlled on preventer (fluticasone 250 - 2 puffs daily)

**Examination:** Temperature 37.5, pulse 82, BP 120/80, respiratory rate 12, obvious nasal congestion, throat red, ears normal, no increased work of breathing, no accessory muscle use, chest scattered wheeze, no crepitations.

**Assessment:**

1. Viral upper respiratory tract infection
2. Infective exacerbation of asthma

**Treatment:**

Ventolin 2 puffs 4-hrly, continue preventer

Medical certificate for work

Review as required

**12/9/14**

**History:** Increasing shortness of breath & wheeze over last 24hrs, feeling feverish at times, minimal yellowy sputum, short of breath on minimal exertion.

**Examination:** Temperature 38, pulse 95, BP 120/80, respiratory rate 16, throat red, ears normal, mildly increased work of breathing, chest - widespread wheeze, no crepitations.

**Assessment**

Infective exacerbation of asthma - symptoms worse.

**Treatment:**

Amoxicillin 500mg 3x daily, prednisolone 25mg daily x3 days

Continue 4-hrly Ventolin & preventer

**13/9/14**

**10.30am**

**History:** More short of breath today despite prednisolone & antibiotics. Feeling feverish & unwell.

**Examination:** Short of breath at rest, respiratory rate 25, obvious accessory muscle use & increased work of breathing, pulse 112, BP 100/65, temp 37.7, chest exam - widespread wheeze, bibasal crepitations.

**Assessment:** Acute asthma, ?pneumonia.

**Treatment:** Ventolin Nebules (salbutamol) 5mg, review.

**10.45am** No improvement. Still obvious respiratory distress

Refer to Emergency Department for acute management & investigation ?pneumonia

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to the Admitting Officer at the Emergency Department, Newtown 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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**October 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

You are a doctor at Bayview Medical Clinic. You are assessing a 22-year-old man who has worsening asthma.

**PATIENT DETAILS:**

**Name:** Mr Zach Foster

**DOB:** 25/10/91 (Age 22)

**Address:** 77 Creek Road, Bayview

**Medical history:**

Asthma, since age 3 - problematic at times, 2 previous hospital admissions (most recent - 3 years ago)

Eczema

Smoker - 4 years, 10-20/day

**Allergies:** Cats and Hay fever

**Medications:**

Ventolin prn

Pulmicort 200mcg one puff bd

**Family history:** Sister (age 18) - asthma

**Social history:** Builder, single

**Presenting complaint:** For last 3/52 (3wks):

- SOB - when playing sport.
- Wheeze & cough - waking Pt at night.
- 1' use of Ventolin for symptoms.

## Treatment Record

### 11.10.14

#### Subjective:

Preventative inhaler (Pulmicort): compliance unclear; claims to use inhaler some of the time.  
Burning sensation in lower part of chest after meals - consistent with gastro-oesophageal reflux disease (GORD).

#### Objective:

Chest clear.

Peak flow 500U/min.

Abdomen lax & non-tender.

#### Tests: CXR, FBE

Diagnosis: Unstable asthma, possible trigger GORD

#### Treatment:

- Ensure compliance with Pulmicort.
- Trial of pantoprazole (PPI) for GORD.
- Discussion about smoking cessation.
- Review 1/52.

### 18.10.14

#### Review:

Still smoking.

Non-compliant with Pulmicort - forgets to take it.

PPI - effective, nil side effects.

#### Test results:

CXR - clear

FBE - normal

#### Treatment:

- Use pantoprazole for another 7/52 (7wks) then review.
- Discussion about Pulmicort missed dosage - take as soon as remember, then back to normal, do not double dose.
- Advice on smoking cessation (e.g., nicotine patch, information brochures, support groups, etc.).
- Continue current management; refer to respiratory specialist for lung function & advice about Rx.
- Review appointment 7/52.

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to Dr Williams, a respiratory specialist, for further management of Mr Foster's asthma. Address the letter to Dr Tanya Williams, Respiratory Specialist, Bayview Private Hospital, 81 Canyon Road, Bayview.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**November 2014**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient Name:** Dolores Hoffmann (Ms)

**Patient History:**

DOB 22.06.1986

Allergic to penicillin.

**Social History:**

Single woman - no family in Australia; lives with long-term boyfriend.

Sales assistant- ladieswear in a department store.

**11 December 2013:** At pub last night with friend. 2 glasses wine + several cocktails. Then fainted 5-10mins unconscious and vomited once. No Hx fits/seizure's/incontinence.

No symptoms gastroenteritis or URTI. Work very busy/stressful. Feels "woozy" today. No appetite. Requested check-up.

**OE:** slightly pale; T 36°, P 72 reg, BP 120/70, medical certificate (Med. Cert.)

- 1 day, rest, watch for new symptoms.

**Blood tests (FBE, LFT, U&E):** normal

**7 August 2014** Skin check. Several moles Land R neck - ok. Advised to monitor for changes.

**2 September 2014** URTI since 2/52, yellow-green sputum; SOB, tight chest, wheezy; lethargic. Smoker.

Anxious re. EBV (Epstein-Bar virus) - work colleague is off with it.

Reassurance.

Rec. rest. Med. Cert. given for 2 days.

Ordered bloods.

**7 September 2014**

**HAEMATOLOGY:**

Haemoglobin 124g/L (115-165)

ABC	4.8 x 10 <sup>12</sup> /L	(3.80-5.50 x 10 <sup>12</sup> /L)
PCV	0.37	(0.35-0.47)
MCV	88 fl	(78-99)
MCH	30 pg	(27-32)
White Cell Count	7.0 X 10 <sup>9</sup> /L	(4.0-11.0 X 10 <sup>9</sup> /L)
Neutrophils	8.8 X 10 <sup>9</sup> /L	(2.0-8.0 X 10 <sup>9</sup> /L)
Lymphocytes	2.8 X 10 <sup>9</sup> /L	(1.0-4.0 x 10 <sup>9</sup> /L)
Monocytes	0.4 X 10 <sup>9</sup> /L	(< 1.0 x 10 <sup>9</sup> /L)
Eosinophils	0.3 X 10 <sup>9</sup> /L	(< 0.6 X 10 <sup>9</sup> /L)
Basophils	0.0 X 10 <sup>9</sup> /L	(< 0.2 x 10 <sup>9</sup> /L)
Platelets	250 X 10 <sup>9</sup> /L	{150-450 x 10 <sup>9</sup> /L}

Paul Bunnell/latex screening test for IM (infectious mononucleosis): negative

Rx: erythromycin 250mg qid

**22 November 2014**

Orofacial HSV-1 for 3 days. Rx: aciclovir 200mg - 4hrly for five days+ topical aciclovir 3% - qid.

Job stress+++ causing depression, nightmares, insomnia, difficulty getting up, loss of appetite, low libido.

Poor memory and concentration; loss of pleasure; loss of confidence.

Low tolerance for alcohol.

Split up with boyfriend. Now living alone. Considering quitting job. Wants a break from working.

Recommended referral to psychiatrist - Pt resistant.

Rx: temazepam 20mg - 30mins before bed

R/V: 1 week

**29 November 2014**

**Diagnosis:** reactive depression and anxiety

Pt has not filled temazepam script - not keen on drug Rx.

Pt has agreed to a referral to psychiatrist.

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr John McLennan, psychiatrist, Royal Mental Health Clinic, 177 Park Avenue, Newtown.*

**In your answer:**

- Expand the relevant notes into complete sentences
- Do or use note form
- Use letter format

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

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**January 2015**

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

**Notes:**

Mr Brett Collister is a male patient in your general practice.

**PATIENT DETAILS:**

**Name:** Mr Brett Collister (DOB: 20 November 1970)  
**Height:** 177cm  
**Occupation:** Factory foreman  
**Social History:** Married, 3 children (18, 16, 13 yrs)  
**Hobbies:** Watching football, playing darts, fishing  
**Medical History:** No known allergies  
Infectious mononucleosis – January 2003

**Treatment Record**

**22/03/14** Productive cough & sore throat for 1 week, green phlegm;  
Pt tired, temp (38°C).  
**Treatment:** Rest, plenty of fluids, salt water gargles.

**26/05/14** Sore throat – suddenly worse after 3 weeks of intermittent pain & fever; Pt feels 'run-down'  
Tonsils inflamed; temp 38.5°C.  
**Treatment:** Prescribed amoxicillin.

**17/08/14** Sore L shoulder – triggered during game of darts 2 weeks previous – ?rotator cuff tear.  
Busy at work – feels tired & stressed.  
**Treatment:** Prescribed ibuprofen.  
R.I.C.E (rest, ice, compression, elevation)  
Refer to physio (Mrs Louise Ferguson) for exercise program &  
treatment for shoulder.

**26/10/14** Sore R knee – pain intermittent, worse going up stairs. No identified trigger.  
?osteoarthritis.  
Shoulder better.  
BP 107/60, HR 78 (reg), Wt 94kg (BMI 30 – overweight).  
**Treatment:** Prescribed ibuprofen.  
Advised to ↓ weight, ↑ exercise (cycling, swimming).  
Refer to physio (as previously) – review in 3 months.

4/01/15	<p>Pt feels tired, 'run-down'; sore eyes, dizzy sometimes (for last 3-4 weeks) – ?orthostatic hypotension.</p> <p>Overweight, unfit – no adjustment to lifestyle, diet, exercise.</p> <p>Reports busy at work.</p> <p>BP 108/61, HR 80 (reg), lungs clear, Wt 93kg (BMI 29.7 – overweight).</p> <p><b>Treatment:</b> Order blood tests to review cholesterol, blood sugars, etc.</p>
24/01/15	<p>Still tired, sore eyes, vision↓.</p> <p>BP 105/60, HR 78 (reg), lungs clear, Wt 89kg (BMI 28.4 – overweight).</p> <p>Review of tests organised 4/01/15:</p> <ul style="list-style-type: none"> <li>• random glucose 13.5mmol/L (high).</li> <li>• fasting glucose 7.4mmol/L (high).</li> <li>• HbA1c 8.5%.</li> <li>• HDL/LDL ↑ (cholesterol 6.4mmol/L, LDL 4.2mmol/L, HDL 2.1mmol/L, Trig 3.3mmol/L).</li> </ul> <p><b>Preliminary diagnosis:</b> Results indicate DM (diabetes mellitus) Type 2.</p> <p><b>Treatment:</b> Refer to endocrinologist for assessment and management plan.</p>

### Writing Task

Using the information in the case notes, write a letter of referral to Dr Grantley Cross, Consultant Endocrinologist, City Hospital, Suite 32, 55 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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**February 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mr Patrick Newton (born on 6 July 1989) is a patient in your General Practice.

**Patient details:**

**Name:** Mr Patrick Newton

**Residence:** 10 Ashwood Street, Stillwater

**Social background:** 25-year-old accountant, single, lives with parents

**21 Feb 2015**

**Subjective**

**Presenting complaint:**

Presentation with 4 month Hx of chronic mild diarrhoea & low-grade intermittent R lower quadrant abdo pain; lethargy, decrease appetite, decrease weight (3kg in 4 months)

**Social/family Hx:**

Smokes 10-15 cigarettes per day

Regular squash player

Uncle has Crohn's disease

increase Anxiety and embarrassment relating to symptoms and impact on social participation:

- dietary modification unsuccessful in alleviating symptoms
- recently stopped attending Friday evening squash matches with work colleagues
- has not sought medical advice (has attempted to self-manage illness by diet and OTC pain relief)

**Past medical Hx:** 6 month Hx low-grade intermittent joint pain in R & L wrists

**Medications:**

OTC Ibuprofen 200-400mg, 3 or 4 times a day (as required)

No known allergies

### **Objective**

T - 36.4°C; P - BO (regular); Ht-175cm; Wt- 79kg

Abdomen - generalized tenderness, no HSMegaly (enlargement of liver and spleen)

Cardiovascular & resp examination - normal

Urinalysis - normal

FBE increase WCC  $11.1 \times 10^9/L$ , decrease RCC  $4.0 \times 10^{12}/L$

decrease Hb 125g/L

Faecal occult blood test - positive

Mildly elevated CRP (13mg/L) and ESR (14mm/hr)

### **Assessment:**

?Inflammatory bowel disease (IBD)

?Crohn's disease/ulcerative colitis (UC)

No urgent systemic signs

### **Plan:**

Advise on smoking cessation

Counsel on IBD & likely investigations

Refer to gastroenterologist for diagnosis & assessment

### **Writing Task:**

*Using the information given in the case notes, write a letter of referral to gastroenterologist, Dr Jack Thomas, seeking his advice on diagnosis and assessment. Address the letter to: Dr Jack Thomas, Department of Gastroenterology, City Hospital, Main Road, Stillwater.*

### **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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**March 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Your patient, an 81-year-old woman, recently had a right total knee replacement (R.TKR) on

**25/02/2015.**

She is being discharged today.

Patient: Ms Betty Johnson

Address: 12 Merry Street, Stillwater

Marital Status: Widowed

**Past Medical History:**

Aortic valve replacement & pacemaker 2010

Osteoarthritis since 2011 - pain & immobility **increase** past 3yrs

For R.TKR Feb 2015: full blood work, typing & cross matching, X-rays, ECG etc.

**Regular Medication (25/2/15):**

Paracetamol 665mg 2 tabs tds

Warfarin 3mg mane - ceased 5 days preoperatively, started Clexane  
(enoxaparin sodium - anticoagulant)

**Social Background:** Widowed 1986. Lives alone. 4 children

**Post Op:**

**25/02/15 11:30am**

Returned to ward following R. TKR.

Vital signs- BP 115/70, P 82, R 16, T 36.9°C.

Circulation observation good, knee high on pillow.

Hb 80g/l = IVT Transfusion.

IV cephalothin 1g qid for 24 hours.

Increase regular oral paracetamol (1g qds).

Patient Controlled Analgesia (PCA) - morphine ✓ effective.

Wound - nil ooze.

**26/02/15**

Wound - good, sponged.

Restart warfarin 5mg today.

sic Clexane 80mg given for anticoagulation.

Cease PCA. Start oxycodone 5 - 10mg pm.

Pathology: FBE, U&Es, Liver Function Tests (LFTs), Hb.

Path results ✓, Hb 100g/l = commence Feratab (iron sulphate) 300mg mane.

**27/02/15**

sic Clexane 80mg.

Start warfarin 5mg nocte.

Removal of (R/O) dressing, wound good, R/O alt. clips on 03/03/15.

**28/02/15**

Crutches, short walks. Wound good, afebrile.

sic Clexane 80mg given.

**01/03/15**

s/c Clexane 80mg given.

**02/03/15**

X-rays, bloods ✓, INR - 3.0, Hb 1119/1, ECG - no abnormalities.

Managing w/ min assistance.

Cease Clexane.

**03/03/15 - 05/03/15** Wound clean, R/O alt clips tomorrow. Mobility good. Obs

**06/03/15** R/O remaining clips. Pathology ✓. Transfer to rehab today.

**Rehab:**

**07/03/15** ✓ Admission complete - stable. Circ ✓. Mobility, crutches good.

**08/03/15 -13/03/15**

Mobility, frame use, trial stick, pool, gentle exercises= good. Showering w/ min assistance.

Path & X-ray.

**14/03/15**

Path ✓, INR - 3.8.

decrease warfarin 4mg nocte, Hb - g/l, decrease Feratab 150mg mane.

**15/03/15-19/03/15**

Uneventful – gradually increase independence.

Wound good. Obs ✓, Physio exercises good. Home list provided.

**21/03/15**

✓ ✓ No cardiac issues.

Discharged w/ home nursing assistance (personal hygiene, home care). Wound exposed, shower w/ min assist. Stick/ frame prn.

Discharge medication: warfarin 4mg nocte, Feratab 150mg mane, paracetamol 1g qds, oxycodone 5-10mg prn.

Rehab appt in 2 weeks.

Advised to see local doctor in 1 week, referral for local doctor - suggest repeat FBE, INR.

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to Ms Johnson's local doctor, Dr Tony Jones, to update him on her condition following her recent surgery and discharge from rehab. Address the letter to Dr Tony Jones, Private Practice, 12 New Street, Stillwater.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**April 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Your long-term patient, Mrs Welshman, has attended your GP surgery with her daughter. Both are concerned about Mrs Welshman's memory.

**Patient:** Mrs Patricia Welshman (D.O.B.: 28/03/1930)

**Address:** 24 Kenneth St, Newtown

**Marital status:** Widowed, 5 adult children

**Next of kin:** Christine - daughter

**Diagnosis:** Osteoporosis. Dementia (?early stage Alzheimer's)

**Social background:** Widowed 40yrs. Lives alone, children within 10km radius.

**2007-2013 Regular GP visits to this clinic, Pathology, BP- stable**

**19 June 2014** Fall - bruised nose only. X-ray- NAO. Will begin to take it easy, slow down.

**27 July 2014**

Occupational Therapist (OT) home assessment: Evaluated shower rails, ramp. Bed ok. Rev 4-6mths.

Discussed shower with OT. All ok.

Shower every other day to avoid falls.

Community Support: Home care provided by local council, 1/fortnight.

**14 December 2014** BP 145/85

**Pathology:** FBE, U&Es, LFTs - all NAO

**Lipids:**

Total cholesterol 4.8mmol/L (< 5.5)

HDL cholesterol 1.4mmol/L (0.9-2.2)

LDL cholesterol 2.9mmol/L (< 2.0)

Triglycerides 1.1mmol/L (0.5-2.0)

LDUHDL 2.1 , Chol/HDL 3.4

Vitamin D < 54 (60-160nmol/L)

**Discussions:** Spare scripts - ?not filling them or taking medication regularly.

Assures me she is taking medication regularly.

Suggested Webster pack (a folder used to store medication on a weekly basis), reluctant, promised to adhere to medication regime.

Rev 2 months, post-pathology.

### **13 February 2015**

**Pathology:** FBE, U&Es, LFTs - all NAO

**Lipids:** Total cholesterol 5.3 mmol/L (< 5.5)

HDL cholesterol 1.3mmol/L (0.9-2.2)

LDL cholesterol 3.5mmol/L (< 2.0)

Triglycerides 1.2mmol/L (0.5-2.0)

LDL/HDL2.7 , Chol/HDL 4.1 , Vitamin D < 20 (60-160nmol/L)

**Discussions:** BP 130/80 ✓ encouraged.

### **19 April 2015**

Vit D low , LDL high agreed to use Webster pack.

Rev 2 months, post-pathology.

BP 130/70, Vit ✓ & Lipids ✓

Medication sorted.

Daughter with Pt, both want to discuss memory issues.

Poor memory noted++, e.g., forgetting hair dresser, dinner engagements, missing social events. Behavioural changes, decision-making issues. Family concerned.

#### **Mini memory assessment:**

Poor short-term memory, day & date - several attempts, no result. Month - 3 attempts. Confirmed the year correctly. Quite worried.

Requested further assessment.

Family history of Alzheimer's.

Asked about dementia - explained difference between Alzheimer's (disease - high amyloids in brain) and dementia (symptom). Alzheimer's - common cause of dementia.

More assessments before diagnosis. Referred to Memory Clinic.

Rev, post-assessment.

#### **Writing Task:**

Using the information given in the case notes, write a letter of referral to Dr Jones at the Newton Memory Clinic, 400 Rail Rd, Newtown, to provide him with your brief assessment and request full memory assessment and diagnosis.

#### **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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**May 2015**

**WRITING TIME: 40 MINUTES**

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

**Notes:**

You are a doctor working in the Stillwater Hospital Emergency Department. Today you treated Ms Garcia, who was referred by her General Practitioner (GP), Dr Bradbury.

**Patient Details**

**Name:** Ms Isabel Garcia

**DOB:** 01.01.1995

**Address:** 29 Greenfield Road, Stillwater

**Medical history:** 2007 Fracture R arm  
2009 Unexplained weight gain, ?stress  
2014 Difficulty sleeping

**Allergies:** Certain washing detergents cause skin irritation.

**Medications:** Doxylamine prn (encouraged not to use).

**Family history:** Mother – breast cancer, age 38.

**Social history:** University student (2nd year).

**Reason for referral:** Suspected meningitis.

**Treatment Record**

**23 May 2015**

**Subjective:** Painful, stiff joints for 1 wk.  
Sensitivity to light.  
↑ bruising.  
Headache, neck stiffness, photophobia, rash.

**On examination:**

Afebrile.  
Bruising L arm.  
Petechial rash abdomen and legs.  
Unable to touch chin to chest when lying supine.

**Tests ordered:**

Full blood count (FBC), renal function, liver function test (LFT), C-reactive protein (CRP), lumbar puncture, blood cultures.

**Results:** White cell count:  $14.0 \times 10^9/L$   
C-reactive protein: 150  
Lumbar puncture: White cell count 1000 (elevated)  
Polymorphonuclear (PMN) predominance  
Glucose: 10mg/dl (reduced)  
Protein: 70mg/dl (elevated)  
Subsequent microscopy and culture: *Neisseria meningitidis*

**Diagnosis:** Bacterial Meningitis.

**Treatment:** Ceftriaxone 2g IV bd while awaiting lumbar puncture culture results.  
Dexamethasone 10mg IV before first dose of antibiotics, then 10mg IV every 6hrs for 4 days.  
Following lumbar puncture results: benzylpenicillin 1.8g IV every 4hrs for 5 days.  
Pt responding well to treatment.  
Department of Human Services notified.  
Discussed with family re: ensure family immunised.

**Plan:** Letter to GP, recommend:  
Contact close family & friends of Pt:

- Seek medical attention ASAP – observation for any signs of unexplained illness required.
- ?chemoprophylaxis for people in recent close contact with Pt.

### Writing Task:

Using the information given in the case notes, write a letter to Dr Bradbury, the doctor who referred Ms Garcia, to update her on the patient's status and follow-up treatment that may be required in the future. Address the letter to Dr Lorna Bradbury, Stillwater Medical Clinic, 12 Main Street, Stillwater.

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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**June 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

You are a doctor at Newtown Medical Clinic. Mr Barry Jones is a regular patient of yours.

**Patient:** Mr Barry Jones

54 Woods Street Newtown

D.O.B. 01.04.1972 (age 44)

**Reason for presenting:** Wants to return to work after back injury - employer supportive

**Medical history:** 1984 - Appendix removed

**Family and social history:**

Married - Susan Jones, 3 children

Work - drives forklift in a large warehouse (requires prolonged sitting / occasional heavy-lifting)

**Current medications:**

Naproxen (non-steroidal anti-inflammatory drug)

Carisoprodol (muscle relaxant, blocks pain)

**Condition history:**

**21/03/15**

**Presentation:** Hurt back lifting heavy box off floor at work. 4 days since initial strain.

No rest, pain worsening.

**X-ray:** No disc problems.

**Diagnosis:** Lower back strain - severe.

**Treatment:**

Exercise: walking daily - gradual t time/distance.

Referral to physio.

Prescription: naproxen and carisoprodol.

30 days off work and certificate to give to employer.

To review in 30 days.

**18/04/15**

**Progress:** Back: Still sore.

Moving very stiffly.

**Physio:** Exercises "very painful" but Pt is compliant.

**Exercise:** Walking up to 10 min per day.

**Treatment:** Extended time off work - 30 days. To review in 30 days.

**19/05/15**

**Progress:** Back: Recovering well - still in pain.

Still moving very stiffly.

**Physio:** Attending regular appointments.

**Exercise:** Walking 15-20 mins per day- "very tiring".

**Treatment:** increase Naproxen dose.

Extended time off work - 30 days. To review in 30 days.

**20/06/15**

**Progress:** Back: Recovering well - still in pain.

Moving stiffly but increase ROM.

Pain increase after 20-30 mins of sitting or lying down.

**Physio:** Still attending appointments.

**Exercise:** Walking 30 mins per day- "tiring".

**Discussions:** Pt bored, discouraged, wants to return to work. Restless.

**Treatment:** Return to work if no lifting & with regular breaks.

Letter to OT requesting assessment of workplace (advise on duties Pt can perform, etc.).

**Writing Task:**

*Using the information in the case notes, write a letter to Ms Jane Graham, an Occupational Therapist, detailing Mr Jones' situation and requesting an assessment of his workplace. Address the letter to Ms Jane Graham, Newtown Occupational Therapy, 10 Johnston St, 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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**July 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mrs Katherine Walter is a patient in your general practice.

**History:**

Name: Mrs Katherine Walter

DOB: 26 November, 1975

Height: 170cm

Asthma - since childhood; budesonide (Pulmicort) inhaler, since 28/06/99

Chronic fungal skin infections (both feet) - currently clotrimazole (Canesten)

Moderate family Hx depression (father, sister, aunt, uncle)

Married; two children (8 & 11 yrs)

Home duties

No hobbies or sport

Family (parents, husband's parents & siblings) live in other states

**19/11/14**

**Subjective:**

Here for 'check-up'. Seems well, happy, volunteers at her children's school.

Reports feeling tired. Asthma controlled, more attacks this year. Fungus on feet flares up periodically

- Pt reports no creams seem effective. Overweight.

**Examination:**

BP-110/95

Heart rate - 76 bpm

Breast check - no palpable mass found

Skin check - no suspicious lesions found

Wt-82kg = BMI-28.4

**Tests:** Pap smear and CBC

**Assessment:** Pt appears well. Needs to decrease weight, increase exercise.

Monitor BMI/fitness/lifestyle.

**Plan:**

Advise Pt re lifestyle changes to decrease weight, increase exercise. Pt to phone for test results in 1 wk. Recommend miconazole (Daktarin) for fungus. R/v appt 3 mths to assess fungal infection, weight and fitness.

**28/05/15**

**Subjective:**

R/v. Pt reports feeling well and energetic. Too busy to come to scheduled r/v 3 mth - didn't think it was necessary. Asthma flared up about two months ago but no attacks since then. Fungus improved. Reports 1<sup>st</sup> involvement with school (now president of parents' association). Has lost weight, joined gym (trains daily).

**Examination:**

BP-108/90

Heart rate - 66 bpm

Wt-69.5kg

BMI-24

CBC-all results in normal range (results of test 19/11/14)

Pap smear - no abnormalities found (results of test 19/11/14)

**25/07/15**

**Subjective:**

Reports feelings of not coping and of wanting to die. Feels tired, but sleeps badly. No energy to complete household tasks, e.g., cooking and cleaning, looking after children. Feels overwhelmed with responsibilities. Doesn't want to eat...

**Examination:**

BP-120/90

Heart rate - 78 bpm

Wt-50kg

BMI-17.3

Temp - 37.5°C

**Assessment:**

Depression - severe / ?bipolar disorder. Requires urgent treatment.

**Plan:**

Refer to psychiatrist for urgent assessment and treatment for depression/ bipolar disorder and suicidal thoughts. Contact husband to discuss child care, household maintenance, etc.

**Writing Task:**

*Using the information in the case notes, write a letter of referral to the psychiatrist, Dr M Jones, 23 Sandy Road, South Seatown.*

**In your answer:**

- Expand the relevant notes into complete sentences
- Do or use note form
- Use letter format

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

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**August 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mrs Mary Clarke (born on 17 September 1960) is a patient in your General Practice.

**Patient details**

**Name:** Mrs Mary Clarke

**Address:** 26 Marine Drive Riverside

**Social background:**

54-year-old office clerk

Married, lives at home with husband and 20-year-old son

Smokes 30-35 cigarettes per day (>30 yrs)

**Family/medical history:**

Mother died 66 y.o. - laryngeal carcinoma

Father (coal miner) died 54 y.o. - mining-related lung disease

Nil medication

No known allergies

**04.07.15**

Patient presented with sore throat, body aches, fever and cough.

**Prescription:** Augmentin (penicillin)

**22.08.15**

**Presenting complaint:**

7-week Hx of dry non-productive cough (no haemoptysis)

Cough commenced with flu-like symptoms, cleared with Augmentin

Associated mild shortness of breath (esp. at night) and "strange sensation of heaviness" in chest

Nil fever, night sweats or rigors

Exercise tolerance OK - chores, shopping, could walk up 2 sets of stairs

**Examination:** T: 36.7°C, P: 80 regular, Ht: 165cm, Wt: 68kg

Respiratory exam - signs of consolidation associated with monophonic wheeze in R mid-zone

No cyanosis/dyspnoea/ascites

No hoarse voice/Homer's syndrome

No cervical lymphadenopathy

No hepatosplenomegaly/bone pain

Systems review- GIT & CV normal

Sputum cytology - normal

Chest X-ray and CT - R middle lobe atelectasis, enlarged R hilum

**Assessment:** ?Bronchogenic carcinoma

**Plan:** Counselled on potential diagnosis and need for further investigations

Refer to thoracic surgeon for follow-up investigations (bronchoscopy, biopsy) and assessment

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to the thoracic surgeon, Dr Penny Clifton, seeking follow-up investigations and assessment. Address the letter to: Dr Penny Clifton, Department of Cardiothoracic Surgery, Central Hospital, Main Street, Stillwater.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**September 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mrs Lucy Clarke is a patient in your General Practice.

**Patient details**

**Name:** Mrs Lucy Clarke

**DOB:** 11 March 1951

**Residence:** 23 Mountain Drive Coast City

**Social background:** 64-year-old retired office clerk

Independent, lives at home with husband

Non-smoker, social drinker

**20.09.15**

**Presenting complaint:**

1 week history central crushing chest pain on exertion (**3x, <15 mins duration**)

Associated dyspnoea, radiation of pain down L arm

Relieved by rest

No palpitations, no orthopnoea (difficulty breathing on lying down), no paroxysmal nocturnal dyspnoea (difficulty breathing at night)

Pt anxious - believes had a "heart attack"

**Past medical history:**

2001 - diabetes mellitus (OM) Type II (currently stable)

2003 - hyperlipidaemia

2005 - hypertension (HT)

**Medications:**

Sitagliptin (Januvia) 100mg per oral (p.o.) mane

Insulin (NovoMix30) 25 units subcutaneously (s.c.) b.d.

Atorvastatin (Lipitor) 40mg p.o. mane

Irbesartan (Avapro) 75mg p.o. mane

**Family history:** Mother - acute myocardial infarction (MI) at 57 y.o.; died of ischaemic stroke at 59 y.o.

**Examination:**

T - 36.7°C, P - 80 regular, Ht- 164cm, Wt - 65kg

No peripheral oedema

Systems review - normal

Resting ECG - normal

**Provisional diagnosis:** Unstable angina

**Plan:**

Hospital admission for urgent assessment

Referral to Emergency Department cardiologist for update & further management

Counsel patient - advised on serious risk of MI

**Writing Task:**

*Using the information in the case notes, write a letter of referral to the Emergency Department cardiologist, Dr Smith. Address the letter to: Dr David Smith, Cardiologist, Emergency Department, Main Hospital, Coast City.*

**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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**October 2015**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Mrs Maria Santini (born on 08 January 1948) is a patient in your General Practice.

**Patient details**

**Name:** Mrs Maria Santini

**Residence:** 23 High Street Greenville

**Social background:**

67-year-old widow, two adult children

Lives alone at home, non-smoker, non-drinker

**Patient history:**

**17.10.2015**

**Subjective:**

**Presenting complaint**

6wk history progressively increase pain R and L knee joints, especially on flexion and extension  
4wk history soft lump on back of R knee, restricted joint mobility, mild-moderate persistent pain  
decrease Activities of Daily Living (AOL) - stopped accessing local shops and friends within walking distance, confined to a two-store house but recently has experienced difficulty in-climbing stairs  
increase Depressive symptoms(+ reclusive, + anti-social, + irritability, + agitation)

**History of presenting complaint**

2003 onset of osteoarthritis (OA)

2008 lumbar laminectomy (L5/S1)

**2010 bilateral hip replacement (restored almost full function, eliminated pain & discomfort)**

**Past medical history:**

2000 hypertension (HT), hyperlipidaemia; 2003 OA; 2006 paroxysmal atrial fibrillation (AF)

**Medications:** OA- Glucosamine 1500mg daily

AF - Flecainide 200mg daily, Digoxin 250mcg daily

HT - Trandolapril 2mg daily, Indapamide 1.5mg daily

Hyperlipidaemia - Simvastatin 20mg daily

Allergies – nil



E2 LANGUAGE

**Family history:** Mother - acute myocardial infarct; ? died bf ischaemic heart disease (IHD)

**Objective:** T - 36.?"C, P - 80 regular, Ht - 164cm, Wt - 72kg, BP - 130/85

No skin changes, no swelling, no valgus/varus deformity

Concomitant crepitus (crackling sounds when moving joints) in Rand L knee joints on flexion and extension

Systems review - normal

MRI - degeneration consistent with OA

FBE - normal

LFT-normal

U&E - normal (serum creatinine 145mmol/L)

**Assessment** Worsening of chronic OA with significant pain ,AoL and signs of depression

**Diagnosis:** Baker's cyst in A knee joint plus worsening OA

**Plan:**

Refer to orthopaedic surgeon for assessment and management of OA

? joint steroid injection

Refer to physiotherapist to improve joint mobility

? Living at Home assessment(? District Nurse)

**Writing Task:**

*Using the information given in the case notes, write a letter of referral to the orthopaedic surgeon, Dr Bronwyn Clarke. Address the letter to: Dr Bronwyn Clarke, Orthopaedic Surgeon, Orthopaedic Department, Main Hospital, Greenville.*

**In your answer:**

- Expand the relevant notes into complete sentences
- Do or use note form
- Use letter format

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

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 1**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Hospital:** St. Mary's Public Hospital, 32 Fredrick Street, Proudhurst

**Patient Details:** Ms Bethany Tailor

**Next of Kin:** Henry Tailor (father, 65) and Barbara Tailor (mother, 58)

**Admission date:** 01 March 2018

**Discharge date:** 18 March 2018

**Diagnosis:** Schizophrenia

**Past medical history:**

- Hypertension secondary to fibromuscular dysplasia
- Primary hypothyroidism Levothyroxine 88 mcg daily

**Social background:**

- Unemployed, on disability allowance for schizophrenia.
- History of polysubstance abuse, mainly cocaine and alcohol. Last used cocaine 28/02/18:

**Admission 01/03/2018:**

- Patient self-admitted: decompensated schizophrenia

**Medical background:**

- Not compliant with medications.
- Admitted for auditory command hallucinations telling patient to harm self.
- Visual hallucinations – shadow figures with grinning faces.
- Delusion – personal connections to various political leaders.

**01/03/2018 –**

- agitated and aggressive, responding to internal stimuli with thought blocking and latency.
- Commenced antipsychotic meds (rispoderone).

**10/03/2018:**

- Patient ceased reporting auditory or visual- hallucinations.
- Less disorganized thinking.
- No signs of thought blocking or latency.
- Able to minimize delusions and focus on activities of daily living.

**Nursing management:**

- Assess for objective signs of psychosis.
- Redirect patient from delusions.
- Ensure medical compliance.
- Help maintain behavioral control, provide therapy if possible.

**Assessment:**

- Good progress, chronic mental illness, can decompensate if not on medications or abusing substances. Insight good, judgment fair.

**Discharge plan:**

- Discharge on Risperidone 4g nightly by mouth.
- Risperidone 1 milligram available twice daily p.r.n for agitation or psychosis.
- back to apartment with follow-up at Proudhurst Mental Health Clinic

**Writing Task:**

*Ms. Bethany Tailor is a 35-year-old patient in the psychiatric ward where you are working as a doctor*

*Using the information given in the case notes, write a discharge letter to the patient's primary care physician, Dr. Giovanni DiCoccio, Proudhurst Family Practice, 231 Brightfield Avenue, Proudhurst*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 2**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Hospital:** Fairbanks Hospital, 1001 Noble St, Fairbanks, AK 99701

**Name:** Mrs Sally Fletcher

**Date of Birth:** 3/10/1993

**Marital status:** Married, 5 years

**Appointment date:** 25/03/2018

**Diagnosis:** Endometriosis

**Past medical history:**

- Painful periods 3 years
- Wants children, trying 1 year ++

**Social background:**

- Accountant, regular western diet.
- Exercises 3 x week local gym

**Medical background:**

- Frequent acute menstrual pain localised to the lower left quadrant.
- Pain persists despite taking OTC = naproxen.
- Shy discussing sexual history.
- Occasional constipation, associated with pain in lower left quadrant.
- Trans-vaginal ultrasound showing 6cm cyst, likely of endometrial origin.
- Patient recovering post op from laparoscopic surgery(25/03/2018) – no complications

**Post op care:** Keep incisions clean and dry.

**Mobility post op:**

- Showering is permitted 26/03/2018
- Driving is prohibited when on analgesics.
- Driving can be resumed 24-48 hrs after final dose analgesics.
- Sexual activity can be resumed 2 weeks post op.

**Nursing management:**

- Encourage oral fluids.
- Patient may return to regular diet.
- Ambulation encouraged as per patient tolerance.

**Medical progress**

- Afebrile. Hct, Hgb, Plts, WBC, BUN, Cr, Na, K, Cl, HCO<sub>3</sub>, Glu all within normal limits.
- Patient sitting comfortably, alert, oriented x 4 (person, place, time, situation).

**Assessment:**

- Good progress overall.

**Discharge plan:**

- Patient to be discharged when can eat, ambulate, urinate independently.
- Patient must be discharged to someone who can drive them home.

**Writing Task:**

You are a first year resident in a surgical ward. Sally Fletcher is a 25-year-old woman who has recently undergone surgery. You are now discharging her from hospital.

*Using the information given to you in the case notes, write a letter of discharge to the patient's GP, Dr Stevens, Mill Street Surgery, Farnham, GU10 1HA.*

**In your answer:**

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

The body of your letter should be approximately 200 words. Use correct letter format

TIME ALLOWED:

READING TIME: 5 MINUTES

Task 3

WRITING TIME: 40 MINUTES

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

**notes:**

**Office:** First Family Primary Care, 3959 Abalone Lane, Omaha

**Patient Details**

**Name:** Tabitha Taborlin (Ms). **Marital status:** Single. **Next of kin:** Gregory Taborlin (69, father).

**Date seen:** 08 April, 2018

**Diagnosis:** Type 1 diabetes mellitus

**Past medical history:**

- Essential hypertension
- Type 1 diabetes mellitus (non-compliant with insulin regimen)
- Multiple episodes of diabetic ketoacidosis (DKA)

**Social background:**

- School teacher, lives alone in apartment
- Does not exercise, BMI 18.2 (underweight - 48kg)
- Smokes moderately (2 cigs daily)

**Medical background:**

- Long history of Type 1 diabetes (since 7 y.o.) and noncompliance with insulin regimen.
- On 45 units Lantus nightly and preprandial correctional scale Humalog with 12 unit nutritional baseline.
- **02/04/2018: admitted DKA (glucose 530 mmol/L) IV fluids and insulin administered.**  
Discharge stable - HbA1c.

**Appointment today:**

- Doing well since discharge.
- Still not using insulin. Has insulin available.
- Not following recommended diet.
- Discussed diabetes education, necessity of glucose testing, insulin administration, smoking cessation education.
- Discussed microvascular/macrovacular complications of diabetes.

**Plan:**

- Discharge today – provide educational pamphlets and refills for Lantus and Humalog.
- Referral to endocrine specialist for stricter glycemic control and possible insulin pump.
- Follow-up in 1 month

**Writing Task:**

You are a physician OR at a family medical practice. Ms Tabitha Taborlin is a 45-yearold patient at your practice.

*Using the information given in the case notes, write a referral letter to Dr. Sharon Farquad, Endocrinologist at Endocrine Specialists and Associates, 115 Burke St. Omaha.*

**In your answer:**

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 4**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**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**

Volatrin 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 answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 5**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Assume Today's Date: 01/06/10

**Patient History**

**Tom Cribb D.O.B: 23/5/82**

Unemployed – builder's labourer recently made redundant because of lack of work

Married/no children

Wife works full time as shop assistant

No hobbies

Smokes 5-6 cig/day, drinks 2-5u of alcohol per week

Father has hypertension

Mother died at 60 due to breast cancer

No known allergies

**12/05/10**

**Subjective**

Very severe pain in lower R abdomen for 3 hrs, radiated to groin, nausea, no vomiting

No red colour urine - frequency normal

No history of trauma, No fever

Anxious about finding new job ASAP – has to make regular home mortgage repayments

**Objective**

BP: 120/80

PR: 80 BPM

Ab-mild tenderness in lower abdo, no guarding and rebound

**Plan**

Diagnosis? Ureteric colic due to renal stone

Diclofenac sodium 50mg suppository dose given and 50mg b.i.d. for 5 days

Advised to drink moderate amount of fluid with regular exercise, especially walking for 2-3 days

Review after 2 days with IVP report, UFR report

**14/05/10**

**Subjective**

No pain, no new complaints

**Objective**

IVP-L/kidney-nl R/enlarged kidney which was ectopic. No evidence of stones

UFR-few red cells

Advised to drink more fluid especially in hot weather

Ordered ultrasound of abdomen to exclude any kidney pathology and review in 2 weeks

**01/06/10**

**Subjective**

Had mild R sided lower abdominal pain 5 days ago, responded to Panadol

Ultrasound-severe hydronephrosis? Mass attached to the liver, L/kidney, spleen, pancreas normal

Rehired as builder's labourer on new job due to start in two weeks -keen to get back to work.

**Objective**

BP: 140/90

PR: 98 regular

Ab-mass in R/lower abdominal area. RDE-felt a hard mass & kidney situated below normal site.

Hydronephrosis +

**Plan**

Refer to a urologist for further investigation including CT scan and assessment.

**Writing Task:**

You are a General Practitioner at a Southport Clinic. Tom Cribb is your patient.

Using the information in the case notes, write a letter of referral to urologist for CT scan and assessment. Address the letter: Dr B Comber, Urologist, Southport Hospital, Gold Coast

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**Task 6**

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

**notes:**

**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 and 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 answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 7**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Today's Date 16.02.13

**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

**15.02.13**

**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

**16.02.13**

**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 Spirit 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
- Use correct letter format

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 8**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 25.08.12

**Patient History**

**James Warden**

**DOB** 05.07.32

**Regular patient in your General Practice**

**09.07.12**

**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

**25.08.12**

**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
- Use correct letter format

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 9**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 08.08.12

**Patient History**

**Dulcie Wood**

**DOB** 15.07.46

New patient in your general practice. Moved recently to be near family.

**03.07.12**

**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.

**17.07.12**

**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  $\frac{1}{2}$  tablet am and  $\frac{1}{2}$  tablet pm

Advise review in one month.

### **08.08.12**

#### **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 14/08/12

#### **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
- Use correct letter format

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 10**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 03.07.12

**Patient History**

**Margaret Leon** 01 .08. 52

Gender: Female

Regular patient in your General Practice .

**14.01.12**

**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

**25.04.12**

**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

**03.07.12**

**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
- Use correct letter format

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 11**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 15.08.12

**Patient History**

**Darren Walker**

**DOB** 05.07.72

**Regular patient in your General Practice**

**09.07.12**

**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 2002.

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

### **14.08.12**

#### **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
- Use correct letter format

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 12**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 21/01/12**

**Patient History**

**Brendan Cross, Male , DOB: 25/12/2003**

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

**14/01/12**

**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.

**19/1/12**

**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

**21/1/12**

No change of symptoms

ECG – prolonged P-R interval

ESR – increased

ASOT – Increased

**Diagnosis**

? Rheumatic fever

**Plan**

Contact Spirit 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.**

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 13**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 24/08/12**

**Patient History**

**Mrs. Jane MacIntyre (DOB 01.03.73)**

Two children age 5 and 3

Two miscarriages

First pregnancy

- developed severe pre-eclampsia
- delivered by emergency Caesarean Section at 32 week
- in intensive care for 3 days, required magnesium sulphate
- baby (Sam) weighed 2.1 kg – in Neonatal Intensive Care Unit 2 weeks
- did not require ventilation only CPAP (Continuous Positive Airway Pressure)

Second Pregnancy

- BP remained normal
- baby (Katie) delivered at full term, weighed 3.4kg

Family history of thrombosis

Known to be heterozygous for Factor V Leiden

Treated with prophylactic low molecular weight heparin in two previous pregnancies

No other medical problems

Not on any regular medication

Negative smear 2010

**24/08/12**

**Subjective**

Positive home pregnancy test – fifth pregnancy

Thinks she is 8 weeks pregnant

Last menstrual period 26.6.12

Painful urination last three days

Request referral to the Spirit Mother's Hospital for antenatal care and birth.

### **Objective**

BP:120/80

Weight: 60kg

Height: 165cm

Some dysuria for the past 3 days

Urine dipstick: 3+ protein, 2+ nitrites, and 1+ blood

Abdomen soft and non-tender

Fundus not palpable suprapublically

### **Assessment**

Needs antenatal referral to an obstetrician in view of her history of severe pre-eclampsia, Caesarean Section, and her age

Needs to start folic acid

Needs to start tinzaparine 3,500 units daily, subcutaneously, in view of thrombosis risk.

Suspected urinary tract infection based on her symptoms and the urine dipstick result

### **Plan**

Refer Jane to Dr Anne Childers at the Spirit Mother's Hospital

Commence her on folic acid 400 micrograms daily, advise to continue until 12 weeks pregnant

Arrange routine antenatal blood tests – results to be sent to the Spirit Mother's Hospital when received

Counsel Jane re antenatal screening for Down's Syndrome in view of her age

Jane elects to have a scan for nuchal translucency, which is done between 11 and 13 weeks

Provide information on Greenslopes Screening Centre.

Prescribe tinzaparine 3,500 units daily subcutaneously

Send a midstream urine specimen to laboratory

Prescribe cefalexin 250 milligrams 6-hourly for five days

**Writing Task:**

You are GP, Dr. Liz Kinder, at a Family Medical Centre. Write referral letter to Dr. Anne Childers MBBS FRANZCOG, Consultant Obstetrician, Spirit Mother's Hospital, Stanley Street, South Brisbane.

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 14**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 14.10.12**

**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 Somalia 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

**09/10/12**

**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

**12/10/12**

**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

**14/10/12**

**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 answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 15**

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

**notes:**

Patient: Anne Hall (Ms)

DOB: 19.9.1965

Height: 163cm Weight: 75kg BMI: 28.2 (18/6/10)

**Social History:** Teacher (Secondary – History, English)

Divorced, 2 children at home (born 1994, 1996)

Non-smoker (since children born)

Social drinker – mainly spirits

**Substance Intake:** Nil

**Allergies:** Codeine; dust mites; sulphur dioxide

**FHx:** Mother – hypertension; asthmatic; Father – peptic ulcer

Maternal grandmother – died heart attack, aged 80

Maternal grandfather – died asthma attack

Paternal grandmother – unknown

Paternal grandfather – died 'old age' 94

**PMHx:** Childhood asthma; chickenpox; measles

1975 tonsillectomy

1982 hepatitis A (whole family infected)

1984 sebaceous cyst removed

1987 whiplash injury

1998 depression (separation from husband); SSRI – fluoxetine 11/12

2000 overweight – sought weight reduction

2002 URTI

2004 dyspepsia

2006 dermatitis; Rx oral & topical corticosteroids

**18/6/10**

**PC:** dysphagia (solids), onset 2/52 ago post viral(?) URTI

URTI self-medicated with OTC Chinese herbal product – contents unknown

No relapse/remitting course

No sensation of lump

No obvious anxiety

Concomitant epigastric pain radiating to back, level T12

Weight loss: 1-2kg

Recent increase in coffee consumption

Takes aspirin occasionally (2-3 times/month); no other NSAIDs

**Provisional diagnosis:** gastro-oesophageal reflux +/- stricture

**Plan:** Refer gastroenterologist for opinion and endoscopy if required

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further investigation and definitive diagnosis to the gastroenterologist, Dr Jason Roberts, at Newtown Hospital, 111 High Street, Newtown.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 16**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Patient: Mrs Priya Sharma , DOB: 08.05.53 (Age 60)

Residence: 71 Seaside Street, Newtown

**Social Background:**

Married 40 years – 3 adult children, 5 grandchildren (overseas). Retired (clerical worker).

**Family History:**

Many relatives with type 2 diabetes (NIDDM)

Nil else significant

**Medical History:**

1994 – NIDDM

Nil significant, no operations

Allergic to penicillin

Menopause 12 yrs

Never smoked, nil alcohol

No formal exercise

**Current Drugs:**

Metformin 500mg 2 nocte

Glipizide Smg 2 mane

No other prescribed, OTC, or recreational

**29/12/13**

**Discussion:**

Concerned that her glucose levels are not well enough controlled – checks levels often (worried?)

Attends health centre – feels not taking her concerns seriously

Recent blood sugar levels (BSL) 6-18 / Checks BP at home

Last eye check October 2012 – OK

Wt steady, BMI 24

App good, good diet

Bowels normal, micturition normal

**O/E:**

Full physical exam: NAD

BP 155/100

No peripheral neuropathy; pelvic exam not performed

Pathology requested: FBE, U&Es, creatinine, LFTs, full lipid profile, HbA1c

Medication added: candesartan (Atacand) tab 4mg 1 mane

Review 2 weeks

**05/01/14 Pathology report received:**

FBE, U&Es, creatinine, LFTs in normal range

GFR > 60ml/min

HbA1c 10% (very poor control)

Lipids: Chol 6.2 (high), Trig 2.4, LDLC 3.7

**12/01/14 Review of pathology results with Pt Changes in medication recommended**

Metformin regime changed from 2 nocte to 1 b.d.

Atorvastatin (Lipitor) 20mg 1 mane added

Glipizide 5mg 2 mane

Review 2 weeks

**30/01/14**

Home BP in range

Sugars improved

Pathology requested: fasting lipids, full profile

**06/02/14 Pathology report received: Chol 3.2, Trig 1.7, LDLC 1.1**

**10/02/14 Pathology report reviewed with Mrs Sharma**

Fasting sugar usually in 16+ (high) range

Other blood sugars 7-8

Refer to specialist at Diabetes Unit for further management of sugar levels

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr Smith, an endocrinologist at City Hospital, for further management of Mrs Sharma's sugar levels. Address the letter to Dr Lisa Smith, Endocrinologist, City Hospital, Newtown.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 17**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Mrs Toula Athena, 47, married, two children, home duties**

**Family history**

Mother diabetes, died stroke 10 years ago aged 67

**Medical history**

Unremarkable, no medications

**Social History** Married 2 children, home duties

**11/11/06**

**Subjective:**

4 months thirst, bulimia, nocturia (4 times per night)

lethargy 7 weeks

dizziness

**Objective:**

Ht. 1.60 Wt. 95kgs.

Pulse 84 reg, BP 160/95

**Plan:** Arrange investigations – blood sugar, mid stream urine (MSU)

Dietary advice re weight loss, appropriate foods

**16/12/06**

**Subjective:**

Reports has followed diet, no weight loss

Symptoms unchanged

Frequent headaches

**Objective:**

No weight loss

BP 170/95

Investigation results: blood sugar 11 mmol / l

- no sugar in urine
- albumin in urine + +

**Plan:**

prescribe antidiabetic and antihypertensive medications, continue diet

07/01/07

**Subjective:**

Complains feeling worse

Blurred vision

Sight spots

**Objective:**

BP 165/90

**Plan:**

Referral Dr. Haldun Tristan, endocrinologist

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr Tristan, an endocrinologist at Melbourne Endocrinology Centre, 99 Brick Road, East Melbourne 3004. The main part of the letter should be approximately 180-200 words long.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 18**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Peter Ludovic, 8 years old

22/12/06

Complains of sore throat. Mother reports fever, irritable.  
Voice hoarse

**O/E:**

enlarged tonsils, exudate  
Tender, large cervical nodes  
T 39.5°

**Assessment:** Tonsillitis

**Plan:** Penicillin v 250mg qid 7 days

15/01/07 Mrs.

Ludovic reported son's urine brown 4 days previously.  
Says Peter is lethargic, no report of frequency, trauma or dysuria.

**O/E:** tonsillar hypertrophy

BP 90/60

Urinalysis – macroscopic haematuria

**Assessment:**

? post streptococcal nephritis  
? urinary tract infection

**Plan:**

R/V 2 days

Fluids, rest

**Tests:**

Full Blood Examination (FBE), urea and creatinine  
[U&E], electrolytes, mid stream urine [MSU]  
micro/culture/sensitivity [M/C/S], Antistreptolysin-O Titre [ASOT] and cell morphology

**18/01/07**

Peter asymptomatic

O/E: BP 110/90

macroscopic haematuria

**Test results:**

FBE normal

U&E ↑

ASOT ↑+++

MSU – 4X 10 # RBC [red blood cells ] of renal origin

**Assessment:**

post streptococcal nephritis with early renal failure

**Plan:** Refer to paediatrician

**WRITING TASK**

*Using the information in the case notes, write a letter of referral to Dr Xavier Flannery, a paediatrician at 567 Church St Springvale 3171.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 19**

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

**notes:**

**Name** Mrs. Larissa Zaneeta, Age 38-years-old

**Family and social history**

Marketing manager, married,  
one child (four-year-old boy).

**Medical history**

Unremarkable, no medications

**11/07/05**

Complains of tiredness, difficulty sleeping for 2 months due to work stress

Plans another child in 12 months, currently on oral contraceptive pill (OCP)

**O/E:**

Appears pale, tired and slightly restless

BP 140/80

No abnormal findings

**Assessment:** Stress-related anxiety

**Plan:**

advised relaxation techniques, reduce working hours,  
prescribe sleeping tablets tds

**15/08/06**

Stopped OCP 4 months earlier, still menstruating

Worried

Sleep still difficult, work stress unchanged, not possible to reduce hours

**O/E:** Tired-looking, slightly teary

**Assessment:** Work stress, growing anxiety failure to conceive

**Plan:**

discussed nature of conception – takes time, patience

discussed frequency sexual intercourse

discussed methods – temperature / cycle

**18/01/07**

Expressed anxiety re failure to conceive, says she's "too old"  
sleep still a problem

**O/E:**

crying, pale, fidgety

Vital signs / general exam NAD

Pelvic exam, pap smear

**Assessment:** as per previous consultation

**Plan:**

1-2 Valium b.d.

Suggested she re-present next week accompanied by husband.

**25/01/07**

Mr. Zaneeta very supportive of having another child

No erectile dysfunction, libido normal

Mrs. Zaneeta unchanged

**O/E:**

Mr. Zaneeta normal

**Plan:** Check Mr. Zaneeta's sperm count

**02/02/07**

Sperm count normal

**Plan:** Refer for specialist advice

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr Elvira Sterinberg, a gynaecologist at 123 Church St Richmond 3121.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 20**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Name Mr Jing ZU

Age 72-year-old man

**Family history unremarkable**

**Medical history**

Hypertension 18 years

Ischaemic heart disease 10 yrs

Acute Myocardial Infarction 1999

Congestive Cardiac Failure (CCF) 5 yrs

**Medications**

Lasix 40mg mane, Enalapril 10mg mane, Slow K TT bd, Nifedipine 10mg tds, Anginine T sl prn

**Social History Job:**

retired school teacher

Home: married

Activities: gardening

Smoking: no

**03/01/07**

**Subjective:**

Angina on exertion – gardening, relief with rest and Anginine

Sleeps two pillows, no orthopnoea

Mild postural dizziness

**Objective:**

Thin, looks well.

Pulse 84 reg, BP 160/90 lying, 145/80 standing

Jugular Venous Pressure (JVP) + 3 cm

Apex beat not displaced

S1 and S2 no extra sounds nor murmurs

Chest - Bilateral basal crepitations

Abdomen – normal

Ankles mild oedema, pulses present

**Assessment:** Stable CCF, angina

**Plan:** Watchful monitoring

**15/01/07**

**Subjective:** ↑ dyspnoea, orthopnoea (sleeps on 4 pillows)

↑ ankle oedema no chest pain

**Objective:**

BP 140/90

JVP + 6 cm

Chest crepitations to mid zones

Heart S1 and S2

Ankles oedema to knees

**Assessment:** Deteriorating CCF ? cause

**Plan:** ECG, ↑ Lasix 80 mg mane, R/V 2 days

19/01/07

**Subjective:**

Dyspnoea "feels a bit better"

Angina 10 min episode on mild exertion yesterday

**Objective:**

JVP + 4 cm

Chest fewer crepitations to mid zones

ECG - ? ischaemic changes anterolaterally

**Assessment:** ischaemic heart disease

**Plan:**

Referral Dr. George Isaacson, cardiologist, management of ischaemic heart disease

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr Isaacson, a cardiologist at 45 Inkerman Street Caulfield 3162.*

**In your answer:**

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

The body of your letter should be approximately 200 words. Use correct letter format.

TIME ALLOWED:

READING TIME: 5 MINUTES

Task 21

WRITING TIME: 40 MINUTES

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

**notes:**

Today's Date 09/11/17

**Patient History**

- Somarni Khaze
- DOB 12/04/71
- Works as an operating room nurse at Spirit Hospital
- Married with 4 children 3 girls aged 17,11 and 7 years and a boy aged 12 years
- Has a regular period
- Sister had cancer breast 7 years ago and was treated by mastectomy and axillary clearance followed by chemotherapy
- Past Hx of right breast lump treated by lumpectomy 5 years ago. Dx Benign lesion
- Does not smoke or drink and not using regular medications.
- Did mammogram 2 years ago which showed no suspicions of malignancy.

22/10/17

**Subjective**

- Discovered a left breast lump 6/52 ago
- Almond size, not painful and not in size
- No nipple discharge

**Objective**

- Mildly obese (BMI 31)
- Pulse 74/M regular
- BP 120/80
- CVS, RS, ABD are all normal
- Local examination: left breast shows 2x2 CM breast lump hard , non tender with ill defined margins
- Palpable mobile axillary lymph nodes
- Rt breast is normal except for the scar from previous surgery

**Assessment**

- ? cancer breast

**Management**

- Repeat mammogram and order ultra sound
- Advise patient to review in 2 weeks time

**6/11/17**

- Pt anxious and worried about results; cannot sleep at night
- BP 150/90 and pulse 88/Min
- U/S shows 18x 16 MM nodule at left breast with variable echogenecety .The mammogram reveals an area highly suspicious of malignancy at the left breast with multiple nodules at the axilla
- You counsel the patient about the different options of treatment and you do core biopsy to confirm the diagnosis
- Prescribe diazepam 10 mg nocte to calm the patient down
- Follow up consultation in 3 days for biopsy result and plan of management.

**9/11/17**

- Biopsy result shows moderately differentiated invasive ductal carcinoma of the left breast.
- Patient ask to be operated by Breast Surgeon Dr. Alaa Omar who had operated on her sister before.
- Asked about possibility of immediate reconstructive surgery.

**Writing Task:**

You are Dr. Tin Aung a GP at Weller Park Medical Centre, 151 Pring St. Weller Park 4121. Write a referral letter to The Breast Surgeon Dr. Alaa Omar: 1414 Wickham Tce. Spring Hill, 4004.

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 22**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 20/10/17

You are Dr. Peter Smith, GP covering 3 satellite clinics in a remote mining area of Western Australia. The nearest tertiary hospital to you is 1250km away in Perth or 2 ½ hours by air evacuation using the Flying Doctor Service. The nearest poly clinic is in Port Hedland with radiology and laboratory facilities but it is a 6 hour drive over dirt roads.

**Patient History**

- Ammar Moustafawy (DOB: 15/1/61) Male
- Divorced and lives alone
- Process Technician at a Copper Mine in the remote Pilbara region of Western Australia
- Works on rotation with 6 weeks on location and 4 weeks off
- Started his present rotation one week ago
- Regular overseas holidays
- Just returned from the Phillipines 2 weeks ago after spending a 2-week vacation
- Enjoys water sports: scuba diving, sailing
- Smokes 20 cigarettes/ day
- Drinks 14 units/week
- Walks half an hour every day
- Hx of typhoid fever, (2009) In hospital for 6 days

**Drug history**

- Not on regular medication
- No known allergy

**Family history**

- Father died of natural causes at 85
- Mother hypertensive and diabetic aged 76
- Older sister treated for cancer breast when she was 40 YO

**18/10/17**

**Subjective**

- Ammar feels unwell, lack of appetite, sense of weakness and lack of energy for 3/7
- Has reduced smoking to 5 cig/day and not drinking for one week
- No vomiting but nauseating and passing motion normally

**Objective**

- Patient looks tired, not jaundiced
- Weight 89 kg; Height 193 cm
- Pulse 84 regular, BP 130 /80, Temp 37.3° C
- CVS, RS are normal
- Abdominal examination: lax and mobile with no mass or rebound but tender Rt. hypochondrium with no organomegaly

**Assessment and planning**

- Prodromal stage of liver disease or mood swings after changing his drinking and smoking habits
- Advise low fat, low protein and rich carbohydrate diet
- Order blood, urine and stool tests
- Prescribe vitamins B complex tablet one TDS and essential forte capsules 2 TDS
- Review in two days for results

**20/10/17**

**Subjective**

- Ammar is getting worse
- Cannot tolerate foods only drinks fruit juice and noticed that the urine is getting darker in color with chills and rigors

**Objective**

- Temperature 39°C; looks jaundiced and dehydrated
- Abdominal examination shows palpable, tender liver
- No ascitis
- Investigations shows normal stool and 2+ urobilinogen in urine test. Leukocytoses with increased serum bilirubin and
- deranged liver enzymes (ALT And ALP) in blood tests

### **Assessment and plan**

- Start IV fluids and medicate Rocephin one gram IV BD and Flagyl 500 MG TDS
- Contact Flying Doctor Service for urgent US examination or evacuation
- Result of US shows enlarged liver 20 CM with a 10x10 cm cystic lesion in the Rt. Lobe of liver
- You diagnose liver abscess and arrange referral to surgeon in Perth by Flying Doctor Service escorted by a registered nurse
- Urgent assessment required including ultrasound guided drainage

### **Writing Task:**

*Refer patient to the Surgical Registrar via the Emergency Department of Perth General Hospital, 268 Brisbane Rd Cottesloe, Western Australia 6542.*

### **In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 23**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 15/3/17

**Patient Details:**

- Mrs Karen Conway
- Age 32
- Occupation: Solicitor
- Husband William - age 33 - Accountant
- Karen: previous pregnancy 10 years ago, terminated. William does not know about this.
- William: no previous pregnancies.

**15/2/17**

**Subjective**

**Karen reports:**

- Neither she nor William has any significant medical problems.
- Neither smokes
- William drinks quite heavily. Also travels regularly with his job.
- Married for 3 years, and decided to try for a pregnancy in May 2014, 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
- Vaginal examination normal
- Cervical smear taken

**Assessment**

- Trying to conceive for only 18 months but Karen clearly anxious
- Further investigation appropriate

#### Action Plan

- Order blood tests to confirm that hormone levels are normal and that Karen is ovulating
- Explain it is necessary to see her husband, William
- Make a joint appointment
- Note - Karen anxious that her history of a termination of pregnancy is not revealed to William.

15/3/17

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

#### Subjective

- Karen states recent home ovulation-prediction test showed positive- likely that she is ovulating.
- William has no significant medical problems
- Contrary to Karen's opinion he states only drinks 10 units per week
- William says works away from home approximately 2 weeks out of 4 - not concerned that Karen hasn't conceived -thinks they haven't been trying long enough.
- Not keen on being investigated

#### Objective

- Karen's baseline blood tests normal
- Ovulation test borderline
- Smear test result negative
- William refuses to be examined - doesn't think there is a problem.

#### Assessment

- Karen more anxious than before - wants to be referred to an infertility specialist. Her sister recently had IVF treatment.
- William is quite reluctant.

#### Action Plan

- Suggest William do a semen analysis – pressured by Karen he agrees
- Reassure Karen no obvious risk factors - not unusual to take up to 2 years to conceive
- Karen requests referral to fertility specialist, while waiting for semen analysis results
- Give general advice regarding timing of intercourse
- Suggest Karen lose some weight
- Check Karen taking folic acid, 400 micrograms daily.

**Writing Task:**

You are Dr Claire Black, GP. Karen Conway has come to consult you as she and her husband have been trying to conceive for about 18 months without success. She is becoming concerned that there may be something wrong. Write the referral letter to Dr John Expert MBBS FRANZCOG, Gynaecologist and IVF Specialist, St Mary's Infertility Centre, Wickham Terrace, Brisbane.

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 24**

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

**notes:**

**Today's Date** 12/09/17

**Patient History**

- Arthur Benson
- DOB: 15/04/92
- Computer Programmer
- Regularly works 55 - 60 hr week
- Married with twin boys aged 6 months
- Non-smoker and social drinker
- Father died at 69 due to stroke
- Mother is a diabetic on metformin

**P.M.H.**

- Asthma since childhood-on steroid inhaler
- Allergic to penicillin

**25/08/17**

**Subjective**

- C/O headache (2/12), mild sensation of pins and needles, no nausea or vomiting
- Had a car accident 3 months ago. Hospitalised and discharged after 24 hrs with no complications.
- CT scan normal

**Objective**

- O/E-overweight BMI 32
- Gait-normal, has lumbar lordosis
- Mild weakness in L/hand
- Vision-good

**Plan**

- Review 2/52
- Panadol 2 tab 4/24 and rest 2/52
- Advise to reduce weight and increase exercise

**06/09/17**

**Subjective**

- Feeling better, no new complaints, no worsening of pins and needles sensation
- Has been walking 30 minutes 3 times a week
- Advised to start work and come back if any concern

**Objective**

- Weight loss 3kg

**12/09/17**

**Subjective**

- C/O worsening headaches for 3 days, dizziness, nausea, blurred vision
- Pain not responded to Panadol but noticed mild response to Panadeine Forte

**Objective**

- No weight change
- Gait-normal
- Could not read 2 line of eye chart
- Odematous optic disk on fundi examination
- BP: 160/70
- PR: 98bpm
- Mild weakness and loss of sensation in medial aspects of L/hand
- Reflexes: Elbow-normal, Wrist- no reflexes
- Diagnosis: subdural haematoma

**Writing Task:**

You are a General Practitioner at a suburban clinic Arthur Benson and his family are regular patients. Using the information in the case notes, write a letter of referral to a neurosurgeon for MRI scan. Address the letter: Dr J Howe, Neurosurgeon, Spirit Hospital, Wooloongabba.

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 25**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 30/09/17**

**Patient History**

- Mr. Dave Cochrane
- D.O.B 20/11/64
- Smoker: 20 cig/day
- Drinks 12-14u alcohol per week
- No reg exercise
- Retired at 50
- lives with wife
- 3 children all married

**12/08/17**

**Subjective**

- Shortness of breath
- tightness in chest
- coughing especially at night
- Shortness of breath worse when lying down and feels better when head is raised at end of bed

**Objective**

- Dyspnoeic
- B/L ankle oedema
- High jugular venous pressure
- Apex beat lateral to mid-clavicular line and in the 6th ICS
- Cardiovascular normal
- Abdomen normal
- Crepitations in lung base
- ECG shows cardiomegaly
- C-xray- features of infection

### **Plan**

- Diagnosed as left ventricular failure
- Broad spectrum antibiotic for 7 days
- Frusemide 40 mg/day
- Digoxin 0.25 mg/day
- Advise to stop smoking and drinking
- Review 14 days later
- Mild tenderness in lower abdo, no guarding and rebound

**25/08/17**

### **Subjective**

- Feels better
- Reduced cig to 10/day and alcohol to 10u week

### **Objective**

- Mild B/L ankle oedema
- Few crepitations in lung bases

### **Plan**

- Continue Frusemide and Digoxin
- Rest for one week

**30/09/17**

### **Subjective**

- Presented with severe shortness of breath, chest pain, sweating for 2 hours
- Anxious

### **Objective**

- Dyspnoeic, B/L ankle oedema
- Jugular venous pressure high
- No murmurs
- Apex beat is 6th ICS
- Lateral mid-clavicular line
- BP: 120/60
- PR: 66 BPM
- **B/L crepitations in both lung bases**

### **Plan**

- Needs admission to Cardiology Unit for stabilisation

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Emergency Department QE11 Hospital, 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
- Use correct letter format

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**Task 26**

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

**notes:**

**Today's Date 27/12/17**

You are a Psychiatrist at Spirit Hospital Psychiatric Emergency Care Centre (SECC) and Jack Mills is a patient on the ward.

**Patient Details**

- Name- **Jack Mills**, DOB 01/09/1996
- Marital Status: Single
- Admission: 23/11/2017 (Spirit Hospital Psychiatric Emergency Care Centre)
- Discharge: 27/12/2017
- Diagnoses: Paranoid Schizophrenia/Nicotine Dependence

**Family History**

- Jack's parents separated 4 years ago and divorced 2 years ago
- No other children in the family

**Psychosocial History**

- Completed high school; above-average student; often involved in school and extracurricular activities
- He smokes a pack of cigs a day and drinks beer daily. Binge drinking episodes while at university. He denies any illicit drug use
- He has a keen interest in computers and collected considerable equipment and software, primarily gifts from his father
- He has been on Disability Support Pension (DSP) since 2016

**Medical History**

- Nil

## Symptoms History

May 14, 2016

- Jack was first admitted to SHPW with a 6-month history of confusion, difficulty concentrating on his studies, and frequent mood swings. He stopped attending university and was not in contact with his friends.

**Diagnosis:** Paranoid schizophrenia

- He was hospitalised for 2 weeks & stabilised on Haldol 20 mg and sodium valproate 125 mg, daily.

## Plan

- Live with his mother in Parramatta (Sydney area)
- Referral to psychiatrist arranged along with weekly group psychotherapy in Spirit Community Mental Health Service, NSW.
- Discharged 28/5/16

August 2017

- Attempted suicide: A possible stressor was that 1 week ago his mother said about ideas to remarry in the near future
- Self-harm through deep cut on both wrists
- Hospitalised in ED, surgical tx, under 24hr supervision. Refused to change medication
- His attendance in group psychotherapy was irregular.

November 2017

- He has been increasingly isolated for the past 2 weeks, working on his computer and is very secretive about what he is doing
- He stopped attending his work program, saying that he had "more important work" to do at home
- His mother believes he stopped taking medications
- Jack refuses to eat or talk with his mother; is nervous because of his mother's plans to remarry
- He was brought to Spirit Hospital Psychiatric Emergency Care Centre (SECC) by his mother on 23/11/17
- He has been irritable, suspicious and stated that he has been hearing multiple voices in his head for the past week

### **Hospital progression**

- The patient's sodium valproate was increased to 125 bd and then 250 tds
- His need for intramuscular (IM) medication, or other medication was explained. The patient fiercely objected about injection, saying, "I am a reliable person, I can always take the medicine." The fact is that he has not been very compliant. After much discussion, the patient has agreed to take 4 mg of Navane IM, qid
- Jack received one-to-one, supportive, and insight-oriented psychotherapy on various issues (importance of compliance,taking meds, and avoiding alcoholic beverages). His participation through the program was less than adequate as he could not concentrate and focus, but he still participated in psychotherapy group

### **Lab tests**

- Serial FBC for had shown WBC ranging from 9.2 to 12. RBC had ranged from 4.88 to 5.5
- Cholesterol was 5.3 mmol/L
- T4 was 12.1, the next T4 was 10.1 (normal range 10 - 25 pmol/L), T3 was 4, 7(normal range 4.0 – 8.00 pmol/L), TSH has ranged from 1.2 to 1.5 (normal range 0.4-5.0 mIU/L)
- Sodium valproate level was 42 µg/mL (normal range - 50-100 µg/mL)
- Urinalysis - normal

### **Condition on discharge**

- Improving

### **Ability to manage funds and finances**

- Improving

### **Ability to use good judgment**

- Still impaired

### **Prognosis**

- Guarded

### **Follow-up**

- The patient will be living with his mother
- Will be continued on medication (Sodium valproate 250 bd and Navane 1.5 mg IM q. 4 weeks (the next dose is due on January 16, 2018)
- LFTs and sodium valproate level to be checked annually
- Cholesterol level to be regularly controlled
- Diet: Low cholesterol
- One-to-one psychotherapy
- Advise to abstain from alcohol & give up smoking
- Vocational rehabilitation and "day programs" to improve self-esteem, quality of life, treatment compliance, and clinical and social stability

### **Writing Task:**

*Using the information in the case notes, write a letter to Dr. Twyford, the Psychiatrist at Parramatta Spirit Community Mental Health Service, NSW, 2345.*

### **In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 27**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 21/02/17**

**Patient Details**

- Sally Webster
- DOB 10/11/00
- High school student

**27/12/16**

**Subjective**

- 3/12 constipation
- 1 firm bowel action every 4 to 5 days
- Diet includes 2 table spoons of bran each morning
- Has tried laxatives
- Otherwise well

**Objective**

- Wt. 54kg
- BP 100/50
- P 70 reg
- Abdo: lax, no masses
- P.R. exam unremarkable
- Advised to increase vegetable, fibres and fluid intake.

**15/02/17**

**Subjective**

- Presents with mother. Mother concerned about Sally's lack of appetite and loss of weight.  
Much fighting at home about
- habits. Sally claims to feel well and can't see "what all the fuss is about". She just isn't hungry.

**Objective**

- Wt. 48kg
- Pale, thin
- BP 100/60 Lying and standing
- Abdo and urinalysis unremarkable

**Plan**

- Review Sally alone
- Tests: FBE/TFT's U+E/LFT's

**21/02/17**

**Subjective**

- Distant, little eye contact. Feels parents are "overreacting". Feels ideal weight is 40 kg (currently 47kg). Denies vomiting.
- Vague about laxative use.
- Test Results: All normal

**Assessment**

- Anorexia Nervosa

**Plan**

- Refer to psychiatrist

**Writing Task:**

*Using the information in the case notes, write a letter of referral to the Psychiatrist Dr. Midori Yabe, 48 Wickham Tce, Spring Hill.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 28**

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

**notes:**

Mrs May Hong is a 43-year-old patient in your general practice.

**07/02/2014**

**Subjective:**

- Noted a productive cough over last 3/7
- No dyspnoea or pain
- Feverish
- Continues to smoke 10 cigarettes/day

**History:**

- Rheumatic carditis in childhood, resulting in mitral regurgitation & atrial fibrillation (AF)

**Objective: Looks tired**

- T: 38°C
- P: 80, AF
- BP: 140/80
- Ear, nose, throat (ENT) – NAD
- Moist cough
- Scattered rhonchi through chest, otherwise OK
- Apical pansystolic murmur

**Assessment:**

- Acute bronchitis; cigarettes increase condition severity ++

**Plan: Advised – cease smoking**

- Amoxycillin 500mg; orally t.d.s.
- Other medications unchanged (digoxin 0.125mg mane, warfarin 4mg nocte)
- No known allergies (NKA)
- Review 2/7
- Check prothrombin ratio next visit

**09/02/2014**

**Subjective:**

- Cough increase, thick yellow phlegm
- Feels quite run-down
- Not dyspnoeic
- Taking all medications
- No cigarettes for last 2 days

**Objective:**

- Looks worn-out
- T: 38.5°C
- P: 92, AF
- BP: 120/80
- Mild crackles noted at R lung base posteriorly
- Occasional scattered crackles. Otherwise unchanged

**Assessment:**

- Bronchitis increase severity , early R basal pneumonia

**Plan:**

- Sputum sample for microscopy and culture (M&C)
- FBE, chest X-ray
- Chest physiotherapy
- Prothrombin ratio today (result in tomorrow)
- Review tomorrow

**10/02/2014**

**Subjective:**

- Brought in by son
- Quite a bad night
- Symptoms
- Pleuritic R-sided chest pain, febrile, dyspnoea
- Prothrombin ratio result 2.4 (target 2.5-3.5)

**Objective:**

- Unwell, tachypnoeic
- T: 38°C
- P: 110, AF
- BP: 110/75
- Jugular venous pressure (JVP) not elevated
- R lower lobe dull to percussion with overlying crackles
- L basal crackles present
- Pansystolic murmur is louder
- M&C: gram-positive streptococcus pneumoniae, sensitive – clarithromycin & erythromycin
- Amoxicillin resistant
- Chest X-ray: Opacity R lower lobe
- FBE: Leukocytosis  $11.0 \times 10^9/L$

**Assessment:**

- R lower lobar pneumonia

**Plan:**

- Urgent hospital admission. Spoke with Dr Roberts, admitting officer, Newtown Hospital Ambulance transport organised

**Writing Task:**

Using the information given in the case notes, write a letter of referral to Dr L Roberts, the Admitting Officer at Newtown Hospital, 1 Main Street, Newtown, for advice, further assessment and treatment.

**In your answer:**

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 29**

**WRITING TIME: 40 MINUTES**

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

**notes:**

### **20.3.97**

#### **Patient History**

**Derek Romano** is a patient in your General Practice.

**Subjective:** 46 year old insurance clerk wants "check up" smokes 1 pkt cigarettes per day  
high blood pressure in past  
no regular exercise  
father died aged 48 of acute myocardial infarction  
married, one child  
no medications or allergies

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

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

### **8.4.97**

**Subjective:** Still smoking, no increase in exercise

**Objective:** BP 155/100

**Assessment:** Hypertension

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

### **23.4.97**

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

**Objective:** BP 155/100

Abdominal and cardiovascular exam otherwise normal.

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

**Plan:** Add Mylanta 30 mls q.i.d.

Increase nifedipine to 20 mg twice daily.

### **30.4.97**

**Subjective:** Crushing retrosternal chest pain. Sweaty. Mild dyspnoea.

Onset while walking, present for about one hour.

**Objective:** BP 160/100 P 64 in obvious distress

Few crepitations at lung bases.

ECG – inferior acute myocardial infarction.

**Assessment:** Acute myocardial infarction

**Plan:** Oxygen given

Anginine given sublingually

Morphine 2.5 mg given IV stat

Maxolon 10 mg given IV stat

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

#### **Writing Task:**

*Using the information in the case notes, write a letter of referral to the Registrar in the Emergency Department of the Royal Melbourne Hospital, Flemington Road, Parkville, 3052.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 30**

**WRITING TIME: 40 MINUTES**

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

**notes:**

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 answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 31**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History**

John Haywood DOB 23.5.85. On holidays after overseas trip – staying with his parents in Brisbane for several weeks before returning to Melbourne his normal residence. You are his parents regular GP. He has experienced pains in his right calf since arriving from UK four days ago. States pain has become increasingly severe and his calf is tender to touch.

**07.01.08**

Single, Monash University student studying commerce.

Smokes 8 – 10 cigarettes a day. Social drinker (4 – 6 small beers) mainly at the weekend.

Plays squash and walks regularly.

Currently not on any medication.

No known allergies

**Objective**

BP 120/70 P 74 regular

Cardiovascular and respiratory examination normal

Tenderness and swelling in right calf

**Assessment**

Suspected Deep Vein Thrombosis – Send to Queensland Xray for Ultra Sound.

**Action**

Schedule appointment for 8.1.08 to review results

**08.01.08**

**Results** 4 cm thrombus in soleal vein 16 cm below knee crease in right calf.

**Action**

Explain diagnosis and treatment to John. Provide literature on "stop smoking" initiatives. Prescribe Clexane 40mg/0.4ml injections twice daily for three weeks. Arrange for nurse practitioner at your clinic to teach John how to self inject. Advise John to avoid further flights for at least 4 – 6 weeks depending on response to Clexane.

**14. 01.08****Subjective**

John comes to your surgery to report what he thinks is an allergic reaction to the injection. Advises he has succeeded in reducing cigarettes to two a day.

**Objective**

BP 120/75 P 74 regular

Cardiovascular and respiratory examination normal

Red rash, bruising and welts around injection site.

**Decision**

Change prescription from Clexane to Fragmin 5000u/0.2ml injections twice daily. Prescribe soothing cream for rash. Arrange appointment for Ultra Sound to monitor progress on 22.1.08

**23.01.08**

John comes to surgery for results of latest Ultra Sound. Advises he has not smoked at all since last visit. He is keen to fly back to Melbourne in early February when his university course recommences.

**Results**

Persistent soleal thrombus - no significant change but evidence of small decrease in size

**Objective**

BP 130/70 P 72 regular

Decrease in tenderness and swelling in right calf.

Injection site improved but still some redness and irritation of the skin.

### **Assessment**

Advised patient to cease Fragmin injections. To take  $\frac{1}{2}$  an aspirin daily. Flight to Melbourne in early February OK Elastic stockings and exercise during flight recommended. Fragmin injection prescribed to be given pre and post flight. Regular GP to be contacted before ceasing daily aspirin dosage.

### **Writing Task:**

*Write a letter to John's regular GP - Dr. Sue Cairns, 291 Rae Street, Fitzroy North Melbourne 3068.*

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 32**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History**

Constance Maxwell is a patient in your General Practice

DOB 08.08.38 Married, 3 adult children

**21.02.10**

**Subjective**

Complains of inflamed, sticky and weeping eyes.

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

**Objective**

BP 135 / 75 P 74

Both eyes – red, watery discharge right eye worse than left

**Assessment**

Bilateral conjunctivitis –likely viral

Chlorsig Drops 4hrly

**03.03.10**

**Subjective**

No improvement to eyes, blurred vision

**Objective**

Odema eye lids ++

Marked conjunctival congestion

**Plan**

Chloramphenicol 0.5% sterile 1 drop 3 times daily

Bion Tears 1 drop each eye 4 hrly



E2 LANGUAGE

Review 2 weeks

**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, Royal Melbourne Eye Hospital.

Husband will drive to hospital

**WRITING TASK**

*Using the information in the case notes, write a letter of referral to the Registrar, Emergency Department, Royal Melbourne Eye Hospital, Alexandra Tce, Fitzroy, Melbourne 3051*

In your answer:

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 33**

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

**notes:**

**John Elvin** is a 48-year-old patient in your General Practice

**5/05/11**

**Subjective:** Complaint of occasional mild central chest pain on exertion

Has mild asthma but otherwise previously well

Nil family history of cardiac disease

1 pack day smoker and drinks 10 standard drinks 5/7

Under significant stress with own business

Medications – seretide two puffs BD salbutamol two puffs prn

Allergies - Nil

**Objective:** Nil chest pain O/E

ECG NAD

Troponin level NAD

**Assessment:** Early stages of IHD

**D/D** - stress related chest pain

Alcohol dependence but not interested in changing

**Plan:** Check serum lipids

Refer for exercise stress test

Review in 1 week

**12/5/11**

**Subjective:** Still only very occasional chest pain on exertion

Has runny nose & pharyngitis at present with ↑ asthma symptoms

Attended stress test with very mild chest pain at high exercise load

**Objective:** Some very slight ischaemic changes present in exercise test

Mild bilateral wheeze present

Cholesterol mildly ↑

**Assessment:** Ischaemic heart disease/angina  
Viral upper respiratory tract infection

**Plan:** Commence on lipitor, nitrates(imdur), aspirin and prn anginine  
Educate anginine use  
Review in 2/52

**26/5/11**

**Subjective:** Chest pain for the last week  
Still c/o frequent mild wheeze  
Often forgets to take seretide puffers because of ETOH consumption

**Objective** Mild bilateral wheeze still present

**Assessment** Mild Asthma 2<sup>o</sup> to ↓ compliance with medication  
Alcohol dependence now affecting medication compliance

**Plan** Emphasised importance of preventative anti-asthma meds  
Recommended pt write put a reminder for asthma and all medications on his fridge.  
Encouraged pt to use prn salbutamol until asthma improves  
Offered ETOH dependence treatment pharmacotherapy- will consider this.

**1/6/11**

**Subjective:** Passing by medical centre and c/o sudden onset crushing chest pain on background of URTI and worsening asthma since last  
Not relieved by anginine  
Very audible wheeze

**Examination** ECG – mild ST elevation in anterior leads. ST 120  
Lungs – O/A moderate wheeze and mild bilateral crackles. SP O<sub>2</sub> 86% on R/A  
Heart – Slight S<sub>3</sub> sound +ve

**Assessment** Likely anterior AMI; ? triggered by respiratory issues  
Acute exacerbation of asthma 2<sup>o</sup> to URTI  
? Mild APO

**Plan Paramedic transfer to ED**

O2 15L via non-rebreather (pt isn't CO2 retainer)

GTN patch applied

IV morphine 5mg given

Ipatropium Bromide 500ug given via nebuliser in view of tachycardia

Frusemide 40mg given

**Writing Task:**

*Using information provided in the case notes, write a referral letter to Dr Jeremy Barnett, the Emergency Registrar on duty at Maroubra Hospital, Lakes Rd, Maroubra.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**  
**WRITING TIME: 40 MINUTES**

**Task 34**

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

**notes:**

Yuxiang Meng is a 21 year old overseas student chef from China in your general practice. He only speaks very basic English and sees you because you are a GP from a Chinese background and speak Mandarin.

**2.03.11**

Chief complaint - URTI symptoms for 5 days.

**O/E:**

- \*Mild pharyngitis & rhinorrhea. T 37.5
- \*C/O chronic insomnia
- \*Observed to be elevated in mood, tangential & ? delusional about fixing the world's nuclear waste problem
- \*Nil obvious signs of organic syndromes

**Assessment:** Mild viral illness & ? mania/1st episode BPAD

**Plan:** Nil treatment for URTI, just rest & ↑fluid intake. Referral made to local community mental health for urgent assessment. Pt. escorted home by his uncle. Diazepam 10mg QID prescribed & to be given with community MH team's supervision.

Investigations ( exclude organic pathology & baseline)

- FBC
- UEC
- TFTs
- LFTs
- CMP
- urgent CT scan

### **3.03.11**

Mental health team used interpreter and concur with provisional diagnosis of mania.  
They state the following: no immediate dangers to self/others; MH keen for GP involvement due to language issues and they will monitor pt. daily; they are keen to avoid hospitalisation as pt. very afraid of idea of psych. ward due to stigma of the same in China  
Today pt's uncle accompanied pt. to GP surgery get blood results.

#### **O/E**

- \* Bloods NAD except mildly ↓ protein & mild hypokalaemia (3.2 K+)
- \* CT NAD
- \* MSE – still tangential and delusional about same theme, but only mildly elevated since sleeping well post diazepam

**Assessment:** Likely non-organic mania

#### **Plan:**

- \* Commence pt. on quetiapine 50mg BD (starting dose)
- \* ↓ diazepam to 10mg either BD or TDS depending on MH team's assessment.
- \* R/V in 3/7; likely ↑ of quetiapine.
- \* Commence pt on K+ (Span K) tablets.

### **7.03.11**

Pt. was relatively settled for 3/7 but uncle suspects he has secreted & discarded meds.  
Last night stayed up all night singing Chinese revolutionary songs (not usual behaviour) and running naked down his street. Uncle didn't want to call MH for fear of 'getting locked up'.

#### **O/E**

- \* Pt very elevated in mood, pressured in speech, loose in associations and fixated on having to rid Australia of all nuclear waste by tomorrow.  
Believes he can draw power from Mao Ze Dong's spirit to achieve this.
- \* Pt stripped naked in front of GP and tried to hug him.

**Assessment** Acute manic episode

**Plan:**

Offered stat quetiapine 100 mg & diazepam 20mg but refused.

Schedule pt under MHA

Have uncle accompany pt with ambulance & police to RNSH ED

Refer to on call psych reg Dr Ben Hinds

Update local MH team.

Long term – try to refer to Chinese speaking psychiatrist.

**Writing Task:**

*Using information provided in the case notes, write a referral letter to Dr Ben Hinds, the Psychiatry Registrar on duty at Maroubra Hospital, Lakes Rd, Maroubra.*

**In your answer:**

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

The body of your letter should be approximately 200 words. Use correct letter format.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 35**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Mrs. Daniela STARKOVIC**

45 years old, married 2 children

**Past history**

Migraines

Medications - nil

**20/01/07**

**Subjective**

presents with abdominal pain

doesn't like fatty foods

otherwise well

**10 days ago**

- epigastric pain radiating to R side 1 hour after dinner
- associated nausea, no vomiting / regurgitation
- pain constant for 1 hour
- no medications
- no change bowel habits, no fever, no dysuria

**Last night**

- recurrence similar pain, worse
- duration 2 hours
- vomited X 1, no haematemesis
- pain constant, colicky features
- aspirin X 2 taken, no relief

**Objective:**

overweight

T 37° P 80 reg, BP 130/70

Medicine Letter 3mild tenderness R upper quadrant abdomen

no masses, no guarding, no rebound, bowel sounds normal

Murphy's sign neg

Urine – trace bilirubin

**Assessment:** ?? biliary colic ?? peptic ulcer

**Plan:**

Liver Function Tests (LFTs)

Biliary ultrasound (US)

R/V 3/7

**23/01/07**

**Subjective:**

No further episodes

Patient anxious re possibility cancer

**Objective:**

LFTs – bilirubin 12 (normal range 6-30)

Alkaline phosphatase (ALP) 120 (normal < 115)

Aspartate transaminase (AST) 20 (normal 12-35)

**Assessment:** ? mild obstruction

US – small contracted gallbladder, multiple gallstones

Common bile duct diameter normal

Normal liver parenchyma

**Assessment:** cholelithiasis

**Plan:**

Reassurance re cancer

Referral Dr. Andrew McDonald (general surgeon) assessment, further management, possible cholecystectomy

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Dr Andrew McDonald a general surgeon at North Melbourne Private Hospital 86 Elm Road North Melbourne 3051.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 36**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Name:** Mr. Antonite Scott

**Date of Birth:** 18th March 1950

**Height:** 160cm

**Weight:** 74kg

**Allergies:** Shellfish

**Substance Intake:** Nil

**Dentures:** Nil

**Social History:**

Patient lives with his wife. All of their children live away. He is a smoker and an alcoholic. He works as a bar tender.

**Depression:** controlled by medication

**Family History:**

**Mother:** History of Pneumonia

**Father:** Died of CVA (Cerebro Vascular Accident) recently.

**Maternal Grandmother:** Died of COPD

**Maternal Grandfather:** Unknown

**Paternal Grandmother:** Hypertensive

**Paternal Grandfather:** Known patient of depression

**Past Medical History:**

**1990:** Typhoid, followed by a jaundice attack

**1996:** HBsAg Positive

**2006:** Diagnosed with depression and kept on medicine to control it.

**Present Symptoms:**

Diabetic (blood sugar levels increasing continuously)

UTI (burning micturition and incontinence)

Cellulitis (swollen and painful legs)

**Provisional Diagnosis:** Type II diabetes mellitus

**Plan:** Refer to diabetologist/podiatrist for further treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the diabetologist/podiatrist, Dr. Britto, at City Hospital.*

**In your answer:**

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

**The body of your letter should be approximately 200 words. Use correct letter format.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 37**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Name:** Mrs. Suzanne Mario

**Date of Birth:** 5th January, 1978.

**Height:** 158cm

**Weight:** 60kg

**Allergies:** dust, vinegar

**Substance Intake:** sleeping pills

**Dentures:** upper

**Social History:**

Patient lives alone, not married. She is a smoker and drinks occasionally too. She works as an assistant manager for a non-profit organization.

Peptic ulcer: controlled by medication.

**Family History:**

Mother: history of cervical cancer

Father: died in an accident two years ago.

Maternal Grandmother: history of cancer

Maternal Grandfather: had LRTI twice

Paternal Grandmother: Unknown

Paternal Grandfather: died at the age of 92

**Past Medical History:**

2000: Irregular menstruation

2008: Removal of cyst from right breast

**Present Symptoms:**

Pain in the sides of both breasts

Can feel lumps

**Provisional Diagnosis:** breast cancer

**Plan:** refer to Oncologist for further examination and treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the Oncologist, Dr. Ansari, at Lake hospital, 14 Lake View Street, Card Well City.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 38**

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

**notes:**

**Patient History:**

**Name:** Mr. Roberto Carlos

**Date of Birth:** 19th April 1948

**Height:** 164cm

**Weight:** 94kg

**Allergies:** iodine

**Substance Intake:** pain killers and sleeping pills

**Dentures:** upper and lower

**Social History:**

Patient is married and has two children. Children are settled away from parents.

They live alone. He is a chain smoker and a chronic alcoholic. He worked as a Professor before he retired.

**Tonsillitis:** had tonsillectomy.

**Family History:**

**Mother:** was healthy, no medical problems.

**Father:** heart attack (died at the age of 88).

**Maternal Grandmother:** unknown.

**Maternal Grandfather:** unknown.

**Paternal Grandmother:** was a hypertensive patient.

**Paternal Grandfather:** had a history of varicose veins.

**Past Medical History:**

**1990:** Protrusion of veins and leg cramps.

Diagnosed as DVT and kept on treatment.

Started weight reduction treatment.

**Present Symptoms:**

Intolerance of leg cramps

**Provisional Diagnosis: DVT**

**Plan:** refer to a general surgeon for further treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the General Surgeon, Dr. Christo, at Wood Park Hospital, 18 Park street, Richmond City.*

**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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 39**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Name:** Mrs. Agnes Rosario

**Date of Birth:** 5th September 1972

**Height:** 152cm

**Weight:** 56kg

**Allergies:** Nil

**Substance Intake:** pain killers

**Dentures:** Nil

**Social History:**

Patient is married and has no children. She works as an English Teacher for an International School.

**Family History:**

**Mother:** history of PCOD

**Father:** history of asthmatic attack.

**Maternal Grandmother:** PCOD

**Maternal Grandfather:** unknown.

**Paternal Grandmother:** was diabetic

**Paternal Grandfather:** had a history of URTI

**Past Medical History:**

**1998:** irregular menstruation, acne. Had treatment for two months.

**1999:** menorrhagia for about 25 days.

**Present Symptoms:**

Menorrhagia and severe lower back abdominal pain

**Provisional Diagnosis:** PCOD

**Plan:** refer to gynecologist and obstetrician for further treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the Gynecologist and Obstetrician, Dr. Amanda, at Whitus Hospital, 112 Bill street, Emerald City.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 40**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Name:** Mr. Stephen Brook

**Date of Birth:** 9th December 1987

**Height:** 168cm

**Weight:** 66kg

**Allergies:** barley

**Dentures:** Nil

**Social History:**

Patient is not married. He is a gym instructor for an international school.

**Family History:**

**Mother:** history of jaundice.

**Father:** history of peptic ulcer

**Maternal Grandmother:** was a healthy woman

**Maternal Grandfather:** CA prostate

**Paternal Grandmother:** had chickenpox during her childhood

**Paternal Grandfather:** had a history of UTI's

**Past Medical History:**

**2010:** food poisoning and vomiting - had treatment.

**2011:** burning sensation and pain at xiphoid process and radiating to back, regurgitation, vomiting. Had treatment but discontinued after six months – reasons unknown.

**Present Symptoms:**

Burning sensation and pain at xiphoid process and radiating to back during mid night, vomiting.

**Provisional Diagnosis:** pancreatitis

**Plan:** refer to a general physician for further treatment.

**Writing Task:**

***Using the information in the case notes, write a letter of referral for further treatment to the General Physician, Dr. Mario, at City hospital, 15 River Street, Herberton City.***

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 41**

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

**notes:**

**Patient History:**

**Patient: Mary Reylon**

**DOB: 4th Sept 1963**

**Allergies: dust / penicillin**

**Social History:** Professor at the university (teaches physics)

Lives with her husband (Winston Reylon)

Works for women rights organization

**Family History:**

- Mother – high BP, rheumatoid.
- Father – liver failure
- Maternal Grandmother- died of a heart attack (75)
- Maternal Grandfather – died of heart attack (81)
- Paternal Grandfather – a patient of high BP
- Paternal Grandmother – died at the age of 65 due to an accident

**Past medical history:**

- RSV illness (1965)
- Chicken pox (1973)
- Tonsils removed (1981)
- Miscarriage due to an accident (1987)
- Hyperthyroid (1989)

**12 June 2009**

Injury to the head (fell down the stairs)

Tourniquet applied (to stop the flow of blood)

Dizziness and queasiness

Large bump on the head

Patient complained of pain even after two days

Unable to sleep (for a week)

Took slipping pills three times (as suggested by the doctor), no effect

**Other signs:**

- ◆ Persistent or worsening headaches
- ◆ Imbalance
- ◆ Vomiting

**Inference:** Suggestive of intracranial hematoma

**Plan:** CT scan is the definitive tool for accurate diagnosis of an intracranial hemorrhage.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further investigation and definitive diagnosis to the neurologist, Dr. Wilson, at London Bridge Hospital, 27 Tooley St London, Greater London.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 42**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Patient: Nicole Katie

DOB: 12 July, 1971

**Social History:**

Lives with her husband (Ivan) and their daughter (Lydia Imogen)

House wife (left work after she was married)

**Family history:** No family history

But mother died of kidney failure

**Past medical history:**

Suffered severe attack of TB (1983)

Appendices (1987)

Depression (due to the sudden death of the first baby – 1992)

Allergic reactions (uterine infection - 1997)

**15 April 2005**

Failure in digestion

Unable to eat properly due to pain in the stomach

Took pain relievers, analgesics (for two continuous days)

Problem worsened

Felt pain, radiating back to the lower abdomen

Change in coloration of urine (yellowish)

Loss of appetite

Weight loss – 2.5 kg within 15 days

Vomited twice

**18 April, 2005**

**Other signs:**

Severe pain, lasted for several hours

Pain and vomiting, shortness of breath

Blood in bowel motions and urine

High fever and sweats

**Plan:** Abdominal CT scan suggested for accurate diagnosis of abdominal pain.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Ralph Emerson, at Royal London Hospital, Whitechapel Rd, Greater London E1 1BB, United Kingdom.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 43**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Mark Henry is 53-year-old patient at your General Practice. Just recently, he complained of acute onset of double vision and right eyelid droopiness.

**Social History:**

The patient lives with his wife

Works as a car mechanic

Denies use of illicit drugs or tobacco

Rarely drinks

**Family History:**

His mother suffered from migraines (died at the age of 83 due to heart attack)

His paternal father had a stroke at the age of 67

No other family history of strokes or vascular diseases

**9/07/2009**

Was sitting in his room; felt sensation in eye lids

Noticed blurred vision

Appearance of double vision (with objects appearing side by side)

Pain in both the eyes

Transferred to the hospital by his son

Intermittent pounding bifrontal headache

Rated the pain as 7 or 8 on a scale of 1 to 10

**General physical examination:**

The patient is significantly overweight.

Temperature is 37.6.

Blood pressure is 130/60.

Pulse is 85.

There is no tenderness over the scalp or neck and no bruits over the eyes or on the neck.

No proptosis, lid swelling, conjunctival injection, or chemosis.

Cardiac exam shows a regular rate and no murmur.

**Past Medical History:**

- 1) Migraine headaches, as described in HPI.
- 2) Depression.

There is no history of diabetes or hypertension.

**Allergies:** None.

**Medications:** Zoloft 50 mg daily, ibuprofen 600 mg a few times per week, and vicodin a few times per week.

**Other necessary information**

He denies associated vomiting, nausea, numbness, weakness, photophobia, loss of vision, seeing flashing lights or zigzag lines etc.

His recent headaches differ from his "typical migraines" (occurred 4 -5 in his entire life time). He has never taken anything for these headaches (other than ibuprofen or vicodin).

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Martin, at National Hospital for Neurology, 33 Queen Square, London WC1N 3BG, United Kingdom.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 44**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Joseph Malcolm** is a patient at your General Practice. Just recently, he started complaining of occasional breathlessness and difficulty in breathing.

**Age:** 42

**Gender:** male

**Occupation:** office manager

**Subjective Patient Complaints:**

Adult onset asthma- dyspnea, cough

Occasional wheezing symptoms upon increased exercise or when under stress.

**Prior contributory health history:**

- 1) Seasonal upper respiratory allergies
- 2) Occasional loose stools when under stress
- 3) Occasional episodes of mild eczema (dermatitis)
- 4) Reports a history of being healthy, aside from this recent asthma problem

**What provokes the symptoms?**

Provoked by exercise, emotional/physical stress

Cigarette smoke

Seasonal respiratory allergies

**Site of symptomatology:**

Bronchial, lung, chest/thoracic region

**Time of day/duration of symptoms:**

Daily episodes of dyspnea

Symptoms often worsen at 3-5 AM (coughing increases)

**Medications:**

Symptoms temporarily eased with prescription (bronchial inhaler medication).

**Writing Task:**

***Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Robert Frances, at St. George's Hospital, Black Shaw Road, London SW17 0QT, United Kingdom.***

**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.**

TIME ALLOWED:

READING TIME: 5 MINUTES

Task 45

WRITING TIME: 40 MINUTES

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

**notes:**

**Patient History:**

Mr. Marques is a patient at your general practice who has recently complained of abdominal pain.

**Name of the patient: Mr. Marques , Age: 65**

**October 7, 2006**

**Chief complaint: abdominal pain**

- ▲ Complained of a sharp, epigastric abdominal pain (gradually worsening over the past 1-2 months).
- ▲ Pain is located in the epigastric region and left upper quadrant of the abdomen.
- ▲ Doesn't radiate.
- ▲ The pain is relatively constant throughout the day and night (but does vary in severity).
- ▲ Rated the pain as 6/10 at its worst.
- ▲ He has not tried taking any medicines to relieve the pain.
- ▲ The pain is not associated with food or eating (but occasional heartburn).
- ▲ Denies any abdominal trauma or injury.
- ▲ Complained of weight loss (5lb weight loss over the past 1-2 months).
- ▲ The patient has experienced some nausea with the abdominal pain but has not vomited.

**Family History:**

Father died due to a heart attack.

Mother's medical history is not known.

No known family history of colon cancer.

**Social History:**

The patient is a retired lecturer.

He lives with his wife and two grandchildren.

He denies past or present tobacco and illicit drug use.

He denies alcohol use.

**Past Medical History: other active problems**

High blood pressure, diagnosed two years ago, but well-controlled now.

Depression poorly controlled; started prozac 2 months ago, but still feels depressed.

**Hospitalizations:** MI, 2003.

**Surgeries/procedures:** Cardiac catheterization, post-MI, 2003.

**Medications:**

Aspirin 81mg po qd, since his MI 3 years ago

Metoprolol 100mg po qd, for two years

Prozac 20mg po qd, started 2 months ago

**Allergies:** No known drug allergies.

No food or insect allergies.

**Other information**

Pulmonary – denies shortness of breath, denies cough.

Cardiovascular – denies chest pain, denies palpitations.

Genitourinary – denies dysuria, denies increased frequency or urgency of urination.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Ivan Gonz, at Willington Hospital, Central Building, 21 Wellington Road, St John's Wood London.*

**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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 46**

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

**notes:**

**Patient History:**

Name: **Jennet Berritto**

Date of Birth: 22 April, 1971

Height: 163 cm

Weight: 75kg

Allergies: Nil

**Social History:**

Lives with her husband

Likes gardening

Doesn't drink / smoke

Sometimes takes betel leaves

Family History: None to report

**Medical History**

Type 2 diabetes mellitus (2/10/2001)

Hypertension (5/4/2006)

Stomach ulcers (12/7/2007)

Ankle injury (22/5/2008)

COPD (27/6/2011)

**Present Symptoms:**

Intense coughing

Pain in the chest, shoulder and back

Shortness of breath

Change in voice

Harsh sounds with each breath

Change in color and volume of sputum

### **Diagnosis**

Chest X-ray - not cleared

CT-Scan - positive

Stage 2A (lung cancer)

The tumor is 5.5 cm

Cancer cells spread across lymph nodes

**Plan:** Refer to Dr. Bryan Hardy for further treatment

### **Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Pulmonologist, Dr Bryan Hardy, at EMR Hospital, v25 Rocklands Rd North Sydney NSW, Australia, outlining the details of the patient.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 47**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Name: Christian Aula

Date of Birth: 12/9/1975

Height: 159 cm

Weight: 69 kg

Allergies: Nil

**Social History:**

Lives with her daughter and son-in-law

Enjoys walking

Doesn't drink / smoke

**Family History:**

Mother - died of heart attack (had a TIA stroke as well)

Father - died of liver failure

**Medical History:**

Allergic rhinitis

History of advanced, home oxygen (O<sub>2</sub>) - dependent COPD and heart failure

Benign essential hypertension

Chronic respiratory failure

**Present Medications**

Prednisone 5 mg qd, montelukast 10 mg every evening, albuterol-ipratropium MDI 2 puffs q4h prn SOB, carvedilol 3.125 mg bid, bumetanide 2 mg bid, fluticasone salmeterol 500-50 mcg/dose disk with device 2 puffs bid, potassium chloride 20 mEq tablet ER bid, tiotropium bromide 18-mcg capsule one inhalation every morning, albuterol/ipratropium hand-held nebulizer q4h prn SOB.

**Present Symptoms:**

Weakness, numbness or paralysis in the face (left side) Slurred or garbled speech / difficulty in understanding others

Double vision

Dizziness

Loss of balance or coordination



E<sup>2</sup> LANGUAGE

**Diagnosis**

**TIA (Transient Ischemic Attack) Confirmed**

BP Checked: 150/95 millimeters of mercury (mm Hg)

Plan: Refer to Dr. Sally Anderson for further treatment

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the Hypertension Specialist, Dr. Sally Anderson, at Community Hospital, 33 Albany St Crows Nest NSW, Australia, outlining the details of the patient.*

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.

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

**Task 48**

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

**notes:**

**Patient History:**

Name: Huang Bowra

Date of Birth: 27/7/1981

Height: 168 cm

Weight: 79 kg

Allergies: sulfa drugs / tetracyclines

**Social History:**

Lives alone

Drinks a lot

Smokes 2ppd of cigarettes daily

**Family History:**

No family history

**Medical History:**

Anxiety, depression (1999 - due to sudden death of his mother)

**Medicine Writing Tests 11 – 15 with**

**Sample Answers**

Obesity (2000)

Urinary incontinence (2003)

Hypertension (2007)

Insomnia (2009)

**Present Medications**

Norvasc 5 mg daily for hypertension

Lorazepam 1 mg HS for insomnia

Vistaril 25 mg BID PRN for anxiety (only when required)

Celexa 10 mg daily for depression (only when required)

**Present Symptoms:**

Indigestion

Dull, burning pain in the stomach

Burning sensation in the chest

Pain elevates after eating, drinking or taking antacids

Weight loss (has lost about 5 kgs in the course of 15-20 days)

Loss of appetite

Not wanting to eat because of pain

Nausea

Vomiting

Burping

Bloating

**Diagnosis**

Endoscopy confirmed the presence of stomach ulcers

Ulcers - one half inch in diameter

**Plan:** Refer to Dr. Mathew Corrado for further treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Mathew Corrado, at Flivo Hospital, 9 Mount Street Hunters Hill NSW, Australia, outlining the details of the patient.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 49**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Name: Abora Qualin

Date of Birth: 7/8/1979

Height: 179cm

Weight: 81 kg

Allergies: sulfa drugs

**Social History:**

Lives with her son

Drinks a lot

Quit smoking three months ago

**Family History:**

Data not available

**Past Medical History**

Hypertension (2001)

Urinary tract infection (2003)

Type 2 diabetes mellitus (2007)

Dyslipidemia (1 year ago)

Constipation (1 year ago)

**Vital Signs**

BP: 124/76, P: 89, RR: 18, T: 37.2°C

**List of Medications**

Lantus 10 units QHS, lisinopril 10 mg, glipizide XL 7.5 mg, ASA 81 mg,

hydrochlorothiazide 12.5 mg, simvastatin 80 mg, docusate 100 mg PRN.

**Present Symptoms:**

Complaining of severe back pain / groin pain

Vomiting

Fever

Chills

Nausea

Painful urination

**Diagnosis**

Urine sample - positive (presence of white blood cells in abundance)

Ultrasound - obstructions in the urinary tract

**Result:** UTI confirmed

**Plan:** Refer to Dr. Katherine Mathel for further analysis and treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Katherine Mathel, at Marino Kidney Center, 3/77 South Terrace Como WA, Australia, outlining the details of the patient.*

**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.**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 50**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Name: Marcello Caprice

Date of Birth: 12/2/1979

Height: 168 cm

Weight: 73 kg

Allergies: Nil

**Social History:**

Married / Lives with his wife and son

Doesn't drink

Smokes

Chews tobacco

Family History: no family history

**Past Medical History**

Hypertension

Type 2 diabetes mellitus

Depression

Osteoarthritis

Hyperlipoproteinemia

**List of Medications**

Metformin 1,000 mg PO BID, atorvastatin 20 mg PO QHS, lisinopril 20 mg PO QD, furosemide 20 mg PO QD, aspirin 81 mg PO QD, glimepiride 2 mg PO QAM, venlafaxine 75 mg PO TID, fish oil 1,200 mg PO QD.

**Present Medical Condition:**

Change in blood pressure (last recorded 150/100)

### **Present Symptoms**

Shortness of breath

Severe headaches

Severe anxiety

Nose bleeding (occurred twice in the last three days)

### **Diagnosis**

High blood pressure noted (170/110)

**Result:** Hypertension (Stage 2)

**Plan:** Refer to Dr. Avelin Cooper for further analysis and treatment.

### **Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Avelin Cooper, at MKZ Hospital, 697 Beaufort St Mt Lawley WA, Australia, outlining the details of the patient.*

### **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.