

OET 2.0 PRACTICE
TESTS
MEDICINE - WRITING



Information

This test has one part.

What is the Writing sub-test?

The writing sub-test takes 45 minutes. It is profession specific. You take this part of OET using materials specifically for your professional – a nurse does the task for nursing, a dentist does the task for dentistry and so on. In each test, there is one task set for each profession based on a typical workplace situation and the demands of the profession.

The task is to write a letter, usually a referral letter. Sometimes, and particularly for some professions, a different type of letter is required: e.g. a letter of transfer, or a letter to advise or inform a patient, carer or group.

With the task instructions, you receive stimulus material (case notes and/or other related documents), which includes information to use in your response.

The first five minutes of the test is reading time. During this time, you may study the task and notes but may not write, underline or make any notes.

For the remaining 40 minutes you may write your response to the task. You will receive a printed answer booklet in which you must write your response. This also has space for rough work. You may write in pen or pencil.

Practice Test 1.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

Alexandra Holme is a patient in your clinic who you believe will need to visit a family medical clinic for further evaluation.

Patient History

Mrs. Alexandra Holme (DOB 11.07.72)

Two children age 5 and 3

Two miscarriages

First pregnancy

- developed severe pre-eclampsia
- delivered by emergency Caesarean Section at 32 weeks
- in intensive care for 3 days, required magnesium sulphate
- baby (Thomas) 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 (Charlotte) 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 2007

Subjective

Positive home pregnancy test – fifth pregnancy

Pt est. 8 weeks pregnant

Painful urination - three days

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

Recommend social wrk visit.

Objective

BP:120/80.

Weight: 64kg

Height: 167cm

Some dysuria for the past 3 days

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

Abdomen soft and non-tender

Fundus not palpable suprapubically.

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

Treatment Plan for Obstetrician

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 All Mother's Hospital when received

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

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

Provide information on Gamston 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

Using the information given in the case notes, write a letter of referral to Dr Marie Perry, Consultant Obstetrician, Family Medical Centre, All Mother's Hospital, Alfred Street, South Cottingham.

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.

Dr Marie Perry
Consultant Obstetrician
Family Medical Centre
All Mother's Hospital
Alfred Street
South Cottingham

12th May 2018

Dear Dr Perry,

Re: Mrs Alexandra Holme (DOB: 11.07.1972)

Thank you for seeing Mrs Holme, who presented to me today with a positive home pregnancy test and painful urination for the past three days. Mrs Holme is a 47 year old patient with a history of severe pre-eclampsia and caesarean section.

This is Mrs Holme's fifth pregnancy and it is estimated that she is currently 8 weeks pregnant; she has had two miscarriages in the past and has two children aged 5 and 3. Mrs Holme developed severe pre-eclampsia during her first pregnancy which led to her son being delivered by emergency caesarean section at 32 weeks. Following this, Mrs Holme was admitted to the ICU for three days and required treatment with magnesium sulphate. Fortunately, Mrs Holme's BP remained normal throughout her second pregnancy and she delivered her daughter at full term. It should be noted that there is a history of thrombosis in the patient's family and she is also known to be heterozygous for Factor V Leiden. As a result of this, Mrs Holme has been treated with prophylactic low molecular weight heparin in two previous pregnancies.

On examination today, Mrs Holme's BP was 120/80. Her abdomen was soft and non-tender and the fundus was not palpable suprapubically. As noted above, Mrs Holme has complained of some dysuria for the past three days and the urine dipstick indicated 3+ protein, 2+ nitrates, and 1+ blood.

In light of the above, please arrange routine antenatal blood tests. Please commence Mrs Holme on folic acid 400mg daily and advise her to continue this until 12 weeks of pregnancy. She will also need to start taking tinzaparine 3,500 units daily, subcutaneously, in view of the thrombosis risk. To treat her suspected UTI, please prescribe cefalexin 250mg, which Mrs Holme should take 6-hourly for five days. A midstream urine sample will also need to be sent to the laboratory. Finally, the foetus will be at increased risk of Down's Syndrome due to Mrs Holme's age; please can you arrange for a social work visit to counsel the patient regarding antenatal screening. Should Alexandra elect to have a scan for nuchal translucency between 11 and 13 weeks, please provide information on Gamston Screening Centre.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely,

Dr Smith

Practice Test 2.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

Riley Precious is a patient in your General Practice. He is a 4-year-old boy accompanied by his father.

25.02.2014

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

Assessment: Tonsillitis

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

18.03.2014

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

Assessment: ? Post streptococcal nephritis
? UTI

Plan: Review in 2 days; drink plenty of fluids

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

20.03.2014

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

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

Assessment: Post-streptococcal nephritis with early renal failure

Plan: Refer to paediatrician Dr F. Shaw

WRITING TASK

Using the information given in the case notes, write a letter of referral to Dr F. Shaw, 201 Albert Street, South Cottingham.

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.

Dr. F. Shaw
201 Albert Street
South Cottingham

20th March 2014

Dear Dr Shaw,

Re: Riley Precious

Thank you for seeing Riley, a four year old boy with a provisional diagnosis of post-streptococcal nephritis with early renal failure.

Riley first presented to me on 25th February 2014 with a history of sore throat, husky voice, fever and irritability. I made a diagnosis of tonsillitis and prescribed penicillin V 250mg q.i.d for seven days.

Three weeks later (18.03.2014), Riley returned to the surgery and his father reported that he had noted that his urine was discoloured four days previously. Riley was also lethargic. His blood pressure was 90/60 and his urinalysis revealed macroscopic haematuria. His throat examination was consistent with tonsillar hypertrophy. His father was advised to increase his oral fluid intake and return to the surgery today (20.03.2014). On examination today, Riley's blood pressure has elevated to 110/90. Although Riley is asymptomatic, his urea and creatinine are slightly elevated. Moreover, there is a marked elevation in AOST (+++), and his mid-stream urine sample has 4 x 10 red blood cells of renal origin. However, his FBE is normal.

As stated above, I believe that Riley is experiencing post-streptococcal nephritis with early renal failure. Therefore, I am referring Riley to you for further assessment and management.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely,

Dr Smith

Practice Test 3.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

Kelsie Jennings is a 10 year old female patient in your general practice.

Patient History

30/11/12

History: Nocturnal cough last 2 wks associated with runny nose and mild fever
 Previously well
 Family history of asthma – mother & older sister aged 17
 Past history – nil
 Medications – nil
 Allergies – none known

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

Assessment: Viral upper respiratory infection
 Possible associated asthma

Plan: Paracetamol, fluids for infection
 Review if worsens

21/12/12

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

Assessment: Probable asthma

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

11/01/13

Examination: Review symptoms slightly improved; exercise tolerance better
 Less nocturnal disturbance
 Chest auscultation – no wheeze heard

PEFR 280 L/min

Assessment: Improved but asthma still slightly unstable

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

08/02/13

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

Assessment: Well-controlled asthma

Plan: Maintain on current therapy
Review 2 mnths

10/04/13

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

Assessment: Severe asthma triggered by viral upper respiratory infection

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

WRITING TASK

Using the information given in the case notes, write a letter of referral to Dr A. Mole in the Emergency Department at the South Cottingham Children's Hospital.

In your answer:

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

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

Dr A. Mole
Emergency Department
South Cottingham Children's Hospital
South Cottingham

10/04/2013

Dear Dr Mole,

Re: Kelsie Jennings, 10 years old

Thank you for seeing Kelsie, a 10 year old girl with severe asthma triggered by a viral upper respiratory tract infection, for which Ventolin nebuliser statim is offering minimal relief. Kelsie is reporting worsening shortness of breath and wheezing over the last 48 hours, along with a runny nose and fever. Chest auscultation today indicates a widespread wheeze and PEFr is 140 L/min.

Kelsie first presented to me on 30/11/12 reporting a nocturnal cough and mild fever. Kelsie reported a family history of asthma. On examination, Kelsie had a temperature of 37.8°C and a red pharynx. There was no obvious wheeze but her peak expiratory rate flow (PEFR) was 250L/min. I diagnosed a viral upper respiratory infection with possible associated asthma and advised treatment with fluids and paracetamol.

Kelsie returned to clinic on 21/12/12 due to her nocturnal cough persisting and now impacting her during exercise. On examination of her chest, I noted a faint basal wheeze and her PEFr had fallen to 230L/min. I therefore prescribed a trial of inhaled salbutamol – Ventolin puffer 2 puffs t.d.s. Upon review on 11/01/13, Kelsie's symptoms had slightly improved, no wheeze was heard from her chest and her PEFr had increased to 280L/min. I felt that her asthma was still unstable she commenced inhaled corticosteroid – Becotide 200 2 puffs t.d.s. while continuing with the Ventolin as required. This appeared to work effectively as when I saw Kelsie on 08/02/13, her chest was clear and her PEFr was 340L/min.

However, as discussed above, Kelsie's asthma has significantly deteriorated in recent days and I would therefore be grateful if you could assess and treat her accordingly.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely,

Dr Smith

Practice Test 4.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: **READING TIME: 5 MINUTES**
 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

10/09/14

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

12/09/14

History: Increasing shortness of breath & wheeze over last 24hrs, feeling feverish at time, 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

12/09/14

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.

Admitting Officer
Emergency Department
Newtown Hospital



12th September 2014

Dear Admitting Officer,

Re: Ms Sally McConville, aged 38

Thank you for seeing Ms McConville, who has presented to me on three occasions since 10/09/2014 with deteriorating symptoms associated with a viral URTI and infective exacerbation of her asthma. Based on her obvious respiratory distress today, I believe that Ms McConville is possibly suffering from pneumonia and needs to be seen by your department for acute management and investigation

As noted above, Ms McConville first presented to me on 10/09/2014 with a two day history of typical symptoms associated with a viral URTI. The patient stated that her asthma is usually well controlled using her preventer (fluticasone 250 – 2 puffs daily) but that she was feeling wheezy. On examination, Ms McConville's pulse was 82, her BP was 120/80 and her respiratory rate was 12. No increased work of breathing or accessory muscle use was noted. I could hear a scattered wheeze in the patient's chest but not crepitations. Therefore, I prescribed Ventolin 2 puffs 4-hrly and advised the patient to continue the preventer.

Ms McConville returned on 12/09/2014 due to increasing shortness of breath and wheezing over the preceding 24 hours. The patient was feverish with a temperature of 38. Her pulse on examination was 95, her BP was 120/80 and her respiratory rate was 16. I noted mildly increased work of breathing and a widespread chest wheeze, but no crepitations. Due to her worsening asthma symptoms, I prescribed amoxicillin 500mg 3x daily, prednisolone 25mg daily x3 days, in addition to continuing the medication above.

This morning at 10.30am, I treated Ms McConville with Ventolin Nebules (salbutamol) 5mg due to a further deterioration in her breathing. Prior to this treatment, Ms McConville's respiratory rate was 25, her pulse was 112 and her BP 100/65. I noted a widespread wheeze, bibasal crepitations and increased use of accessory muscles for breathing upon a chest examination. Unfortunately, after 15 minutes of this treatment, there was no improvement in the patient's condition, hence my referral to yourselves.

Please do not hesitate to contact me if you have any further queries.

Yours sincerely,

Dr Smith

Practice Test 5.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

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

Patient History

Date of birth: 22/07/69

31/01/10

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

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

Assessment: Reactive depression

Plan: Bereavement counselling – liaising with local social worker

22/02/10

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

Assessment: Reactive depression

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

16/03/10

Examination: Brought in by family
Very withdrawn; not giving answers to most questions

Relatives report refusing food at home last few days; not taking medication for last six days; muttering to herself at odd times – not seeming to make sense
Mild dehydration
Weight 56kg

Assessment: Depressive psychosis

Plan: Warrants urgent admission to hospital
Phone discussion with Dr J Blackthorne, Admitting Officer, Newtown Psychiatric Hospital – will accept patient

WRITING TASK

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

In your answer:

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

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

Dr J. Blackthorne
Admitting Officer
Newtown Psychiatric Hospital
Main Road
Newtown

10/04/2010

Dear Dr Blackthorne,

Re: Ms Marjorie Jackson, DOB: 27/07/69

Thank you for accepting Marjorie Jackson, a 40 year-old patient with the presumptive diagnosis of depressive psychosis.

Ms Jackson initially presented on 13/01/10, complaining of sleep disturbances, weight loss and depressed mood related to the sudden death of her sister six weeks previously. At that point, I felt that she had reactive depression following her recent bereavement and arranged counselling with the local social worker.

She returned on 22/02/10 with worsening symptoms and further weight loss. Ms Jackson reported difficulty engaging in daily activities and being increasingly withdrawn. At this stage, I commenced anti-depressant drug therapy by prescribing doxepin 25mg nocte increasing to 100mg nocte over the following 10 days, in addition to the ongoing counselling sessions.

Ms Jackson was brought in by her family today (16/03/10) due to being increasingly withdrawn and muttering softly to herself at odd times. She not taken her medication for the last 6 days and has also been refusing food over the past few days. Ms Jackson is clinically dehydrated and has lost a further 3kg since the previous visit on 22/02/10.

Ms Jackson has a family history of depressive illness and is known to have suffered post-natal depression in the past.

Given this history and the presenting symptoms today, I believe that she is experiencing a depressive psychosis and would appreciate your further assessment and management.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely,

Dr Smith

Practice Test 6.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

Patient: Anne Hall (Ms)

Date of birth: 19.9.1965
 Height: 163cm Weight: 75kg BMI: 28.3 (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

PHMx: 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 and topical corticosteroids

18/6/10 PC: dysphagia (solids), onset 2/52 ago post viral (?) URTI
 URT self-medicated with OTC Chinese herbal product – contents unknown
 No relapse/remittent course
 No sensation of lump
 No obvious anxiety
 Concomitant epigastric pain radiating to back, level T12

Weight loss: 1 – 2 kg
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 given in the case notes, write a letter of referral for further investigation and definitive diagnosis to the gastroenterologist, to Dr Jason Roberts, at Newtown Hospital, 111 High 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.

Dr Jason Roberts
Newtown Hospital
111 High Street
Newtown

18/06/2010

Dear Dr Roberts,

Re: Ms Anne Hall, DOB 19.9.1965

Thank you for see Ms Hall, a 44-year-old secondary school teacher, who is presenting with a two-week history of symptoms of dysphagia for solids, epigastric pain radiating posteriorly to T12 level, and concomitant weight loss. The symptoms follow a constant course.

Mr Hall believes the problem commenced after an upper respiratory tract infection two weeks ago for which she self-prescribed an over-the-counter Chinese herbal product with unknown ingredients. However, she has also recently increased her coffee consumption and takes aspirin 2 – 3 times a month. She has a history of dyspepsia (2004), and dermatitis for which she was prescribed oral and topical cortisone. There are no apparent signs of anxiety. She has not smoked for 15 years. She drinks socially (mainly spirits), has a family history of peptic ulcer disease and is allergic to codeine. Her BMI is currently 28.2.

My provisional diagnosis at this point is gastro-oesophageal reflux with possible stricture. I am therefore referring Ms Hall to you for further investigation.

Thank you for assessment and ongoing management of this woman. If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Dr Smith

Practice Test 7.

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

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

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

NOTES

Patient: Mrs Priya Sharma
Date of birth: 08.05.53 (Age 60)
Residence: 71 Seaside Street, Newtown

Social History: Married 40 years – 3 adult children, 5 grandchildren (overseas). Retired-clerical work.

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 5mg 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
- 10/01/14** 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 given 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 notes into complete sentences.**
- **Do not use note form.**
- **Use letter format.**

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

Dr Lisa Smith
Endocrinologist
City Hospital
Newtown

10 February 2014

Dear Dr Smith,

Re: Mrs Priya Sharma
71 Seaside Street, Newtown
DOB 08.05.53

Thank you for seeing Mrs Priya Sharma, a type 2 diabetic. I would be grateful if you would assist with her blood sugar control.

Mrs Sharma is 60 years old and has a strong family history of diabetes. She was diagnosed with NIDDM in 1994 and has been successfully monitoring her BP and sugar levels at home since then. She first attended my surgery on 29/12/13 as she was concerned that her blood sugar levels were no longer well controlled.

On initial presentation her BP was 155/100 and she said that her blood sugars were running between 6 and 18. Her medication at that time was metformin 500mg x2 nocte and glipizide 5mg x2 mane.

Mrs Sharma is allergic to penicillin. A pathology report on 05/01/2014 showed HbA1C levels of 10% and GFR greater than 60ml/min. Her cholesterol was high (6.2)

On 29/12/13, I instituted Atacand 4mg, 1 tablet each morning. Since then her home-monitored BP has been within range. On 12/01/14, I also prescribed Lipitor 20mg daily, and her lipids have improved, with cholesterol falling from 6.2 to 3.2.

Mrs Sharma reports that her fasting BSL is in the 16+ range (other blood sugars are 7 – 8). I am concerned about her fasting blood sugars, which remain high, and would appreciate your advice.

Yours sincerely,

Dr Smith