

OET FUTURE LAND

Corrected letters by
Benchmark

Dear Dr. Jones,

Re: Mrs. Katherine Walter

DOB: 26/11/1975

Thank you for seeing Mrs. Walter who is presenting with symptoms and signs suggestive of severe depression with a possibility of bipolar disorder. Your urgent management is highly appreciated.

Mrs. Walter is a married women with two children. Regarding her medical history, she has been suffering from asthma since her childhood during which she has been taking budesonide inhaler. Her family history revealed that moderate depression was diagnosed among four members. Please note that the patient has no hobbies or playing sports as she is busy with her home duties.

On 19/11/2014, Mrs. Walter presented tiredness and was overweight; therefore, she was advised to change her lifestyle and increase exercises in order to lose some weight. On the next visit, she was reported with a decrease of 13 kilograms of her weight as a result of daily training in the gym. Besides, she became the president of the parents' association in her children's school.

Today, the patient complained of loss of energy to the extend that she couldn't complete her household tasks as she has been overwhelmed with her responsibilities. Moreover, she suffered from insomnia and poor appetite along with a feeling of not coping and a desire to die.

In view of the above, I am referring Mrs. Walter for urgent management of her condition including suicidal thoughts. Please, contact her husband to discuss the issues of child care and household maintenance. For any queries, please contact me

Yours sincerely,

Doctor

Comment [bnchmrk1]: woman

Comment [bnchmrk2]: , and

Comment [bnchrk3]: She has a family history of moderate depression.

Comment [bnchmrk4]: with the complaints of

Comment [bnchmrk5]: her condition improved and she reported weight loss along with participation in social activities.

Comment [bnchmrk6]: extent

Comment [bnchmrk7]: could not (avoid contractions)

Comment [bnchmrk8]: childcare

Report	
Word length	239
Comments	The letter is a bit long and contains mistakes pertaining to word choice and spelling. Some case notes could be written in a better way. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Avoid writing more than 200 words. 2. Try to write information in brief wherever possible. 3. Be careful of spelling. 4. Always proofread your letter after finishing it.

Admitting Officer
Emergency Department
Children’s Hospital
Newtown

18/01/2014

Dear Sir,
Re: Joshua Vance

DOB: 17/11/2013

I am writing to refer Joshua, a 2-month-old male infant who is presenting with constipation and symptoms suggestive of mild dehydration. Your further assessment and management including rehydration would be appreciated.

Joshua was delivered vaginally at 38 weeks’ gestation with no complications. Kindly note, his birth weight was 3250g.

At the age of six weeks, Joshua was presented with his mother who was concerned that despite Joshua being well breast-fed, his bowel action was infrequent and his stools were hard. His examination was unremarkable. Therefore, the mother was reassured and advised to express her milk from one feed a day and give it in a bottle with some water. However, 2 weeks later, Joshua’s condition was worsening as his sleep pattern was disturbed. The prior advice of milk expression was modified to be at a rate of twice instead of once daily. In addition, Coloxyl drops were prescribed.

Today, Joshua’s constipation got more severe; moreover, he was irritated, vomited once and had anuria. On examination, he had dry mucous membranes; nevertheless, his tissue turgor and capillary return time were normal. Please note, he is refusing feeds and lost 100g in the last five days.

In view of the above, my provisional diagnosis is constipation and mild dehydration. I believe Joshua needs further assessment regarding his constipation in addition to being reviewed at the Emergency Department for rehydration. Please do not hesitate to contact me for any further queries.

Yours sincerely,
Doctor

Report	
Word length	221
Comments	There are only a few minor inaccuracies. However, some important information is missing. The letter is good!
Grade	B+
Advice	1. Revise grammar. 2. Always proofread your letter after finishing it.

Comment [teacher1]: with satisfactory weight gain.

Comment [teacher2]: was much

Comment [teacher3]: was

Comment [teacher4]: repetitive of introduction

Associate Professor Simon Anderson
Surgeon
Suite 65
City Hospital
25-29 Main Road
Centreville

22/02/2014

Dear Dr Anderson,

Re: Mr Daniel McCrae, DOB: 17/10/1962

Thank you for seeing Mr McCrae, a 51-year-old barrister, who has features consistent with colon cancer. Your further assessment as early as possible would be highly appreciated.

Mr McCrae is an overweight smoker patient who is married with four children. He has no family history of colorectal carcinoma, colonic polyps or inflammatory bowel disease.

Comment [teacher1]: and has

On 08/02/2014, Mr McCrae presented complaining of fatigue, gaseous abdominal discomfort, and diarrhoea alternating with constipation. He also did not experience a full recovery from the last-viral infection that he had had since September, 2013. On examination, his abdomen was soft, lax, and masses were noticed.

Comment [teacher2]: in

On today’s review, Mr McCrae is still feeling unwell. CBC test results have been within normal values apart from low Hb (91) and high Hct (34%) beside positive FOBT. Colonoscopy has revealed an ascending colon malignance; moreover, histopathological examination of the biopsy has confirmed the diagnosis of adenocarcinoma.

In light of the above, I would be grateful if you could evaluate Mr McCrae’s condition urgently. Should there be any more queries, kindly do not hesitate to contact me.

Yours sincerely,

Doctor

Report	
Word length	179
Comments	Other than a few minor inaccuracies, the letter is meritorious.
Grade	A
Advice	1. Revise grammar. 2. Always proofread your letter after finishing it. 3. Keep up the good work!

Dr Malcom Still
Rheumatologist.
5 Grant St
Fairmont

03 May 2014

Dear Dr Still,

Re: Mr James Seymour, DOB: 19/09/1953

Thank you for seeing Mr Seymour, a 60-year-old retired academic, who is presenting with very painful left first toe consistent with gout. Your valuable assessment would be highly appreciated.

Mr Seymour is a heavy drinker who has been suffering from recurrent first toe inflammation since 2010. He is non-compliant with his regular medications including colchicine, indomethacin, and allopurinol. His family history is notable for RA related to his father.

Comment [teacher1]: and

On 25/04/2014, Mr Seymour presented with a four-week history of gouty bout despite diet modification. His left first toe appeared red and moderately inflamed with no evidence of other joints involvement. Accordingly, in addition to paracetamol and oxycodone, compliance with his regular medications was recommended. Moreover, lifestyle modifications regarding diet and alcohol intake were discussed.

On today’s review, Mr Seymour’s gout episode is subsiding. X-ray result has shown mild degenerative changes of the left first metatarsophalangeal joint. Furthermore, pathology tests results have revealed high CRP (6.0mg/L) beside mildly elevated MCH and urate levels (32.3pg and 0.48mmol/L, respectively). In addition to previous visit’s advice, I have recommended urgent synovial fluid sample in the next episode.

However, the patient suspects that he has RA and wants a referral to a rheumatologist.

In light of the above, I am referring Mr Seymour for further treatment and investigations. Should there be any queries, kindly do not hesitate to contact me.

Yours sincerely,

Doctor

Report	
Word length	210
Comments	Other than the missing piece of important information, the letter is meritorious.
Grade	A
Advice	1. Always proofread your letter after finishing it.

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. NAD.
Reacted to contrast medium.

Objective: Full examination.
CVS, RS, RES, CNS: NAD.
P 68bpm 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 B White, Neurosurgeon, City Hospital, Newtown.

Dr B White
Neurosurgeon
City Hospital
Newtown

04/8/2018

Dear Dr White,
Re: Mr George Poulos Aged 45 years old

I am writing to refer Mr. Poulos, a 45-year-old patient who is presenting with features suggestive of lumbar disc prolapse and requiring urgent urgent medical attention.

Comment [teacher1]: ,

Comment [teacher2]: requires

Mr. Poulos is married and has 3 children. He is a smoker and he drinks alcohol frequently. Pleased note, he is allergic to pethidine and radioactive contrasts agents.

He has been seen me on several occasion after he has suffered from a low back pain followed lifting a heavy object at work. During which time ,his pain was progressing and started to radiate along his calf into the foot. Examination findings revealed painful limited flexion and extension. However, analgesics were prescribed and he had medical leave from his work.

Today, Mr. Poulos reported that his pain became severe and there was tingling in his calf. Moreover, he became immobile. Examination revealed light sensation loss and ankle reflexes were absent .In addition, straight leg raise test was positive.

My provisional diagnosis is lumbar disc prolapse compounded by radiculopathy. However, I would be appropriated if you could arrange a consultation to order an MRI and assesses his suitability for surgery.

Yours Sincerely,
Doctor

Report	
Word length	184
Comments	The letter has inaccuracies pertaining to articles, tenses, punctuation, word choice and sentence formation. Information could be written in a better way. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Improve choice of words. 3. Always proofread the letter after finishing writing it.

Comment [teacher3]: , penicillin and a

Comment [teacher4]: contrast agent

Comment [teacher5]: presented on 20/01/14

Comment [teacher6]: that

Comment [teacher7]: of

Comment [teacher8]: This pain tended

Comment [teacher9]: Thus

Comment [teacher10]: was

Comment [teacher11]: had become

Comment [teacher12]: and I would appreciate

Dr Jack Thomas
Department of Gastroenterology
City Hospital
Main Road
Stillwater

21/02/15

Dear Dr Thomas,
Re: Mr Patrick Newtown

I am writing to refer Mr Newtown, a 22_year-old single accountant, whose features are suggestive of a chronic inflammatory bowel disease . Your further assessment would be highly appreciated.

Comment [teacher1]: Newton, a 22-year

Mr Newtown has a habit of smoking and lives with his parents. Please note, his uncle has had Crohn's disease.

Regarding his past medical history, the patient reported mild on and off pain in the right and left wrist joints.

Comment [teacher2]: 6 months ago.

Today, Mr Newtown has been complaining of chronic mild diarrhoea associated with low-grade intermittent pain in the right lower quadrant abdominal side since 10/14. Moreover, he has had lethergy, weight loss and poor appetite. Although he has not sought medical advice, he has tried ibuprofen and diet modification.

Comment [teacher3]: Newton presented complaining

Comment [teacher4]: suffers from lethargy

Comment [teacher5]: He

Comment [teacher6]: but got no relief.

His examination is unremarkable a part from generlized abdominal tenderness. His blood test as follow: positive faecal occult blood test , mildly elevated CRP and ESR along with anaemia and a high WBC count. He has been advised to quit smoking.

Comment [teacher7]: came as follows

Based on the above, Mr Newtown is referred to you to be diagnosed and advised to cease smoking in addition to information about IBD and relevant investigation.

Comment [teacher8]: Newton

Comment [teacher9]: for IBD.

Please do not hesitate to contact me if you require any futher details.

Comment [teacher10]: further

Yours sincerely,
Doctor X

Report	
Word length	192
Comments	An effort to accomplish the task is visible. However, the letter has several inaccuracies. These pertain to word choice, grammar and spelling. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Dr. Tanya Williams
Respiratory Specialist
Bayview Private Hospital
81 Canyon Road
Bayview

18/10/2014

Dear Dr. Williams,

RE: Mr. Zach Foster

DOB: 25/10/1991

I am writing to refer Mr. Foster, a 22-years-old man who is suffering from bronchial asthma.

Comment [benchmark1]: year

Your further assessment and management would be highly appreciated.

Mr. Foster has been smoking for 4 years. Regarding his medical history, he is allergic to cats and hay fever. He suffers from eczema. Furthermore, he was admitted in hospital 2 times. It is worth mentioning that his sister is asthmatic.

On 11/10/2014, Mr. Foster presented with dyspnea, wheezing, cough and heartburn. He was non-compliant with medications. I advised him to comply with pulmicort and stop smoking. Pantoprazole was prescribed for gastro-esophageal reflux disease. CXR and FRE were ordered.

Comment [benchmark2]: quit

On examination of Mr. Foster today, he is still suffering from the same symptoms because he does not cessate smoking and does not take pulmicort regularly. Tests results were normal. He was advised to take pulmicort erratically and he forget it, he should take it as soon as possible but do not duplicate the dose. Some strategies regarding smoking cessation were discussed with him namely, nicotine patch, information brochures and involvement with supporting groups. An appointment was made within 7 weeks.

Comment [benchmark3]: but

Comment [benchmark4]: forgets

Comment [benchmark5]: . He

Comment [benchmark6]: must

In view of the above, diagnosis with bronchial asthma was established. Therefore, I am referring Mr. Foster for further assessment, lung function, and management.

Comment [benchmark7]: of

If you have any queries, please do not hesitate to contact me.

Yours sincerely,

Report	
Word length	221
Comments	There are only minor grammatical inaccuracies Also, the length is more than desired; however, the case notes have been covered well and explained coherently. Overall, the letter meets the expectations.
Grade	B
Advice	1. Pay a little more attention to grammatical range and accuracy. 2. Try to finish your letter in 200 words.

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 Hayfever
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. - ↑ use of Ventolin for symptoms.

Doctor

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 500L/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 asthma management. • 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.

John McLennan
Psychiatrist
Royal Mental Health Clinic
Newtown

29/11/2014

Dear Dr McLennan,
Re: Ms Dolores Hoffman

D.O.B: 22/6/1986

I am writing to refer Ms Hoffman, a 27-year-old patient, who presented with signs and symptoms of reactive depression and anxiety. Your further assessment and management would be appreciated.

Ms Hoffman is single; however, she was in a long-term relationship with a single male partner before splitting-up last week. She has no family members in Australia and she works as a sales assistant in a department store. She is a smoker and a drinker.

On 11/12/2013, she visited me after having fainted and lost her consciousness for 5-10 minutes in the preceding night. That happened after drinking 2 glasses of wine and several cocktails at a pub. She visited me several visits after that for other issues and she had been always anxious in all the visits.

A week ago, she complained that she is experiencing a heavy workload and stress. She reported having signs and symptoms of repression such as disturbed sleep, loss of appetite, low libido along with other symptoms of disturbed cognitive functions. I recommended a referral to a psychiatrist; however, she refused. Temazepam was prescribed for her with a 1 week review scheduled for her.

On review today, the patient informed me that she did not take her medicine and preferred to avoid drug therapy. Additionally, she agreed to be referred to a psychiatrist.

In view of the above, I am referring Ms Hoffman for further assessment and management. Please do not hesitate to contact me for any queries.

Yours sincerely,

Doctor

Report	
Word length	243
Comments	There are several minor inaccuracies related to grammar and word choice. Also, the length is more than desired, thereby showing lack of effort in writing information in brief/summary form. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Pay a little more attention to grammar and improve sentences. 2. Be careful of word choice. 3. Try to finish your letter in 200 words.

Comment [benchmark1]: previous

Comment [benchmark2]: It

Comment [benchmark3]: times

Comment [benchmark4]: always been

Comment [benchmark5]: was

Comment [benchmark6]: 1-week

Comment [benchmark7]: Upon today's review,

Comment [benchmark8]: if you have

Dr Lorna Bradbury
General Practitioner
Stillwater Medical Clinic
12 Main Street, Stillwater
Stillwater
23/05/2015

Dear Dr Bradbury
Re: Ms Isabel Garcia D.O.B 01/01/1995

I am writing to refer Ms Garcia to be under your care after being successively treated from bacterial meningitis .your further follow up is highly appreciated .

Ms Garcia was referred with suspected meningitis, she complained of headache, stiff joints, photophobia, neck stiffness and multiple bruises .On examination, she was afebrile and was unable to touch her chin with chest while lying supine in addition to petechial rash all over her abdomen and legs. multiple Blood tests , FBC , CRP ,lumber puncture as well as blood culture were done . investigations results confirmed Neisseria meningitidis. Subsequently , empirical ceftriaxone , dexamethasone and benzympenicillin course of treatment were given to the patient as well as Human Services had been notified .

Ms Garcia responded well for treatment, moreover, her family members were immunized.

In lieu of the above, I am discharging Ms Grace, and referring her to you for close follow up during her recovery. Furthermore I would appreciate your arrangement of chemoprophylaxis for friends and people who were in recent contact with her along with advice of reporting unexplained illness and seek the medical care ASAP.

For any queries please contact me.

Your sincerely,

Doctor.....

Report	
Word length	189
Comments	It appears the candidate did not understand the case notes well. Other inaccuracies pertain to grammar, capitalisation and word choice. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with capitalization. 3. Improve choice of words. 4. Read case notes carefully. 5. Try to write more complex sentences by combining two smaller sentences. 6. Always proofread the letter after finishing writing it.

Comment [teacher1]: update you regarding

Comment [teacher2]: who is now confirmed to be suffering

Comment [teacher3]: and presented with

Comment [teacher4]: M

Comment [teacher5]: b

Comment [teacher6]: , the

Comment [teacher7]: was

Comment [teacher8]: wrong interpretation of case notes

Comment [teacher9]: In view of above,

Comment [teacher10]: any

Comment [teacher11]: seeking

Comment [teacher12]: Yours

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 pm (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:

14.0x10⁹/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.

Admitting Officer
Emergency Department
Children's Hospital
Newtown

18/01/2014

Dear Doctor,
Re: Joshua Vance D.O.B: 17/11/2013

Thank you for seeing Joshua, a 9-week-old baby, whose symptoms are suggestive of constipation and mild dehydration. Your further assessment would be greatly appreciated.

Joshua was born by a normal vaginal delivery at 38 weeks' gestation. Fortunately, there were no perinatal or neonatal complications. Please note, His birth weight was 3250 gram.

Initially, on 31/12/2013, the patient's mother was concerned about his bowel motions because he had only one bowel action every three days. Although he had a little hard stool, he was making wet nappies and sleeping through the night. His six-week's check was unremarkable; moreover, his weight reached 3900 gram. Therefore, a diagnosis of mild constipation in a breastfed baby was made. Consequently, the mother was reassured and advised on giving Joshua a mixture of expressed milk from one feed and some water. Two weeks later, he still had hard stool every 3 days. In spite of making wet nappies, he frequently wakes up crying at night.

His abdominal examination showed hard faeces so coloxyl drops were commenced. The mother was encouraged to express milk from two feeds and mix it with water.

Today, Joshua unluckily had absolute constipation and vomited once. His examination revealed mild dehydration as well as mild generalized abdominal tenderness. It is worth mentioning that his weight was 4100 gram.

In view of the above, I am referring this patient for rehydration and further assessment. If you have any queries, please do not hesitate to contact me.

Yours sincerely,
Doctors

Comment [benchmark1]: I am writing to thank

Comment [benchmark2]: his

Comment [benchmark3]: grams

Comment [benchmark4]: grams

Comment [benchmark5]: His

Comment [benchmark6]: grams

Report	
Word length	237
Comments	The length of the letter is too long. However, flow of information is logical and relevant case notes have been covered. Overall, the letter meets the expectations despite a few errors made.
Grade	B
Advice	1. Pay a little more attention to grammatical range and accuracy. 2. Try to finish your letter in 200 words.

Dr F Goldman
171 Victoria St
Northfield

20/03/2010

Dear Dr Goldman,
Re: Jamie Brown, 5 years of age

Thank you for seeing Jamie whose symptoms are consistent with post streptococcal nephritis accompanied by early renal failure. Your further assessment would be greatly appreciated.

Initially, on 25/02/2010, Jamie had presented with a fever, sore throat, husky voice and being irritable. His signs and symptoms were suggestive of tonsillitis; thus, penicillin was commenced. Three weeks later, his mother noticed increase lethargy, tiredness and brown urine. On examination, Jamie had tonsillar hypertrophy and a low blood pressure reading. Moreover, his urine analysis revealed microscopic haematuria; therefore, a diagnosis of post streptococcal nephritis versus UTI was considered. Investigations were carried out and a review appointment was scheduled.

Today, the patient was still asymptomatic, but his urinalysis demonstrated macroscopic haematuria. Regarding the tests' results, ASOT, urea and creatinine levels were elevated. Please note, RBC of renal origin were in his MSU test.

In view of the above, I am referring this patient for further management. If you have any queries, please do not hesitate to contact me.

Yours sincerely,
Doctor

Report	
Word length	164
Comments	There are only minor inaccuracies pertaining to spelling and word choice. Also, the length is shorter than minimum 180 words. However, these do not reduce communication.
Grade	B+
Advice	1. Improve word choice. 2. Be careful of spelling. 3. Ensure that the length is at least 180 words. 4. Keep up the good work!

Comment [bnchmrk1]: accompanied

Comment [bnchmrk2]: penicillin

Comment [bnchmrk3]: lethargy

Comment [bnchmrk4]: According to

Comment [bnchmrk5]: a bit unclear!

Dr Jones
Newtown Memory Clinic
400 Rail Rd Newtown
19/04/2015

Dear Dr Jones,
Re: Mrs Patricia Welshman D.O.B.: 28/03/1930

Thank you for seeing Mrs Welshman, an 85-year-old widow, whose features are consistent with Alzheimer's. Your further assessment would be greatly appreciated.

Mrs Welshman has five children. She lives alone. Her medical record shows that she has osteoporosis; for which, she is on oste-vitamin D, Liptor, Brufen, Metral and Panadol. Unfortunately, she has family history of Alzheimer's.

On 19/06/2014, initially, Mrs Welshman presented with a bruised nose after fall. Therefore, x-ray was ordered which revealed normal. One week later, assessment was done by occupational therapist who advised that shaver should be every other day to avoid fall. Additionally, home care provided by local council should be every two weeks.

After two month, her blood tests showed low level of vitamin D. Webster pack was advised to ensure compliance of medications.

Today, Mrs Welshman has poor memory and behavioural changes. Moreover, she had defect in decision making. Consequently, mini-mental test was done which revealed poor short-term memory. The difference between Alzheimer's and dementia was explained to her.

In view of the above, my provisional diagnosis is Alzheimer's. Thus, I am referring her for further assessment. For any queries, please contact me.

Yours faithfully,
Doctor

band
Liptor
came normal
not relevant to current condition
months
came with her daughter reporting
difficulties
stage of

Report

Word length	190
Comments	Mistakes pertain to word choice, tenses, capitalization and spelling. Some information provided is not relevant while some has not been included. Overall, the letter requires further improvements.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling and capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Dr Jones
Newtown Memory Clinic
400 Rail RD
Newtown

19/04/2015

Dear Dr Jones,

Re: Mrs. Patricia Welshman

DOB 28/03/1930

I am writing to refer Mrs. Welshman, a 85-year-old widow, whose symptoms and signs are suggestive of dementia. Your effort would be highly appreciated.

Comment [teacher1]: assessment

Mrs. Welshman lives alone. She was diagnosed with osteoporosis. Moreover, she has a family history of Alzheimer's.

Comment [teacher2]: and suffers from

On 14/12/2014, the patient's blood pressure was mildly elevated. Thus, some laboratory tests were ordered. The results showed only a high LDL cholesterol level at 2.9mmol/L and a low vitamin D concentration at 54nmol/L. The patient showed a poor commitment to spare scripts. However, she reported taking all medications in time. Webster pack was recommended, but the patient refused it. 2 months later, while the LDL cholesterol level increased significantly, the vitamin D concentration declined considerably. Consequently, she agreed to depend on Webster pack.

Comment [teacher3]: medicine

Comment [teacher4]: without her realizing it.

Comment [teacher5]: So, a Webster

Comment [teacher6]: use a Webster

Today, the patient presented with a poor memory, including not remembering to do some daily activities, such as dinner engagements and missing social events along with some behavioural changes. The mini memory assessment revealed a poor short memory towards the date. Although she could not remember the current day and month, she could confirm the year. Finally, the difference between dementia, which is a symptom, and Alzheimer's, the cause of dementia, was discussed.

Comment [teacher7]: with her daughter and both were concerned about her

Comment [teacher8]: as she was forgetting about

Comment [teacher9]: a

On light of the above, the patient is being referred for further memory assessment before the final diagnosis. Should you have any queries, please do not hesitate to contact me.

Comment [teacher10]: in

Comment [teacher11]: to reach the

Yours sincerely,

Doctor

Report

Word length	228
Comments	The letter has inaccuracies pertaining to spelling, tenses, word choice and sentence formation. Information could be written in a better way. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling and capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Dr Malcolm Still
Rheumatologist
5 Grant St
Fairmont
03/05/2014

Dear Dr Still,

Re: Jones Seymour, D.O.B:19/09/1953

Thank you for seeing Mr Seymour, a 60-year-old retired academic, whose features are consistent with gout. ~~Your co-operation would be greatly appreciated.~~

Comment [teacher1]: *repeated in the conclusion*

Mr Seymour is divorced with no children. ~~However,~~ he is a heavy drinker, he has not smoked since 1994. His medical record shows that he has had ~~a~~ history of regular episodes of inflammation of the left first big toe since 2010. Subsequently, he is on ~~colchicine~~, indomethacin and allopurinol. **He has a family history of rheumatoid arthritis.**

Comment [teacher2]: Though

Comment [teacher3]: regular episodes

Comment [teacher4]: colchicine

On 25/04/2014, initially, Mr Seymour presented with a four-week history of gout attack. Since he was not satisfied about gout medications, he did not comply ~~by~~ it. His examination showed that the left big toe was painful, red and moderately inflamed. ~~subsequently,~~ he was advised to comply ~~by~~ gout medications and ~~decreasing~~ alcohol consumption. In addition, improving dietary compliance was discussed. **But he requested a referral to a rheumatologist suspecting having rheumatoid arthritis as his father.**

Comment [teacher5]: with

Comment [teacher6]: with

Comment [teacher7]: decrease

Today, unluckily, ~~left foot~~ x-ray showed minor degenerative changes of left first ~~metatarsophalangeal~~ joint. Therefore, synovial fluid sample is recommended. Additionally, allopurinol was started as a long-term prevention. ~~finally,~~ the previous advice about alcohol consumption and dietary improvement was emphasized.

Comment [teacher8]: the

Comment [teacher9]: metatarsophalangeal

Comment [teacher10]: Meanwhile, gout has subsided.

In view of the above, I am referring him upon his request for further assessment and management. please note, copy of his pathology record was sent. For any queries, please feel free to contact me.

Yours sincerely,
Doctor

Report

Word length	206
Comments	Several useful case notes are missing. Other inaccuracies pertain to word choice, spelling, punctuation and subject-verb agreement. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Stillwater

23/05/2015

Dear Dr Bradbury,

Re: Ms Isabel Gracia

D.O.B.: 01/01/1995

Thank you for seeing Ms Gracia, a 20-year-old student, whose features are consistent with meningitis. Your further follow-up would be greatly appreciated.

Ms Gracia is a university student. Her medical record shows history of fracture right arm, unexplained weight gain and insomnia. please note, she is allergic to washing detergents; for which, she is on Doxylamine.

Today, Ms Gracia presented with painful joint and sensitivity to light. Moreover, she mentioned that having headache, bruising, neck stiffness, photophobic and rash. Her examination revealed bruising in left term together with petechial rash in a abdomen and legs. Additionally, she was unable to touch her chin to chest during supine position. Consequently, lumbar puncture and blood culture were ordered. However, protein and white cell count was increase glucose was decreased. In addition, poly morph nuclear predominance was detected. Regrettably, blood culture revealed Neisseria meningitis. Subsequently, ceftriaxone, Dexamethasone, and benzylpenicillin were prescribed. Fortunately, she responded well to treatment. Notification to human service department was sent. Furthermore, family immunization was insured.

In view of the above, my provosinal diagnosis is bacterial meningitis. Thus, I am referring her for chemoprophylaxis for people who close contacted with her. Additionally, family and close friends follow-up for any serious illness for any queries, please contact me.

Your faithfully,

Doctor

Report

Word length	208
Comments	The candidate has not understood case notes properly. Mistakes of spelling, word choice, grammar and sentence structures are also visible.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling and capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Dr B White
Neurosurgeon
City Hospital
Newtown
05/07/2014

Dear Dr White,
Re: Mr George Poulos, 45 years of age

Thank you for seeing Mr Poulos, a 45-year-old stockbroker. Whose features are consistent with discogenic back pain. Your co-operation would be greatly appreciated.

Mrs Poulos is married with 3 children. He is a smoker and alcoholic. Please note, he is allergic to pethidine, penicillin, and probably radiographic iodine.

On 21/06/2014, initially, Mr Poulos presented with severe lower back pain after lifting logs. He felt a click and locked in semi flexed position. The pain was located in lower back which was improved gradually. In addition, the pain had no radiation. His examination revealed pain during flexion of fingertips to patella which limited the extension. Unfortunately, there was loss of lumbar lordosis. Subsequently, paracetamol and paracetamol were prescribed. One week later, pain had extended down to the back of right thigh, lateral calf and into dorsum of the foot.

Today, Mr Poulos had severe pain down the right leg and tingling in the calf. Unluckily, he was almost immobile. His examination has showed restriction of movements due to pain. Additionally, lumbar flexion was almost absent. Moreover, there was a loss of light touch sensation on the lateral distal calf and the plantar aspect of the foot. Finally, his right ankle reflex was lost.

In light of the above, my provisional diagnosis is discogenic low back pain with radiculopathy. Thus, I am referring him for your advice of MRI and possibility of surgery. For any queries, please feel free contact me.

Yours Faithfully,
Doctor

Comment [teacher1]: .

Comment [teacher2]: no need to repeat age related information

Comment [teacher3]: whose

Comment [teacher4]: management

Comment [teacher5]: an

Comment [teacher6]: penicillin

Comment [teacher7]: was

Comment [teacher8]: a

Comment [teacher9]: and

Comment [teacher10]: U

Comment [teacher11]: P

Comment [teacher12]: F

Comment [teacher13]: O

Comment [teacher14]: had

Comment [teacher15]: repetitive

Comment [teacher16]: F

Comment [teacher17]: f

Report	
Word length	249
Comments	The letter contains more than 200 words. Effort to write information in brief is missing. Also, many inaccuracies pertaining to punctuation, capitalization, tenses and word choice are visible. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing it.

Dr M Jones
Psychiatrist
23 Sandy Road
South Seatown

03/04/2018

Dear Dr Jones,

Re: Mrs Katherine Walter

DOB: 26/11/1975

I am referring Mrs Walter urgently as her condition is highly suggestive of depression/bipolar disorder. Your help would be highly appreciated.

Mrs Walter is a 43-year-old married house-wife with two children. She has a history of bronchial asthma since childhood for which, she has been receiving budesonide inhaler. Furthermore, she has strong family history of depression; to be noticed, her family are a way, thus, she is currently living alone. She has no other significant past medical history apart from over-weight. She was advised about the importance of weight reduction and exercise. She has been doing voluntary work at a local school; hence she was feeling well and happy, her BMI returned to normal level.

Regrettably, today Mrs Walter reported fatigability, not coping well, with suicidal ideas. She has no energy to fulfill her daily activities such as house chores and caring after her children. She has been feeling overwhelmed with her responsibilities in addition to poor appetite but her physical examination was normal.

In view of the above, my provisional diagnosis is depression/bipolar disorder. I am referring her for further management. Her husband needs to be contacted in order to arrange children care and house hold maintenance. In case of any queries, please contact me.

Yours sincerely,

Doctor

Comment [teacher1]: housewife

Comment [teacher2]: lives in another state

Comment [teacher3]: is

Comment [teacher4]: and during a previous check up, she was

Comment [teacher5]: in the next follow-up, she was

Comment [teacher6]: fatigue

Comment [teacher7]: felt lack of

Comment [teacher8]: chores

Comment [teacher9]: looking

Comment [teacher10]: reported a poor appetite and has lost considerable weight

Comment [teacher11]: repetitive of the introduction

Report	
Word length	207
Comments	An effort to accomplish the task is visible. However, the letter has several inaccuracies. These pertain to word choice, tenses and spelling. Coherence-related issues exist as some information is missing. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling. 3. Improve choice of words. 4. Write information in brief wherever possible. 5. Always proofread the letter after finishing writing it.

Dr Penny Clifton
Thoracic Surgeon
Department Of Cardiothoracic Surgery
Central Hospital
Main Street
Stillwater

22/08/2015

Dear Dr. Clifton.
Re: Mrs. Mary Clarke, D.O.B.: 17/09/1960

I am writing to refer Mrs. Clarke who has demonstrated features suggestive of bronchogenic carcinoma. Your help would be highly appreciated.

Mrs. Clarke is an office clerk and married. She is a heavy smoker for more than 30 years with consumption of 30-35 cigarettes per day. Moreover, she has no allergies and her mother died from laryngeal carcinoma. She presented once with sore throat upon which she was prescribed Augmentin.

On review today, Mrs. Clarke has been suffering from dry non-productive cough with no haemoptysis for the last 7 weeks. Associated with chest pain (heaviness) and shortness of breath which is more noticeable during night, however she can exercise well, do her shopping and walking. Respiratory examination revealed right mid-zone consolidation accompanied with monophonic wheeze. Other systems' examination were normal; no cyanosis, no cervical lymphadenopathy and no hoarseness of voice. Chest X-ray and CT scan showed right middle lobe atelectasis with enlarged right hilum.

In view of the above, my provisional diagnosis is bronchogenic carcinoma. I am referring her for further investigations (bronchoscopy with biopsy) and assessment. If you have any query, please contact me.

Yours sincerely,
Doctor

Comment [bnchmrk1]: has been

Comment [bnchmrk2]: associated

Comment [bnchmrk3]: systemic and respiratory examinations

Comment [bnchmrk4]: , and there was

Comment [bnchmrk5]: or

Report	
Word length	185
Comments	Some issues pertaining to sentence formation and word choice are visible. There are mistakes of tenses and punctuation as well. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Revise grammar and sentence formation. 2. Improve word choice. 3. Always proofread your letter after finishing it.

Dr M McLaren
Neurologist
Suite 3
67 The Cewscent
Newtown
09/08/2014

Dear Dr McLaren,
Re: Mr Michael Weir, D.O.B:20/09/1970

Thank you for seeing Mr Weir, a 44- year-old real estate agent ,Whose features are consistent with multiple sclerosis . Your co-operation would be greatly appreciated.

Mr Weir is married with 3 children .He is a smoker ,his medical record shows depression,for which,he is on Zoloft.

On 29/06/2014, initially, Mr McLaren presented with stress and tiredness. Subsequently, blood tests were ordered. One-week later, he complained of weakness in the left leg. His examination revealed low WBC, RBC, Hb and Hct. Additionally, his BMI increased up to 28.5. Consequently, he was advised to decrease weight and quitting smoking. In addition, he should doing a regular exercise and watching his cholesterol level.

Today, Mr Weir complained of dizziness and two recent blackouts.Moreover,he had labile mood, tingling in both hands, breathless, occasional constipation, and shortness of the energy. Unfortunately, he had loss of sensation on both hands. In addition, left patellar reflex was diminished. Therefore, head and lumbar spinal CT were ordered.

In view of the above, my provisional diagnosis is multiple sclerosis. Thus, I am referring him for full neurological assessment and MRI. For any queries, please feel free to contact me.

Yours Sincerely,
Doctor

Report	
Word length	194
Comments	Mistakes pertain to word choice, capitalization and sentence structures. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Revise grammar. 2. Be careful with capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Dr Penny Clifton
Thoracic Surgeon
Department Of Cardiothoracic surgery
Central Hospital
Main Street
Stillwater

22/08/2015

Dear Dr Clifton,
Re: Mrs Mary Clarke D.O.B: 17/09/1960

Thank you for seeing Mrs Clarke, a 54-year-old office clerk, whose symptoms are suggestive of bronchogenic carcinoma. Your further assessment would be greatly appreciated.

Mrs Clarke, who is a married woman, lives with her husband and son. Please note, she is a heavy smoker and she has no known allergies. Her mother died from laryngeal carcinoma while her father was suffering from a mining related lung disease.

Initially, on 04/07/2015, the patient had presented with a sore throat, fever, cough and body aches. Therefore, Augmentin was commenced.

On today's visit, Mrs Clarke complained of a dry non-productive cough with no haemoptysis. Additionally, there was mild shortness of breath especially at night associated with a heaviness sensation in the chest. On examination, there were signs of consolidation accompanied by monophonic wheezes in the right mid-zone. The X-ray and CT revealed right middle lobe atelectasis and enlarged right hilum. Consequently, she was counselled on the potential diagnosis together with the need for further investigations.

In view of the above, I am referring this patient for a bronchoscopy and biopsy. If you have any queries, please do not hesitate to contact me.

Yours sincerely,
Doctor

Comment [bnchmrk1]: woman

Comment [bnchmrk2]: is married and

Comment [bnchmrk3]: but

Comment [bnchmrk4]: of

Comment [bnchmrk5]: suffered

Comment [bnchmrk6]: consolidation

Comment [bnchmrk7]: x

Report

Word length	189
Comments	Mistakes pertain to spelling, capitalisation and preposition. However, flow of information is logical and relevant case notes have been covered. Overall, the letter meets the expectations.
Grade	B+
Advice	1. Revise grammar. 2. Improve word choice. 3. Be careful of spelling.

Bayview Hospital
81 Canyon Road
Bayview

18/10/14

Dear Dr Williams,

Re: Mr Zach Foster

D.O.B: 25/10/1991

Thank you for seeing Mr Foster, a 22-year-old builder, who is presenting with bronchial asthma. Your further investigations and management would be greatly appreciated.

Comment [

Mr Foster is single. He has been smoking for four years. His medical record shows that he has been complaining of bronchial asthma since 1994. Consequently, he has been using ventolin and pulmicort. Please note, he is allergic to cats and hay fever.

Initially, Mr Foster complained of shortness of breath during playing sport. Moreover, he mentioned wheeze and cough which waking him at night. On 11/10/2014, he presented with features consistent with gastro-esophageal disease. His examination was unremarkable. Therefore, pantoprazole was prescribed. Additionally, he was advised to stop smoking together with good compliance on pulmicort.

Comment [

Comment [

Comment [

Comment [

Comment [

Comment [

Comment [

Today, Mr Foster mentioned that he is still smoking. In addition, he was not complaint on pulmicort. His blood tests as well as chest X-ray were normal. Subsequently, pantoprazole was prescribed for another seven weeks. Furthermore, he was advised again to stop smoking and good compliance on pulmicort.

Comment [

and medication

In view of the above, my diagnosis is bronchial asthma. Thus I am referring him for further management and lung function test. For any queries, please contact me.

Yours sincerely,

Doctor

Report

Word length	197
Comments	Mistakes mainly pertain to word choice and sentence formation. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Revise grammar and sentence formation. 2. Be careful of capitalisation. 3. Improve word choice.

Dr Bronwyn Clarke
Orthopedic Surgeon
Orthopedic
Department
Main Hospital
Greenville

17/10/2015

Dear Dr Clarke,

Re: Mrs Maria Santini D.O.B.: 08/01/1948

Thank you for seeing Mrs Santini, a 67-year-old widow, whose features are consisting with bilateral knee chronic osteoarthritis and right knee Baker's cyst. Your further assessment and management would be greatly appreciated.

Despite having two children, she lives alone. She has history of osteoarthritis, lumbar laminectomy, bilateral hip replacement, hypertension and paroxysmal atrial fibrillation which have been managed accordingly. Subsequently, she is on glucosamine, flecainide, trandolapril, indapamide and simvastatin.

Today, Mrs Santini presented with a six week history of progressively increasing pain in both knees joints especially on flexion and extension. Moreover, she mentioned that having soft lump on the back of right knee. Consequently, her daily life activities were decreased. Her examination revealed concomitant crepitus in both knees on flexion and extension. Unluckily, knee MRI showed degeneration which was consistent with osteoarthritis.

Therefore, referral to physiotherapist and home living assessment were done.

In light of the above, my diagnosis is Baker's cyst and worsening of osteoarthritis. Thus, I am referring her for further assessment and management for any queries, please contact me.

For further information, please feel free to contact me.

Yours faithfully,
Doctor

Comment [bnchmrk1]: The patient

Comment [bnchmrk2]: a

Comment [bnchmrk3]: six-week

Comment [bnchmrk4]: and a

Comment [bnchmrk5]: , whereas FBE, (FT and U&E were normal. (you can write this to ensure 180 words in your letter)

Comment [bnchmrk6]: was

Comment [bnchmrk7]: made

Comment [bnchmrk8]: This information is pretty much repetition of what you wrote in introduction

Comment [bnchmrk9]: sincerely

Report

Word length	173
Comments	The letter covers the relevant case notes well. Information is written in a logical order and use of cohesive devices is visible. Some inaccuracies pertaining to grammar and word choice exist, but these do not reduce communication.
Grade	B
Advice	1. Revise grammar. 2. Improve word choice. 3. Keep up the good work!

Dr John McLennan
Psychiatrist
Royal Mental Health Clinic
177 Park Avenue
Newtown

29/11/2014

Dear Dr McLennan,
Re: Ms Dolores Hoffmann, D.O.B:22/06/1986

Thank you for seeing Ms Hoffmann, a 28-year-old sales assistant, whose features are consistent with reactive depression and anxiety. ~~Your co-operation would be greatly appreciated.~~

Ms Hoffmann is single and lives alone in Australia.

On 25/04/2014, initially, Ms Hoffmann complained of wooziness and stress at work. Additionally last night, she fainted at pub after taking several cocktails. Nine-months later, she presented with features which are consistent with upper respiratory tract infection, upon which, erythromycin was prescribed. She was anxious about having Epstein bar virus as her colleague. One-month later, she presented with depressed mood, nightmares, insomnia, loss of appetite and poor libido. Moreover, she had poor memory, poor concentration, loss of pleasure, loss of confidence. Unfortunately, she split up with her boy-friend. In addition, she had intent to quitting her job. Consequently, Lemazepam was prescribed.

Today, Ms Hoffmann reported poor compliance on the Lemazepam regime. In addition, she accepted to be seen by psychiatrist.

In view of the above, I am referring her for further assessment and management. For any queries, please feel free to contact me.

Yours sincerely,
Doctor

Comment [teacher1]: also mentioned in conclusion

Comment [teacher2]: A

Comment [teacher3]: the earlier

Comment [teacher4]: a

Comment [teacher5]: were

Comment [teacher6]: S

Comment [teacher7]: suspected having contracted

Comment [teacher8]: O

Comment [teacher9]: M

Comment [teacher10]: was considering

Comment [teacher11]: C

Comment [teacher12]: T

Comment [teacher13]: with

Comment [teacher14]: I

Comment [teacher15]: However,

Report	
Word length	178
Comments	An effort to accomplish the task is visible. However, the letter has inaccuracies pertaining to punctuation, capitalisation and word choice. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with capitalization. 3. Improve choice of words. 4. Unnecessary pieces of information are visible. 5. Always proofread the letter after finishing writing it.

Dr Jiminez
Surgeon
Melbourne Private Hospital
19 Grange Road
Melbourne 3000

06/04/2018

Dear Dr Jiminez,

Re: Ms Ann Howard

Age: 36 years old

I am referring Ms Howard whose presentation is suggestive of early bowel obstruction, diverticulitis or bowel carcinoma.

Ms Howard is married with three children. Her past medical history includes ovarian cystectomy and appendicectomy. Her last period was in October 2016.

Ms Howard current condition started four days ago with sudden onset of lower abdominal pain which improved temporary after ingestion of valium. She described her pain as sharp and constant and exacerbates by movement, but she has neither nausea nor vomiting. Moreover, she has no urinary or bowel symptoms. On examination, she has tenderness in the left lower quadrant associated with vague abdominal mass. Some tests were ordered including urine pregnancy test. One day latter, her pain improved but the patient reported 3 days of constipation, her last bowel action was hard blood coated stool.

Today, Ms Howard's condition deteriorated. Her pain got worse after eating. Moreover, she became moderately distressed, and her abdominal examination showed tense abdomen with sluggish bowel sounds and mild left shift. It worth mentioning that she did not open her bowel yet. Her haemoglobin was 9.3 g/dl.

In view of the above, my differential diagnoses are early bowel obstruction, diverticulitis or colonic cancer. I am referring her for further management. If you have any queries, please contact me.

Yours sincerely,
Doctor

Comment [bnchmrk1]: appendectomy

Comment [bnchmrk2]: Howard's

Comment [bnchmrk3]: temporarily

Comment [bnchmrk4]: had

Comment [bnchmrk5]: later

Comment [bnchmrk6]: and

Comment [bnchmrk7]: worsened

Comment [bnchmrk8]: is

Comment [bnchmrk9]: has not opened

Comment [bnchmrk10]: your assessment and management would be highly appreciated.

Report	
Word length	215
Comments	Mistakes pertain to spelling, punctuation, tenses and word formation. However, paragraphing is logical and relevant case notes have been covered. Nevertheless, the letter requires further improvements.
Grade	C+
Advice	1. Revise grammar and sentence formation. 2. Improve word choice. 3. Always proofread your letter after finishing it .

Dr George Isaacson
Cardiologist
45 Inkerman Street
Caulfield 3162

31/03/2018

Dear Dr Isaacson,

Re: Mr Jing ZU

I am writing to refer Mr. ZU whose presentation is suggestive of ischemic heart disease. Your help would be highly appreciated.

Mr ZU is a 72-year-old retired school teacher. He is married and nonsmoker. He is a known case of hypertension for 18 years, with IHD and MI for many years. In addition, he has been suffering from CCF for the last 5 years. He is on Lasix 40mg, Enalapril, slow K, nifedipine and anginine sublingual as needed. He has reported anginal symptoms on gardening which relieved by rest and anginine use. Moreover, he has mild postural dizziness. On examination, there were features of CCF with normal heart sounds and unremarkable abdominal examination. His diagnosis was stable CCF associated with mild angina thus, required only follow-up.

Mr ZU presented 2 weeks later with deteriorating CCF which manifested as worsening dyspnea, orthopnea, lung crepitation to mid zone along with further engorgement in the JVP. ECG was done and the patient commenced on high dose of Lasix 80mg with review plan in two days. Today he has improved, his JVP and lung congestion were better. He still has anginal symptoms on activity and ECG detected anterolateral ischemia.

In light of the above, my provisional diagnosis is IHD. I am referring him for further management. If you have any queries, please contact me.

Yours sincerely,

Doctor

Report	
Word length	221
Comments	There are minor inaccuracies of grammar and word choice. However, these do not reduce communication.
Grade	B
Advice	1. Revise grammar. 2. Try to finish your letter in 200 words. 3. Always proofread your letter after finishing it.

Comment [bnchmrk1]: are

Comment [bnchmrk2]: An

Comment [bnchmrk3]: was

Comment [bnchmrk4]: However, he

DR Jeremy Barnet
The Emergency Registrar On duty
Maroubra Hospital
Lake Road
Maroubra
26.03.2018

Dear DR Barnet

RE: MR John Elvin

Age: 48 years

I am referring MR Elvin urgently as his presentation is highly suggestive of anterior myocardial infarction with exacerbation of bronchial asthma.

MR Elvin has been suffering from exertional dyspnea lately. He has bronchial asthma for which he takes Seretide and salbutamol inhalers. In addition, he smokes 1 pack and consumes about 10 drinks almost daily. Moreover, he is stressed about his own work but has no other significant medical history. Patient has no allergies or family history of heart diseases.

Comment [teacher1]: a history of

On his previous visits, ECG and troponin were done and turned out to be normal. Exercise stress test revealed only mild chest pain. Patient was commenced on Lipitor (for mildly elevated cholesterol), nitrates, Aspirin and anginine. Patient asthma was not well controlled due to noncompliance with medications.

Comment [teacher2]: but his

Patient presented today with a sudden onset crushing chest pain. He has been suffering from worsening asthma since last visit. ECG shows ST segment elevation. Furthermore, cardiovascular examination revealed S3 sound with bilateral wheeze. Patient given oxygen, 5mg iv morphine, nebulized ipratropium, GTN patch and frusemide 40mg.

Comment [teacher3]: of

Comment [teacher4]: showed

Comment [teacher5]: while

Comment [teacher6]: He was

With regard to MR Elvin condition my provisional diagnosis is anterior MI with exacerbation of asthma. Paramedic transfer to the hospital has been arranged for your further care and management. Please, do not hesitate to contact me for any query regarding his condition.

Comment [teacher7]: In view of the above,

Comment [teacher8]: transfer

Sincerely yours

Doctor-I

Report	
Word length	217
Comments	The letter is well written and well structured however two smaller sentences can be joined to make longer and complex sentences. A few minor inaccuracies pertaining to grammar and word choice are seen. The letter meets the expectations.
Grade	B+
Advice	1. Revise grammar. 2. Improve choice of words. 3. Always proofread the letter after finishing writing it.

Admitting Officer
Emergency Department
Children’s Hospital
Newtown

18/01/2014

Dear Sir/Madam,

Re: Joshua Vance D.O.B: 17/11/2013

Thanks you for seeing Joshua, ~~first child~~ aged 8-1/2 week old. Joshua was born at 38 weeks gestation by normal vaginal delivery. There was no perinatal or neonatal complications, birth weight 3250 gm. The patient has demonstrated features consistent with constipation and mild dehydration.

Upon first visit, Joshua came accompanied by his mother for 6-week routine baby check. At that time, his mother was worried as he opened his bowel once every 3 days. Apart from this, Joshua is breastfed and wetting his nappies. On examination, no significant findings have noticed, gaining weight by 650 gm. Therefore, she was reassured and advised to express milk, to be given in a bottle with some water.

5 days ago, Joshua was presented with signs and symptoms suggestive of colic; he started to pull away from breast. However, he still gaining weight. Abdominal examination revealed hard faeces. Coloxyl drops daily was prescribed, in addition to milk expression two feeds a day.

On review today, the baby has not opened his bowel for 5 days. Moreover, he refusing feeds, no wet nappies and vomits once. Let me inform you that he looked irritable with dry mucous membrane and tissue turgor, vital data are normal and finally mild generalised abdominal tenderness with no guarding or rebound tenderness.

Would you kindly review Joshua for dehydration and ~~if any further investigations needed for~~ his constipation?

Yours sincerely

Dr

Report	
Word length	228
Comments	An effort to accomplish the task is visible. Information has been written in logical paragraphing. However, the letter is longer than 200 words and the effort to write in brief is missing. Also many mistakes pertaining to punctuations, tenses, sentence structures and word choice are visible. Overall, the letter requires further improvements.
Grade	C
Advice	1. Revise grammar. 2. Improve choice of words. 3. Try to finish the letter in 200 words by writing information in brief wherever possible. 4. Always proofread the letter after finishing writing it.

- Comment [teacher1]: Thank
- Comment [bnchmrk2]: an 8-1/2-week-old baby boy who
- Comment [teacher3]: were
- Comment [teacher4]: and
- Comment [teacher5]: was
- Comment [teacher6]: When
- Comment [teacher7]: , she
- Comment [teacher8]: were
- Comment [teacher9]: he had increased his
- Comment [teacher10]: had
- Comment [teacher11]: for
- Comment [teacher12]: is
- Comment [teacher13]: has
- Comment [teacher14]: even vomited
- Comment [teacher15]: looks
- Comment [teacher16]: there is

Dr Granthy Cross
Consultant Endocrinologist
City Hospital
Suite 32
55 Main Road
Newtown

24/01/2015

Dear Dr Cross,
Re: Mr. Brett Collister, D.O.B.: 20/11/1970

Thank you for seeing Mr. Collister who has features consistent with type 2 DM.

Mr. Collister is married and working as a foreman. His hobbies do not include any regular exercises.

Regarding the patient's past history, he was suffering from repeated infections, pain and sore throat, therefore analgesics and antibiotics were prescribed. The patient had been referred to the physio twice last year. Firstly, he complained of sore L shoulder due to playing darts on which he received treatment. Secondly, he presented with sore R knee and there was query osteoarthritis. The patient's BMI was 30, accordingly he was advised to practice more sports and to reduce weight.

3 months later, Mr. Collister developed sore eye, tiredness, dizziness and may be orthostatic hypotension. He was still overweight with 29.7 BMI, unfit and he did not follow the previous recommendations. Laboratory investigations were requested including cholesterol and blood sugars.

On today review, the patient is in the same condition, however there is mild improvement in his BMI (28.4). The laboratory results have revealed high random glucose, high fasting glucose, increased HDL/LDL and 8.4% HgA1C.

I would very much appreciate your further assessment and management regarding this patient.

Yours sincerely,
Doctor

Report	
Word length	196
Comments	An effort to accomplish the task is visible. Flow of information in logical. However, mistakes pertaining to word choice, word order, articles and prepositions is visible. Sentence formation and paraphrasing of case notes could be better. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Improve sentence structures and revise grammar. 2. Learn more vocabulary and word choice. 3. It is better to give dates than writing firstly, secondly etc. 4. Always proofread your letter after finishing it.

Comment [bnchmrk1]: ,

Comment [bnchmrk2]: left

Comment [bnchmrk3]: His recent medical history includes an episode of tonsillitis and sore left shoulder which were cured successfully .

Comment [bnchmrk4]: Upon his visit on 26/10/2014,

Comment [bnchmrk5]: right

Comment [bnchmrk6]: with intermittent pain

Comment [bnchmrk7]: of

Comment [bnchmrk8]: ibuprofen for pain

Comment [bnchmrk9]: On his subsequent visit

Comment [bnchmrk10]: a

Comment [bnchmrk11]: and complained of

Comment [bnchmrk12]: possible

Comment [bnchmrk13]: review today

Dr Lisa Smith
Endocrinologist
City Hospital
Newtown

10/02/2014

Dear Dr Smith,
Re: Mrs. Priya Sharma, D.O.B.: 08/05/1954

Thank you for seeing Mrs. Sharma who ~~is 60 years old and married 40 years ago. She~~ has features consistent with uncontrolled level of blood sugar.

Comment [teacher1]: *repetitive/not required in the introduction*

Regarding the patient’s family history; many family members suffer from NIDDM. Mrs. Sharma ~~has been~~ diagnosed with NIDDM ~~since~~ 1994. Furthermore, she is known allergic to penicillin. She is on metformin 500mg 2 nocte and glipizide 5mg 2 mane.

Comment [teacher2]: was

Comment [teacher3]: in

Mrs. Sharma visited me on 29/12/2013 complaining of uncontrolled blood sugar level, which was ranging between 6-18. ~~However~~ her examination was normal, blood pressure was found to be high. Therefore, I prescribed candesartan tab 4mg 1 mane to her. FBE, U&Es, creatinine, LFTs, full lipid profile and HBA1C were requested. The patient ~~would~~ be reviewed within 2 weeks.

Comment [teacher4]: Though

Comment [teacher5]: was to

Two weeks later, I discussed the pathology report with the patient which revealed GFR > 60ml/min, HBA1C 10% and high lipid profile. Accordingly, metformin ~~had~~ changed to 1 b.d., while glipizide ~~to be~~ continued as before. Atrovastatin 20mg 1 mane was added ~~as new drug~~.

Comment [teacher6]: was

Comment [teacher7]: was

After regular follow up and investigations, ~~however~~ there was improvement in her pathology report, ~~her~~ fasting sugar is still high around 16+.

Comment [teacher8]: however,

I would very much appreciate your further management regarding this patient.

Yours sincerely
Doctor

Report	
Word length	201
Comments	There are a few inaccuracies of grammar and word choice. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Revise grammar. 2. Improve choice of words. 3. Always proofread the letter after finishing writing it.

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 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

10/02/14 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 notes into complete sentences
- Do not use note form
- Use letter format

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

28/03/2014

Dr Susan Clayton
Endocrinologist
Women’s Health Centre
11-13 Bell Street
Newtown

Dear Dr Clayton,
Re: Ms Tracy Bowen, DOB: 22/07/1988

Thank you for seeing Ms Bowen, who is presenting with symptoms suggestive of PCOS. Your further management is highly recommended.

Ms Bowen is a 30-year-old women, who has an abnormal menarche. It was irregular, infrequent and associated with dysmenorrheal. She uses OCP for this disturbed menstruation along with inhaler for asthma.

On 21/09/2015, Ms Bowen presented with severe facial, shoulder, neck and back acne. Her acnes were infected, inflamed and filled with pus, more over multiple scars were noted at their sites. Therefore, topical and systemic tetracycline were started. A review on 24/11/2014 was done which revealed no improvement of her condition. Therefore, I referred her to a dermatologist for further management.

On today’s visit, Ms Bowen discontinue her OCP as she got married. Her examination revealed high BMI and hair sutism. Her investigation were abnormal. LH, GTT and free androgen index were high. Her Vit D and FSH were on lower side, more over her prolactin level were very high. The patient was depressed and asked for endocrinologist opinion.

In view of the above, I suspect she has polycystic ovaries. A report of her pelvic U/S was attached along. I would appreciate if you could offer your expert opinion and management of her condition.

Please contact me for any questions.

Yours sincerely,
Doctor

Report	
Word length	206
Comments	Mistakes pertain to spelling, word choice, punctuation and sentence formation. However, relevant case notes have been covered in a logical order. Overall, the letter meets the expectations.
Grade	B
Advice	1. Revise grammar and sentence formation. 2. Improve word choice. 3. Always proofread your letter after finishing it.

Comment [bnchmrk1]: polycystic ovary syndrome

Comment [bnchmrk2]: woman

Comment [bnchmrk3]: as her intermenstrual interval stayed up to 90 days

Comment [bnchmrk4]: acne was

Comment [bnchmrk5]: . Moreover,

Comment [bnchmrk6]: in

Comment [bnchmrk7]: discontinued

Comment [bnchmrk8]: after getting married

Comment [bnchmrk9]: hirsutism

Comment [bnchmrk10]: and

Comment [bnchmrk11]: whereas her

Comment [bnchmrk12]: was

Dr Malcolm Still
Rheumatologist
5 Grant St
Fairmont

03/05/2014

Dear Dr Malcolm,
Re: Mr James Seymour, 60-year-old

Comment [bnchmrk1]: 60 years old

Thank you for seeing Mr James, who has demonstrated features consistent with gout.

Comment [teacher2]: Seymour

Regarding the patient social history; his alcohol consumption is exceeding the recommended limit. Mr James's father was diagnosed with RA.

Comment [teacher3]: patient's family and

Comment [teacher4]: and his

The patient has had regular episodes of inflammation in his 1st toe since 2010. He is on colchicine 500 mcg 2 tablets to be reduced to 1 tablet each 2/24 until pain is relieved (total dose less than 6 mg in 4 days) and indomethacin 25 mg 2 tablets twice daily. Mr James had taken allopurinol after his last acute attack, however, he stopped it two months ago before the current episode.

Comment [teacher5]: He

On 25/04/2014, he presented with 4 weeks into current attack of gout, there was poor compliance to his medications and he was completely convinced that he has RA. By examination, 1st left toe was red and inflamed. I recommended him to continue on his medications, taking regular paracetamol and oxycodone 5 mg if he is in pain with decrease alcohol intake. Some investigations were ordered.

Comment [teacher6]: had

Comment [teacher7]: On

Comment [teacher8]: found to be

Comment [teacher9]: plus

Comment [teacher10]: . he was also asked to

Comment [teacher11]: , Mr. Seymour

Today Mr James is in remission state, I informed him about synovial fluid sample stat next episode, also he must commence allopurinol now and for long time.

Comment [teacher12]: while the x-ray has revealed degenerative changes of the left first metatarsophalangeal joint. Therefore, he has been asked to take allopurinol.

Would you kindly review Mr James? I attached a copy of his pathology results.

Comment [teacher13]: Seymour? I have

Yours sincerely
Doctor

Comment [teacher14]: faithfully

Report	
Word length	211
Comments	Mistakes pertaining to grammar and word choice are visible. Some case notes can be covered in a better way. The letter does not meet the expectations.
Grade	C+
Advice	1. Revise grammar. 2. Improve choice of words. 3. Try to finish the letter in 200 words by writing information in brief wherever possible. 4. Always proofread the letter after finishing writing it.

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:

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 Powlet 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 71yrs.
Grandparents' history unknown, died when old.

PMHx: Appendicectomy 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 ↓ 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 NAD.
*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.

Dr Charles White
Bayview Private Hospital
81 Canyon Road
Bayview

01/06/2014

Dear Dr White,
Re: Ms. Lola Duval, D.O.B. :27/05/1990

Thank you for seeing this pleasant 24 years old lady, she has demonstrated features suggestive of hyperthyroidism most likely, Grave’s disease.

Comment [teacher1]: I am writing to request an urgent review for this
Comment [teacher2]: who

Ms. Duval is a student of engineering at Bayview University.

Regarding the patient’s medical and family history; she has insomnia and anxiety, therefore, she is occasionally taking sleeping pills. Her mother has been diagnosed with depression.

Comment [teacher3]: suffers from

She visited our clinic yesterday complaining of sudden weight loss of 10 Kg over the last 2 months in spite of eating well. There were symptoms of tremors, palpitations, sweating, heat intolerance and fatigue. Examination revealed normal vital data and slightly enlarged non-tender thyroid gland. Exophthalmose with lid lag had seen in her eyes. Routine blood tests, ECG and thyroid function tests were requested.

Comment [teacher4]: Ms Duval

Comment [teacher5]: but

Comment [teacher6]: Exophthalmos

Today the results came back showing sinus tachycardia in the ECG, low TSH; less than 0.05 mU/L and elevated T4 and T3. The results have been explained to the patient with the most likely diagnosis. Furthermore, I have requested thyroid auto-antibody tests and thyroid scan.

Comment [teacher7]: in

Understandably she is anxious, I would very much appreciate your early attention to the patient.

Comment [teacher8]: and would like to be seen by you at the earliest.

Please contact me if you have any queries.

Yours faithfully
Doctor

Report	
Word length	171
Comments	An effort to accomplish the task is visible. Information has been written in logical paragraphing. However, the letter is shorter than 180 words and many mistakes pertaining to punctuations, spelling, sentence structures, tenses and word choice are visible. Some pieces of information are missing as well. Overall, the letter requires further improvements.
Grade	C
Advice	1. Revise grammar. 2. Be careful with spelling. 3. Improve choice of words. 4. Try to write at least 180 words. 5. Always proofread the letter after finishing writing it.

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 overlying anxiety

Treatment: Routine blood tests, ECG, thyroid function tests

2

01.06.14

Test results: 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)

Treatment: 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.

Ms Jane Graham
Newtown Occupational Therapy
10 Johnston St
Newtown

20/06/2015

Dear Ms. Graham,
Re: Mr. Barry Jones, D.O.B.: 01/04/1972

I am writing to you regarding Mr. Jones who presented to the clinic asking for returning to his work after back injury incident 3 months ago.

Regarding the patient’s family and social history; he is married and working as forklift driver in a huge warehouse. Moreover, his job requires prolonged sitting and sometimes heavy lifting. Mr. Jones is on naproxen and carisoprodol (muscle relaxant).

Back to 21/03/2015, Mr. Jones was diagnosed with severe lower back strain due to lifting heavy box off floor at work. His X-ray showed no disc problems. As a result, the patient was advised to walking daily with gradual increase to time/distance. He was prescribed naproxen and carisoprodol. He also referred to physiotherapist furthermore, I gave him certificate with 30 days off work to be given to the employer.

After regular visits and follow up over the last 3 months, Mr. Jones was attending his physiotherapist appointments regularly and was exercising. However On review today, he is still in pain and stiff on movement, he is recovering well. He is walking 30 minutes per day but feel tired after that. Pain is increasing after nearly 30 minutes of sitting or lying down. But, he is bored and disheartened and wants to return to work.

I would very much appreciate your assessment of his workplace. Baring in mind he should take regular breaks during work and does not lift any heavy objects.

Yours sincerely,
Doctor

Comment [teacher1]: is

Comment [teacher2]: a

Comment [teacher3]: a

Comment [teacher4]: On

Comment [teacher5]: a

Comment [teacher6]: walk

Comment [teacher7]: in

Comment [teacher8]: was

Comment [teacher9]: for

Comment [teacher10]: Over

Comment [teacher11]: has been

Comment [teacher12]: and followup

Comment [teacher13]: , on

Comment [teacher14]: bearing

Comment [teacher15]: that

Report

Word length	217
Comments	The letter has many inaccuracies pertaining to articles, tenses, word choice and sentence formation. Some important information is missing while some has been repeated. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Improve choice of words. 3. Try to finish the letter in 200 words by writing information in brief wherever possible. 4. Repetitions of information are visible. 5. Always proofread the letter after finishing writing it.

Dr Penny Clifton
Thoracic Surgeon
Department Of Cardiothoracic Surgery
Central Hospital
Main Street
Stillwater

22/08/2015

Dear Dr. Clifton.
Re: Mrs. Mary Clarke, D.O.B.: 17/09/1960

I am writing to refer Mrs. Clarke who has demonstrated features suggestive of bronchogenic carcinoma. Your help would be highly appreciated.

Mrs. Clarke is an office clerk and married. She is a heavy smoker for more than 30 years with consumption of 30-35 cigarettes per day. Moreover, she has no allergies and her mother died from laryngeal carcinoma. She presented once with sore throat upon which she was prescribed Augmantin.

On review today, Mrs. Clarke has been suffering from dry non-productive cough with no haemoptysis for the last 7 weeks. Associated with chest pain (heaviness) and shortness of breath which is more noticeable during night, however she can exercise well, do her shopping and walking. Respiratory examination revealed right mid-zone consolidation accompanied with monophonic wheeze. Other systems' examination were normal; no cyanosis, no cervical lymphadenopathy and no hoarseness of voice. Chest X-ray and CT scan showed right middle lobe atelectasis with enlarged right hilum.

In view of the above, my provisional diagnosis is bronchogenic carcinoma. I am referring her for further investigations (bronchoscopy with biopsy) and assessment. If you have any query, please contact me.

Yours sincerely,
Doctor

Report	
Word length	185
Comments	Some issues pertaining to sentence formation and word choice are visible. There are mistakes of tenses and punctuation as well. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Revise grammar and sentence formation. 2. Improve word choice. 3. Always proofread your letter after finishing it.

Comment [bnchmrk1]: has been

Comment [bnchmrk2]: associated

Comment [bnchmrk3]: systemic and respiratory examinations

Comment [bnchmrk4]: , and there was

Comment [bnchmrk5]: or

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/Horner'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: Counselling 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.

Dr David Smith
Cardiologist
Emergency Department
Main Hospital
Coast City

20/09/2015

Dear Dr. Smith,
Re: Mrs. Lucy Clarke, D.O.B.: 11/03/1951

I am referring Mrs. Clarke urgently as her features are highly suggestive of an unstable angina.

Mrs. Clarke is a retired office clerk. She is non- smoker and drinks occasionally. She has been suffering from DM for 14 years now, in addition to, hyperlipidemia and hypertension since 2005. Her mother was diagnosed with MI and died at age of 59 from ischemic stroke. Mrs. Clarke is on sitagliptin 100mg (p.o) mane, insulin 25 units (s.c) b.d., atrovastatin 40mg (p.o) mane and irbesartan 75mg (p.o) mane.

On review today, she has been complaining of a chest pain on exertion for the last week. The pain was presented 3 times with less than 15 minutes duration each. Moreover, it was radiated to the left arm and was relieved by rest. The patient developed dyspnea, however there were no palpitation, no orthopnea and no paroxysmal nocturnal dyspnea. Mrs. Clarke is worried and convinced that she had a heart attack. On examination, her vital data were normal with normal resting ECG.

In view of the above, my provisional diagnosis is unstable angina. She needs a hospital admission for your further management. Would you kindly advise the patient on the risks of MI?

Yours sincerely,
Doctor

Report	
Word length	198
Comments	There are only minor inaccuracies of grammar and sentence formation. The letter meets the expectations.
Grade	B+
Advice	1. Revise grammar. 2. Keep up the good work!

Comment [teacher1]: a

Comment [teacher2]: complained of

Comment [teacher3]: of

Comment [teacher4]: in the past week.

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 (DM) 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.

Dr John McLennan
Psychiatrist
Royal Mental Health Clinic
177 Park Avenue
Newtown

29/11/2014

Dear Dr McLennan,
Re: Ms Dolores Hoffmann, D.O.B:22/06/1986

Thank you for seeing Ms Hoffman, a 28-year-old sales assistant , whose features are consistent with reactive depression and anxiety .
~~Your co-operation would be greatly appreciated .~~

Ms Hoffmann is single and lives alone in Australia.

On25/04/2014, initially, Ms Hoffmann complained of wooziness and stress at work. additionally ,last night, she fainted at pub after taking several cocktails. Nine-months later, she presented with features which are consistent with upper respiratory tract infection, upon which, erythromycin was prescribed. she was anxious about having Epstein bar virus as her colleague. one -month later, she presented with depressed mood, nightmares, insomnia, loss of appetite and poor libido. moreover, she had poor memory, poor concentration, loss of pleasure ,loss of confidence. Unfortunately ,she split up with her boy-friend. In addition, she had intent to quitting her job. consequently, temazepam was prescribed .

Today,Ms Hoffmann reported poor compliance on temazepam regime. In addition she accepted to be seen by psychiatrist.

In view of the above, I am referring her for further assessment and management. For any queries, please feel free to contact me.

Yours sincerely,
Doctor

Report	
Word length	178
Comments	An effort to accomplish the task is visible. However, the letter has inaccuracies pertaining to punctuation, capitalisation and word choice. Overall, the letter does not meet the expectations.
Grade	C
Advice	1. Revise grammar. 2. Be careful with capitalization. 3. Improve choice of words. 4. Unnecessary pieces of information are visible. 5. Always proofread the letter after finishing writing it.

Comment [teacher1]: also mentioned in conclusion

Comment [teacher2]: A

Comment [teacher3]: the earlier

Comment [teacher4]: a

Comment [teacher5]: were

Comment [teacher6]: S

Comment [teacher7]: suspected having contracted

Comment [teacher8]: O

Comment [teacher9]: M

Comment [teacher10]: was considering

Comment [teacher11]: C

Comment [teacher12]: T

Comment [teacher13]: with

Comment [teacher14]: T

Comment [teacher15]: However,

Admitting Officer
Emergency Department
Children’s Hospital
Newtown
18/01/2014
Dear Sir/Madam,

RE: Joshua Vance DOB: 17/11/2013

I am referring Joshua Vance, a 2-month-old infant, who has recently developed constipation with mild dehydration. Further assessment would be highly appreciated.

Joshua is the first baby of his parents. He was delivered vaginally after a full-term pregnancy with normal weight and there were neither perinatal nor neonatal complications.

On 31/12/2013, Joshua's mother attended, for a routine baby check, concerning about her baby's bowel actions. He had only one bowel action every three days with hard stools. Examination revealed normal findings with a normal weight gain. Consequently, his mother was reassured and was advised to give him some water along with breast feeding. Next visit, the mother was worried about her baby because he was waking up crying every half hour throughout the night with no improvement of his symptoms. Examination revealed normal hydration; therefore, Coloxyl drops was prescribed and increasing water intake for the baby was recommended.

Today, Joshua's mother reported that he has not passed stool for the last five days; besides, refusing feeds, vomiting once and there were no wet nappies. Examination showed that the baby is irritable and mildly dehydrated.

In view of the above, my provisional diagnosis is constipation with mild dehydration. I am therefore referring this patient for further management. For any queries, please do not hesitate to contact me.

Yours faithfully,

Doctor

Report	
Word length	217
Comments	There are mistakes pertaining to sentence formation, punctuation, spelling and word choice. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Revise grammar. 2. Be careful with spelling. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Comment [teacher1]: vaginally

Comment [teacher2]: complications

Comment [teacher3]: and expressed concerns

Comment [teacher4]: including

Comment [teacher5]: On the

Comment [teacher6]: still

Comment [teacher7]: previous

Comment [teacher8]: were

Comment [teacher9]: the

Dr M McLaren

Neurologist

Suite 3

67 The Crescent

Newtown

Dear Dr McLaren,

Re : Mr Michael Weir, 44 years of age

Thank you for seeing Mr Weir, whose symptoms and signs are indicative of multiple sclerosis. Your further management would be highly appreciated.

Mr Weir is a married real estate agent and has three children. Regarding his medical history, he has been taking Zoloft for depression since 2012. Please note, he is a smoker.

In 29/06/2014, Mr Weir complained of tiredness and stress. Her examination reveled nothing abnormal except for high body mass index; therefore, laboratory tests were ordered. On the next review visit, he reported that he was still tired in addition to a weakness in his left leg. High level of cholesterol with low Hb was noticed in the tests' results. Consequently, the patient was advised on lifestyle changes such as increasing exercise, decreasing saturated fats intake and smoking cessation. Besides, a review visit was scheduled in one month.

Today, Mr Weir reported two recent blackouts with dizziness. Moreover, he complained of mood swinging, stress, loss of energy beside tingling in his both hands. The examination revealed loss of sensation in his both hands with a diminished left patellar reflex. Consequently, head and neck CT scan was ordered.

In view of the above, I am referring the patient for MRI and your full neurological assessment. For any queries, please dont hesitate to contact me.

Yours sincerely,

Doctor

Report	
Word length	214
Comments	An effort to finish the task is visible. Flow of information is logical and relevant case notes have been covered well. However, there are minor inaccuracies related to spelling, word choice and sentence formation. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Pay a little more attention to grammar and word choice. 2. Be careful of spelling and avoid contractions such as <i>don't</i> .

Comment [benchmark1]: a 44-year-old real estate agent

Comment [benchmark2]: the patient's

Comment [benchmark3]: revealed

Comment [benchmark4]: test

Comment [benchmark5]: swing

Comment [benchmark6]: besides

Comment [benchmark7]: do not

Ms Jane Graham
Occupational Therapist
Newtown Occupational Therapy
10 Johnson Street
Newtown

20/06/2015
Dear Ms Graham,

Re: Mr. Barry Jones D.O.B 01/04/1972

Thank you for seeing Mr. Jones, a 44-year-old forklift driver who desires for returning to work. Your assessment would be highly appreciated.

Commented [AH1]: driver,
Commented [AH2]: would like to return

On 21/03/2015, Mr. Jones presented with a 4-day history of back pain, after he had lifted a heavy box off floor at his work. The x-ray revealed no disc problems. Therefore, he was diagnosed with a severe low back strain, for which he was prescribed naproxen and carisoprodol. In addition, he was referred to a physiotherapist and was given a medical certificate of a 30-day duration off work. On the next visit, the patient was still in pain and complained of movement stiffness. Although he was compliant with physiotherapy, he was concerned about the painful exercises. His sick-leave was extended another month.

Commented [AH3]: the
Commented [AH4]: for 30 days
Commented [AH5]: compliant with
Commented [AH6]: pain during his
Commented [AH7]: for

One month later, Mr. Jones attended complaining of severe movement stiffness and pain during walking. Therefore, he was advised on increasing naproxen dose with an extension of his sick-leave duration.

Commented [AH8]: to increase his
Commented [AH9]: , and was given

Today, Mr. Jones reported that he was still in pain, however; the range of movement was improving. He was very bored and wanted to return to his work. Therefore, he was advised to return to work with no lifting and to take breaks regularly.

In view of the above, I am referring the patient for assessment of his workplace and your advice. Should there be any queries, please do not hesitate to contact me.

Yours sincerely,

Doctor

Report	
Word length	228
Comments	Wording needs improving to enhance coherence and reduce the length of the letter. Order of content is good. Revision on grammar and capitalisation would be useful.
Estimated Grade	B-
Advice	1. Revise grammar and vocabulary. 2. Try to finish the letter in 200 words by writing information in brief wherever possible. 3. Always proofread the letter after finishing writing it.

Dr M McLaren
Neurologist
Suit 3
67 The Cresent
Newtown
09/08/2014

Dear Dr MClarent

Re: Mr Michael Weir, D.O.B.: 20/09/1970

Thank you for seeing Mr Weir, whose features are suggestive of multiple sclerosis. Your further assessment and management are highly appreciated.

Mr Weir, who is an overweight real estate agent, has been suffered from depression for 2 years for which takes Zolof.

Initially, the patient presented to me for his regular check-up on 29/06/2014. At that time, he reported weakness in his general health and his blood pressure was low. On the review visit one week later, he reported weakness in the left leg. His blood tests showed hypercholesterolemia and anaemia. Therefore, he was advised to modify his lifestyle and to stop smoking.

Today, Mr Weir presented with complaints of dizziness, two recent blackouts and a tingling sensation in his both hands. Besides, the weakness in the left leg has been persistent. His neurological examination revealed loss of both sharp and blunt sensations on both hands in addition to a diminution in the left Pallar reflex. For those reasons, I have ordered a CT for the head and Lumar spine to rule out either spinal pathological conditions or central causes.

In view of the above, my provisional diagnosis is possible multiple sclerosis. Thus, I am referring this patient to you for further assessment and possible MRI imaging. Please contact me, for further information.

Yours sincerely,

Doctor

Report	
Word length	213
Comments	Apart from minor inaccuracies, the letter meets the expectations.
Grade	B+
Advice	1. Always try to write information in brief form (comment 3). 2. Use synonyms. 3. Keep up the good work!

Comment [bnchmrk1]: will/would be highly

Comment [bnchmrk2]: suffering

Comment [bnchmrk3]: During initial visit on 29/06/2014, the patient

Comment [bnchmrk4]: came (use synonyms wherever possible)

Dr Hazem Gouda
Psychiatrist
Royal mental health clinic
177 Park Avenue
Newtown

29 11 2017

Dear Dr Gouda,
Re: Ms Hannah Modi D.O.B.: 22/ 06 /1987

I am writing to refer Ms Modi, a 30-year-old sales assistant lady, who presented with symptoms and signs suggestive of depression. Your further management is appreciated.

Ms Modi is a single lady who lives with a boyfriend only. Unfortunately, she is a smoker and alcohol drinker. Moreover, she experiences a lot of stress during her busy work.

On 11/10/2016, Ms Modi came with history of loss of consciousness (5-10 minutes) and one attack of vomiting following heavy drinking on the previous night. Her examination was unremarkable together with normal routine blood tests after that she was reassured.

On 07/06/2017, Ms Modi presented with several moles on both sides of her neck to which only observation was advised. 4 weeks later, she presented again with a picture of chest infection. In addition, she was concerned about being avoided by her colleague and about having EBV infection. Reassurance was offered and Erythromycin was prescribed for nonspecific mild elevation of neutrophils.

After about 2 months, she presented with clear symptoms of depression and anxiety due to the increasing work load. Moreover, she has splitted up with her boyfriend and considering leaving the job aiming to have rest. Unfortunately, she doesn't accept to be seen by psychiatric; moreover, she was uncompliant to the prescribed temazepam.

Today, Ms Modi has accepted my recommendation; therefore, I am referring her with provisional diagnosis of depression and anxiety. I will be glad if you manage her condition.

Yours sincerely,
Doctor

Comment [bnchmrk1]: her boyfriend

Comment [bnchmrk2]: S (there is nothing unfortunate about it)

Comment [bnchmrk3]: work-related stress

Comment [bnchmrk4]: the

Comment [bnchmrk5]: instance

Comment [bnchmrk6]: During subsequent visits, she complained of moles on both sides of the neck and

Comment [bnchmrk7]: split

Comment [bnchmrk8]: is

Comment [bnchmrk9]: does not

Comment [bnchmrk10]: a

Comment [bnchmrk11]: she is not complaint with her temazepam and refused to be seen by a psychiatrist

Comment [bnchmrk12]: Your assessment and management of this patient’s condition will be highly appreciated.

Report	
Word length	239
Comments	The letter ably addresses the case notes. Flow of information is logical and paragraphing is relevant. Sentence formation is broadly fine. However, mistakes pertaining to spelling, articles, word choice and tenses are visible. Also, the letter is longer than recommended 200 words.
Grade	C+
Advice	1. Since this is a letter to a psychiatrist, unimportant medical issues can be written in summary form to reduce the length. 2. Be careful of spelling and punctuation marks. 3. Learn more vocabulary and word choice. 4. Revise grammar.

Patient Name: (Ms)

Patient History: DOB 22.06.
Allergic to penicillin.

Social History: Single woman – no family in Australia; lives with long-term boyfriend.
Sales assistant – ladieswear in a department store.

At pub last night with friend. 2 glasses wine + several cocktails. Then fainted 5-10mins unconscious → vomited once. No Hx fits/seizures/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

Skin check. Several moles L and R neck – ok. Advised to monitor for changes.

URTIs 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.

HAEMATOLOGY:

Haemoglobin	124g/L	(115-165)
RBC	$4.8 \times 10^{12}/L$	$(3.80-5.50 \times 10^{12}/L)$
PCV	0.37	(0.35-0.47)
MCV	88 fL	(78-99)
MCH	30 pg	(27-32)
White Cell Count	$7.0 \times 10^9/L$	$(4.0-11.0 \times 10^9/L)$
Neutrophils	$8.8 \times 10^9/L$	$(2.0-8.0 \times 10^9/L)$
Lymphocytes	$2.8 \times 10^9/L$	$(1.0-4.0 \times 10^9/L)$
Monocytes	$0.4 \times 10^9/L$	$(< 1.0 \times 10^9/L)$
Eosinophils	$0.3 \times 10^9/L$	$(< 0.6 \times 10^9/L)$
Basophils	$0.0 \times 10^9/L$	$(< 0.2 \times 10^9/L)$
Platelets	$250 \times 10^9/L$	$(150-450 \times 10^9/L)$

Paul Bunnell/latex screening test for IM (infectious mononucleosis): negative
Rx: erythromycin 250mg qid

Ofrofacial 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

Diagnosis: reactive depression and anxiety

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

Pt has agreed to a referral to psychiatrist.

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

In your answer:

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

Dr. Hazem Gouda
Suit 3
67 The Crescent
Newtown

09/ 11/ 2016

Dear Dr. Gouda,
Re: Mr. Tamer Sultan

D.O.B.: 20/ 09 /1974

I am writing to refer Mr. Sultan, a 42-year-old real estate agent, who presented by symptoms and signs suggestive of multiple sclerosis. Your further assessment is highly appreciated.

Comment [bnchmrk1]: with signs and symptoms

Mr. Sultan is married with three children. He is a smoker and has no time for exercise which resulted in being overweight. Besides, he takes zoloft for depression since 2012.

Comment [bnchmrk2]: him

Comment [bnchmrk3]: has been taking

During subsequent visits, he presented by his regular complaint of tiredness, feeling depressed and stressed. However, on 7 /10/ 2016, he reported left leg weakness. At that time, his examination was unremarkable along with being anaemic with high cholesterol level. Consequently, he was advised to change his lifestyle and to continue same medication.

Comment [bnchmrk4]: with

Comment [bnchmrk5]: complaints

Comment [bnchmrk6]: apart from

Comment [bnchmrk7]: the

Today, Mr. Sultan came with a history of 2 recent blackouts that were associated with dizziness and mood changes. Moreover, he reported the same weakness of the left leg together with tingling in his hands. Although he has started exercise, he is still overweight. His examination showed loss of sensation on both hands and diminished left patellar reflex. Our next step is to do CT on his head and lumbar spine.

Comment [bnchmrk8]: the recent history of 2

Based on the above information, I am suspecting multiple sclerosis. Therefore, I am referring this patient for your further assessments including an MRI study.

Yours sincerely,
Doctor

Report	
Word length	206
Comments	The letter ably covers the case notes and there is a logical flow of information. Some mistakes pertaining to grammar are visible, but these do not reduce communication.
Grade	B
Advice	1. Revise grammar. 2. Improve word choice. 3. Always proofread your letter after finishing it. 4. Keep up the good work!

is a patient in your general practice.

Name:
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:

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)

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
Sertraline hydrochloride — ongoing
BMI: 28.5 (Wt: 95.5kg)
Test results: Cholesterol: 6.37mmol/L
CBC - low WBC; low RBC, low Hb & Hct; other results in normal range
Assessment: Repeat assessment of hypercholesterolaemia in 3mths.
Monitor general health - tiredness, depressed feelings.
Pt should make lifestyle changes (smoking, diet, exercise, recreation).
Plan: Pt to ↓dietary saturated fat, incorporate regular exercise to ↓weight & cholesterol levels; stop smoking.
R/v in approx 1mth to assess general health, feelings of tiredness & being 'down'.

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
Loss of sensation on L & R hands (sharp/blunt)
Reflexes - diminished L patellar reflex
Tests: 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 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.

Dr. O Shawki
Neurosurgeon
City Hospital
Newton
25/01/2018

Dear Dr. Shawki
Re: Mr Anees Ford, 45 Years of age

Thank you for seeing Mr Ford, a 45-year-old stock broker, who has presented with a discogenic low back pain. For your kind care.

Mr. Ford is married with three children. He is a smoker and he drinks alcohol daily. He is mildly overweight. Of note to mention that he is allergic to Pethidime, penicillin and a radiographic contrast. Otherwise, he is medically free.

On 11/01/2018, the patient has visited the clinic complaining of severe low back pain which was not radiating to thighs then after lifting a heavy object. On examination, he was vitally stable. He had loss of lumbar lordosis as well as painful limitation of spinal flexion & extension. However, he maintained full range of lateral flexion. At that time, his SLR test was 90° bilaterally. Mr Ford was advised to have a sick leave and to continue oral analgesics. He was given a follow-up appointment one week later. Unfortunately, he showed no improvement. In addition, the pain has radiated to his right thigh and leg.

Today, and after another week of rest and pain killers, Mr Ford has been almost immobile because of the agonizing low back pain and right sciatica. His examination shows more restricted spinal movements in all direction. While SLR test is only 50° on the right side.

I am referring Mr Ford to you as my provisional diagnosis is discogenic radiculopathy for performing MRI and your opinion regarding possibility of surgery accordingly.

Yours sincerely,
Doctor

Report	
Word length	239
Comments	The letter is quite long. Also, mistakes pertaining to grammar and word choice are visible. Effort to write information in brief is missing as well. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Avoid writing more than 200 words. 2. Pay attention to tenses. 3. Improve word choice.

Comment [bnchmrk1]: a 45-year-old stock broker

Comment [bnchmrk2]: Please note that

Comment [bnchmrk3]: and

Comment [bnchmrk4]: , and

Comment [bnchmrk5]: rest

Comment [bnchmrk6]: Upon his following visit,

Comment [bnchmrk7]: and his

Comment [bnchmrk8]: with

Comment [bnchmrk9]: of

Comment [bnchmrk10]: He requires

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

Dr. O Shawki

Neurosurgeon

City Hospital

Newton

25/01/2018

Dear Dr. Shawki

Re: Mr. Anes Ford, 45 years of age

Thank you for seeing Mr Ford, a 45-year-old stockbroker, who has presented with a discogenic low back pain. For your kind care.

Mr Ford is married with three children. He is a smoker and he drinks alcohol daily. He is mildly overweight. Of note to mention that he is allergic to Pethidine, penicillin and a radiographic contrast. Otherwise, he is medically free.

On 11/01/2018, the patient has visited the clinic complaining of severe low back pain which was not radiating to thighs then after lifting a heavy object. On examination, he was vitally stable. He had loss of lumbar lordosis as well as painful limitation of spinal flexion & extension. However, he maintained full range of lateral flexion. At that time, his SLR test was 90° bilaterally. Mr Ford was advised to have a sick leave and to continue

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

oral analgesics. He was given a follow-up appointment one week later. Unfortunately, he showed no improvement. In addition, the pain has radiated to his right thigh and leg.

Today, and after another week of rest and pain killers, Mr Ford has been almost immobile because of the agonizing low back pain and right sciatica. His examination shows more restricted spinal movements in all directions while SLR test is only 50° on the right side.

I am referring Mr Ford to you as my provisional diagnosis is discogenic radiculopathy for performing MRI and your opinion regarding possibility of surgery accordingly.

Yours sincerely,
Doctor

Admitting Officer
Emergency Department
Newtown Hospital

13/09/2014

Dear Sir/Madam,
Re: Ms Sara Adams

Thank you for seeing Ms Adams, who is having an acute exacerbation of asthma and pneumonia. Your urgent management is highly appreciated.

Ms Adams is a 38-year-old administrator who is known to be asthmatic and hypertensive. For both conditions she is receiving ramipril, fluticasone and Ventolin.

On 10/09/2014, the patient presented with runny nose, productive cough as well as wheezy chest. At that time, she had no shortness of breath. On examination, she showed nasal congestion, red throat, in addition to scattered chest wheezes. Ventolin dose was augmented and she was advised of rest. Unfortunately, Ms Adams came back 2 days later as her chest condition became worse. She complained of shortness of breath and fever. Therefore, Amoxicillin and oral prednisone were prescribed.

Today, Ms Adams, in spite of receiving the antibiotic and the prednisone, appeared very unwell. Her fever has not settled; her shortness of breath has become more significant. When examining her chest, a generalized wheeze as well as bibasal crepitations were found.

Showing no improvement on Ventolin Nebules, Ms Adams is most propably having an exacerbating attack of asthma on top of pneumonia. Thus, I am referring her to you for your urgent management. Should u have any queries, please do not hesitate to contact me.

Yours sincerely,
Doctor

Report	
Word length	209
Comments	Mistakes pertain to articles, conjunctions and punctuation. On the bright, paragraphing is logical and relevant case notes have been covered adequately. Overall, the letter meets the expectations.
Grade	B
Advice	1. Try to write information in brief wherever possible. 2. Revise grammar. 3. Keep up the good work!

Comment [teacher1]: , Peroxetine

Comment [teacher2]: V

Comment [teacher3]: two days later, her

Comment [bnchmrk4]: Her condition has still not improved and she appeared unwell today.

Comment [teacher5]: and

Comment [teacher6]: was (simply write and in place of as well as to avoid confusion)

Comment [teacher7]: The dosage were increased accordingly.

Comment [teacher8]: With her condition worsening, I suspect

Comment [teacher9]: you

Dr Malcolm Still
Rheumatologist
5 Grant st
Fairmont

03/05/2014

Dear Dr Still,

Re: Mr James Seymour D.O.B.: 19/09/1953

Thank you for seeing Mr Seymour, a 60-year-old retired academic, whose his features are suggestive of gout. Your further management is greatly appreciated.

Mr Seymour, who lives alone as he is divorced with no children, has been an ex-smoker for the past 20 years. However, he is a heavy drinker. His father had suffered from rheumatoid arthritis for about 50 years till his death. The patient's past history shows recurrent attacks of possible gout affecting his large toe over the last 4 years. Regarding medications, he takes lengout, indocind and allopurinal on occasions.

One week ago, the patient presented with a complaint of a swollen left large tow. He reported that it had been the third bout of gout over the last 8 months for which he had been taking a low dose of colchicin and irregular doses of Indocid. At that time he was not taking allopuranal; nevertheless, he modified his diet. His examination showed an inflamed left big toe with no other joint affection. Therefore, I ordered an x-ray and some blood tests and advised him on taking proper doses of gout medications along with regular analgesics. Moreover, oxycodone 5mg was prescribed only when required.

Today, the gout attack has been improving with good compliance to his medication. The x-ray indicated some degeneration at the left metatarsophalangeal joint as well as an elevation of CRP level was noted. Unfortunately, the patient is very concerned about the possibility of rheumatoid arthritis and requested a referral to a rheumatologist. Please note, synovial fluid sampling was discussed with the patient as well as the importance of diet control and alcohol reduction.

In view of the above, I am referring this patient to you upon his insistence for your further management. Please contact me if you require further information.

Yours sincerely
Doctor

Report	
Word length	297
Comments	This is an excessively long letter with no effort to write information in brief. Also, mistakes pertaining to word choice and grammar are visible. Overall, the letter requires further improvements.
Grade	C+
Advice	1. Try to finish your letters in 200 to 220 words. 2. Improve word choice. 3. Revise grammar.

Comment [bnchmrk1]: will/would be

Comment [bnchmrk2]: and

Comment [bnchmrk3]: He has a family history of arthritis

Comment [bnchmrk4]: a

Comment [bnchmrk5]: N

Comment [bnchmrk6]: The patient's

Comment [bnchmrk7]: Therefore, the patient has requested

Comment [bnchmrk8]: along with

Admitting Officer
Emergency Department
Newtown Hospital
13/9/2014

Dear Sir/Madam,

Re: Ms Sally McConville

Thank you for urgently seeing this 38-year-old lady, whose features are suggestive of pneumonia. Your urgent management would be highly appreciated.

Ms McConville, ~~who is a non-smoker administrator,~~ has a history of asthma, hypertension and depression for which she takes regular medications. She has no known allergies.

Comment [teacher1]: this information is not really important for emergency doctor I suppose!

She presented on 10th of this month with acute asthmatic symptoms, and on 12th of this month, was diagnosed with infective exacerbation of asthma. She was commenced on amoxicillin 500mg three times a day in addition to Ventolin.

This patient presented today, ~~after being seen twice in the previous 3 days,~~ with obvious respiratory distress, fever and the feel of unwellness. She has a diffue wheeze and basal criptations over both lung fields. Moreover, her temperature is 37.7, Pulse 112 and Blood Pressure is 100/65. Although she was given salbutamol 5mg, she is still suffering of respiratory distress.

- Comment [teacher2]: worsening
- Comment [teacher3]: feeling unwell
- Comment [teacher4]: diffused wheezing
- Comment [teacher5]: crepitations
- Comment [teacher6]: p
- Comment [teacher7]: b
- Comment [teacher8]: p
- Comment [teacher9]: mentioning
- Comment [teacher10]: a
- Comment [teacher11]: mg
- Comment [teacher12]: dose

It is worth mentioning that this patient was diagnosed with an infective exacerbation of asthma yesterday; for this reason, she was commenced on Amoxicillin 500mg three times a day. Those were added to her regular doses of Ventolin which had been prescribed since 10/9/2014.

In view of the above, my provisional diagnosis is acute asthmatic attack with possible pneumonia. Therefore, it would be highly appreciated if you could urgently manage her condition as you feel appropriate.

Yours sincerely,

Doctor

Report	
Word length	183
Comments	Inaccuracies pertaining to word choice, grammar, capitalization and spelling have been made. The order of information needs to be improved. Nevertheless, the letter meets the expectations.
Grade	B
Advice	1. Revise grammar. 2. Be careful with spelling and capitalization. 3. Improve choice of words. 4. Always proofread the letter after finishing writing it.

Admitting Officer
Emergency Department
Newtown Hospital

13/9/2014

Dear Sir/Madam,
Re: Ms Sally McConville

Thank you for urgently seeing this 38-year-old lady, whose features are suggestive of pneumonia. Your urgent management ^{will be} highly appreciated.

Ms McConville, who is a non-smoker, administers her history of asthma, hypertension and depression for which she takes regular medications. She has no known allergies.

This patient presented today, after being seen twice in the previous 3 days, with obvious respiratory distress, ^{the feel of} ~~feeling~~ ^{unwell} ~~unwell~~ and has a diffuse wheeze and basal crackles over both lung fields. Moreover, her temperature is 38.7, pulse 112 and blood pressure is 100/65. Although she was given salbutamol 5mg, she is still suffering of respiratory distress.

It is worth mentioning that this patient was diagnosed with "infective exacerbation of asthma" yesterday; for

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

Two reasons, she was commenced on Amoxicillin 500mg three times a day and Prednisolone 25mg three times a day. These were added to her regular dose of Ventolin which had been prescribed since 10/9/14.

In view of the above, my provisional diagnosis is acute asthmatic attack with possible pneumonia. Therefore, it would be highly appreciated if you could urgently manage her condition as you feel appropriate.

Yours sincerely,
Doctor