

# **50 MEDICAL WRITING TASK + Sample Letters**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 1**

**WRITING TIME: 40 MINUTES**

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

**notes:**

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

**Patient Details:** Ms Bethany Taylor

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

**Admission date:** 01 March 2018

**Discharge date:** 18 March 2018

**Diagnosis:** Schizophrenia

**Past medical history:**

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

**Social background:**

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

**Admission 01/03/2018:**

- Patient self-admitted: decompensated schizophrenia

**Medical background:**

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

**01/03/2018 –**

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

**10/03/2018:**

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

**Nursing management:**

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

**Assessment:**

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

**Discharge plan:**

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

**Writing Task:**

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

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

**In your answer:**

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

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

Dr. Giovanni DiCoccio  
Proudhurst Family Practice  
231 Brightfield Avenue  
Proudhurst

19/03/2018

Dear Dr. DiCoccio,

Re: Bethany Taylor, 35 years of age

Your patient, Ms Taylor, admitted herself on 1 March 2018 with decompensated schizophrenia. She is now ready for discharge and follow-up at your clinic.

On admission, she was experiencing significant thought disorder, including thought blocking and latency. She was also exhibiting delusions and experiencing auditory command and visual hallucinations.

During her stay in hospital Ms Taylor was placed back on her medications, and her mental condition has stabilised and she is able to focus on her activities of daily living. Her insight is now good and judgment fair. Her nursing management in the hospital focused on compliance with her antipsychotic medications, behavioral control, and therapy. Since 10 March, she has not reported visual or auditory hallucinations.

Ms Taylor is on oral Risperidone 4mg nightly. Additional oral risperidone 1mg can be administered as needed twice daily for agitation or psychosis. She will be discharged from the hospital to her apartment where she lives alone. She will follow-up with you in order to continue her treatment of chronic schizophrenia and to avoid non-compliance of her medications or substance abuse. If you have any queries, please contact me.

Yours sincerely,

Doctor

**[183 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 2**

**WRITING TIME: 40 MINUTES**

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

**notes:**

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

**Name:** Mrs Sally Fletcher

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

**Marital status:** Married, 5 years

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

**Diagnosis:** Endometriosis

**Past medical history:**

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

**Social background:**

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

**Medical background:**

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

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

**Mobility post op:**

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

**Nursing management:**

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

**Medical progress**

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

**Assessment:**

- Good progress overall.

**Discharge plan:**

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

**Writing Task:**

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

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

**In your answer:**

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

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

Dr Stevens  
Mill Street Surgery  
Farnham  
GU10 1HA

25 March 2018

Dear Dr Stevens,

Re: Mrs Sally Fletcher D.O.B 3/10/1993

Your patient, Sally Fletcher, was admitted to the surgical ward of Fairbanks Memorial Hospital on 25 March 2018 for the purpose of laparoscopic surgery to treat an endometrial cyst. She is now ready for discharge into the care of her husband.

When admitted, Sally had been suffering from painful periods over the past 3 years, which she had been attempting to treat with naproxen, but the pain persisted. An ultrasound scan revealed a cyst had formed in her abdomen. She arrived at the ward this morning and underwent laparoscopic surgery, which successfully located and removed a 6cm cyst from her abdomen without complication.

She has been advised to keep the incision sites clean and dry. She has received narcotic pain medication and has been advised that she is unable to drive while taking this medication. You should monitor her progress, and advise when to cease taking this medication. She may resume driving 24-48 hours after the last dose is taken.

Sally may resume her normal diet today, and is encouraged to drink plenty of fluids. She is also encouraged to walk as much as she can tolerate.

Sexual activity can resume in two weeks.

If you have any questions please feel free to contact me.

Yours sincerely,

Doctor

**[194 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 3**

**WRITING TIME: 40 MINUTES**

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

**notes:**

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

**Patient Details**

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

**Date seen:** 08 April, 2018

**Diagnosis:** Type 1 diabetes mellitus

**Past medical history:**

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

**Social background:**

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

**Medical background:**

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

**Appointment today:**

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

**Plan:**

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

**Writing Task:**

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

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

**In your answer:**

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

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

Dr. Sharon Farquad  
Endocrinologist  
Endocrine Specialists and Associates  
115 Burke St.  
Omaha

08/04/2018

Dear Dr. Farquad

Re: Tabitha Taborlin, 45 years of age

Thank you for seeing Ms Tablorin as a new patient at Endocrine Specialists and Associates. She is a 45 year old female with a past medical history of essential hypertension and uncontrolled Type 1 diabetes mellitus.

Ms Tablorin was seen at my clinic today as a follow-up from a hospital admission for diabetic ketoacidosis with a glucose measure of 530 mmol/L. She has had multiple prior hospitalisations for the same issue. She also has a long history of being noncompliant with her insulin medications, which are 45 units of Lantus nightly, and preprandial correction scale Humalog with 12 units of nutritional baseline. Her HbA1c is 11.0%.

She has been educated multiple times on diabetes risks and complications, regarding her insulin regimen, exercise, diet, and tobacco cessation. However, she has continued to ignore these recommendations and her condition has progressively worsened. It is my recommendation that she seek a higher level of care, thus I refer her to your practice. Ms Tablorin would likely benefit from a stricter insulin regimen and glycemic monitoring, as well as an insulin pump for reliability of medication administration.

If you have any queries, please contact me.

Yours sincerely,

Doctor

**[183 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 4**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 07/11/10

**Patient History**

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

Landscape Gardener

Runs own business.

No personal injury insurance

Active, enjoys sports

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

Smokes 20-30 cigarettes/day

**P.M.H**-Left Inguinal Hernia Operation 2008

**12/08/10**

**Subjective**

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

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

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

Finds injury is inhibiting his ability to work productively.

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

**Objective**

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

Temperature- normal

BP 120/80

Pulse rate -78/min

**Investigation** - X ray knee joint

**Management**

Voltarin 50 mg bid for 1/52

Advise to reduce smoking

Review if no improvement.

**25/8/10**

**Subjective**

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

No fever

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

Reduced smoking 15/day

**Objective**

Swelling +

No effusion

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

Flexion, extension – normal

Impaired range of power - passive & active

**Diagnosis ?** Injury of medial cartilage

Investigation – ordered MRI

**Management**

Voltarin 50mg bid for 1 week

Review after 1 week with investigations

**07/11/10**

**Subjective**

Limp still present

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

Desperate to resolve the problem

Weight increase of 5kg

**Objective**

Pain decreased, swelling – no change

No new complications

MRI report – damaged medial cartilage

**Management Plan**

Refer to an orthopaedic surgeon, Dr James Brown to remove damaged cartilage in order to prevent future osteoporosis. You have contacted Dr Brown's receptionist and you have arranged an appointment for Mr Taylor at 8am on 21/11/10

**Writing Task:**

*You are the GP, Dr Peter Perfect. Write a referral letter to Orthopaedic Surgeon, Dr. James Brown:  
1238 Gympie Road, Chermside, 4352.*

**In your answer:**

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

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

Dr. James Brown  
1238 Gympie Rd  
Chermside, 4352

07/11/10

Dear Dr. Brown,

Re: David Taylor

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

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

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

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

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

Yours sincerely,

Doctor

**[200 words]**

**TIME ALLOWED:**

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

**Task 5**

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

**notes:**

Assume Today's Date: 01/06/10

**Patient History**

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

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

Married/no children

Wife works full time as shop assistant

No hobbies

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

Father has hypertension

Mother died at 60 due to breast cancer

No known allergies

**12/05/10**

**Subjective**

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

No red colour urine - frequency normal

No history of trauma, No fever

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

**Objective**

BP: 120/80

PR: 80 BPM

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

**Plan**

Diagnosis? Ureteric colic due to renal stone

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

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

Review after 2 days with IVP report, UFR report

**14/05/10**

**Subjective**

No pain, no new complaints

**Objective**

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

UFR-few red cells

Advised to drink more fluid especially in hot weather

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

**01/06/10**

**Subjective**

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

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

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

**Objective**

BP: 140/90

PR: 98 regular

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

Hydronephrosis +

**Plan**

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

**Writing Task:**

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

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

**In your answer:**

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

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

Dr. B. Comber  
Urologist  
Southport Hospital  
Gold Coast

June 1 2010

Dear Doctor,

Re: Mr. Tom Cribb   DOB: 23/05/1982

I am writing to refer Mr. Cribb, a married and unemployed male who has a renal mass.

Mr. Cribb first came to see me on the 12/05/10 complaining of severe pain in the right lower abdomen which was radiating to the groin. It was not associated with urinary or gastrointestinal symptoms, trauma or fever. His vital signs were normal and his lower abdomen was mildly tender. He was prescribed diclofenac suppositories 50mg twice a day for 5 days. He was advised to drink fluids and walk regularly. The IVP report on the 14/05/10 showed an enlarged and ectopic right kidney, no stones were reported and the UFR had a few red cells. With regard to his risk factors, he is a smoker and drinks alcohol. His father has hypertension and his mother died from breast cancer.

On today's consultation, he complained of right lower abdominal pain of 5 day duration which was relieved by Panadol. His vital signs were normal and a mass was palpated in the right abdominal area. His right kidney was below the normal site. The ultrasound showed severe hydronephrosis and a mass attached to the liver. He was advised to undergo further CT scan investigations.

I would appreciate your assessment to Mr. Cribb's urologic problem.

Yours sincerely,

Doctor

**[209 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 6**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date 10/02/10**

**Patient History**

**Alison Martin** , Female ,28 year old, teacher.

Patient in your clinic for 10 years

Has 2 children, 4 years old and 10 months old, both pregnancies and deliveries were normal.

Husband, 30 yr old, manager of a travel agency. Living with husband's parents.

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

Smoking-nil

Alcohol- nil

Use of recreational drugs – nil

**09/01/10**

**Subjective**

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

**Objective**

Appearance- nearly normal

Mood – not depressed

BP- 120/80

Pulse- 80/min

Ab, CVS, RS, CNS- normal

**Management**

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

**20/01/10**

**Subjective**

Previous symptoms – no change

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

**Objective**

Mood- mildly depressed

Little eye contact

Speech- normal

Physical examination normal

**Tentative diagnosis**

Early depression or schizophrenia

**Management plan**

Relaxation therapy, counselling

Need to talk to the husband at next visit

Prescribed Diazepam 10mg/nocte and paracetamol as required

Review in 2/52

**10/02/10**

**Subjective**

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

**Objective**

Mood – depressed

Little eye contact

Speech – disorganised

Behaviour- bizarre

BP 120/80 , Pulse- 80

Ab, CVS, RS, CNS- normal

**Probable diagnosis**

Schizophrenia and associated disorders

**Management plan**

Refer to psychiatrist for assessment and further management.

**Writing Task:**

*You are the GP, Dr Ivan Henjak. Write a referral letter to Psychiatrist, Dr. Peta Cassimatis: 1414 Logan Rd, Mt Gravatt, 4222.*

**In your answer:**

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

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

Dr. Peta Cassimatis  
1414 Logan Rd  
Mt Gravatt, 4222

10/02/12

Dear Doctor,

Re: Alison Martin

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

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

She first presented at my clinic on 9 January 2012 complaining of tiredness, a lack of motivation at work and a low grade fever. On review after ten days, she did not show any improvement. She displayed symptoms of paranoia and was suffering from poor sleep, anxiety and frequent headaches. In addition, she was mildly depressed with little eye contact. Relaxation therapy and counselling were started and Diazepam 10 mg at night was prescribed based on my provisional diagnosis of early depression or schizophrenia.

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

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

Yours sincerely,

Doctor

**[204 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 7**

**WRITING TIME: 40 MINUTES**

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

**notes:**

Today's Date 16.02.13

**Patient History**

**Miss Cathy Jones** - 25 year old single woman

Occupation - receptionist

Family history of deep vein thrombosis

On progesterone-only pill (POP) for contraception

No previous pregnancies

**15.02.13**

**Subjective**

Presents to GP surgery at 7 pm, after work

Complains of lower abdominal pain since the evening before, worse in right iliac fossa

Unsure of last menstrual period, has had irregular bleeding since starting

POP 2 months ago, New partner for past 2 months

No bladder or bowel symptoms

**Objective**

Mild right iliac fossa tenderness, no rebound / guarding

Apyrexial, pulse 88, BP 110/70

Vaginal examination - quite tender in right fornix. No masses

Assessment

Non-specific abdo pain

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

**16.02.13**

**Subjective**

Pain has worsened overnight. Now severe constant pain.

Some slight vaginal bleeding overnight also.

Felt faint while waiting in reception.

On questioning, has left shoulder-tip pain also.

## **Objective**

Very tender in the right iliac fossa, with guarding and rebound tenderness

Apyrexial, Pulse 96, BP 110/70

On vaginal examination, has cervical excitation and markedly tender in the right fornix.

Pregnancy test result positive

Urine dipstick clear

## **Assessment**

Suspected ectopic pregnancy

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

## **Writing Task:**

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

### **In your answer:**

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

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

Gynaecology Registrar  
A&E Department  
Spirit Hospital  
South Brisbane

16/02/13

Dear Doctor,

Re: Cathy Jones

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

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

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

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

Please keep me informed of the outcome.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 8**

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

**notes:**

**Today's Date** 25.08.12

**Patient History**

**James Warden**

DOB 05.07.32

Regular patient in your General Practice

**09.07.12**

**Subjective**

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

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

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

Current medication noted 50 mg daily, ½ aspirin daily, normison 10mg nightly when required, fifty plus multivitamin 1 daily, allergic reaction to penicillin.

**Objective**

BP 155/85 P 80 regular

Cardiovascular and respiratory examination normal

Urinalysis normal

Slight swelling in right groin consistent with inguinal hernia.

**Plan**

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

Discussed options re hernia. Patient wants to avoid surgery.

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

**25.08.12**

**Subjective**

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

Has reduced alcohol intake as suggested.

## **Objective**

BP 140/80 P70 regular

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

## **Assessment**

Bilateral inguinal hernia

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

## **Writing Task:**

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

### **In your answer:**

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

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

Dr. Glynn Howard  
Surgical Department  
249 Wickham Tce  
Brisbane 4001

25/08/2012

Dear Doctor,

Re: Mr. James Warden

DOB 05/07/32

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

Initially, Mr. Warden presented to me on 09/07/12 for a regular checkup. On examination, he had a mild swelling of the right groin, his blood pressure was 155/85 and pulse was 80 beats per minute. Otherwise his condition was normal. He was diagnosed as having an inguinal hernia. I discussed the possibility of surgery; however, he indicated he did not want an operation. Therefore, I advised that he avoid heavy lifting and reduce alcohol consumption. A review consultation was scheduled for 3 months later.

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

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

Yours sincerely,

Dr X (GP)

**TIME ALLOWED:**

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

**Task 9**

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

**notes:**

**Today's Date** 08.08.12

**Patient History**

**Dulcie Wood**

DOB 15.07.46

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

**03.07. 12**

**Subjective**

Widowed January 06, three children, wants regular check up, has noticed uncomfortable feeling in her chest several times in the last few weeks like a heart flutter.

Mother died at 52 of acute myocardial infarction, non smoker, rarely drinks alcohol

Current medication: zocor 20mg daily, calcium caltrate 1 daily

No known allergies

**Objective**

BP 145/75 P 80 regular

Ht 160cm Wt 61kg

Cardiovascular and respiratory examination normal ECG normal

**Plan**

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

Review in 2 weeks if no increase in frequency.

**17.07.12**

**Subjective**

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

**Objective**

BP 135/75 P70 regular

**Assessment**

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

**08.08.12****Subjective**

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

**Objective**

BP 180/90 P70

**Action**

Contact Dr. Raymond's receptionist and you are able to arrange an appointment for Mrs. Wood at 8am on 14/08/12

**Writing Task**

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

**In your answer:**

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

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

Dr Vincent Raymond  
422 Wickham Tce  
Brisbane, 4001

08/08/12

Dear Dr. Raymond,

Re: Dulcie Wood DOB: 15/07/46

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

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

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

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

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

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

Yours sincerely,

Dr Z

**[191- words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 10**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 03.07.12

**Patient History**

**Margaret Leon** 01 .08. 52

Gender: Female

Regular patient in your General Practice .

**14.01.12**

**Subjective**

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

Father died bowel cancer aged 50.

Had colonoscopy 3 years ago. Clear

Does not smoke or drink

**Objective**

BP 160/90 PR 70 regular

Ht 152cm

Wt 69 kg

On no medication

No known allergies

**Assessment**

Overweight. Advised on exercise & weight reduction.

Borderline hypertension

Review in 3 months

**25.04.12**

**Subjective**

Feeling better in part due to weight loss

**Objective**

BP 140/85

PR 70 regular

Ht 152cm

Wt 61 kg

**Assessment**

Making good progress with weight. Blood pressure within normal range

**03.07.12**

**Subjective**

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

**Objective**

BP 180/95 P 88 regular

Ht 152cm Wt 50 kg

Cardiovascular and respiratory examination normal.

Rectal examination shows no obvious abnormalities.

**Assessment**

Need to investigate for bowel cancer

Refer to gastroenterologist for assessment /colonoscopy.

Prescribe 15 gram Alepam 1 tablet before bed.

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

Review after BP appointment with gastroenterologist

**Writing Task:**

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

**In your answer:**

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

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

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

03/07/2012

Dear Dr Carlson,

Re: Margaret Leon DOB 01/08/1952

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

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

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

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

Yours sincerely,

Dr X (GP)

**[194 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 11**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Today's Date** 15.08.12

**Patient History**

**Darren Walker**

DOB 05.07.72

Regular patient in your General Practice

**09.07.12**

**Subjective**

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

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

Mother age 68 hypertension diagnosed 2002.

Smokes 20 cigarettes per day –trying to give up

Works long hours – no regular exercise

Light drinker 2 –3 beers a week

**Objective**

BP 165/90 P 80 regular

Cardiovascular and respiratory examination normal

Height 173 cm Weight 85kg

Urinalysis normal

**Plan**

Advise re weight loss, smoking cessation

Review BP in 1 month

Request PSA test before next visit

## 14.08.12

### Subjective

Reduced smoking to 10 per day

Attends gym twice a week, Weight 77 kg

Complains of discomfort urinating

### Objective

BP 145/80 P76

DRE hardening and enlargement of prostate

PSA reading 10

### Plan

Review BP, smoking reduction in 2 months

Refer to urologist – possible biopsy prostate

### Writing Task:

**Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001.**

**Ask to be informed of the outcome.**

### In your answer:

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

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

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

15/08/2012

Dear Doctor,

Re: Mr. Darren Walker

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

Initial examination on 09/07/12 revealed a strong family history of related illness as his elderly father was diagnosed with prostate cancer and mother was diagnosed as hypertensive. Mr Walker is a smoker and light drinker. He works long hours and does not do any regular exercise. His blood pressure was initially 165/90 mmhg and pulse was 80 and regular. He is 173cm tall and his weight, at that time, was 85 kg. He was advised to reduce weight and stop smoking and a prostate specific antigen test was requested. There were no other remarkable findings.

When he came for the next visit on 14/08/2012, Mr Walker had reduced smoking from 20 to 10 cigarettes per day and was attending gym twice a week. He had lost 8kg of weight. His blood pressure was improved at 165/90mmhg. However digital rectal examination revealed an enlarged prostate and the PSA reading was 10.

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

Yours sincerely,

Dr.X

**[206 words]**

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 12**

**WRITING TIME: 40 MINUTES**

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

**notes:**

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

**Patient History**

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

Has a sister 6 years, brother 3 years

Mother – housewife

Father – Naval Officer currently on active duty in Indonesia

P.M.H- NAD

Brendan is on 50th percentile for height & weight

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

**14/01/12**

**Subjective**

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

**Objective**

Temperature - 39.8°C

Enlarged tonsils with exudate

Enlarged cervical L.N.

Ab - NL

CVS – NL

RR – NL

**Probable Diagnosis**

Tonsillitis (bacterial)

**Management**

Oral Penicillin 250mg 6/h, 7days + Paracetamol as required.

Review after 5days if no improvement.

**19/1/12**

**Subjective**

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

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

**Objective**

Temperature - 39.2°C

Hypertrophied tonsils

Cervical limp node – NL

Swollen R. Knee Joint

No effusion

Mid systolic murmur, RR - normal

**Investigation**

ECG, FBC, ASOT ordered

**Treatment**

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

**21/1/12**

No change of symptoms

ECG – prolonged P-R interval

ESR – increased

ASOT – Increased

**Diagnosis**

? Rheumatic fever

**Plan**

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

**Writing Task:**

*You are GP, Dr Joseph Watkins, Greenslopes Medical Clinic, 294 Logan Rd, Greenslopes, Brisbane 4122. Write a referral letter to Dr Alison Grey, Mater Paediatric Centre, Vulture Street, Brisbane 4101.*

**In your answer:**

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

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

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

21/01/2012

Dear Dr. Grey,

Re: Brendan Cross

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

He presented with symptoms suggestive of acute bacterial tonsillitis on 14/01/12, when fever and sore throat had occurred over the previous 3 days, associated with lethargy and crying spells. High temperature (39.8), enlarged tonsils with exudate and cervical lymphadenopathy were found. Therefore, oral penicillin and paracetamol were prescribed.

Regrettably, he returned on 19/01/12 with worsening symptoms. Fever had persisted with right knee joint pain. He appeared restless, and was finding it difficult to eat and sleep. Examination revealed hypertrophied tonsils and a swollen right knee joint without signs of effusion. There was mid-systolic murmur on heart auscultation. Brufen was prescribed but was not effective. Today, blood tests results reported elevated erythrocyte sedimentation rate and anti-streptolysin O titre. An abnormal electrocardiogram indicated prolonged P-R interval.

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

Yours sincerely,

Dr. Watkins

**[202 words]**

**TIME ALLOWED:**

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

**Task 13**

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

**notes:**

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

**Patient History**

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

Two children age 5 and 3

Two miscarriages

First pregnancy

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

Second Pregnancy

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

Family history of thrombosis

Known to be heterozygous for Factor V Leiden

Treated with prophylactic low molecular weight heparin in two previous pregnancies

No other medical problems

Not on any regular medication

Negative smear 2010

**24/08/12**

**Subjective**

Positive home pregnancy test – fifth pregnancy

Thinks she is 8 weeks pregnant

Last menstrual period 26.6.12

Painful urination last three days

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

## **Objective**

BP:120/80

Weight: 60kg

Height: 165cm

Some dysuria for the past 3 days

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

Abdomen soft and non-tender

Fundus not palpable suprapubically

## **Assessment**

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

Needs to start folic acid

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

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

## **Plan**

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

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

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

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

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

Provide information on Greenslopes Screening Centre.

Prescribe tinzaparine 3,500 units daily subcutaneously

Send a midstream urine specimen to laboratory

Prescribe cefalexin 250 milligrams 6-hourly for five days

**Writing Task:**

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

**In your answer:**

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

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

Dr. Anne Childers  
(MBBS, FRANZCOG)  
Consultant Obstetrician  
Spirit Mother's Hospital  
Stanley Street  
South Brisbane

24/08/12

Dear Dr. Childers,

Re: Mrs. Jane MacIntyre DOB 01/03/73

Thank you for accepting this 39-year-old mother of 2, who is 8 weeks pregnant and has a strong history of severe pre-eclampsia in her first pregnancy which resulted in an emergency caesarean section at 32 weeks of gestation. However, her second pregnancy and delivery was normal. In addition, she has had 2 miscarriages. In view of her age and history, I believe Mrs. MacIntyre needs urgent specialist assessment and care.

On presentation today, Mrs. MacIntyre reported that she is heterozygous for Factor 5 Leiden and has a family history of thrombosis. Therefore, I commenced her on trizaparine 3,500 units daily. In addition, Mrs. MacIntyre complained of difficulty in urination for the previous 3 days and her urine dipstick test showed presence of a large amount of protein and nitrate along with slight blood. Therefore, in view of urinary tract infection, cefalexim 250 miligrams 6 hourly daily for 5 days was prescribed and mid-stream urine test was ordered.

Please note, I have commenced Mrs. MacIntyre on folic acid 400 microgram daily and have advised her for nuchal translucency scan in order to rule out Down's syndrome.

I am happy to share her antenatal care with you, as you think appropriate.

Yours sincerely,

Dr. Liz Kinder

General Practitioner

[200 words]

**TIME ALLOWED:**

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

**Task 14**

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

**notes:**

**Today's Date** 14.10.12

**Patient History**

**Amina Ahmed** aged 8 years – new patient at your clinic Parents – Mother Ayama, house-wife. Father Talan, cab driver Brothers Dalma aged 4 and Roble aged 2 Family refugees from Somali 2005. Have Australian Citizenship Amina and father good understanding of English, mother has basic understanding of slowly spoken English. Amina had appendicectomy 2 years ago. No known allergies

**09/10/12**

**Subjective**

Fever, runny nose, mild cough, loss of appetite  
Unable to attend school

**Objective**

Pulse 85/min  
Temperature 39.4  
No rash  
No neck stiffness  
CVS, RS & abdo – normal

**Assessment**

Viral infection

**Management**

Keep home from school  
Rest and paracetamol three times daily  
Review in 3 days if no improvement

**12/10/12**

**Subjective**

Amina not well

Cough +, continuous headache, lethargic, loss of appetite

Difficult to control temperature with Paracetamol

Mother worried

**Objective**

Fever 39.8 C

No rash or neck stiffness

**Management**

Prescribe Brufen 200mg as required

FBC & UFR were ordered

Review in two days with results of reports

**14/10/12**

**Subjective**

Both parents very concerned

Reported Amina lethargic and listless

Vomited twice last night and headaches worse

**Objective**

FBC- WBC(18000) and left shift

Urinary Function Report Normal

Temperature 40.2C

Pulse 110/min

Macula-papular rash over legs

Neck Stiffness+

**Assessment**

Meningococcal meningitis. Penicillin IV given (stat dose)

**Plan**

Arrange urgent admission to the Emergency Paediatric Unit, Brisbane General Hospital, for further investigation and treatment.

**Writing Task:**

*You are GP, Dr. Lucy Irving, Kelvin Grove Medical Centre, 53 Goma Rd, Kelvin Grove, Brisbane.  
Write a referral letter to the Duty Registrar, Emergency Paediatric Unit, Brisbane General Hospital,  
140 Grange Road, Kelvin Grove, QLD, 4222.*

**In your answer:**

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

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

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

14/10/12

Dear Doctor:

Re: Amina Ahmed (8years)

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

Initially, accompanied by her parents, she presented to me on 9.10.12 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next two days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.

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

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

Yours sincerely,

Dr. Lucy Irving

**[208 words]**

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

14/10/12

Dear Doctor,

Re: Amina Ahmed

Thank you for urgently seeing this 8-year-old child, who is presenting with features suggestive of meningococcal meningitis.

She is the first child of a family of 5, which includes her parents and younger siblings. The family immigrated from Somalia 7 years ago. however, they understand English.

The patient, accompanied by her parents, initially presented on 09/10/12 complaining of fever, runny nose, mild cough and loss of appetite. On examination, her vitals were normal except for a temperature of 39.4 Celsius. At that time, neck stiffness or rash were not noticed. After three days, she reported having constant headaches and lethargy with the deterioration of her earlier symptoms. Additionally, her temperature was not responding to the antipyretic. Therefore, blood and urine tests were ordered.

Unfortunately, today, Amina became lethargic and listless. Her parents were worried as she vomited twice last night and her headaches have been worsening. Examination revealed that she was severely febrile with a temperature of 40.2 and a pulse rate of 110 per minute. A maculopapular rash over the legs and neck stiffness were also observed. The blood test showed elevated WBC with a left shift. As a result, penicillin IV was commenced.

In view of the above, I believe she needs urgent admission.

Yours faithfully,

Doctor

**[203 words]**

**TIME ALLOWED:**

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

**Task 15**

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

**notes:**

**Patient: Anne Hall (Ms)**

**DOB: 19.9.1965**

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

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

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

Non-smoker (since children born)

Social drinker – mainly spirits

**Substance Intake:** Nil

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

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

Maternal grandmother – died heart attack, aged 80

Maternal grandfather – died asthma attack

Paternal grandmother – unknown

Paternal grandfather – died 'old age' 94

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

1975 tonsillectomy

1982 hepatitis A (whole family infected)

1984 sebaceous cyst removed

1987 whiplash injury

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

2000 overweight – sought weight reduction

2002 URTI

2004 dyspepsia

2006 dermatitis; Rx oral & topical corticosteroids

**18/6/10**

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

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

No relapse/remittent course

No sensation of lump

No obvious anxiety

Concomitant epigastric pain radiating to back, level T12

Weight loss: 1-2kg

Recent increase in coffee consumption

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

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

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

**Writing Task:**

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

**In your answer:**

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

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

Dr Jason Roberts  
Newtown Hospital  
111 High Street  
Newtown

18/6/10

Dear Dr Roberts

Re: Ms Anne Hall, DOB 19.9.1965

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

Ms Hall believes the problem commenced after an upper respiratory tract infection two weeks ago for which she self-prescribed an over-the-counter Chinese herbal product with unknown ingredients. However, she has also recently increased her coffee consumption and takes aspirin 2-3 times a month.

She has a history of dyspepsia (2004), and dermatitis for which she was prescribed oral and topical cortisone. There are no apparent signs of anxiety. She has not smoked for the last 15 years. She drinks socially (mainly spirits), has a family history of peptic ulcer disease and is allergic to codeine. Her BMI is currently 28.2.

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

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

Yours sincerely

Doctor

**TIME ALLOWED:**

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

**Task 16**

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

**notes:**

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

**Residence:** 71 Seaside Street, Newtown

**Social Background:**

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

**Family History:**

Many relatives with type 2 diabetes (NIDDM)

Nil else significant

**Medical History:**

1994 – NIDDM

Nil significant, no operations

Allergic to penicillin

Menopause 12 yrs

Never smoked, nil alcohol

No formal exercise

**Current Drugs:**

Metformin 500mg 2 nocte

Glipizide 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 case notes into complete sentences
- Do not use note form
- Use correct letter format

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

Dr Lisa Smith  
Endocrinologist  
City Hospital  
Newtown

10 February 2014

Dear Dr Smith,

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

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

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

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

Mrs Sharma is allergic to penicillin. A pathology report on 05/01/2014 showed HbA1c levels of 10% and GFR greater than 60ml/min. Her cholesterol was high (6.2).

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

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

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 17**

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

**notes:**

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

**Family history**

Mother diabetes, died stroke 10 years ago aged 67

**Medical history**

Unremarkable, no medications

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

**11/11/06**

**Subjective:**

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

lethargy 7 weeks

dizziness

**Objective:**

Ht. 1.60 Wt. 95kgs.

Pulse 84 reg, BP 160/95

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

Dietary advice re weight loss, appropriate foods

**16/12/06**

**Subjective:**

Reports has followed diet, no weight loss

Symptoms unchanged

Frequent headaches

**Objective:**

No weight loss

BP 170/95

Investigation results: blood sugar 11 mmol / l

- no sugar in urine
- albumin in urine + +

**Plan:**

prescribe antidiabetic and antihypertensive medications, continue diet

**07/01/07****Subjective:**

Complains feeling worse

Blurred vision

Sight spots

**Objective:**

BP 165/90

**Plan:**

Referral Dr. Haldun Tristan, endocrinologist

**Writing Task:**

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

**In your answer:**

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

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

Dr Haldon Tristan  
Melbourne Endocrinology Centre  
99 Brick Road  
East Melbourne VIC 3004  
7 January 2007

Dear Dr. Tristan,

Re: Mrs Toulia Athena, 47, married, two children, home duties

Thank you for seeing Mrs Athena who presents today with symptoms consistent with late onset Diabetes Mellitus (DM).

Please note, the patient's mother suffered from DM and died of a stroke at the age of 67. Mrs. Athena's past medical history is unremarkable and she currently takes no medications.

Mrs. Athena initially presented on 11 November last year with a four-month history of thirst, bulimia and nocturia.

She urinated four times a night. Furthermore, she complained of lethargy during the preceding seven weeks. At that time she was overweight. Dietary advice was given and relevant investigations arranged.

On 16 December, the patient re-presented with her symptoms unchanged and raised BP. In addition, she reported frequent headaches. Her test results showed that her blood sugar was 11 mmol/l and that the albumin in her urine was elevated but without any evidence of sugar. Antidiabetic and antihypertensive medications were prescribed and she was advised to continue her diet.

As mentioned above, Mrs. Athena presents today with worsening diabetic symptoms. Moreover, her vision is blurred and she has sight spots.

I would be grateful for your assessment of this patient. Should you require further information please contact me directly at my surgery.

Yours sincerely

Doctor

Dr. Haldun Tristan (Endocrinologist)  
Melbourne Endocrinology Centre  
99 Brick Road  
East Melbourne, 3004

Dear Dr. Tristan,

Re: Ms. Toula Athena

I am writing to refer this patient to you in order to rule out diabetes. Ms. Athena is a 47-year-old housewife. She is married and has 2 children. Her risk factors include: hypertension, obesity, strong family history (her mother was diagnosed with diabetes and died of stroke 10 years ago), elevated blood sugar and albuminuria.

Initially, she came to see me two months ago. She had been suffering from thirst, bulimia, nocturia and dizziness during the previous four months. In addition, she had been lethargic for the previous 7 weeks. Her blood pressure was elevated at 160/95 mm hg and pulse rate was 84 beats per minute. She was advised to keep on diet in order to reduce weight, blood and urine tests were ordered.

One month later, her condition did not improve and her weight was unchanged. Due to her symptoms and test results antidiabetic and antihypertensive medications were prescribed.

Regrettably, today Ms. Athena`s condition deteriorated. She complained of blurred vision and sight spots. Despite treatment her blood pressure also was elevated at 165/90 mmhg.

I believe she requires admission to the Endocrinology Centre for treatment and stabilization. Please keep me informed of her condition.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 18**

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

**notes:**

**Peter Ludovic**, 8 years old

**22/12/06**

Complains of sore throat. Mother reports fever, irritable.

Voice hoarse

**O/E:**

enlarged tonsils, exudate

Tender, large cervical nodes

T 39.5°

**Assessment:** Tonsillitis

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

**15/01/07** Mrs.

Ludovic reported son's urine brown 4 days previously.

Says Peter is lethargic, no report of frequency, trauma or dysuria.

**O/E:** tonsillar hypertrophy

BP 90/60

Urinalysis – macroscopic haematuria

**Assessment:**

? post streptococcal nephritis

? urinary tract infection

**Plan:**

R/V 2 days

Fluids, rest

**Tests:**

Full Blood Examination (FBE), urea and creatinine

[U&E], electrolytes, mid stream urine [MSU]

micro/culture/sensitivity [M/C/S], Antistreptolysin-O Titre [ASOT] and cell morphology

**18/01/07**

Peter asymptomatic

**O/E:** BP 110/90

macroscopic haematuria

**Test results:**

FBE normal

U&E↑

ASOT↑+++

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

**Assessment:**

post streptococcal nephritis with early renal failure

**Plan:** Refer to paediatrician

**WRITING TASK**

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

**In your answer:**

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

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

Dr. Xavier Flannery  
Paediatrician  
567 Church Street  
Springvale, 3171

18 January 2008

Dear Dr. Flannery,

Re: Peter Ludovic, 8 years old

Thank you for seeing Peter who I suspect has post-streptococcal nephritis with early renal failure.

Initially, Peter presented on 22 December 2006 with symptoms suggestive of acute bacterial tonsillitis. According to his mother, he had been suffering from sore throat, associated with fever (39.5), hoarse voice and irritable mood. Enlarged tonsils with exudate and cervical lymphadenopathy were found, and oral penicillin was prescribed.

On the second examination 15 January 2007, the patient reported blood in urine over the previous four days, as well as lethargy. Examination revealed hypertrophied tonsils, and urine analysis showed macroscopic haematuria. Blood pressure was normal.

Today, blood test results reported elevated urea and creatinin, antistreptilysin-O titre, and mid-stream urine showed red blood cells of renal origin ( $4 \times 10$ ).

In view of the above signs and symptoms, I would appreciate your urgent assessment and treatment of this patient.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 19**

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

**notes:**

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

**Family and social history**

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

**Medical history**

Unremarkable, no medications

**11/07/05**

Complains of tiredness, difficulty sleeping for 2 months due to work stress  
Plans another child in 12 months, currently on oral contraceptive pill (OCP)

**O/E:**

Appears pale, tired and slightly restless

BP 140/80

No abnormal findings

**Assessment:** Stress-related anxiety

**Plan:**

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

**15/08/06**

Stopped OCP 4 months earlier, still menstruating

Worried

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

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

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

**Plan:**

discussed nature of conception – takes time, patience

discussed frequency sexual intercourse

discussed methods – temperature / cycle

**18/01/07**

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

**O/E:**

crying, pale, fidgety

Vital signs / general exam NAD

Pelvic exam, pap smear

**Assessment:** as per previous consultation

**Plan:**

1-2 Valium b.d.

Suggested she re-present next week accompanied by husband.

**25/01/07**

Mr. Zaneeta very supportive of having another child

No erectile dysfunction, libido normal

Mrs. Zaneeta unchanged

**O/E:**

Mr. Zaneeta normal

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

**02/02/07**

Sperm count normal

**Plan:** Refer for specialist advice

**Writing Task:**

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

**In your answer:**

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

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

Dr. Elvira Sterinberg  
Gynaecologist  
123 Church Street  
Richmond, 3121

02 February 2007

Dear Dr. Sterinberg,

Re: Mrs. Larissa Zanetta, a 38-year-old woman, marketing manager, married, has one child (a four-year-old boy) and Mr. Zanetta, her husband

Thank you for seeing my patients who have been trying to conceive for 10 months without any success.

Initially, Mrs. Zanetta came to see me on 11/07/05 complaining of tiredness and difficulty sleeping for the previous 2 months due to work stress. She was on oral contraceptive pill at that time and was planning another pregnancy in 12 months. Her medical history was unremarkable.

The patient demonstrated signs of anxiety, such as paleness, tiredness and slightly elevated blood pressure (140/80mmhg). Accordingly, relaxation techniques, reducing work hours and sleeping tablets were recommended.

One year later, Mrs. Zanetta visited me again complaining of failure to conceive since she had stopped the pill. Sleeping problem and work-related stress persist. Therefore, reassurance was given and advice regarding nature of conception was provided.

However, on review six months later the patient had not managed to conceive and her anxiety had increased. As a result, Valium was prescribed 1-2 tablets at night. Pelvic examination was normal and Pap smear was taken. Next consultation with her husband was organized the following week.

Examination of Mr. Zanetta was unremarkable and sperm count was normal.

I would be grateful if you could take over the further management of this couple.

Yours faithfully,

Doctor

**TIME ALLOWED:**

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

**Task 20**

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

**notes:**

**Name Mr Jing ZU**

Age 72-year-old man

**Family history unremarkable**

**Medical history**

Hypertension 18 years

Ischaemic heart disease 10 yrs

Acute Myocardial Infarction 1999

Congestive Cardiac Failure (CCF) 5 yrs

**Medications**

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

**Social History Job:**

retired school teacher

Home: married

Activities: gardening

Smoking: no

**03/01/07**

**Subjective:**

Angina on exertion – gardening, relief with rest and Anginine

Sleeps two pillows, no orthopnoea

Mild postural dizziness

**Objective:**

Thin, looks well.

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

Jugular Venous Pressure (JVP) + 3 cm

Apex beat not displaced

S1 and S2 no extra sounds nor murmurs

Chest - Bilateral basal crepitations

Abdomen – normal

Ankles mild oedema, pulses present

**Assessment:** Stable CCF, angina

**Plan:** Watchful monitoring

**15/01/07**

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

↑ ankle oedema chest pain

**Objective:**

BP 140/90

JVP + 6 cm

Chest crepitations to mid zones

Heart S1 and S2

Ankles oedema to knees

**Assessment:** Deteriorating CCF ? cause

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

**19/01/07**

**Subjective:**

Dyspnoea “feels a bit better”

Angina 10 min episode on mild exertion yesterday

**Objective:**

JVP + 4 cm

Chest fewer crepitations to mid zones

ECG - ? ischaemic changes anterolaterally

**Assessment:** ischaemic heart disease

**Plan:**

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. George Isaacson  
Cardiologist  
45 Inkerman Street  
Caulfield, 3162

19 January 2007

Dear Dr. Isaacson,

Re: Mr. Jing Zu

I am writing to refer Mr. Zu, a 72-years-old retired school teacher, to you. Mr. Zu has been suffering from ischemic heart disease for ten years, hypertension for 18 years and has had congestive cardiac failure for five years. He was diagnosed with acute myocardial infarction in 1999. He takes lasix (40mg), Enalapril (10 mg), Nifedepin (10 mg) and Anginine (as necessary).

The patient first came to see me on 03/01/07 complaining of pain in his chest while gardening and mild postural dizziness. The pain was easily relieved with rest and Anginine. Stable congestive cardiac failure with angina was diagnosed, and watchful monitoring was recommended.

On the second examination (15/02/2007) his condition had deteriorated. The patient reported increased dyspnoea with orthopnoea. The oedema on his ankle had worsened. The examination revealed slightly increased blood pressure (140/90mmhg), chest crepitation to mid zones, and jugular venous pressure was doubled (+6cm) compared to the previous visit. Therefore, electrocardiogram was requested, a higher dose of lasix was prescribed (80mg) and another review was scheduled two days later.

Today (19/01/2007) the patient's condition has improved, however, electrocardiogram shows some ischemic changes anterolaterally.

In view of the above, I appreciate your taking over of this patient.

Yours sincerely,

Doctor

Dr. George Isaacson  
Cardiologist  
45 Inkerman Street  
Caulfield 3162

19th January 2007

Dean Dr. Issacson,

Re: Mr. Jing Zu, Age: 72 years

I am writing to refer Mr. Zu, whose features are consistent with ischaemic heart disease. Your further comprehensive management would be highly appreciated.

Mr. Zu, is a diagnosed case of hypertension and ischaemic heart disease. Please note, he had a history of acute myocardial infarction and congestive cardiac failure (CCF). However, his family history is unremarkable and he is a non-smoker. His current medications are Lasix, enalapril, nifedipine, slow KTT and Anginine Tsl.

Initially, on 31/01/07, he presented with angina while gardening, which was relieved with rest and Anginine. On examination, he was found apparently well along with typical signs of CCF. Therefore, stable CCF with angina was diagnosed and watchful monitoring was recommended.

On 15th of January, his condition had deteriorated with worsened symptoms. Examination findings revealed raised JVP (from +3 to +6), crepitations up to mid zones of the chest and ankle oedema up to his knees. Thus, considering deteriorating CCF, Lasix dosage was increased, electrocardiogram (ECG) was ordered and a review in 2 days was advised.

Today, he reported that he has been feeling better though he had an episode with mild exertion yesterday. Moreover, his JVP was reduced and lesser crepitations were found on the chest. Furthermore, ECG showed ischaemic changes anterolaterally.

In view of the above, I would appreciate it if you could manage the patient as you feel appropriate.

Yours sincerely,

Doctor

**[225 words]**

**TIME ALLOWED:**

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

**Task 21**

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

**notes:**

**Today's Date** 09/11/17

**Patient History**

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

**22/10/17**

**Subjective**

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

**Objective**

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

## Assessment

- ? cancer breast

## Management

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

## 6/11/17

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

## 9/11/17

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

## Writing Task:

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

### **In your answer:**

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

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

Weller Park Medical Centre  
151 Pring St.  
Weller Park 4121  
Dr. Alaa Omar  
1414 Wickham Tce.  
Spring Hill, 4004

09/11/17

Dear Dr. Omar,

Re: Mrs. Somarni Khaze DOB: 12/04/71

I am writing to refer Mrs. Khaze, a 46-year-old married nurse with 4 children who has been diagnosed with left breast cancer.

Mrs. Khaze is a premenopausal woman whose sister was your patient (you treated her for breast cancer 7 years ago). She is a non-smoker, non-drinker and not on any regular medications. She has a history of benign right breast lump which was treated by lumpectomy 5 years ago and her mammogram was normal 2 years ago.

Initially, she presented to me on 22/10/17 after she had discovered a left breast lump 6 weeks previously which was not increasing in size. She was overweight with a body mass index of 31 but her general examinations were normal. However, a local examination revealed a 2x2 cm hard non-tender nodule in the left breast accompanied by palpable left axillary lymph nodes while her right breast showed the scar of the previous surgery. I suspected breast cancer and ordered ultrasound and mammogram. 2 weeks later, she was anxious and worried with sleep disturbance and the results found a 1.6x 1.8 cm nodule in the left breast which was suspected to be malignant with multiple axillary lymph nodes. Therefore, I prescribed diazepam 10 mg at night and did a core biopsy of the nodule.

Today, the biopsy result confirmed the diagnosis of moderately differentiated invasive ductal carcinoma of the left breast.

I would appreciate your urgent attention to her condition. Please be advised that Mrs. Khaze has expressed a wish for immediate reconstructive surgery.

Yours sincerely,

Dr. Tin Aung (GP)

[253 words]

**TIME ALLOWED:**

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

**Task 22**

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

**notes:**

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

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

**Patient History**

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

**Drug history**

- Not on regular medication
- No known allergy

**Family history**

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

**18/10/17**

**Subjective**

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

**Objective**

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

**Assessment and planning**

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

**20/10/17**

**Subjective**

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

**Objective**

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

### **Assessment and plan**

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

### **Writing Task:**

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

### **In your answer:**

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

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

Surgical Registrar  
via Emergency Department  
Perth General Hospital  
268 Brisbane Rd  
Cottesloe 6542  
Western Australia

20/10/17

Dear Doctor,

Re: Mr. Ammar Mostafawy  
DOB: 15/01/1961

I am writing to refer Mr. Moustafawy, a 57-year-old male who is a process technician in a copper mine in the Pilbara region. I suspect he is suffering from liver abscess which requires your urgent attention and management.

Mr. Moustafawy works on rotation and returned from the Philippines 2 weeks ago. He is a heavy smoker and heavy drinker but he exercises regularly. Apart from a history of typhoid fever 8 years ago, he has no significant medical or family history.

Initially, he presented to me 2 days ago because he had not been feeling well and had felt a sense of weakness and nausea over the previous 3 days. He had stopped drinking and reduced smoking markedly one week ago. His examination was otherwise normal except for tenderness over the right hypochondrium. Therefore, blood and urine tests were ordered and he was prescribed vitamin B and essential forte and advised to increase carbohydrates intake.

Unfortunately, his condition deteriorated over the next 2 days. Today, he is dehydrated, jaundiced and febrile with chills and rigors. His temperature reached 39°C and his liver is enlarged and tender as well. His blood test showed leukocytosis and deranged liver functions in addition to increased urobilinogen in the urine test. The Flying Doctors Agency was contacted and through their ultra sound machine a 10x10 cm liver abscess could be diagnosed.

I started him on intravenous fluids and antibiotics (Rocephine and Flagyl) and arrangements were made to evacuate him by the Flying Doctors to your centre.

I would appreciate your urgent attention to his condition as I believe he will need ultrasound-guided drainage.

Yours Sincerely,

Dr. Peter Smith (GP)

[268 words]

**TIME ALLOWED:**

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

**Task 23**

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

**notes:**

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

**Patient Details:**

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

**15/2/17**

**Subjective**

**Karen reports:**

- Neither she nor William has any significant medical problems.
- Neither smokes
- William drinks quite heavily. Also travels regularly with his job.
- Married for 3 years, and decided to try for a pregnancy in May 2014, when Karen stopped the pill
- Was on Microgynon 30 for the previous 5 years.
- Periods are regular
- No history of gynaecological problems, or sexually transmitted diseases.

**Objective**

- Karen overweight BMI 28
- Pulse and BP normal
- Abdo exam normal
- Vaginal examination normal
- Cervical smear taken

**Assessment**

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

## Action Plan

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

15/3/17

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

## Subjective

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

## Objective

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

## Assessment

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

## Action Plan

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

**Writing Task:**

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

**In your answer:**

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

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

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

15/03/17

Dear Dr. Expert,

Re: Karen Conway, 32 years old  
William Conway, 33 years old

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

Karen has regular periods and has no history of gynaecological problems or sexually transmitted diseases. She had been using Microgynon 30 as contraceptive pills for 5 years; however, she stopped taking them 18 months ago. Her hormone tests are all normal and ovulation confirmed. I did a smear test on 15/02/17, which was negative and examination then was normal. She is a little overweight, with a Body Mass Index of 28 and I have advised that she lose some weight. Karen is taking folic acid 400 mcg daily.

William is a non smoker and drinks 10 units per week, although Karen reports that he drinks heavily. William has no significant medical problems and he declined examination. However, he has agreed to do a semen analysis, but I don't as yet have the results. I will forward them on in due course.

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

Yours sincerely,

Dr. Claire Black (GP)

[235 words]

**TIME ALLOWED:**

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

**Task 24**

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

**notes:**

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

**Patient History**

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

**P.M.H.**

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

**25/08/17**

**Subjective**

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

**Objective**

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

**Plan**

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

**06/09/17**

**Subjective**

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

**Objective**

- Weight loss 3kg

**12/09/17**

**Subjective**

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

**Objective**

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. J. Howe  
Neurosurgeon  
Spirit Hospital  
Wooloongabba

12/09/17

Dear Doctor,

Re: Arthur Benson  
DOB: 15/04/1992

I am writing to refer Mr Benson, a married computer programmer and father of 6-month-old twins, who I suspect has a subdural haematoma.

Mr Benson first presented to me on 25/08/17 complaining that he had been suffering from headaches for the previous two months as well as a sensation of pins and needles. He was overweight but his gait and vision were normal. He had mild weakness in the left hand. He was prescribed Panadol and advised to rest for 2 weeks, reduce weight and increase exercise. He is a non-smoker and social drinker. He has a past history of asthma, which has been treated with steroid inhaler since childhood.

He is allergic to penicillin and had a car accident 3 months ago at which time he was hospitalised for 24 hours without complications and his CT scan was normal.

On today's consultation, he complained of severe headache of 3-day duration with mild response to Panadeine forte. It was associated with dizziness, nausea and blurred vision. His blood pressure was 160/70, with normal pulse and blurred fundi margins. His gait and elbow reflexes were normal. He has mild weakness with loss of wrist reflexes and sensation in the medial aspect of the left hand.

I would appreciate your urgent attention to Mr. Benson's case.

Yours sincerely,

General Practitioner

**[214 words]**

**TIME ALLOWED:**

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

**Task 25**

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

**notes:**

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

**Patient History**

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

**12/08/17**

**Subjective**

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

**Objective**

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

## Plan

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

**25/08/17**

## Subjective

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

## Objective

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

## Plan

- Continue Frusemide and Digoxin
- Rest for one week

**30/09/17**

## Subjective

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

## Objective

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

## Plan

- Needs admission to Cardiology Unit for stabilisation

**Writing Task:**

*Using the information in the case notes, write a letter of referral to Emergency Department QE11 Hospital, 249 Wickham Tce, Brisbane, 4001 explaining the patient's current condition.*

**In your answer:**

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

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

Emergency Registrar  
Emergency Department  
QE11 Hospital  
249 Wickham Tce.  
Brisbane, 4001

30/09/2017

Dear Doctor,

RE: Dave Cochrane D.O.B. 20/11/1964

I am referring Mr.Cochrane, who is suffering from an acute left ventricular failure and requires admission to your Cardiology Unit in order to stabilise his condition.

Mr.Cochrane retired when he was 50 years old. He smokes 10 cigarettes a day and drinks 10 units of alcohol per day. He exercises regularly.

On 12/8/2017, Mr.Cochrane presented with night cough, chest tightness and shortness of breath which was worse when lying down but improved on raising the head at the end of the bed. On examination, he was dyspneic. There was bilateral leg oedema, high jugular vein pressure , laterally deviated apex beat which was located in the 6th intercostal space and basal crepitation on the lung auscultation. These symptoms were indicative of left ventricular failure. Moreover, electrocardiography revealed cardiomegaly and the chest X-ray showed features of infection. Consequently, antibiotic, frusemide and digoxin were prescribed for left ventricular failure. An appointment in 2 weeks was made.

Two weeks later, the patient's condition had partially improved. Therefore, he was advised to continue his medications and to rest for one week.

Unfortunately today, Mr.Cochrane has been suffering from severe shortness of breath, chest pain and sweating for the last 2 hours. On examination, he was anxious and dyspneic. His blood pressure was 120/80 mmhg and his pulse was 66. In addition, the same previous signs of left ventricular failure were observed.

I would appreciate your urgent assessment of this patient.

Yours sincerely,

Doctor

**[233 words]**

**TIME ALLOWED:**

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

**Task 26**

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

**notes:**

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

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

**Patient Details**

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

**Family History**

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

**Psychosocial History**

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

**Medical History**

- Nil

## Symptoms History

May 14, 2016

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

## Diagnosis: Paranoid schizophrenia

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

## Plan

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

## August 2017

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

## November 2017

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

## **Hospital progression**

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

## **Lab tests**

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

## **Condition on discharge**

- Improving

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

- Improving

## **Ability to use good judgment**

- Still impaired

## **Prognosis**

- Guarded

## Follow-up

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

## **Writing Task:**

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

## **In your answer:**

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

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

Dr. Twyford  
Psychiatrist  
Spirit Community Mental Health Service  
Parramatta  
NSW 2345

27/12/2017

Dear Dr. Twyford,

Re: Mr. Jack Mills, DOB 01/09/1995

I am referring this patient, a 22-year-old man who has a history of paranoid schizophrenia.

Jack was initially diagnosed with schizophrenia 18 months ago and has had frequent admissions due to recurrent episodes of psychosis including an attempted suicide. His compliance has been poor for medications and structured work programs. With regard to his psychosocial history, he has a history of nicotine dependence and binge drinking episodes. His parents divorced 2 years ago and he is currently living with his mother. Furthermore, he has been on disability support pension since 2016.

He was admitted to our hospital on 23/11/2017, with signs of suspiciousness, oversensitivity, auditory hallucinations and irritable mood. During hospitalisation, sodium valproate and Navane were used, and psychotherapy was commenced, although his participation was inadequate because of his difficulties in concentrating. Apart from this, his laboratory tests were unremarkable.

Jack's condition has generally improved and he will be discharged today. I have advised him to avoid alcoholic beverages, quit smoking, follow psychotherapy and vocational rehabilitation and have blood tests annually. Moreover, he will be continued on sodium valproate 250mg twice daily and Navane 1.5mg every 4 weeks intramuscularly. Please note that the next injection of Navane is on 16/01/2018.

I would appreciate it if you could take over his care for ongoing management.

Yours sincerely,

Psychiatrist

**[217 words]**

**TIME ALLOWED:**

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

**Task 27**

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

**notes:**

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

**Patient Details**

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

**27/12/16**

**Subjective**

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

**Objective**

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

**15/02/17**

**Subjective**

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

## Objective

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

## Plan

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

**21/02/17**

## Subjective

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

## Assessment

- Anorexia Nervosa

## Plan

- Refer to psychiatrist

## Writing Task:

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

## In your answer:

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

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

Dr. Midori Yabe  
Psychiatrist  
48 Wickham Tce  
Spring Hill

21/02/17

Dear Dr. Yabe,

Re: Miss Sally Webster  
DOB: 10/11/00

I am writing to refer Sally, a 16-year-old high school student who is suffering from anorexia nervosa.

Initially, she came to see me on 27/12/16, complaining of constipation, and requesting strong laxatives for this problem. Her weight was 54 kg and her vital signs and physical examination were normal. Her diet included 2 spoons of bran each morning. Therefore, she was advised to increase vegetables, fibre and fluid intake.

On the 15/02/17 consultation, despite Sally claiming that she did not believe she had a problem, her mother reported that she was concerned about Sally's poor appetite, loss of weight and argumentative behaviour. Her weight was 48 kg and her vital signs, physical examination and urinalysis were normal. I requested blood samples for blood chemistry and electrolytes.

On today's consultation, Sally was interviewed alone. She had poor eye contact and she believes that her parents were overreacting about her idea of reducing her weight to 40 kg. She denied vomiting and she was vague reporting about laxative use. Her weight was 47 kg and her blood tests were normal.

I would appreciate your urgent assessment of Sally's case. Please let me know if you need further information.

Yours sincerely,

Dr. X

**[198 words]**

**TIME ALLOWED:**

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

**Task 28**

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

**notes:**

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

**07/02/2014**

**Subjective:**

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

**History:**

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

**Objective:** Looks tired

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

**Assessment:**

- Acute bronchitis; cigarettes increase condition severity ++

**Plan:** Advised – cease smoking

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

**09/02/2014**

**Subjective:**

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

**Objective:**

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

**Assessment:**

- Bronchitis increase severity , early R basal pneumonia

**Plan:**

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

**10/02/2014**

**Subjective:**

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

**Objective:**

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

**Assessment:**

- R lower lobar pneumonia

**Plan:**

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

**Writing Task:**

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

**In your answer:**

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

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

Dr L Roberts  
Admitting Officer  
Newtown Hospital  
1 Main Street  
Newtown

10 February 2014

Dear Dr. Roberts,

Re: Mrs May Hong

Thank you for seeing this 43-year-old patient with right lower lobar pneumonia for assessment. Mrs Hong has a past history of rheumatic carditis, with resultant mitral regurgitation and atrial fibrillation. Her usual medications are digoxin 0.125mg mane and warfarin 4mg nocte. She has no known allergies. Her last prothrombin ratio taken on 09/02 was 2.4.

Today, she presents with a six-day history of productive cough with associated fever and lethargy. This was treated initially with oral amoxicillin (ineffective) and then chest physiotherapy, but today she has deteriorated with tachypnoea and right pleuritic chest pain. The right lower lobe is dull to percussion and crackles are present in both lung fields, worst at the right base. Her temperature is 38°C, BP 110/75, pulse 110 (irregular) and her usual pansystolic murmur is louder than normal. Sputum M&C showed gram-positive streptococcus pneumoniae. The X-ray showed opacity in the right lower lobe.

I believe her rapid deterioration warrants inpatient treatment.

I would appreciate your assessment and advice regarding this. I will be in touch to follow her progress.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 29**

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

**notes:**

**20.3.97**

**Patient History**

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

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

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

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

**8.4.97**

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

**Objective:** BP 155/100

**Assessment:** Hypertension

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

### 23.4.97

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

**Objective:** BP 155/100

Abdominal and cardiovascular exam otherwise normal.

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

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

Increase nifedipine to 20 mg twice daily.

### 30.4.97

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

Onset while walking, present for about one hour.

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

Few crepitations at lung bases.

ECG – inferior acute myocardial infarction.

**Assessment:** Acute myocardial infarction

**Plan:** Oxygen given

Anginine given sublingually

Morphine 2.5 mg given IV stat

Maxolon 10 mg given IV stat

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

### **Writing Task:**

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

**In your answer:**

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

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

Emergency Department  
Royal Melbourne Hospital  
Flemington Road  
Parkville 3052

The Registrar 30 April, 1997

Dear Doctor,

Re: Mr Derek Romano

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

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

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

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

Yours sincerely,

Dr X

**TIME ALLOWED:**

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

**Task 30**

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

**notes:**

Today's Date: 15/03/10

**Patient History**

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

Karen is a 32 year old solicitor.

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

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

William: no previous pregnancies.

**15/02/10**

**Subjective**

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

Married for 3 years, and decided to try for a pregnancy in May 2006, when Karen stopped the pill.

Was on Microgynon 30 for the previous 5 years.

Periods are regular

No history of gynaecological problems, or sexually transmitted diseases.

**Objective**

Karen overweight BMI 28.

Pulse and BP normal.

Abdo exam normal.

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

**Assessment**

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

**Plan**

Blood tests for Karen required to confirm that her hormone levels are normal and that she is ovulating. You explain to Karen that it is necessary for you to see her husband, William also, and ask her to make an appointment for him. Karen anxious that you do not reveal her history of a termination of pregnancy to him.

**15/03/10**

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

**Subjective**

Karen's baseline blood tests are normal, except the test for ovulation is borderline. However Karen informs you that she has used a home ovulation-prediction test which did show positive, so it is likely that she is ovulating. Smear test result negative.

As Karen reported, William has no significant medical problems. He says he only drinks 10 units per week, which does not agree with Karen's previous comments that he drinks heavily. He also explains that he works away from home approximately 2 weeks out of 4, so he is not so concerned that Karen has not conceived yet, as he thinks that it is because they haven't been trying long enough. Therefore not keen on being investigated.

**Objective**

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

**Assessment**

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

**Plan**

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

**Writing Task:**

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

**In your answer:**

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

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

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

15.3.10

Dear Dr Expert,

Re: Karen Conway, DOB 1.2.78

William Conway, DOB 2.1.77

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

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

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

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

Yours sincerely,

Dr Claire Black (GP)

[184 words]

**TIME ALLOWED:**

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

**Task 31**

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

**notes:**

**Patient History**

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

**07.01.08**

Single, Monash University student studying commerce.

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

Plays squash and walks regularly.

Currently not on any medication.

No known allergies

**Objective**

BP 120/70 P 74 regular

Cardiovascular and respiratory examination normal

Tenderness and swelling in right calf

**Assessment**

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

**Action**

Schedule appointment for 8.1. 08 to review results

### **08.01.08**

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

#### **Action**

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

### **14. 01.08**

#### **Subjective**

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

#### **Objective**

BP 120/75 P 74 regular  
Cardiovascular and respiratory examination normal  
Red rash, bruising and welts around injection site.

#### **Decision**

Change prescription from Clexane to Fragmin 5000u/0.2ml injections twice daily. Prescribe soothing cream for rash. Arrange appointment for Ultra Sound to monitor progress on 22.1 08

### **23.01.08**

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

#### **Results**

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

#### **Objective**

BP 130/70 P 72 regular  
Decrease in tenderness and swelling in right calf.  
Injection site improved but still some redness and irritation of the skin.

## Assessment

Advised patient to cease Fragmin injections. To take ½ an aspirin daily. Flight to Melbourne in early February OK Elastic stockings and exercise during flight recommended. Fragmin injection prescribed to be given pre and post flight. Regular GP to be contacted before ceasing daily aspirin dosage.

## Writing Task:

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

**In your answer:**

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

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

Dr. Sue Cairns  
291 Rae Street  
Fitzroy,  
Victoria, 3068

23/01/2008

Dear Doctor Cairns,

Re: John Haywood  
DOB 23/05/1985

Mr Haywood came and saw me because he has been experiencing pain in his right calf after his long flight from Melbourne. He normally studies in Melbourne and was visiting his parents in the UK for a couple of weeks. He smokes 8-10 cigarettes a day, is a social drinker and is not on any medication.

On examination today, his right calf was tender. I suspected a deep vein thrombosis which was confirmed by ultrasound. The imaging showed a 4cm thrombosis in the soleal vein 16 cm below the knee extending into the right calf. I advised that he stop smoking and prescribed 40mg clexane twice daily. Unfortunately he developed an allergy to this treatment one week later. I changed the medication to fragmin 5000 IV twice daily and decided to review his condition with a new ultrasound in two weeks.

Today the report showed that the thrombosis has decreased in size. Furthermore the tenderness and swelling has decreased. I put him on half an aspirin daily and recommended that he inject fragmin before and after his flight back to Melbourne which he has planned in early February.

I advised him to contact you regarding further management of his condition.

Yours sincerely,

Dr X (GP)

**TIME ALLOWED:**

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

**Task 32**

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

**notes:**

**Patient History**

Constance Maxwell is a patient in your General Practice  
DOB 08.08.38 Married, 3 adult children

**21.02.10**

**Subjective**

Complains of inflamed, sticky and weeping eyes.

Thyroidism diagnosed Feb 07

High blood pressure June 09

Hip replacement July 09

Medications – Thyroxine 1mg daily, Atacand 4mg daily, Fosamax 10mg daily

No known allergies

**Objective**

BP 135 /75 P 74

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

**Assessment**

Bilateral conjunctivitis –likely viral

Chlorsig Drops 4hrly

**03.03.10**

**Subjective**

No improvement to eyes, blurred vision

**Objective**

Odema eye lids ++

Marked conjunctival congestion

**Plan**

Chloramphenicol 0.5% sterile 1 drop 3 times daily

Bion Tears 1 drop each eye 4 hrly

Review 2 weeks

**05.06.10**

### **Subjective**

Accompanied by husband. Very distressed. Has lost most sight in both eyes –can make out light or dark shapes but unable to read or watch TV.

### **Objective**

Marked odema upper and lower lids

White sticky discharge Unable to read eye chart

### **Plan**

Refer immediately Emergency Dept, Royal Melbourne Eye Hospital.

Husband will drive to hospital

### **WRITING TASK**

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

#### **In your answer:**

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

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

The Emergency Department  
Royal Melbourne Eye Hospital  
Alexandra Parade  
Fitzroy

05/06/10

Dear Doctor  
Re. Mrs Constance Markwell

I am writing to refer Mrs Howell, a 72 year old married mother of 3 adult children who is presenting with a visual impairment.

Initially, she presented to me on 21/2/10, complaining of inflamed, sticky and weeping eyes. Both her eyes were reddish with watery discharge. However, her right eye was worse than the left eye. Therefore she was prescribed chlorisig drops 4 hourly. She has had thyroidism for 3 years, high blood pressure for 1 year and a hip replacement was done in 2009. Her current medications are Thyroxin 1 mg, Atacand 4 mg and Fosamax 10 mg daily. She has no known allergies.

On review after 2 weeks, she had made no improvement. In addition she had blurred vision with oedematous eye lids and conjunctival congestion., so chloramphenicol was prescribed 0.5% one drop three times daily and Bion tears one drop 4 hourly.

Unfortunately, today she was accompanied by her husband with complaints of impaired vision in both eyes and an inability to read books or watch television. There was oedema in both eyelids with white discharge. She could not read the eye chart.

In view of the above signs and symptoms I believe she needs immediate eye care facilities. I would appreciate your urgent attention to her condition.

Yours sincerely

Dr X

**[211 words]**

**TIME ALLOWED:**

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

**Task 33**

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

**notes:**

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

**5/05/11**

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

Has mild asthma but otherwise previously well

Nil family history of cardiac disease

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

Under significant stress with own business

Medications – seretide two puffs BD salbutamol two puffs prn

Allergies - Nil

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

ECG NAD

Troponin level NAD

**Assessment:** Early stages of IHD

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

Alcohol dependence but not interested in changing

**Plan:** Check serum lipids

Refer for exercise stress test

Review in 1 week

**12/5/11**

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

Has runny nose & pharyngitis at present with ↑asthma symptoms

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

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

Mild bilateral wheeze present

Cholesterol mildly ↑

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

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

**26/5/11**

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

**Objective** Mild bilateral wheeze still present

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

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

**1/6/11**

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

**Examination** ECG – mild ST elevation in anterior leads. ST 120  
Lungs – O/A moderate wheeze and mild bilateral crackles. SP O2 86% on R/A  
Heart – Slight S3 sound +ve

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

**Plan** Paramedic transfer to ED

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

GTN patch applied

IV morphine 5mg given

Ipratropium Bromide 500ug given via nebuliser in view of tachycardia

Furosemide 40mg given

**Writing Task:**

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

**In your answer:**

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

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

Dr Jeremy Barnett  
The Emergency Registrar on Duty  
Maroubra Hospital  
Lakes Road  
Maroubra

29/06/2018

Dear Dr Barnett,

Re: Mr John Elvin,

I am writing to refer Mr. Elvin, a 48-year-old businessman who is presenting with signs and symptoms suggestive of anterior myocardial infarction and acute exacerbation of asthma. Your urgent treatment and assessment would be greatly appreciated.

Mr Elvin presented to the general practice on 5/05/11 complaining of associated mild central chest pain on exertion. He has a history of mild asthma for which he takes seretide and salbutamol inhalers. He smokes 1 pack daily and consumes about 10 drinks 5/7. In addition, he is under significant stress with his own business. Please note, there are no family history and allergies.

On his subsequent visits, exercise stress test revealed very slight ischemic changes. Also, mild bilateral wheeze was presented due to viral upper respiratory tract infection. He was commenced on Lipitor, nitrates, aspirin and Anginine. I gave him some advice regarding improving his compliance with medications.

Today, Mr Elvin presented complaining of sudden onset of crushing chest pain and very audible wheeze. Cardiovascular examinations showed mild ST elevation in anterior leads with ST 20 and slight S3 sound. Moreover, mild bilateral crackles were noted. GTN patch, IV morphine 5 mg, Ipratropium bromide 500 mg via nebulizer and Frusemide 40 mg were given.

In view of the above, my provisional diagnosis is acute myocardial infarction with exacerbation of asthma. and have requested a paramedic transfer. If you have any queries, please do not hesitate to contact me.

Yours sincerely,

Doctor X

**[241 words]**

**TIME ALLOWED:**

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

**Task 34**

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

**notes:**

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

**2.03.11**

Chief complaint - URTI symptoms for 5 days.

**O/E:**

\*Mild pharyngitis & rhinorrhea. T 37.5

\*C/O chronic insomnia

\*Observed to be elevated in mood, tangential & ? delusional about fixing the world's nuclear waste problem

\*Nil obvious signs of organic syndromes

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

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

Investigations ( exclude organic pathology & baseline)

-FBC

-UEC

-TFTs

-LFTs

-CMP

-urgent CT scan

### 3.03.11

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

#### O/E

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

**Assessment:** Likely non-organic mania

#### Plan:

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

### 7.03.11

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

#### O/E

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

**Assessment** Acute manic episode

**Plan:**

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

Schedule pt under MHA

Have uncle accompany pt with ambulance & police to RNSH ED

Refer to on call psych reg Dr Ben Hinds

Update local MH team.

Long term – try to refer to Chinese speaking psychiatrist.

**Writing Task:**

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

**In your answer:**

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

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

Dr Ben Hinds  
Psychiatry Register  
Maroubra Hospital  
Lakes Rd  
Maroubra

7/3/2011

Dear Dr Hinds,  
Re: Yuxiang Meng

I am writing to refer Mr Meng, a 21-year old student who is presenting with signs and symptoms suggestive of an acute manic episode. It is important to note that he only speaks very basic English.

On 2/03/11, the patient initially presented with his first episode of mania complaining of chronic insomnia where he was found to be elevated in mood and had tangential as well as delusions thoughts. Therefore, he was referred to local community mental health, and diazepam 10 mg 4 times a day was prescribed. In addition, routine investigations were ordered to exclude organic pathology.

A day later, Mr Meng was still tangential and delusional, but he was sleeping well with diazepam. Investigation results were normal except mildly decreased protein and mild hypokalemia. At that time, the diagnosis of mania was confirmed by mental health team. Accordingly, quetiapine 50 mg two times a day and Span K tablets were commenced, but diazepam was adjusted to 10 mg either two or three times a day.

Today, the patient presented with worsening symptoms, was pressured in speech with abnormal behavior and refused to take medications. Consequently, I have referred him to KNSH ED. Please note that his uncle who accompanies him suspects non-compliance with medicines.

Based on the above, I believe that this patient needs a psychiatric consultation and would appreciate your assessment and management of his condition. For further information, please feel free to contact me.

Yours sincerely,

Doctor

**[222 words]**

**TIME ALLOWED:**

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

**Task 35**

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

**notes:**

**Mrs. Daniela STARKOVIC**

45 years old, married 2 children

**Past history**

Migraines

Medications - nil

**20/01/07**

**Subjective**

presents with abdominal pain

doesn't like fatty foods

otherwise well

**10 days ago**

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

**Last night**

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

**Objective:**

overweight

T 37° P 80 reg, BP 130/70

Medicine Letter 3 mild tenderness R upper quadrant abdomen

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

Murphy's sign neg

Urine – trace bilirubin

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

**Plan:**

Liver Function Tests (LFTs)

Biliary ultrasound (US)

R/V 3/7

**23/01/07**

**Subjective:**

No further episodes

Patient anxious re possibility cancer

**Objective:**

LFTs – bilirubin 12 (normal range 6-30)

Alkaline phosphatase (ALP) 120 (normal < 115)

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

**Assessment:** ? mild obstruction

US – small contracted gallbladder, multiple gallstones

Common bile duct diameter normal

Normal liver parenchyma

**Assessment:** cholelithiasis

**Plan:**

Reassurance re cancer

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

**Writing Task:**

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

**In your answer:**

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

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

Dr Andrew McDonald  
General Surgeon  
North Melbourne Privet Hospital  
86 Elm Road  
North Melbourne

23/01/2007

Dear Doctor,

Re: Mrs. Daniel STARKOVIC

I am writing to refer this patient, a 45-year old lady who is presenting with signs and symptoms suggestive of cholelithiasis.

On 20/01/07, Mrs. Starkovic first presented with abdominal pain. 10 days earlier, she had the first episode of the epigastric pain radiating to the right side, which occurred one hour of her dinner and was associated with nausea. This pain was constant and colicky in character and lasted for one hour. However, in the previous night, she had worsening of symptoms with pain of 2 hours' duration and vomited once. On examination, mild tenderness over the right upper quadrant was noticed and bilirubin was observed in her urine sample.

Therefore, LFTs and US were ordered and a review consultation was scheduled for 3 days later. It is important to note that she is overweight.

Upon today's review, US revealed a small contracted gallbladder as well as multiple gallstones, and alkaline phosphatase was 120 but all the other findings were normal.

Based on the above, I would be grateful if you could assess and manage her condition with possible cholecystectomy. For further information, please feel free to contact me.

Yours faithfully,

Doctor

**[184 words]**

**TIME ALLOWED:**

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

**Task 36**

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

**notes:**

**Patient History:**

**Name:** Mr. Antonite Scott

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

**Height:** 160cm

**Weight:** 74kg

**Allergies:** Shellfish

**Substance Intake:** Nil

**Dentures:** Nil

**Social History:**

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

**Depression:** controlled by medication

**Family History:**

**Mother:** History of Pneumonia

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

**Maternal Grandmother:** Died of COPD

**Maternal Grandfather:** Unknown

**Paternal Grandmother:** Hypertensive

**Paternal Grandfather:** Known patient of depression

**Past Medical History:**

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

**1996:** HBsAg Positive

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

**Present Symptoms:**

Diabetic (blood sugar levels increasing continuously)

UTI (burning micturation and incontinence)

Cellulitis (swollen and painful legs)

**Provisional Diagnosis:** Type II diabetes mellitus

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Britto  
City Hospital  
(Near to 154 Newcastle St)  
Perth WA  
Australia

(Today's date)

Dear Dr. Britto,

Re: Mr. Antonite Scott, DOB 18th March 1950

Mr. Antonite Scott is being discharged from our hospital into your care today. He has been a regular patient at our hospital for many years and has just been diagnosed as diabetic; there was an increase in his blood pressure when the patient was admitted into our hospital recently.

The patient also complained of feeling a burning sensation while passing urine. The problem was diagnosed by our team of doctors as a urinary tract infection (UTI), with burning micturation and incontinence. The patient took several days to begin to recover, as the problem of the increase in sugar was a continuous one.

The patient displayed problems with walking as well; his legs are swollen and he feels pain. These symptoms can be attributed to the increase in blood sugar.

The patient has no significant medical history and none of his family members were diabetic. The patient once suffered from typhoid followed by an attack of jaundice in 1990 and was also diagnosed as HBsAg positive in 1996. He was also diagnosed with depression in 1996 and takes medication to control this condition.

The patient was feeling well at the time of discharge but there is still a necessity to control his blood sugar levels.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 37**

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

**notes:**

**Patient History:**

**Name:** Mrs. Suzanne Mario

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

**Height:** 158cm

**Weight:** 60kg

**Allergies:** dust, vinegar

**Substance Intake:** sleeping pills

**Dentures:** upper

**Social History:**

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

Peptic ulcer: controlled by medication.

**Family History:**

Mother: history of cervical cancer

Father: died in an accident two years ago.

Maternal Grandmother: history of cancer

Maternal Grandfather: had LRTI twice

Paternal Grandmother: Unknown

Paternal Grandfather: died at the age of 92

**Past Medical History:**

**2000:** Irregular menstruation

**2008:** Removal of cyst from right breast

**Present Symptoms:**

Pain in the sides of both breasts

Can feel lumps

**Provisional Diagnosis:** breast cancer

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Ansari  
Lake Hospital  
14 Lake View Street  
Card Well City

(Today's date)

Dear Dr. Ansari,

Re: Mrs. Suzanne Mario, DOB 5th January 1978

Mrs. Suzanne Mario is being discharged from our hospital into your care today. She has been a patient of cancer for several years now and has recently complained of intense pain in both of her breasts; she could feel lumps in her breasts as well. She had a cyst removed from her right breast in 2008 and the reports on the provisional diagnosis showed the possibility of breast cancer.

There are two other cases of cancer in her family history: her mother had cervical cancer and her maternal grandmother also had a cancer related problem, but we don't have the full details about this.

The patient has no medical history apart from the problems related to irregular menstruation, noted in the year 2000. The patient takes sleeping pills and she smokes and drinks occasionally. There is a necessity to tackle this problem as the patient is experiencing a lot of pain as well as anxiety about the potential diagnosis. The patient lives alone and is not married.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 38**

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

**notes:**

**Patient History:**

**Name:** Mr. Roberto Carlos

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

**Height:** 164cm

**Weight:** 94kg

**Allergies:** iodine

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

**Dentures:** upper and lower

**Social History:**

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

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

**Tonsillitis:** had tonsillectomy.

**Family History:**

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

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

**Maternal Grandmother:** unknown.

**Maternal Grandfather:** unknown.

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

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

**Past Medical History:**

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

Diagnosed as DVT and kept on treatment.

Started weight reduction treatment.

**Present Symptoms:**

Intolerance of leg cramps

**Provisional Diagnosis:** DVT

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Christo  
Wood Park Hospital  
18 Park Street  
Richmond City

(Today's date)

Dear Dr. Christo,

Re: Mr. Roberto Carlos, DOB 19th April 1948

Mr. Roberto Carlos is being discharged from our hospital into your care today. The patient is suffering from intolerable leg cramps; on complaints of intense pain and cramps, the patient was admitted into our hospital. Reports on the provisional diagnosis showed the possibility of DVT (deep vein thrombosis).

Several years ago, the patient suffered from the same problem of cramping. Due to protrusion of veins and leg cramps, the patient was diagnosed to have DVT in 1990 and a treatment plan was suggested too – he began weight reduction treatment. Several years on, the patient is now complaining of the same problem.

The patient is a chain smoker and he is alcoholic as well. Additionally, he sometimes uses pain killers and sleeping pills as well; however, the names were not mentioned by the patient, nor the purpose or reason for taking them.

The patient was well at the time of discharge from our hospital, apart from the problem related to DVT.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 39**

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

**notes:**

**Patient History:**

**Name:** Mrs. Agnes Rosario

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

**Height:** 152cm

**Weight:** 56kg

**Allergies:** Nil

**Substance Intake:** pain killers

**Dentures:** Nil

**Social History:**

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

**Family History:**

**Mother:** history of PCOD

**Father:** history of asthmatic attack.

**Maternal Grandmother:** PCOD

**Maternal Grandfather:** unknown.

**Paternal Grandmother:** was diabetic

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

**Past Medical History:**

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

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

**Present Symptoms:**

Menorrhagia and severe lower back abdominal pain

**Provisional Diagnosis:** PCOD

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Amanda  
Whitus Hospital  
112 Bill Street  
Emerald City

(Today's Date)

Dear Dr. Amanda,

Re: Mrs. Agnes Rosario, DOB 5th September 1972

Mrs. Agnes Rosario is being discharged from our hospital into your care today. The patient is suffering from severe menorrhagia and lower back abdominal pain. The reports on the provisional diagnosis showed the possibility of polycystic ovary syndrome (PCOS) as well.

This is not the first time that the patient has been admitted into our hospital due to menorrhagia. She also experienced the same problem of menorrhagia in 1999, treatment of which lasted for about 25 days.

In the past, the patient has complained of irregular menstruation and acne and she underwent treatment for this condition which lasted for about two months.

Her family history showed the presence of PCOS; her mother suffered from PCOS and her maternal grandmother also showed signs of a PCOS related problem.

The patient was well at the time of discharge from our hospital, apart from the problem related to menorrhagia or PCOS.

There is a need to take great care as the problem is severe this time and the patient is in a lot of pain.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 40**

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

**notes:**

**Patient History:**

**Name:** Mr. Stephen Brook

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

**Height:** 168cm

**Weight:** 66kg

**Allergies:** barley

**Dentures:** Nil

**Social History:**

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

**Family History:**

**Mother:** history of jaundice.

**Father:** history of peptic ulcer

**Maternal Grandmother:** was a healthy woman

**Maternal Grandfather:** CA prostate

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

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

**Past Medical History:**

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

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

**Present Symptoms:**

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

**Provisional Diagnosis:** pancreatitis

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Mario  
City Hospital  
15 River Street  
Herberton City

(Today's Date)

Dear Dr. Mario,

Re: Mr. Stephen Brook, DOB 9th December 1987

Mr. Stephen Brook is being discharged from our hospital into your care today. He was admitted into our hospital due to a problem related to his pancreas and the reports on the provisional diagnosis showed the presence of pancreatitis.

The patient was suffering from an intense pain and burning sensation at the xiphoid process. There was an increase in this pain and burning sensation during the night time and the patient also complained of vomiting.

Mr. Stephen Brook suffered from and was treated for food poisoning in 2010. He had faced a similar kind of problem related to pancreatitis (the burning sensation and pain) earlier as well, in 2011. The treatment for this was not completed; it was discontinued after six months, but we are unaware of the reasons why at this stage.

The patient was well at the time of discharge from our hospital, apart from the problem related to pancreatitis.

There is a need to take great care as the problem is severe this time.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 41**

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

**notes:**

**Patient History:**

**Patient: Mary Reylon**

**DOB:** 4th Sept 1963

**Allergies:** dust / penicillin

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

Lives with her husband (Winston Reylon)

Works for women rights organization

**Family History:**

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

**Past medical history:**

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

**12 June 2009**

Injury to the head (fell down the stairs)

Tourniquet applied (to stop the flow of blood)

Dizziness and queasiness

Large bump on the head

Patient complained of pain even after two days

Unable to sleep (for a week)

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

**Other signs:**

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

**Inference:** Suggestive of intracranial hematoma

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Wilson  
London Bridge Hospital  
27 Tooley St London  
Greater London

(Today's date)

Dear Dr. Wilson,

Re: Mrs. Mary Reylon, DOB 4th Sept 1963

Mrs. Mary Reylon is a patient, who was admitted into our hospital on the 12th of June 2009.

Mrs. Mary Reylon fell from the staircase and suffered an injury to her head. As she was profusely bleeding, a tourniquet was also applied around her head, to stop the flow of blood. The patient began to feel dizziness and queasiness after that and a large bump on her head developed too. The patient began to complain of pain even though pain killers were given.

The patient has not been able to sleep for about a week now; the patient even tried sleeping pills to get enough sleep but the sleeping pills have proven to be ineffective for her. The patient has also complained of persistent headaches, imbalance and vomiting, which are all suggestive of intracranial hematoma. The CT scan is the definitive tool for accurate diagnosis of intracranial hemorrhage. Hence, it is requested that the scan is taken so that proper action can be taken.

Please, contact me with any queries or if you would like to know more about the patient.

Yours sincerely,

Doctor

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 42**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

**Patient: Nicole Katie**

**DOB:** 12 July, 1971

**Social History:**

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

House wife (left work after she was married)

**Family history:** No family history

But mother died of kidney failure

**Past medical history:**

Suffered severe attack of TB (1983)

Appendices (1987)

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

Allergic reactions (uterine infection - 1997)

**15 April 2005**

Failure in digestion

Unable to eat properly due to pain in the stomach

Took pain relievers, analgesics (for two continuous days)

Problem worsened

Felt pain, radiating back to the lower abdomen

Change in coloration of urine (yellowish)

Loss of appetite

Weight loss – 2.5 kg within 15 days

Vomited twice

**18 April, 2005**

**Other signs:**

Severe pain, lasted for several hours

Pain and vomiting, shortness of breath

Blood in bowel motions and urine

High fever and sweats

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Ralph Emerson  
Royal London Hospital  
Whitechapel Rd  
Greater London E1 1BB  
United Kingdom

(Today's date)

Dear Dr. Ralph Emerson,

Re: Mrs. Nicole Katie, DOB 12 July 1971

Mrs. Nicole Katie is a patient, who was admitted into our hospital on the 15th of April 2005. Nicole Katie was suffering from some kind of digestion problem, which was undetected.

The patient was not able to eat properly and was feeling a lot of pain in her stomach. The patient took some pain relievers (names are mentioned in the attached report) which, in fact, worsened the problem. The patient began to feel pain which radiated back to her abdomen and also noted a change in the color of her urine. The patient had lost her appetite, causing her to lose almost 2.5 Kg within the course of 15 days.

During her stay at our hospital from April 15 to April 18, the condition of the patient continued deteriorating; especially on the 18th of April, when the patient complained of much more severe pain which lasted for hours. She experienced pain, shortness of breath and vomiting. Blood in her bowel motion and urine was also noted. The patient has had a high fever and has been suffering from severe sweating.

Hence, it is requested that the abdominal CT scan should be taken for an accurate diagnosis of the abdominal pain, as a matter of urgency.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 43**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

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

**Social History:**

The patient lives with his wife

Works as a car mechanic

Denies use of illicit drugs or tobacco

Rarely drinks

**Family History:**

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

His paternal father had a stroke at the age of 67

No other family history of strokes or vascular diseases

**9/07/2009**

Was sitting in his room; felt sensation in eye lids

Noticed blurred vision

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

Pain in both the eyes

Transferred to the hospital by his son

Intermittent pounding bifrontal headache

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

**General physical examination:**

The patient is significantly overweight.

Temperature is 37.6.

Blood pressure is 130/60.

Pulse is 85.

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

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

Cardiac exam shows a regular rate and no murmur.

**Past Medical History:**

1) Migraine headaches, as described in HPI.

2) Depression.

There is no history of diabetes or hypertension.

**Allergies:** None.

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

**Other necessary information**

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

His recent headaches differ from his “typical migraines” (occurred 4 -5 in his entire life time).

He has never taken anything for these headaches (other than ibuprofen or vicodin).

**Writing Task:**

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

**In your answer:**

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

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

Dr. Martin  
National Hospital for Neurology  
33 Queen Square London WC1N 3BG  
United Kingdom

(Today's date)

Dear Dr. Martin,

Re: Mr. Mark Henry, acute onset of double vision and right eyelid droopiness.

Mr. Mark Henry is a patient, who was admitted into our hospital on 9 / 7 / 2009 with complaints of acute onset of double vision and right eyelid droopiness.

On 9 / 7 / 2009, the patient was sitting in his room when he felt a strange sensation in his eyelids; he began to feel pain in his eyes as well. He also complained of the sudden appearance of double vision and an intermittent pounding bifrontal headache.

Reports on the general examination were clear: his pulse was 85 and BP 130 / 60; there was no swelling of the lids or proptosis.

His medical history shows that he has suffered from migraines (headaches) and depression. The patient was prescribed Zoloft (50 mg - daily) and ibuprofen (600 mg - a few times per week).

The patient denied associated vomiting, nausea, numbness or weakness or loss of vision etc. but said that his recent headaches differ from his typical migraines, which actually only occurred 4-5 times in his whole life time. The patient has never taken anything for the headaches, except ibuprofen or vicodin.

As the problem presented by the patient is a complex one, further investigation and a definitive diagnosis is required.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 44**

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

**notes:**

**Patient History:**

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

**Age:** 42

**Gender:** male

**Occupation:** office manager

**Subjective Patient Complaints:**

Adult onset asthma- dyspnea, cough

Occasional wheezing symptoms upon increased exercise or when under stress.

**Prior contributory health history:**

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

**What provokes the symptoms?**

Provoked by exercise, emotional/physical stress

Cigarette smoke

Seasonal respiratory allergies

**Site of symptomatology:**

Bronchial, lung, chest/thoracic region

Time of day/duration of symptoms:

Daily episodes of dyspnea

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

**Medications:**

Symptoms temporarily eased with prescription (bronchial inhaler medication).

**Writing Task:**

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

**In your answer:**

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

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

Dr. Robert Frances  
St. George's Hospital  
Black Shaw Road  
London SW17 0QT  
United Kingdom

(Today's date)

Dear Dr. Robert Frances,

Re: Mr. Joseph Malcolm, age 42

Mr. Joseph Malcolm is a patient at our hospital who visits regularly. Just recently, he complained of occasional breathlessness and difficulty in breathing. The patient's health history shows seasonal upper respiratory allergies and occasional episodes of mild eczema. The patient is reported to be healthy, apart from this recent asthma related problem.

This problem related to asthma, or breathlessness, in the words of the patient, increases with exercise, emotional or physical stress and cigarette smoking.

The patient has been experiencing problems related to dyspnea for many days (dates are not mentioned). The symptoms often get worse in between 3-5 am; the patient coughs a lot and he is not able to have full control over his daily activities.

Sometimes, the above symptoms temporarily go away when the patient uses bronchial inhaler medication; but when the patient doesn't pay attention to medication or gets involved in any kind of physical activity, then the same problem of difficulty in breathing occurs.

Further investigation and a definitive diagnosis is vital here as the patient has not been feeling well for quite a while now.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 45**

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

**notes:**

**Patient History:**

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

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

**October 7, 2006**

**Chief complaint:** abdominal pain

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

**Family History:**

Father died due to a heart attack.

Mother's medical history is not known.

No known family history of colon cancer.

**Social History:**

The patient is a retired lecturer.

He lives with his wife and two grandchildren.

He denies past or present tobacco and illicit drug use.

He denies alcohol use.

**Past Medical History: other active problems**

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

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

**Hospitalizations:** MI, 2003.

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

**Medications:**

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

Metoprolol 100mg po qd, for two years

Prozac 20mg po qd, started 2 months ago

**Allergies:** No known drug allergies.

No food or insect allergies.

**Other information**

**Pulmonary** – denies shortness of breath, denies cough.

**Cardiovascular** – denies chest pain, denies palpitations.

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

**Writing Task:**

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

**In your answer:**

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

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

Dr. Ivan Gonz  
Willington Hospital  
Central Building  
21 Wellington Road  
St John's Wood London

(Today's date)

Dear Dr. Ivan Gonz,

Re: Mr. Marques, age 65

Mr. Marques has been a patient with us for several months now. Just recently, he complained of severe abdominal pain; the patient complained of a sharp, epigastric abdominal pain which he says has increased over the last two months.

The pain is located in the epigastric region and left upper quadrant of the abdomen. This pain is relatively constant throughout the day, but may sometimes vary in severity. The patient has rated this pain as 6 on a scale of 1-10 and hasn't taken anything to relieve the pain. He has denied any abdominal trauma or injury.

The patient's medical history includes the fact that he has been a BP patient for over two years; his blood pressure is now well controlled. In addition, he has been suffering from depression related problems too; he started taking prozac two months ago, but he still feels depressed. The patient is reported to have no drug allergies or food or insect allergies.

Mr. Marques was once hospitalized for myocardial infarction, in 2003, and he has been on medications regularly since then. Presently, the patient is taking aspirin - 81mg po qd, and has been since his MI, 3 years ago; and metoprolol 100 mg po qd, which he has been taking for the past two years.

There is a need for further investigation and a definitive diagnosis.

Please, contact me with any queries.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 46**

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

**notes:**

**Patient History:**

Name: **Jennet Berritto**

Date of Birth: 22 April, 1971

Height: 163 cm

Weight: 75kg

Allergies: Nil

**Social History:**

Lives with her husband

Likes gardening

Doesn't drink / smoke

Sometimes takes betel leaves

Family History: None to report

**Medical History**

Type 2 diabetes mellitus (2/10/2001)

Hypertension (5/4/2006)

Stomach ulcers (12/7/2007)

Ankle injury (22/5/2008)

COPD (27/6/2011)

**Present Symptoms:**

Intense coughing

Pain in the chest, shoulder and back

Shortness of breath

Change in voice

Harsh sounds with each breath

Change in color and volume of sputum

## **Diagnosis**

Chest X-ray - not cleared

CT-Scan - positive

Stage 2A (lung cancer)

The tumor is 5.5 cm

Cancer cells spread across lymph nodes

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

## **Writing Task:**

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

### **In your answer:**

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

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

Dr. Bryan Hardy  
EMR Hospital  
25 Rocklands Rd  
North Sydney NSW  
Australia

(Today's date)

Dear Dr. Bryan Hardy,

Sub: Jennet Berritto, DOB 22 April 1971

Jennet Berritto is an elderly woman who visited our hospital due to complaints of intense coughing, shortness of breath, change in her voice etc. She was feeling pain in the chest and pain around her shoulder as well. This pain was accompanied by back pain as well and she was aware of a harsh sound with each breath. The patient complained of a change in color and volume of sputum too.

Her medical history reveals that she has been a patient of diabetes for over 14 years now. She has also been a patient of hypertension (5/4/2006) and has problems related to COPD (27/6/2011).

X-rays taken were not clear so a CT scan was suggested. The reports on the CT were positive; the diagnosis showed that she has lung cancer - stage 2A). The tumor seemed to be growing and presently measures at 5.5 cm. Cancer cells are spreading across the lymph nodes.

The patient doesn't drink or smoke but she is habituated to taking betel leaves.

The condition of the patient at the time of discharge was as good as can be expected.

I would like to request for you to look into this case and provide a suitable treatment. Please, do let me know if you would like any further details about the patient.

Yours sincerely,

Doctor Adams

**TIME ALLOWED:**

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

**Task 47**

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

**notes:**

**Patient History:**

Name: **Christian Aula**

Date of Birth: 12/9/1975

Height: 159 cm

Weight: 69 kg

Allergies: Nil

**Social History:**

Lives with her daughter and son-in-law

Enjoys walking

Doesn't drink / smoke

Family History:

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

Father - died of liver failure

**Medical History:**

Allergic rhinitis

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

Benign essential hypertension

Chronic respiratory failure

**Present Medications**

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

**Present Symptoms:**

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

Double vision

Dizziness

Loss of balance or coordination

## **Diagnosis**

**TIA (Transient Ischemic Attack) Confirmed**

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

**Plan:** Refer to Dr. Sally Anderson for further treatment

## **Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to the Hypertension Specialist, Dr. Sally Anderson, at Community Hospital, 33 Albany St Crows Nest NSW, Australia, outlining the details of the patient.*

## **In your answer:**

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

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

Dr. Sally Anderson  
Hypertension Specialist  
Community Hospital  
33 Albany St Crows Nest NSW  
Australia

(Today's date)

Dear Dr. Sally Anderson

Sub: Christian Aula, DOB 12/9/1975

Christian Aula is an elderly woman who was admitted to our hospital due to weakness, numbness or paralysis on the left side of her face. The patient was not able to speak properly (garbled speech) and was displaying difficulty in understanding people around her. She complained of double vision, dizziness and loss of balance and coordination as well.

The diagnosis confirmed the presence of TIA - transient ischemic attack. Her BP was checked at the time of admission and was recorded as 150/95 millimeters of mercury (mm Hg).

Her medical history reveals that she has allergic rhinitis, has problems related to COPD and benign essential hypertension. The list of her medications include the following: prednisone 5 mg qd, montelukast 10 mg every evening; albuterol/ipratropium MDI 2 puffs q4h prn SOB; carvedilol 3.125 mg bid; bumetanide 2 mg bid; fluticasone-salmeterol 500-50 mcg/dose disk with device 2 puffs bid; potassium chloride 20 mEq tablet ER bid; tiotropium bromide 18-mcg capsule one inhalation every morning; albuterol/ipratropium hand-held nebulizer q4h prn SOB.

The condition of the patient at the time of discharge was good, aside from the symptoms listed above.

I would like to request that you look into this case and provide suitable treatment. Please, do let me know if you require any further information about the patient.

Yours sincerely,

Doctor

**TIME ALLOWED:**

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

**Task 48**

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

**notes:**

**Patient History:**

Name: **Huang Bowra**

Date of Birth: 27/7/1981

Height: 168 cm

Weight: 79 kg

Allergies: sulfa drugs / tetracyclines

**Social History:**

Lives alone

Drinks a lot

Smokes 2ppd of cigarettes daily

Family History:

No family history

**Medical History:**

Anxiety, depression (1999 - due to sudden death of his mother)

**Medicine Writing Tests 11 – 15 with**

**Sample Answers**

Obesity (2000)

Urinary incontinence (2003)

Hypertension (2007)

Insomnia (2009)

**Present Medications**

Norvasc 5 mg daily for hypertension

Lorazepam 1 mg HS for insomnia

Vistaril 25 mg BID PRN for anxiety (only when required)

Celexa 10 mg daily for depression (only when required)

**Present Symptoms:**

Indigestion

Dull, burning pain in the stomach

Burning sensation in the chest

Pain elevates after eating, drinking or taking antacids

Weight loss (has lost about 5 kgs in the course of 15-20 days)

Loss of appetite

Not wanting to eat because of pain

Nausea

Vomiting

Burping

Bloating

**Diagnosis**

Endoscopy confirmed the presence of stomach ulcers

Ulcers - one half inch in diameter

**Plan:** Refer to Dr. Mathew Corrado for further treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Mathew Corrado, at Flivo Hospital, 9 Mount Street Hunters Hill NSW, Australia, outlining the details of the patient.*

**In your answer:**

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

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

Dr. Mathew Corrado  
Flivo Hospital  
9 Mount Street  
Hunters Hill NSW  
Australia

(Today's date)

Dear Dr. Mathew Corrado,

Sub: Huang Bowra, DOB 27/7/1981

Huang Bowra is an elderly man who visited our hospital with complaints of symptoms which were related to stomach ulcers. The patient complained of indigestion, a dull, burning pain in his stomach and a burning sensation in his chest.

The pain elevated when he was eating or drinking and when he took antacids.

The patient had also lost about 5 Kgs within the course of 15-20 days, probably resulting from his loss of appetite; it was painful for the patient to eat. He also complained of nausea, vomiting, burping and bloating and he was quite distressed upon admission to hospital.

An endoscopy confirmed the presence of stomach ulcers which are one half inch in diameter. Therefore, a course of treatment needs to be put into place.

The patient's medical history shows that he has had problems related to obesity and urinary incontinence. He is currently taking medicine for hypertension, insomnia, anxiety and depression.

The list of present medications includes the following: norvasc 5 mg daily for hypertension; lorazepam 1 mg HS for insomnia; vistaril 25 mg BID PRN for anxiety (only when required); and celexa 10 mg daily for depression (only when required).

The condition of the patient at the time of discharge was good, but his stomach ulcers need so be treated as a matter of urgency.

I would like to request for you to look into this case and provide suitable treatment. Please, do let me know if you require any further information about the patient.

Yours sincerely,

Doctor

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 49**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Name: **Abora Qualin**

Date of Birth: 7/8/1979

Height: 179cm

Weight: 81 kg

Allergies: sulfa drugs

**Social History:**

Lives with her son

Drinks a lot

Quit smoking three months ago

Family History:

Data not available

**Past Medical History**

Hypertension (2001)

Urinary tract infection (2003)

Type 2 diabetes mellitus (2007)

Dyslipidemia (1 year ago)

Constipation (1 year ago)

**Vital Signs**

BP: 124/76, P: 89, RR: 18, T: 37.2°C

**List of Medications**

Lantus 10 units QHS, lisinopril 10 mg, glipizide XL 7.5 mg, ASA 81 mg, hydrochlorothiazide 12.5 mg, simvastatin 80 mg, docusate 100 mg PRN.

**Present Symptoms:**

Complaining of severe back pain / groin pain

Vomiting

Fever

Chills

Nausea

Painful urination

**Diagnosis**

Urine sample - positive (presence of white blood cells in abundance)

Ultrasound - obstructions in the urinary tract

**Result:** UTI confirmed

**Plan:** Refer to Dr. Katherine Mathel for further analysis and treatment.

**Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Katherine Mathel, at Marino Kidney Center, 3/77 South Terrace Como WA, Australia, outlining the details of the patient.*

**In your answer:**

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

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

Dr. Katherine Mathel  
Marino Kidney Center  
3/77 South Terrace Como WA  
Australia

(Today's date)

Dear Dr. Katherine Mathel,

Sub: Abora Qualin, DOB: 7/8/1979

Abora Qualin is an elderly woman who visited our hospital with complaints of symptoms which were related to a UTI. Upon admission, the patient complained of severe back pain and groin pain, vomiting and nausea. The patient was also suffering from a fever and was feeling pain whilst passing urine. Consequently, a urine test was done which confirmed the presence of a urinary tract infection.

The patient's medical history shows that she had this urinary tract infection at an earlier date as well; she first experienced this problem in the year 2003. For the last year, she has been suffering from problems related to dyslipidemia and constipation as well. She has high BP, which was diagnosed in the year 2001, and high blood sugar levels as well, diagnosed in the year 2007.

The medications which she is taking at the moment include the following: lantus 10 units QHS; lisinopril 10 mg; glipizide XL 7.5 mg; ASA 81 mg; hydrochlorothiazide 12.5 mg; simvastatin 80 mg; and docusate 100 mg PRN.

The patient is reported to be allergic to sulfa drugs.

The condition of the patient at the time of discharge was good, aside from the symptoms related to the UTI.

I would like to request for you to look into this case and provide suitable treatment. Please, do let me know if you require any further details about the patient.

Yours sincerely,

Doctor Lewis

**TIME ALLOWED:**

**READING TIME: 5 MINUTES**

**Task 50**

**WRITING TIME: 40 MINUTES**

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

**notes:**

**Patient History:**

Name: **Marcello Caprige**

Date of Birth: 12/2/1979

Height: 168 cm

Weight: 73 kg

Allergies: Nil

**Social History:**

Married / Lives with his wife and son

Doesn't drink

Smokes

Chews tobacco

Family History: no family history

**Past Medical History**

Hypertension

Type 2 diabetes mellitus

Depression

Osteoarthritis

Hyperlipoproteinemia

**List of Medications**

Metformin 1,000 mg PO BID, atorvastatin 20 mg PO QHS, lisinopril 20 mg PO QD, furosemide 20 mg PO QD, aspirin 81 mg PO QD, glimepiride 2 mg PO QAM, venlafaxine 75 mg PO TID, fish oil 1,200 mg PO QD.

**Present Medical Condition:**

Change in blood pressure (last recorded 150/100)

### **Present Symptoms**

Shortness of breath

Severe headaches

Severe anxiety

Nose bleeding (occurred twice in the last three days)

### **Diagnosis**

High blood pressure noted (170/110)

**Result:** Hypertension (Stage 2)

**Plan:** Refer to Dr. Avelin Cooper for further analysis and treatment.

### **Writing Task:**

*Using the information in the case notes, write a letter of referral for further treatment to Dr. Avelin Cooper, at MKZ Hospital, 697 Beaufort St Mt Lawley WA, Australia, outlining the details of the patient.*

### **In your answer:**

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

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

Dr. Avelin Cooper  
MKZ Hospital  
697 Beaufort St  
Mt Lawley WA  
Australia

(Today's date)

Dear Dr. Avelin Cooper,

Sub: Marcello Caprige, change in blood pressure (last recorded 150/100)

Marcello Caprige is an elderly man who was admitted into our hospital due to a significant change in his blood pressure. The patient was not able to breath properly and was experiencing a shortness of breath. In addition, he was suffering from severe headaches and anxiety. The patient also complained of nose bleeding, which has occurred twice in the last three days.

After thorough testing, the diagnosis revealed that the patient was at hypertension stage 2. His blood pressure, which was noted at that time, was very high (170/110).

His medical history shows that he has diabetes as well (type 2 diabetes mellitus) and that he has been suffering from depression, osteoarthritis and hyperlipoproteinemia as well.

The list of the medications which the patient is taking at present include the following: metformin 1,000 mg PO BID; atorvastatin 20 mg PO QHS; lisinopril 20 mg PO QD; furosemide 20 mg PO QD; aspirin 81 mg PO QD; glimepiride 2 mg PO QAM; venlafaxine 75 mg PO TID; and fish oil 1,200 mg PO QD.

The patient does not drink alcohol but he does smoke and chew tobacco.

The condition of the patient at the time of discharge was good, apart from his symptoms related to high blood pressure.

I would like to request that you look into this case and provide suitable treatment.

Please, don't hesitate to contact me if you require any further information about the patient.

Yours sincerely,

Doctor