OET UPDATED PREP PLUS FOR NURSES

THE THREE IN ONE GUIDE FOR WRITING SPEAKING & LISTENING

2021 EDITION

JAYDEN LACHLAN

OET UPDATED
PREP PLUS
FOR NURSES

DETAILED GUIDE FOR
WRITING SPEAKING & LISTENING

JAYDEN LACHLAN

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INTRODUCTION TO OET WRITING SUB-TEST

The Writing sub-test takes 45 minutes and is profession-specific. There is one task set for each profession based on a typical workplace situation and the demands of the profession. The task is to write a letter, usually a referral letter. Sometimes a different type of letter is required: e.g. a letter of transfer or discharge, or a letter to advise or inform a patient, carer, or group. There is a five minutes of reading time given at the start of the Writing sub-test. Make use of this time to understand the task and the case notes and to plan your response. The tasks given in the Writing sub-test are designed in such a way that the remaining 40 minutes is enough for you to write a response of the required length and to check over what you have written. Remember that you can always consult the task and the case notes at any point during the 40 minutes allocated for writing, not just during the reading time.

Usually, the writing task will provide you with:

- The recipient's name
- The recipient's profession or position
- The recipient's place of work and address
- A reference to what type of letter you must write: referral, discharge, transfer or information

You can also see or infer from the task whether the recipient knows the patient or whether you are introducing the patient to the recipient for the first time. Learn to adapt your written communication according to the different scenarios and keeping mind the reader. For this, you have to pay attention to finding the relevant information in the case notes given in the question. You should address the intended reader of the letter using the title and address details specified in the task instructions.

Write the letter only for the recipient, keeping the recipient's needs in mind at all times. Knowing this information is critical for case note selection. The case notes are not written in perfect sentences and so you will have to interpret the case notes without any confusion. Because, if you misinterpret the case notes, it may result in letter with incorrect information. You should pay close attention while interpreting the category or sub-headings in the case notes, short ungrammatical phrases, symbols such as downward and upward arrows and abbreviations.

While reading and correctly interpreting the case notes, you will also have to think more carefully about the relevance of case note. Keeping in mind that your letter should only be between 180 and 200 words, you should not include all of the case notes. Selecting case notes is very challenging because while some case notes will clearly be relevant and irrelevant, others will be semi-relevant. You have to make decisions about which case notes to include and which case notes to ignore based on the task, to whom you are writing and why you're writing the letter. This is why practice is so important: by practicing the OET writing sub-test, you will develop an understanding of how many case notes you should include in order to write an appropriate length. You do not want to write a letter on test day that is well below or well above the word count.

Avoid repeating everything from the case notes or a chronological account. Always keep in mind that it is more important to produce a letter that is appropriate for the situation given in the task. So, you should select and organise the information in a way that informs the reader appropriately and effectively. Always try to show your knowledge of workplace language which occurs frequently in health professional contexts. For that, you should regularly review common workplace expressions to make sure you can produce them appropriately and accurately while writing letter.

Always read and thoroughly understand the question to organize and

prioritise the important points from the case notes effectively in your letter. Always answer yourself these three questions before you start writing the letter.

1. *Who is the intended reader?*
2. *What are the main things I want the reader to do?*
3. *What does the reader need to know?*

After selecting the relevant case notes, you have to organise the short hand case notes given in the question into paragraphs in a logical and coherent way after transforming them into accurate sentences. So, it is always wise to make rough sketch of the structures of paragraphs before your begin writing.

In the introductory sentence or paragraph, you should include the reason why you are writing the letter (i.e. to refer/discharge/transfer) and the chief medical issue. You should always place the important information at the beginning of the letter, rather than burying it deep in the letter.

Always organize information within a paragraph wisely, so that it contains only related information structured coherently to make it clear to the reader what the paragraph is about in a logical order. A paragraph should be never made up with mixed information; as it can be turned out to be very confusing.

LAYOUT OF THE LETTER

There are a number of different formats, which are accepted by health professionals in different local contexts. Therefore, there is no single particular format that you have to use in the OET Writing sub-test. But, it is very important that your letter is clearly laid out and

appropriate for the particular task.

The standard and widely used layout of the letter:

The title and full name of the recipient Ms Amanda Roxby

Position or Profession of the recipient Senior Nurse

Name of the Hospital/Clinic Old Hill Community Nursing Home

Address of the Hospital/Clinic 108 Green Park, Old Hill

Date of your exam (Today's date) Day/Month/Year

Re: Name of the patient, age Re: Darwin Kilmer, aged 72 years

Salutation Dear Ms Roxby,

Introduction _____________

First Paragraph _____________

Second Paragraph _____________

Third Paragraph, if necessary. _____________

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

Sign off Yours sincerely,

Your profession Charge Nurse.

After you finish writing, re-read what you have written from the target

reader's point of view. Ask yourself whether it is clear what you have to do. If it is not clear, check to see that you have included everything relevant from the case notes. You should also check your written work in the test to correct and verify the unnecessary errors that you failed to notice while writing. It is better to prepare a mental checklist of types of error that you happen to make very often like spelling errors, punctuation or subject-verb agreement; so, always proofread your letter specifically for those errors.

PARALLEL STRUCTURES & BALANCED SENTENCES

The information in the case notes will be in note form and does not follow any conventional grammatical rules. However, when this information is transformed into complete sentences in a letter, it is very important to follow standard conventions of English grammar and sentence structure. This can be achieved by making sure that verbs, adjectives, nouns, prepositions, phrases and clauses are parallel. Parallel structures within a sentence are joined with coordinating conjunctions such as and/or as well as with commas. Here are some examples:

With active verbs

- *She is now worried about her condition because she* ***is*** *overweight,* ***lacks*** *exercise and* ***smokes*** *regularly.*

With passive verbs

- *During hospitalization, IV fluids* ***were commenced*** *and a transdermal patch* ***was used*** *for her pain.*

With nouns & noun phrases

- *She is now worried about her condition because of her* ***increased weight****,* ***lack of exercise*** *and* ***her habit of smoking.***
- *She will require information about* ***how and when to take her medication, how to stop smoking*** *and* ***the necessity of doing regular exercise.***

With gerunds

- *In order to handle the above mentioned effects be cautious when* ***driving*** *a car,* ***operating*** *machinery or* ***performing*** *any hazardous activities especially after* ***taking*** *your regular dose.*

With prepositions

- *Threadworms resemble pieces of 1.5 cm cotton thread which is normally detectable* ***at*** *the surface of the feces or* ***around*** *the anus at night.*

With verbs in the conclusion

- *I* ***am*** *worried about Mr. Zane and* ***would*** *appreciate your urgent assessment and treatment as you think appropriate.*

NB: The important point to remember is that the structures must be balanced.

STARTERS & PHRASES FOR WRITING LETTER

Opening Clause

Referral letter

Thank you for (urgently) **seeing** (the above patient/ Mr. Zane),

/a 49 year-old (worker, profession) **with** (medical condition) **for further** (management) **and possible** (operation).

/who is currently

/in this hospital recovering from/ suffering from (medical condition)

/bedridden/immobile with possible (medical condition) **following** (type of activity that led to the medical condition) **on** (date).

Or,

I am writing to refer/ I am pleased to refer (the above patient/ Mr. Zane) **aged 49 and** married **with** 3 children of school age.

Reason for Referral

(Mr. Zane) **presented to me** (today) **with signs of a** (possible) (medical condition)

/at my clinic complaining of (symptom).

/to emergency.

(Mr. Zane) **initially presented with** (medical condition) **for which he was treated with** (medication).

He has been suffering his first episode of (medical condition).
He was admitted to this hospital on

/for a fracture of his/her (name of the bone).

/suffering from (medical condition).

/with signs for early (medical condition).

Admission letter

(Mr. Zane/ The patient) **was admitted to your facility/ this hospital/ clinic on (date) for**

/further (type of [eg: neurological]) **assessment and possible treatment of** (medical condition).

/operation of (medical condition).

/management of (medical condition).

/for a fracture of his/her (name of the bone).

/for post fracture rehabilitation.

Advice letter

(Further to our earlier conversation, I am reporting you about)/ (I am writing to follow up our conversation earlier today about) (the intro [eg: your son's management plan]).

Provisional Diagnosis (not yet diagnosed)

My provisional diagnosis is (medical condition)**, possibly related to** (cause).

He/She is diagnosed with (medical condition).

The complaints may result from (medical condition) **caused by** (cause).

I believe he/she has (medical condition).

I believe that the cause of his complaints is (medical condition) **and is at risk of developing** (...).

Investigation Diagnosis

The (test) **indicated possible** (medical condition)

The (organ) **function tests showed possible** (medical condition).

The Xray detected (medical condition).

Present Illness

He/She first attended my clinic for a check-up

complaining of / suffering from (symptom).

with symptoms of (medical condition)

On his/her first visit to me on (date) **he was / has been suffering** (symptom).

On (date) **Mr. Zane presented at my clinic/ the hospital complaining of** (symptom) **for the previous (time period) which was not responding to** (medication).

His/Her complaints set in (time period) **earlier and were related to** (activity performed).

Symptoms

<table>
<tr><td>Apart from this,</td><td rowspan="5">he/she</td><td colspan="2"></td><td rowspan="5">(symptom)</td></tr>
<tr><td>In addition,</td><td>experienced</td><td>a new episode of</td></tr>
<tr><td>Moreover,</td><td>reported</td><td>no further</td></tr>
<tr><td>Otherwise,</td><td>noticed</td><td>progressively worsening</td></tr>
<tr><td></td><td colspan="2"></td></tr>
</table>

At times,		
Occasionally,		

He/ She (initially) **had** (symptom), **but has had none since that time until** (now / [time period] ago).

He/ She reported no history of (symptom).

Past History

(using past tense)

[**He/ She reported**]/ [**There has been no history of**] (medical condition/ being overweight).

He/ She has not suffered from (medical condition) **or other significant illness/injuries before** (accident/ incident).

(using present tense)

He/ She has a (time period) **history of** (medical condition)

He/ She has a history of (medical condition) **well controlled by** (medication).

His/ Her (medical) **history includes** (specifics) **for which he/she is given /treated with** (medication).

Current Medication

Abbreviations:

stat (latin: statim) – immediately

BD – twice

t.d.s./t.i.d. – thrice

q.d.s./q.i.d. – four times

p.c. – after food

nocte – at night

s.l. – sublingual

s.c. – subcutaneous

His/ Her current medications include/ are (the list).

He/ She also uses (medication) **for** (purpose).

No effect/effect

The pain

/has (not) **responded to** (medication).

/was (not) **relieved by** (medication).

/was persistent.

/resistant to (medication).

His/ Her complaint usually settles with (medication).

Side-effect

But the medication caused significant {side effect).

<u>*Treatment*</u>

Prescription

He was treated here with (prescription).

Combination Treatment

He was given (first/ more important treatment)

/**followed by** (second/ less important treatment).

/**in addition to** (second/ less important treatment).

/**combined with** (second/ less important treatment).

/**and advised on** (advice).

I prescribed (first/ more important treatment)

/**combined with** (second/ less important treatment).

/in addition to (second/ less important treatment).

Effect

Initially his response to (treatment) **was good, but unfortunately his/ her pain flared up. Therefore,**

/I commenced him on (the change made).

/I changed him on (the change made).

Dose

After persistently elevated (readings around x units), **he/ she was commenced/started on** (medication), **this has recently been increased to** (dose).

Operation

A/ An (operation) **was performed.**

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

Recovery

He/She has been able to (activity) **with assistance.**

Since the operation his/her wounds have healed and sutures have been removed.

His/Her post operative recovery was

successful/uncomplicated/uneventful /normal.

Subsequently,/ In the following days, he/she recovered

by taking (medication) **for** (time period). /after (time period) **treatment with** (medication).

Complications

	has (extreme) difficulty	**using a walking frame / the crutches.**
While here, he/she		**to walk./ to walk with extreme difficulty.**
	has been able	**to have shower with assistance.**

His/ Her (medical condition) **has worsened while here.**

His/ Her general condition has deteriorated.

Examination

	neurological		**he/she scored** (score) **on a** (test)**.**
On	**physical**	**examination**	**no abnormalities were found.**
	cardiovascular		**he/she was** (condition) **with normal vital signs**.

The examination was unremarkable/ normal.

The examination revealed elevated (findings)/**no abnormalities.**

(Findings) **were noted on** (name of) **examination**.

Otherwise, examination was normal.

Readings

The (name of tests)

/showed (no) **pathological findings/ significant abnormalities.**

/were consistent with (medical condition).

Technical Investigations

Tests including/ The tests taken here on Mr. Zane revealed/ indicated no significant abnormalities.

Tests for/on Mr. Zane were done and showed (findings).

I had test for Mr. Zane done which showed (findings).

I ordered the following test for Mr. Zane which showed (findings).

Results

All tests in summary

indicate pathological findings consistent with (medical condition).

confirm my provisional diagnosis of (medical condition).

(Tests) **showed/ confirmed signifcant** (medical condition).

(Tests) **showed possible** (medical condition).

The (test) **at that time appeared** (unremarkable/ normal).

Review

On review today, Mr. Zane reports no further episodes of (symptom).

On review, investigations showed (medical condition).

Concerns

<table>
<tr><td rowspan="3">He/She</td><td>was anxious</td><td rowspan="3">that she may have (medical condition), about which I have reassured her.</td></tr>
<tr><td>showed concerns</td></tr>
<tr><td>worried</td></tr>
</table>

He/ She is most concerned of (concern).

He/ She is a widower/widow and has managed alone until now.

<table>
<tr><td rowspan="3">He/ She</td><td>receives</td><td>support from</td><td></td></tr>
<tr><td>needs</td><td>assistance</td><td>to manage (concern)</td></tr>
<tr><td>requires</td><td colspan="2"></td></tr>
</table>

Advice

He/ She was advised to/ on (advice) **and return in** (time

period).

Mr. Zane was given advice on (advice).

I advised him/her that he/she may need to re-present to hospital for admission

/if he/she gets any worse.

/or if he/she isn't getting better in (time period).

To avoid future episodes, he/ she needs (advice).

<u>*Request/ Future Management*</u>

I would appreciate your further assessment and management/treatment

/regarding his/ her (medical condition).

/of the possibility of (medical condition).

/of the suspected/potential (medical condition).

I would appreciate/ be grateful

/(for) **your opinion regarding his/her future management.**

/if you could please assess this patient.

/if you could see Mr. Zane fairly soon for further management.

/if you could arrange an appointment with

/a physiotherapist.

/an occupational therapist.

/a social worker.

I would be interested if he/she would be a suitable candidate for (medical procedure).

I would appreciate if you could keep me informed about his/her further management.

OET SPEAKING ASSESSMENT CRITERIA

Your performance on the Writing sub-test is marked independently by a minimum of two trained Assessors. Neither Assessor knows what scores the other has given you, or what scores you have achieved on any of the other sub-tests. Your performance is scored against five criteria and receives a band score for each criterion:

1. *Overall Task Fulfillment*

   This criterion assesses the candidate's performance on all the analytical criteria; in addition to the assessor's general view of the effectiveness of the candidate's writing sample.

2. *Appropriateness of Language*

   This criterion assesses accurate use of appropriate vocabulary and expression, as well as organisation and style of the letter. This assessment also considers control of genre and the level of formality, that is polite and relatively formal. The response should be logically organised in a formulaic sequence appropriate to both task and professional context.

3. *Comprehension of Stimulus*

   This criterion assesses the extent to which the candidate understands the stimulus notes and task requirements. It focuses on the selection and transformation of relevant material from the notes and is thus concerned with adequacy of content (coverage of main points) and accuracy of interpretation of the task instructions.

4. *Linguistic Features (Grammar and Cohesion)*

   This criterion assesses the extent to which the response demonstrates control of grammatical elements and cohesive devices to express and connect information clearly. Cohesion also refers to the use of appropriate pronouns, conjunctions and connectives, including the absence of redundancy and repetition.

5. Presentation Features (Spelling, Punctuation and Layout)

This criterion assesses the extent to which the candidate demonstrates control of spelling and conventions of punctuation to produce writing that reads clearly and without strain. This criterion also assesses the conventional layout of the letter, the inclusion of the addressee's name and address, and the opening and closing salutations.

Dos

- Summarise all the information from the case notes into sections such as: treatment given and obvious trends, medication, medical history. This will be both easier to write and read as well as avoiding repetition.
- Try to write somewhere between 180 and 200 words for the body of the letter.
- Omit information which is not directly relevant to your task. This is a big trap for many candidates in that they try to write down all the information from the task sheet.
- Provide a simple clear summary of the condition so that a lay person could understand.
- Use articles such as a/the before countable nouns as this is a requirement of formal writing.
- Use synonyms so that you can express the information from the case notes in different ways.
- Spend time reading the case notes and grouping information which are related such as medication, persistent high blood pressure etc etc.
- Allow 5 minutes at the end of the test to proof read your work and fix up any mistakes.

Don'ts

- Follow a strict chronological order as your letter may become too long, difficult to read and will not focus on the main problem and related factors.
- Write over 220 words as it may affect your overall result. You being tested on your ability to write a clear concise letter, not a long letter.
- Don't write under 160 words as there may not be sufficient range language to get a B grade.

- Try to put all the information from the case notes into the letter. Your letter will be too long and also poorly organised and difficult to read.
- Use too much medical jargon.
- Forget that case notes are written in short form, so they do not follow standard grammatical rules. For example, it is common to omit articles.
- Copy directly from the case notes without any changes. You are expected to put the information into your own words.
- Start writing without planning your letter. You should allow 10 to 15 minutes reading case notes and planning the letter.
- Submit the letter without checking for basic mistakes such as grammar/spelling.

Abbreviations in the Letter

Abbreviations that are commonly accepted in the candidate's profession and clear to the qssessors can be used in the writing sub-test. If your target reader is a health professional, a number of commonly used abbreviations are likely to be acceptable. However, if you are writing to somebody from a non-health professional background, full word-forms may be more preferable. For example BMI for body mass index, or units of measurement such as mg, whereas you should write OPG as orthopantamogram, PR as pulse rate and hx as history. So, you should always consider who the intended reader is, while using abbreviations. OET Assessors do not refer to any specific lists of abbreviations and there is no recommended dictionary or handbook of abbreviations.

Writing sub-test

Nursing

Sample Test 1

OCCUPATIONAL ENGLISH TEST		
WRITING SUB-TEST:	NURSING	
TIME ALLOWED:	READING TIME:	5 MINUTES
	WRITING TIME:	40 MINUTES

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

Notes:

Ms Rachel Feynman is an 19 year old woman who has just given birth to her first child at the General Hospital in Hobart. You are the nurse looking after her.

Patient Details:

Address: Flat 7, 203 Macquarie St, Hobart TAS 7000, Australia

Phone: +61 3 6231 5250

Admitted: 9th September

Discharged: 13th September

Marital Status: Single

Country of birth: Australia

Social Background

Rachel is single and has had no contact with father of child for six months.

She does not know his current address.

No family members in Hobart.

Parents and brother live in Townsville.

Does not currently have contact with them.

Lives in a rental share flat with one other woman.

Currently receives sole parent benefits.

Feels very isolated and insecure.

Doubts her ability to be a good mother.

Talked about offering the baby for adoption.

Medical History

General health good

Had appendicectomy at 14 years

Non-smoker

No alcohol or illicit drug use.

No drug or other allergies

Obstetric History

First pregnancy

Attended for first antenatal visit at 16 weeks gestation.

8 antenatal visits in total.

No antenatal complications.

Birth details

Presented to hospital at 1900hrs on 9th September

Contracting 1:10mins

1st stage of labour: 16 hrs

Mode of delivery: Emergency Caesarean Section

Reason: Fetal distress and failure to progress.

Baby Details

born on 10th September

Time: 1120hrs

Sex: Male

Weight: 4.4 kg

Apgar Score: 6 at 1 min, 9 at 5 mins

Resusitation: O_2 only for few minutes

Postnatal Progress

Maternal post partum haemorrhage of 800mls

Blood loss now minimal

Wound: Clean and dry

Haemoglobin on 12/09/08: 90 g/L

Started on Fefol (Iron supplement) and Vitamin C

Started breast feeding but not confident. Prefers to change to bottle feeding.

Not confident in bathing and caring for baby

Weight at discharge: 4.1 kg

Feeding well

No jaundice

Writing task:

Using the information in the case notes, write a letter to The Director, Community Child Health Service, 60 Collins St, Hobart TAS 7000 requesting a home visit to provide advice and assistance for Rachel and her baby.

In your answer:

- expand the relevant notes into complete sentences
- do not use note form
- use letter format
- The body of the letter should be approximately 180-200 words.

OCCUPATIONAL ENGLISH TEST

Sample Test 1

WRITING SUB-TEST: NURSING

SAMPLE RESPONSE: LETTER

The Director
Community Child Health Service
60 Collins St,
Hobart TAS 7000

(Today's Date)

Re: Ms Rachel Feynman, aged 19

Dear Sir/Madam,

I am writing to refer Ms Feynman who has encountered several problems of caring her first baby boy. She will require a home visit for assistance and advice on the matter of caring her baby as a single mother.

Ms Feynman was admitted to our hospital on 9th September, and underwent an emergency caesarean section due to the fetal distress detected after 16-hour labour. Post-operatively, her mild anaemia was treated with supplements of iron and vitamin C.

As Ms Feynman is new to the motherhood without family support, therefore is not confident of breastfeeding and caring her son alone. She has no contact with the father or her family. As a result of her isolated circumstances, she is considering to offer her baby for adoption.

After discharge, Ms Feynman will require some advice on the method of feeding and caring of her son as well as an encouragement and support to do so alone. Would you please arrange a home visit to assist her for this difficult transition?

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

Yours sincerely,

Charge Nurse
General Hospital
Hobart

Writing sub-test

Nursing

Sample Test 2

OCCUPATIONAL ENGLISH TEST		
WRITING SUB-TEST:	NURSING	
TIME ALLOWED:	READING TIME:	5 MINUTES
	WRITING TIME:	40 MINUTES

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

Notes:

Michael Redford, 24, is a university student who was involved in a car accident three months previously. He has been in the St. Vincent's Hospital, for three months and is ready to be transferred to the Community Rehabilitation Centre.

Patient Details:

Admitted on: July 17

Discharged on : October 25

Diagnosis: Broken neck and fractured pelvis.

Probable permanent neurological damage affecting mobility, speech and memory areas

Social background: Single.

4th year architectural studies student at Liverpool University

Was living in flat but now needs long term rehabilitation

Parents living and willing to care for him; may eventually return home

Currently eligible for disability pension

Nursing management and progress:

Has made good progress but will need high level care for some time

Recently started using a wheelchair

Needs daily physiotherapy, hydrotherapy 2x a week and speech therapy 3x a week

Was suffering bed sores but improving with increased mobility

Frequent headaches Nurofen 200g max 4x a day

Discharge plan: Depression needs to be treated with activities and interests; likes reading & writing

Contact university for possible continuation of studies externally

Needs contact with people his own age – community access?

No special dietary requirements

Writing task:

Write a letter to Martha Sigmoid, Sister in Charge, Community Rehabilitation Centre, Prescot St, Liverpool L7 8XP, using the information in the case notes. Do not use note form in the letter; expand the relevant case notes into full sentences.

In your answer:

- expand the relevant notes into complete sentences
- do not use note form
- use letter format
- The body of the letter should be approximately 180-200 words.

OCCUPATIONAL ENGLISH TEST

Sample Test 2

WRITING SUB-TEST: NURSING

SAMPLE RESPONSE: LETTER

Martha Sigmoid

Sister in Charge

Community Rehabilitation Centre,

Prescot St, Liverpool L7 8XP

(Today's Date)

Re: Michael Redford, a 24-year-old university student

Dear Ms Sigmoid,

I am writing regarding Michael, who was diagnosed with probable permanent neurological damage following a car accident. He requires a continuous rehabilitative care after his discharge on the 25th of October.

Michael has been hospitalized for about three months for his broken neck and pelvis fracture resulting from a car accident. He has made good progress. His bed sores were improved due to increased mobility using a wheelchair.

Michael's mobility, speech, and memory might be affected due to the permanent neurological damage, for which he requires physiotherapy, hydrotherapy and speech therapy. In addition, he takes Nurofen for his frequent headache. For your information, he is eligible for disability pension, and his parents are keen to care for him.

Michael will require your assistance to overcome his depression that has developed after the accident. This can be alleviated with an engagement of activities and interests that he enjoys. Connecting him with people at same age via community access services will also be

helpful as well as continuing his studies externally during his recovery.

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

Yours sincerely,

Charge Nurse
St. Vincent's Hospital

Writing sub-test

Nursing

Sample Test 3

OCCUPATIONAL ENGLISH TEST		
WRITING SUB-TEST:	NURSING	
TIME ALLOWED:	READING TIME:	5 MINUTES
	WRITING TIME:	40 MINUTES

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

Notes:

Miss Carol Jefferson, a 28-year-old, is a patient in the medical ward in which you work.

Hospital: Royal Hospital, 255 Ryrie St, Geelong VIC 3220.

Patient Details:

Marital status: Single

Residence: Westfield

Next of kin: unknown

Admission date: 9 March

Discharge date: 9 March

Admission diagnosis: Lip laceration (alleged assault by boyfriend / did not seek medical care)

Abdominal pain

Burning with urination last several days

May have STD

Denies vomiting / diarrhea

Sexually active, does not use protection

Social background: Smoker (chain)

Alcoholism

Denies illicit drugs

Past medical history: History of schizophrenia

Diagnosis: 1. Lip laceration

2. Urinary tract infection (UTI)

Medical progress: Denies fever, chills, dizziness, weakness

Denies chest pain / palpitations

Denies shortness of breath / cough

All other review of systems negative

Nursing management:

For lip: Cipro 500 mg orally twice daily x 6 days

Clindamycin 300 mg orally 4 x daily x 10 days

Peridex mouthwash 10 mL swish and spit after meals and before bed

Oxycodone one orally every 4 hours.

UTI: follow up with GP

Assessment: Discharged home good condition

Discharge plan: Appointment made at sexual health clinic.

Follow up with GP. Monitor antibiotics.

Urine appears infected.

Treat for UTI.

Writing task:

Using the information given in the case notes, write a referral letter to Miss Carol's General Practitioner Wilfred Meacham at City Medical Clinic, 66 Bellerine St, Geelong VIC 3220 for further medical evaluation.

In your answer
:

- expand the relevant notes into complete sentences
- do not use note form
- use letter format
- The body of the letter should be approximately 180-200 words.

OCCUPATIONAL ENGLISH TEST

Sample Test 3

WRITING SUB-TEST: NURSING

SAMPLE RESPONSE: LETTER

Dr. Wilfred Meacham

City Medical Clinic

66 Bellerine St

Geelong VIC 3220

(Today's Date)

Re: Ms Carol Jefferson, aged 28

Dear Dr. Meacham,

I am writing to refer Ms Jefferson, who was admitted to our hospital on 9th March due to a lip laceration and UTI. She will require further medical evaluation after being discharged today.

Upon admission, Ms Jefferson presented with a lip laceration, resulting from an alleged assault by her boyfriend, for which she did not seek medical care. In addition, she had experienced burning urination and abdominal pain that was diagnosed as UTI. STD was also suspected because of her unprotected sexual activities. Apart from those, no other abnormality was noticed.

Miss Jefferson has been placed on two antibiotics, Cipro and Clindamycin, for her lip infection, and Oxycodone for her pain. It is important for her to complete the full course. Peridex mouthwash was also prescribed to her for regular use. The dosage and frequency of her medications will be enclosed in the side notes for your reference.

Would you please continue to assess the progress of her lip laceration and UTI as well as her response to those antibiotics? Please also follow up on her appointment at sexual health clinic for suspected STD.

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

Yours sincerely,

Charge Nurse
Royal Hospital
255 Ryrie St,
Geelong VIC 3220

Writing sub-test

Nursing

Sample Test 4

OCCUPATIONAL ENGLISH TEST		
WRITING SUB-TEST:	NURSING	
TIME ALLOWED:	READING TIME:	5 MINUTES
	WRITING TIME:	40 MINUTES

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

Notes:

You are a Maternal and Child Health Nurse working at the Leeds Community Child Health Service.

Patient Details:

Name: Luke Quinn

Baby boy of age 1 month

Born on: July 7th, at Leeds Maternity Hospital

First baby of Ned and Cheryl Quinn

Address: 4 Park Square E, Leeds LS1 2NE

Family History

Mother: Aged 23

First Child

Father: Aged 26

Architect, currently working abroad

Birth History Normal vaginal birth at term

Birth weight: 3400gm

Apgar score at 5 min: 9

No antenatal or postnatal complications

Subjective:

Cheryl and baby attended for routine 6 week check-up.

Cheryl says she is concerned about constipation

Once every three days, hard stool.

Mother is asking about stool softener or prune juice for baby.

Breast fed for first three weeks after birth.

Baby became unsettled during summer heat wave.

Cheryl got sick and had a fever for a few days.

Mother-in-law (Clara Quinn) came to visit

Advised changing baby to formula feeds.

Clara advised extra powder in formula feeds to improve weight gain.

Cheryl worried she does not have enough breast milk.

Now gives extra formula feeds as well as breast feeding

Luke difficult to bottle feed.

Cheryl wishes to breast feed properly

She believes it would be the best thing for her son.

Clara Quinn plans to stay with the family for at least a further month to help with baby.

Tensions developing between mother and mother-in-law over what is best feeding method for Luke.

Objective

Reflexes normal

Slightly lethargic

No abdominal tenderness

Heart Rate: 174

Respirations: 56

Temperature: 37.1° C

Weight: 4200 gm

3 wet nappies in last 24 hours

Urine dark

Assessment: Mild constipation and dehydration

Plan: Increase breast feeds

Refer to breast feeding support service

Check formula is correctly prepared

If continuing formula feeds, advise to supplement with water (boiled and cooled)

Advise on keeping baby cool in hot weather

Return for review in 48 hours.

Writing task:

Write a referral letter to the Lactation Consultant at the Breast Feeding Support Centre, 45 Park Square N, Leeds LS1 2NP.

In your answer:

- expand the relevant notes into complete sentences
- do not use note form
- use letter format
- The body of the letter should be approximately 180-200 words.

OCCUPATIONAL ENGLISH TEST

Sample Test 4

WRITING SUB-TEST: NURSING

SAMPLE RESPONSE: LETTER

The Lactation Consultant

Breast Feeding Support Center

45 Park Square N,

Leeds LS1 2NP

(Today's date)

Re: Luke Quinn, a one-month-old baby

Dear Sir/ Madam,

I am writing regarding Luke Quinn and his mother, Cheryl. She needs support regarding breastfeeding and formula preparation.

Mrs. Quinn presented to us today with a concern about Luke's constipation initially. A physical investigation of her son found that he was mildly dehydrated as he only had three wet nappies in the past 24 hours with dark urine colour. He was slightly lethargic but generally normal, with weight gain of 1000 gm, since his birth on the 7th of July.

Luke was breast fed for the first three weeks after birth, but is switched to a combination of formula feeds and breast feeds because Mrs. Quinn is concerned about insufficient amount of her breast milk, as well as his difficulty in bottle feeding. However, she thinks breast feeding is the best method for him.

As Mrs. Quinn wishes to continue breast feeding properly, would you kindly provide some guidance and support to improve her breast feeds? Also, she will need to be advised to supplement with boiled and cooled water if continuing formula feeds. In addition, advice on how to keep the baby cool in hot weather is necessary. Please note, the patient

is due for review in 48 hours.

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

Yours sincerely,

Samantha Simon
Maternal and Child Health Nurse
Leeds Community Child Health Service.

Writing sub-test

Nursing

Sample Test 5

WRITING SUB-TEST:	NURSING	
TIME ALLOWED:	READING TIME:	5 MINUTES
	WRITING TIME:	40 MINUTES

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

Notes:

Vamuya Obeki was admitted through the Children's Emergency Department for acute meningoencephalitis as a result of a complication following mumps.

Patient Details:

Address: 32 Sexton St, Ekibin

Phone: (07) 38485555

Date of Birth: 23 May

Admitted: 15th July

Gender: Male

Discharged: 25th July

Country of birth: Sudan

Diagnosis: acute meningoencephalitis

Social History

Parents: Miri & Abdullah Obeki, refugees, arrived in Australia.

Employment: Abdullah: Golden Circle pineapple factory, shift worker

Miri: housewife

Accommodation: Recently moved to rental accommodation

GP: No family doctor

Sibling: 2 year old brother, Saeed

Language: Dinka, Arabic Interpreter needed

Abdullah understands spoken English but has limited written skills.

Miri has limited understanding of English.

Abdullah attends English classes.

Medical History

Parents state that both children had some kind of vaccination at birth but the vaccination record has been lost.

Parents unaware of vaccine for Mumps.

Discharge Plan

Appears to have fully recovered from mumps and acute meningoencephalitis.

Will need advice on recommended vaccines for both children.

Will need neurological check-up.

Writing task:

Using the information in the case notes, write a letter to The Director, Community Child Health Service, 41 Jones Street, Ekibin, requesting follow-up of this family.

In your answer:

- expand the relevant notes into complete sentences
- do not use note form
- use letter format
- The body of the letter should be approximately 180-200 words.

OCCUPATIONAL ENGLISH TEST

Sample Test 5

WRITING SUB-TEST: NURSING

SAMPLE RESPONSE: LETTER

The Director

Community Child Health Service

41 Jones Street, Ekibin

(Today's Date)

Re: Vamuya Obeki

Dear Sir/Madam,

I am writing to refer Vamuya, a 4 year-old child and his family to you. He was admitted to our hospital on the 15th of July through the Children's Emergency Department with the diagnosis of acute meningoencephalitis following mumps. He is due to be discharged today.

He was born in Sudan and arrived in Australia with his parents and a 2 year-old little brother as refugees. They recently moved to rental accommodation. Their only income is made by his father, Abdullah, who is employed as a factory shift worker. This family has no family doctor now. As well as this, they have a language barrier. His father can understand spoken English but his mother, Miri, has limited understanding of English.

During his stay in hospital, he has fully recovered from the mumps and meningoencephalitis. However he will need a neurological check up. For both children, the advice on recommended vaccines will be needed.

I hope you will be able to arrange someone who can help this family

and provide proper medical support. Please do not hesitate to contact me if you require any further information about this family.

Yours sincerely,

Charge Nurse.

INTRODUCTION TO OET SPEAKING SUB-TEST

The test can be segmented into three sessions.

1. ***Warm up session***: In the beginning, your identity and profession are checked by the interlocutor. Then, he/she will start a conversation about your professional background. This section of the Speaking sub-test is not assessed. You can use this time to familiarize and gain confidence in speaking to the interlocutor.

2 & 3. **Role plays 1 & 2** respectively: After the warm up session, you are given two role-plays each with a different scenario, which are introduced one by one. These two role plays are based on typical workplace situation to demonstrate your ability to deal with situations that occur in the workplace. In each role-play, you take your professional role while the interlocutor may be playing one among the following four roles:

1. a patient
2. a client
3. a patient's relative
4. a patient's carer

You will have three minutes to prepare for each. If you have any questions about the content of the role-play or how a role-play works, you can ask them during this preparation time. You can also ask the interlocutor if you have any questions about what a word/phrase means or how it is pronounced. Use the preparation time to think about which elements of the role-play might require you to explain something in more detail or to ask the patient for more clarification.

The role-plays take about five minutes each. It is usual for a role-play to come to a natural end at around the 5-minute mark. If this does not happen, the interlocutor will signal clearly that it is time to conclude the role-play. You will receive information for each role-play on a card that you can keep while you do the role-play. The card will explain the situation and what you are required to do.

You can make notes on the role-play cards if you want, and you can refer to the card at any time during the role-play. But, you must return the card to the interlocutor at the end of the role-play. The interlocutor follows a script so that the speaking test structure is similar for each candidate. The interlocutor also has detailed information to use in each role-play.

Always remember your test day interlocutor plays no role in the assessment of your performance. The whole Speaking test is recorded and it is this audio recording that is assessed. The recorded Speaking sub-test is marked independently by a minimum of two trained OET Assessors. Neither Assessor knows what scores the other has given you, or what scores you have achieved on any of the other sub-tests.

OET Assessors are trained to focus on how a candidate responds to the particular task on the day. They apply specific assessment criteria that reflect the demands of communication in the health professional workplace. (described in the next section). Candidates who are familiar with the assessment criteria and pay attention to the details of the specific role-play task have a better chance of demonstrating their ability in the key areas. Whereas, candidates who use memorised material or merely rely on techniques that worked in other circumstances tend not to perform to their full potential in the test.

You don't have to worry if the interlocutor stops the role-play after five minutes. There is no penalty for not completing all the elements on the role card. However, the more elements of the role-play you cover, the more evidence you are likely to give of your ability to communicate in spoken English.

Total time taken for the test – ***about 20 minutes***

Warm up session – ***about 4 minutes***

Role plays 1 & 2 (each one) – ***3 minutes preparation time (fixed)***

– ***about 5 minutes for role play***

OET SPEAKING ASSESSMENT CRITERIA

Divided into two sets:

1. Linguistic Criteria

2. Clinical Communication Criteria

I. Linguistic Criteria: used to assess English-language skills and again divided into four sets.

A. Intelligibility

This criterion refers to candidate's capacity to make understandable speech. It is assessed by evaluating pronunciation, intonation, stress, rhythm and accent. To get a better score under this criteria, you should

- ***pronounce clearly***
  - ***pitch the voice appropriately without mumbling***
  - ***stress selectively and use intonation to emphasize the meaning***
  - ***exhibit a natural rhythm while speaking in English.***

B. Fluency

This criterion refers to the rate and flow of speech. Evidences in the speaking that may reduce your score under this criteria are:

1. ~~searching for sentence structures or words~~

2. ~~beginning with false starts~~

3. ~~overuse of fillers like yeah, Ok~~

4. ~~inappropriate repetition of words or phrases~~

To get a better score under this criteria, you should

• ***at a normal rate that is easily comprehensible***

• ***continuously and smoothly with pauses appropriate to the situation.***

C. Appropriateness of Language

This criterion refers to the ability to use and speak English in a tone according to the circumstances and the patient's situation.

To get a better score under this criteria, you should

• ***use simple expressions while describing medical conditions or procedures that a common man can understand***

• ***use a voice tone according to the situation.***

D. Resources of Grammar and Expression

This criterion refers to the spectrum and accuracy that you exhibit in proper use of grammar and vocabulary.

To get a better score under this criteria, you should

• ***have a good range of vocabulary and grammatical expressions***

• ***paraphrase when necessary***

• ***maintain long utterances using proper cohesive devices***

• ***use idioms precisely***

II. Clinical Communication Criteria: used to assess how you can conduct a professional workplace communication with the

interlocutor who may be acting the role of a patient/ a client/ a patient's relative/ a patient's carer. This criteria is again segmented into five more sub-sections with further division for each sub-section.

A. Indicators of relationship building

A1. Initiating the interaction appropriately

You should start the conversation, since you are the medical professional.

It involves:

- ***greeting the patient***
- ***introducing yourself***
- ***explain the nature of the interview and if necessary, you can negotiate too.***

A2. Demonstrating an attentive and respectful attitude

You should always demonstrate attentiveness and respect throughout the role plays.

These can be show by

- ***attending to the patient's comfort***
- ***asking permission and consent to proceed***
- ***being sensitive to potentially embarrassing or distressing matters.***

A3. Demonstrating a non-judgemental approach

To fulfill criterion you should

- ***not judge the patient***
- ***reassuringly and non-judgementally accept the***

patient's perspective

- ***never attempt to prove that the patient views are wrong***

A4. Showing empathy

To fulfill criterion you should

- ***show that understanding back in a supportive way***
- ***understand plight or feelings in interlocutor's cues***

- *use non-verbal behaviors like silence and appropriate voice tone*
- *use verbal cues that shows your understanding of emotions or plight*

B. Indicators of understanding & incorporating the patient's perspective

B1. Eliciting and exploring patient's concerns

To fulfill criterion you should ***volunteer to take the initiative to elicit and explore unique experience of sickness that interlocutor enact, by probing direct statements or cues conveyed by interlocutor.***

B2. Picking up the patient's cues

*F*or picking up cues you should use techniques such as:

1. Echoing: simply repeating the last words of patient to encourage the further contribution of more factual details and feelings

2. Directly checking out patient's statements or clues: For example I sense that you are little uncomfortable about the explanations you've been given.

B3. Relating explanations to elicited concerns

To fulfill criterion you should ***incorporate patient's perspective into explanations as the role play progress.***

C. Indicators of providing structure

C1. Sequencing the interview logically

To fulfill criterion you should

- ***maintain an ordered approach for both information gathering and giving***
- ***keep a logical sequence as you lead the role play|***
- ***also be flexible at any instant to focus on any concerns that patient may present out of the blue***

C2. Signposting changes in topic

To fulfill criterion you should ***use words or phrases to express the relation between two ideas within a sentence or two/more sentences to make a smooth transition from one point to the next while speaking.***

For example,

Firstly, ...

Secondly, ...

Similarly, ...

C3. Organizing techniques in explanations

To fulfill criterion you should use organizing techniques such as:

1) Categorization: refers to arranging information into categories while you give out information to the patient.

2) Labeling: refers to marking the important points using emphatic phrases or adverb intensifiers like definitely, especially, etc., to persuade the patient while giving advice.

3) Chunking: refers to delivering a huge piece of information in small pieces by using pauses in between them in order to let the patient understand the points clearly.

D. Indicators for information gathering

D1. Using active listening techniques and avoiding interruptions

To fulfill criterion you should

- ***be supportive and show interest during the role play***
- ***Pick up cues of the patient's feelings and emotions.***
- ***avoid interrupting while the patient is speaking***

D2. Using open questions in the beginning and appropriately moving to closed questions

To fulfill criterion you should

- ***use open question in the beginning of exploring of any concern.***
- ***use closed questions only when it is necessary to get more specifics from the patient.***

D3. NOT using compound questions or leading questions

To fulfill criterion you should

avoid compound question: refers to more than one question, in a single delivery that can confuse the patient. For example, Have you had trouble with sleep or bowel?

avoid leading question: refers to a question with your

assumption in the question itself which makes it hard for the patient to contradict your assumption. For example, You haven't had any migraines?

D4. Clarifying statements which are vague

To fulfill criterion you should ***you may need to prompt patients for more precision, clarity or completeness, when patients' statements can have two (or more) possible meanings and you've to ascertain which one is the intended.***

D5. Summarizing information to encourage correction or to contribute more if information is omitted

To fulfill criterion you should ***take initiative to make the summary of the information gathered so far from the patient and providing an opportunity to the patient to correct if something is different from what you have understood or add if the patient has missed something.***

E. Indicators for information giving

E1. Establishing initially what the patient already knows

To fulfill criterion you should ***determine how much and what information the patient needs, and the degree to which your view of the problem differs from that of the patient.***

E2. Periodically pausing and using the response while giving information

To fulfill criterion you should ***give information in small pieces by pausing in between and checking for understanding and should be guided by the patient's reactions before proceeding to see what information is required next.***

E3. Encouraging the patient to contribute reactions and feelings

To fulfill criterion you should ***provide opportunities to the patient to ask questions, clarifications or doubts.***

E4. Checking whether the patient has understood information

To fulfill criterion you can ***either ask plainly whether the patient understood the information being provided or by asking the patient to repeat back what has been discussed so far to ensure that the patient's understanding is the same as yours.***

E5. Discovering what further information the patient needs

To fulfill criterion you should ***ask the patient deliberately about what other information would be helpful to the patient and asking directly is an obvious way to prevent the omission of any important information.***

STRUCTURE OF A ROLE PLAY

A typical role play can be divided to five parts according to the order of the progress in the interview.

1. Introducing yourself as a healthcare professional to the patient.

---

2. Finding the 'Chief Concern' from the patient perspective.

3. Gathering all the relevant information from the patient.

4. Giving all the relevant information to the patient and answering additional concerns.

---

5. Concluding the role play professionally.

The tasks given for a role play will be generally based on parts 2, 3 and 4.

Things to Remember

1. You should take the initiative to introduce yourself. Don't wait for the interlocutor to begin the conversation after he inform that your 3 minutes preparation time is over.

2. Don't start giving out information(part 4) before fulfilling part 2 and 3.

3. Don't conclude before confirming whether patient understood all the information that you provided.

Introducing Yourself As A Healthcare Professional

Examples:

Hello. My name is Sarah Delware and I

/(will be looking after you today/ your attending nurse today)

/ (am one of the registered nurses in this facility/on duty today/… etc).

/Can you give me your name, please?

/ May I know your name please?

Or if the name is given in the role play card

Hello Simon,

/you're here regarding your blood test results aren't you?

/how are you feeling today?

/you are looking better today. How do you feel?

/what has brought you along here today?

/Why have you come to see me today?

2. Finding the 'Chief Concern' from the patient perspective.

Mr/Mrs. Martin, (what brings/ what concerns bring you here today?) /(what would you like to discuss?)/ (can you tell me what you are concerned/worried about?)/ (Can you tell me what you have difficulty/ problems with?)

3. Gathering all the relevant information from the patient.

Now, you should listen attentively. Listen to the patient's answer without interrupting or efficiently make use of continuers like – *Mm-hmm /Uh-hmm / Uh huh /Go on/ I see/ Right,* to maintain the flow of the patient's conversation.

When the patient finish his/her story ask again if there is something more to it. Use open ended questions like:

Is there something else?

Open & Closed Questions

Open questions: encourage the patient to give more information and explain more about their emotions and behaviors. These questions require more than a yes/ no/ a short answer and often begin with question words like what, how, or tell me. They don't require a precise answer, so the patient is free to talk anything about the question.

For example:

Tell me more about the accident.

Closed questions: are used for finding specific information. They are often yes or no questions or questions that are to be answered in a few words. Overuse of such questions can end up in incomplete responses by discouraging a complete disclosure from the patient. So, they are only efficient, when it comes to collect specific information needed during the OET role-play.

For example:

Does this answer your question?

4. Giving all the relevant information to the patient and answering additional concerns.

The general relationship between common concerns and their respective information to be given according to the tasks mentioned in the role play card are like:

In case of diabetes, it will be to minimize the sugar and carbohydrate rich food intake.

In case of hypertension, it will be to minimize high-fat and high-salt content food intake.

In case of lung problems, it will be to quit smoking.

In case of liver problems, it will be to quit drinking.

So, you have to provide the relevant information in such a way that it is not criticizing the patient.

For example:

I am afraid your weight/smoking/alcohol consumption/intake can worsen/deteriorate your condition.

Reducing your weight/smoking/alcohol consumption/intake is an essential step towards avoiding medical problems like heart diseases.

I do understand your reluctance. It's a daunting prospect to make such huge changes in your everyday routine. However, you must consider the risks associated with smoking/ drinking/ carrying excess weight.

Informing the patient

Based on my examination it will be necessary to.......

The x-ray indicates that your child has.........

The blood test results indicate that child has.........

The tests show that it is probably a condition known as......

Describing the condition

Make sure your explanation is clear and well organised.

For example:

The blood tests results indicate that you have Hepatitis A. Do you know anything about this condition? (No) Okay I will explain it to you. It is a condition caused by.... The symptoms include....... The best treatment is to....... It is highly contagious so you need to....

Try not to talk continuously. Stop from time to time to check if the patient understands your explanation.

Is that clear?

Do you understand so far?

Do you have any questions?

Reassuring the patient

Commonly, the patient will be concerned about their condition or treatment method, so there are some standard expressions you can use to reassure the patient.

It's nothing to get alarmed about. It's just a routine check.

There really is nothing to worry about. It's a standard procedure.

Let me reassure you, if you follow my advice the risks of future problems will be greatly reduced.

Persuading the patient

If you return to work you run the risk of doing further damage to your health.

What is more important? The risk of permanent damage to your arm or a single game?

Let me reassure you, if you follow my advice the risk of heart attack will be greatly reduced. However if you do not follow my advice, and continue to smoke and drink heavily, then the risk of heart attack is much higher.

In some other cases, you have to negotiate a plan with the patient according to the tasks given and in such cases begin with starters like:

Here is what I propose we do. [plan in your own words].

Given your health, a better solution might be [plan in your own words].

If you're willing to accept a compromise, how about [plan in your own words]?

You would also have to answer any additional concerns that the patient my bring up while you giving information with patience.

5. Concluding the role play professionally.

Between now and then/next visit/that, time if you have any problem don't hesitate to come and see me.

Well, if you run into any problems, I want you to call and come to see me. Just to see how you are coming along. So, make an appointment and I'll see you then.

If there is any concluding tasks in the role play card like, scheduling an appointment for review or offer a patient information-leaflet, you can conclude the role play right after fulfilling the task. For example:

Thank you, for all the information you have given me. Here is a patient –information leaflet which you will find useful. If you have any additional questions, please, do not hesitate to contact me.

If there is any concluding tasks in the role play card, you can directly guide the conversation to a proper closing. For example:

Well, it was great meeting you. Please, call the hospital if you have any questions. Our number is on your label.

At a suburban medical clinic or general practice

Please make an appointment with reception to see me in a week. Take care now.

Here is your prescription. Take it to your chemist and they will give you the medication. All the best.

Thanks for coming to see me today.

Please come and see me again in a week.

I would like to see your child again in two months time. Take care now.

In a hospital ward

I'll come back and check on your condition later today.

If there is any change in your condition please let me know.

If you need me again, just press the buzzer.

HOW TO IMPROVE SPEAKING SKILLS

To improve your OET speaking skills, you can develop the required skills by working through the following stages.

Stage 1

- Write out dialogues of a medical interview between a health professional and patient using the role play scenarios.
- Research medical conditions and learn how to explain them simply and clearly in layman (common man)'s language.
- Practice doing the role-plays at home by yourself or even better with a friend and record your voice.
- Analyse your own speaking and keep practicing until your fluency, range of expression, grammar and confidence improves. Ask yourself the following questions:

  Could I ask appropriate questions?

  Was able to clearly explain the dental condition?

  Was my fluency good?

  Did I hesitate a lot?

  Was my pronunciation clear?

  Was my grammar and sentence structure accurate?

  Could I lead the role-play?

  Do this every day with different conditions and keep doing it until you feel confident in your ability to complete a medical interview.

Stage 2

Once you have developed confidence and have a good

understanding of how to structure a medical interview you can begin doing role-plays by simply researching the topic, but not reading the role-play cards. This will give you a good idea of your level, and your ability to respond appropriately to the patient without preparation. Make sure you continue to record your own speech, so that can identify your strengths and weaknesses and do the necessary study.

Stage 3

The final stage is when you can confidently respond to any role-play scenario, regardless of the topic, and complete a medical interview without any preparation, apart from the 3 minutes allowed by OET on exam day. Once you have reached this stage, you will know you have a chance of achieving a B grade or higher.

Dos

- Do always maintain a audibly pleasant pitch.
- Do control intonation by rising or falling the voice to enhance the meaning
- Do alternate between stressed and unstressed syllables.
- Do take pauses between phrases.
- Do use appropriate synonyms.
- Do connect phrases into a lengthy utterances.
- Do use varying transitional words.
- Do use medical idioms according to the situation.
- Do read the role play card carefully and ask the interlocutor if you are unsure of any of the words or expressions in the task.
- Do react to what the interlocutor (as patient) asks or says and respond accordingly. This is much more important than simply following the tasks on the card.
- Do focus on the patient and respond to their questions and concerns.
- Do take charge of the role play. You are a medical professional and should act accordingly by leading the role play. This means you must start and conclude the role play, and if the patient is quite or silent, then it is your responsibility to keep the conversation moving.
- Do utilise the allowed 2~3 minutes to identify the key points on your card including:
  • the setting
  • whether you know the patient, or if it's the first time to meet
  • the main topic of conversation and relevant background information
  • task requirements
- Do refer to your card occasionally during the exam, especially if you are unsure of what to say.

- Do be prepared to discuss matters which are not on your card. The patient's card usually contains information which is not on your card.
- Do look at the patient during the role play. Although only your speech is recorded, your communication will be more effective if you have eye contact with the interviewer.
- Do stay focused on the task at hand. You only have 5 minutes to complete all the tasks!
- Do practise as many tasks as possible with a partner to ensure you are familiar with the speaking test. Remember it is very different to IELTS and requires different language skills, such as the ability to persuade, convince and reassure.
- Do act confidently and speak with a positive voice. If you are unsure of the details of the condition, it is okay to make it up! Remember it is a test of English not your medical knowledge.
- Do slow down your speech when using unfamiliar words such as names of medications or treatment procedures. Always be prepared to explain the meaning of any medical terminology you use.
- Do regularly check that the patient understands your explanations. Ask questions such as: *Is that clear?*
- *D*o stop speaking if the patient wants to interrupt you. You must respond to the patient.
- Correct a grammatical or vocabulary mistake immediately if you are aware that you have made one.
- Do be aware of the gender of your patient and if you say he instead of she, try to correct it.

Don’ts

- Don’t create your own idioms/translate idioms from other languages.

- Don’t omit relevant information while paraphrasing.
- Don’t speak with words that are hard to grasp for listener.
- Don’t speak with wrong grammatical structures.
- Don’t utter complex terms for medical conditions or procedures.
- Don’t stress on the wrong syllable.
- Don’t speak without intonation.
- Don’t show the influence of mother tongue while English speaking.
- Don’t try to fake an accent or use mixed accents.
- Don't plan what you are going to say in advance. React to the scenario on your role play card and plan your role accordingly.
- Don't plan what you are going to say in advance. React to the scenario on your role play card and plan your role accordingly.
- Don't be card focused at the expense of the patient. It is much more important to respond to the patient in a natural and caring manner (where required).
- Don't wait for the interviewer to lead the role play. They may not and this is your job.
- Don't rush through your card in 30 seconds and say you are ready to start! You may miss some important details.
- Don't try to memorise the whole card. You can refer to it as required during the role play.
- Don't feel you must complete every aspect of your task. Remember it is a guide only and you will not be penalised if you do not complete every detail of your card.
- Don't look at you card only and read it while the patient is talking as you must listen carefully to what they the patient says so that you can respond appropriately.
- Don't spend too much time on unrelated matters such as a detailed medical history as you do not have time for this.

- Don't ignore the task requirements and say what you think based on your medical knowledge. Remember it is a test of English language ability and not a place to demonstrate your medical knowledge.
- Don't show how nervous you are as this can negatively affect your result. Lots of practice is the best way to overcome nerves.
- Don't use a lot of medical jargon and technical words. You need to use layman's language to describe the condition.
- Don't speak in a continuously in a monologue. You are taking part in a 2 way conversation.
- Do not talk over the patient. You will be definitely penalised for this.
- Don't rush your sentences as you are more likely to make an error. Try to remain calm and in control.

MISCELLANEOUS QUESTIONS

How old are you?

Are you married?

Do you have any children?

Do you have a partner?

How frequently do you have sex?

When did you last have sex?

Do you use any form of contraception?

Have you had any serious problem in the past?

Have you ever been in hospital for any reason?

Have you had any problem with pregnancy?

Have you ever had accident or injuries?

How long ago was this diagnosis done?

Have you ever been hospitalized for any reason?

Have you ever had problem with your pregnancy?

Have you ever had accidents or injuries?

Is there anything else I need to know?

What do you think your problem is?

How do you think I can help you?

When did you first have the problem?

What do you understand by 'heartburn'?

When have you been getting it?

Have you ever noticed any particular kind of other discomfort, perhaps associated with the heartburn?

Do any particular foods seem to bring on your heartburn?

Now, have you noticed that any particular foods that trigger the heartburn?

Family history

Is anyone taking regular medication?

How old was your father when he died?

What did he die of?

Does anybody in your family have serious illness?

When did you last go abroad and where?

Drug history

Are you taking any medication at the moment?

Did you take it regularly on time?

To what extent, was it successful?

Do you use any over-counter remedies/ herbal/ homeopathy?

Do you know if you allergic to drug?

Past history

Have you ever fainted?

Have you ever had any dizziness?

Do you get ringing in your ears?

Have you ever had any numbness in your limbs?

Weight

What is your weight?

How much do you weight?

As you know your weight is not proportional to your height. You need to lose your weight.

You should cut down on your smoking / your fatty foods.

Work

What are your work hours like?

Do you have work at the weekend?

Do you have to stand around (per day) a lot, on your work?

Do you work shift / on shift?

What did you do before this job?

How long have you been out of job?

How long were you in that job?

Alcohol

What about alcohol?

What do you normally drink?

How much do you drink in the week?

How often do you drink?

What is the most you would drink in a week?

Can you give up alcohol if you want?

Are you aware of any difference in your alcohol consumption over the past few years?

Pregnancy

How long did your pregnancy last?

Did you have any trouble during your pregnancy, such as high blood pressure?

How long were you in labor?

Have you had a miscarriage?

Menstrual problems

Are your periods regular?

How often do you get them?

When was your last period?

How old were you when you start to get them?

How long do your periods usually last?

Would you say they are light or heavy?

Do you feel edgy (nervous condition) or irritable?

Do you get clot?

How many pads do you use each day?

Have you seen clot?

Do you get period pains?

Have you had any discharge?

What color is it?

Do the flushes interrupt your sleep?

When did you see the last one?

Did it come on slowly or suddenly?

Does it wake you up at night?

What type of pain do you have?

Have they made you feel sick?

Stress

Are you worried?

What sort of things make you stressed?

Tell me how you feel when you are stressed?

What do you do to relieve it?

Are you worried about anything?

Baby problem

Do *you give him foods supplement (supplementary foods)?*

What's his appetite like?

Is he breast fed or bottle fed?

Do you eat low fat dairy product?

I'm afraid calorie is necessary for the child growth.

The more calorie you give him, the his growth will be better.

Difficult patient

I cannot find anything seriously wrong with you. But I would like to have some blood tests before you leave the hospital.

That really interests me.

Tell me more.

It seems important.

Tell me more about things at home/work.

Are you afraid that something bad is going to happen to you?

Is your relationship with any particular person causing you stress?

I am concern about what you are not telling me.

What kind of troubles have you been having?

... yes, I understand please continue.

Ok, we will come to that later/ we will deal with that later.

But I hope the problem will solve with this medications.

Confrontation

You look sad.

You seem frightened.

You sound angry.

You seem tense.

You seem very sad today.

It seems your having trouble coping.

You seem to be telling me that.

Is there anything else I can help you?

Summarizing

If I have understood you correctly, you have told me … . If there are any questions, I will be pleased to answer them.

Physical exam

I am going to press gently on your stomach, let me to know if you feel pain. Well, I'll check you out, then after that, we will talk.

I'll just take your blood pressure now. Would you roll up your sleeve, please?

Could you slip into this gown and leave it open at the back. I am going to check your pulse.

Giving Advice

If you want to get rid of the infection, you will need to persevere. You will need to complete the course, to allow them to take effect. I am afraid only antibiotic will clear this up.

The less you smoke, the sooner you will recover.

With all due respect to your doctor, but I am not agreeing with him. It might not very delicious, but it is healthier.

ESSENTIAL VERBS IN ROLE PLAY

Start	*Decline*	*Assure*
Come on	*Lower*	*Inflammate*
Bring on	*Weaken*	*Swell*
Break out	*Strengthen*	*Protrude*
Notice	*Increase*	*Appear*
Seem	*Raise*	*Disappear*
Sound	*Recover*	*Get infected*
Experience	*Get rid of*	*Feel*
Get	*Feel better*	*Suffer from*
Get used to	*Clear up*	*Bother*
Have got	*Improve*	*Take care*
Transmit	*Prescribe*	*Watch (your weight)*
Trigger	*Apply (cream)*	*Consider*
Trigger off	*Perhaps*	*Control*
Stimulate	*Suppose*	*Help*
Aggravate	*Insist*	*Manipulate*
Provoke	*Recommend*	*Cut down (on)*
Deteriorate	*Advise*	*Cut off*
Worsen	*Refer*	*Quit*
Sort out	*Check*	*Keep away*

Sooth	*Explain*	*Be aware of*
Alleviate	*Arrange*	*Be complaining of*
Alley	*Make*	*Reduce*
Relieve	*Promise*	*Persevere*

OET SPEAKING SUB-TEST SAMPLE QUESTIONS

NOTE: There is no sample answers for these questions as it may limit your scope of the conversation that can happen in the real test.

OET SAMPLE TEST 1	
ROLEPLAYER CARD NO. 1	**NURSING**
SETTING	A Medical Centre
PATIENT	You are Kendra, a 32 year old mother. Your three year old son sustained a cut to his right arm in an accident in your home. You had left a pair of scissors on the kitchen table. Your son is very upset about the accident and won't stop crying. You feel so guilty about what happened.
TASK	• Explain what happened to your son. • Ask the nurse how the cut will be treated. • Find out how you can make your house safer for your son.

OET SAMPLE TEST 1	
CANDIDATE CARD NO. 1	**NURSING**
SETTING	A Medical Centre
NURSE	You are talking to Kendra, a 32 year old mother. Her three year old son Ken sustained a cut to his right arm today after an accident in the kitchen at their home. Ken seems to be in a lot of pain and Kendra feels very bad about what happened.
TASK	• Try to calm the mother down. • Find out the details of the accident.

	• Explain how you will treat Ken's cut. • Advise Kendra on future safety precautions in her home.

OET SAMPLE TEST 2	
ROLEPLAYER CARD NO. 1	**NURSING**
SETTING	Hospital Ward
PATIENT	You are a patient recovering from a minor operation. You are in considerable pain. However, you are strongly opposed to taking pain-killing drugs such as Panadol. The nurse has come to offer pain relief.
TASK	• When offered painkillers, flatly refuse them. • Keep resisting if the nurse presses you to change your mind. • Explain why you are against them (preference for naturopathic methods/fear of side effects/you don't like to appear weak/you think people take too many pain-killing drugs, etc.).

OET SAMPLE TEST 2	
CANDIDATE CARD NO. 1	**NURSING**
SETTING	Hospital Ward
NURSE	You are attending to a patient who is recovering from a minor operation. The patient is obviously in pain but reluctant to take drugs. You are sure that Panadol will relieve the pain.
TASK	• Suggest that the patient take some Panadol tablets. • Explain why he/she needs analgesia and outline its benefits. • Try to persuade the patient to take the tablets.

OET SAMPLE TEST 3	
ROLEPLAYER CARD NO. 1	**NURSING**
SETTING	A Hospital Geriatric Ward
PATIENT	You are an 79 year old woman. You had a fall in your home four days ago and broke your arm. You cannot remember the circumstances of the fall. All you remember is your neighbour coming to hospital with you in the ambulance. You have lived alone in your own home since your husband died 7 years ago, but you are finding it increasingly difficult to manage. You often feel confused and forgetful. Your daughter, who works full time, and your doctor have told you that you need to go into a nursing home. You are very frightened and distressed about this as you do not wish to leave your home and lose your independence. You believe that you will die soon if you move into a home.
TASK	• Discuss your fears and worries. • Have an emotional react on to the situation and be hard to get through to.

OET SAMPLE TEST 3	
CANDIDATE CARD NO. 1	**NURSING**
SETTING	A Hospital Geriatric Ward
NURSE	Your patent is an 79 year old woman. When she was admitted to hospital four days ago, she was confused and had sustained a broken arm during a fall in her home. She has been diagnosed with early stage dementia. Your patient has lived alone in her own home since her husband died 7 years ago. However, both her doctor and daughter, who works full time, believe that it is no longer safe for her to live on her own, and want her to move to a nursing home. The patient is very resistant and distressed by this.
TASK	• Encourage the patient to talk about her feelings and her fears. • Discuss her concerns with her and provide reassurance.

OET SAMPLE TEST 4	
ROLEPLAYER CARD NO. 1	**NURSING**
SETTING	Home Visit
PATIENT	You have been a diabetic for a number of years and have managed your diabetes with diet and tablets. However, your doctor wants you to start having insulin injections and has asked the district nurse to visit you at home to teach you how to give yourself these injections. You don't really understand why you have to have insulin injections. Also, you are very nervous about the procedure of injecting yourself.
TASK	• Ask the nurse why you have to have insulin injections, stressing that you feel you have been managing your diabetes well. • When the nurse is explaining the procedure for giving the insulin injections, show that you are anxious about it.

OET SAMPLE TEST 4	
CANDIDATE CARD NO. 1	**NURSING**
SETTING	Home Visit
NURSE	A general practitioner has asked you to visit a patient who has diabetes. Until recently the diabetes has been moderately well controlled by diet and oral medication. However, recently the patient's blood sugars have been high and the doctor has decided to commence insulin 'injections. The doctor wants you to show the patient how to give himself/herself the insulin injections. On arriving at the patient's home you find that he/she is very unsure why he/she needs insulin injections and very nervous about the procedure of administering the insulin.
TASK	• Explain to the patient, when requested, why he/she needs insulin injections.

	• Explain slowly and clearly the whole process of giving the injection (including using clean needles, administering the injection, sites for injection etc.). • Try to reassure the patient that he/she will be able to manage the injections. • Emphasise the importance of safe needle disposal (suitable containers, proper care and handling).

OET SAMPLE TEST 5	
ROLEPLAYER CARD NO. 1	**NURSING**
SETTING	A Hospital Ward
PATIENT	You are Alvin, a 76 year old retiree. You have just been admitted to hospital following a fall. You can vaguely remember feeling very dizzy when you stood up after lunch today and then collapsing.
TASK	• Tell that you have been taking various medications for several years and feel very comfortable with them. • Show that you feel particularly worried that, now that you are in hospital, the doctors may decide to change you medications. • Explain that your wife died two years ago, and you think this happened after her doctor changed. her medications. Since this time, you have felt very anxious about changing yours.

OET SAMPLE TEST 5	
CANDIDATE CARD NO. 1	**NURSING**
SETTING	A Hospital Ward
NURSE	You are talking to Alvin, a 76 year old man. He has just arrived on the ward following a fall yesterday, probably due to postural hypotension. It is believed

	that his medication is partially to blame for this, so it has been decided to change his medication as well as to conduct some tests.
TASK	• Talk to Alvin about the change in his medications. • Explain why he needs to take the new medication. • Persuade him that this is the right thing to do.

INTRODUCTION TO OET LISTENING SUB-TEST

The Listening sub-test is designed to assess a range of listening skills, such as identifying specific information, detail, gist, opinion or the speaker's purpose. These skills are assessed through note-completion tasks and multiple-choice questions. The Listening sub-test is divided into three parts, and a total of 42 question items. Across all three parts, a range of accents are used to reflect the global nature of the healthcare workforce. The main accents are: Australian, British, American, and other varieties such as New Zealand, Irish, Canadian, South Africa, etc.

The topics will be of generic healthcare interest, which is accessible to candidates across all professions. Therefore, the health professionals in a listening extract may be any one of the 12 professions who can take OET. The total length of the Listening sub-test is 50 minutes and the Listening audio is about 40 minutes, including recorded speech and pauses to allow you time to write your answers. You will hear each recording once only and are expected to write your answers while you are listening. You will have two minutes at the end of the sub-test to check your answers for all three parts of the sub-test. The test-takers usually award grade B to the candidates, who have a score of at least 30 marks.

You can use abbreviations that are commonly accepted in your profession and which are clear to other professionals, for example "BP" for blood pressure. However, you should avoid abbreviations that are specific to a particular workplace or specialism, because these might not be commonly understood. OET assessors are trained to accept a reasonable range of abbreviations, but OET does not refer to any specific dictionaries or lists.

There is no penalty for including information that is not in the marking guide. However, you will lose marks if you contradict yourself or make your meaning unclear. Names for conditions and medications are often difficult to spell, therefore in the Listening sub-test, you will not be penalised for misspelling, provided the meaning is clear to other healthcare professionals. Any reasonable attempt at spelling the

correct answer has a good chance of being accepted. Where possible, reference is made in the audio recording to both the generic and brand names for medications, and to both medical and lay terms discussed during the consultations. The marking guide gives assessors extensive guidance on the range of misspellings which are to be accepted.

Please note that the Listening sub-test is different from the Reading and Writing sub-tests in the way misspellings are treated. So, don't waste time hanging around for the correct spelling of names for conditions and medications that are often difficult to spell.

OET LISTENING SUB-TEST STRUCTURE

Part A (24 marks)

Part A consists of two consultation recorded extracts to assess your ability to identify specific information during a consultation. You will listen to two recorded health professional-patient consultations for about 5 minutes each and you will complete the health professional's notes using the information you hear. In Part A, you must complete the notes using the same words you hear on the recording. You should not paraphrase the information and you should not change the information.

Your answers for Part A are double-marked by trained OET assessors. These answers are randomly assigned to assessors to avoid any conflict of interest. For Part A, you must write your answers in the space provided in the question booklet.

Part A is all about gathering specific information, usually from what the patient says. You don't have to waste time making sure your grammar is perfect. Often, grammar words like articles are given in the answer key itself. OET Assessors are specifically instructed to accept small grammatical and spelling errors.

In Part A you have to write down information as note completion; so, carefully listen for words which indicate the structure of what the speaker is saying. This includes names or terms which match headings on the page. These will help guide you through the information on the

page and choose answers which fit logically.

In Part A, write your answers directly onto the lines provided for the two extracts in the question booklet. The length of the line should be sufficient to write the correct answer.

Part B (6 marks)

Part B consists of six short workplace recorded extracts (e.g. team briefings, handovers, or health professional-patient dialogues) of about 1 minute each to assess your ability to identify the purpose of short extracts from the healthcare workplace. You will have to answer one multiple-choice question for each extract you hear.

Part B is more about understanding the main idea of the communication between two healthcare colleagues, a healthcare professional and their patient or by a healthcare professional to a group of colleagues. You have to choose the most relevant option from the given three which represents the content of the communication. All the answer options may be offered, therefore it's always important to check which one is covered completely.

Part C (12 marks)

Part C consists of two presentation extracts of about 5 minutes each to assess your ability to follow a recorded presentation or interview on a range of accessible healthcare topics. You will have to answer six multiple-choice questions for each extract.

Part C contains two main types of listening questions; (1) understanding direct meaning and (2) understanding inferred meaning. In questions about direct meaning, you will for instance be asked about the speaker's main idea. In questions about inferred meaning might focus on the speaker's attitude. As it is in Part B, you need to choose the most relevant option from the given three to answer each question. The difference is that In Part C you have to demonstrate deeper understanding of the meaning of what has been said rather than the main idea.

Note: In multiple choice tasks (Part B and Part C), be careful not to choose an option just because you hear a word or phrase from it on the recording. Think about the whole meaning of what is said and match it to the closest option.

Your answers for Part B and Part C are computer scanned and automatically scored, therefore it's essential that you follow the instructions provided on the front page of the question booklet when entering your answers. You must fill in the circle containing your chosen answer A, B or C using a 2B pencil. Working as quickly as you can, shade in the whole of the circle including the letter with your pencil so it can be clearly read by the computer. If you want to change your answer, erase it and fill in the circle of the answer you now want to choose. Answers written elsewhere in your booklet will not be marked.

Tips To Improve Listening Skills

1. ***Developing your Listening skills***

   You should broaden your ability to deal with fresh content and unfamiliar voices by listening to radio programs and online lectures; never limit your listening practice to test preparation materials. Listening skills can be developed by listening regularly to a wide range of speech, at natural speeds, from speakers with different accents in different healthcare contexts. Try to listen to sources where the speaker is giving their own point of view. This will give you a proper practice in identifying and following the speaker's line of argument and attitude, which is very different from picking out factual content.

2. ***Using the pauses efficiently***

   For all parts of the test, use the pauses included in the recording to read the question booklet carefully; this will help you identify what you need to listen for. Remember that your main objective is to answer correctly; it may not be necessary to understand every word you hear.

3. ***Managing your time efficiently***

   In the Listening sub-test you hear the recording only once, so it's very important to write your answers as you listen. You check your answers during the short breaks between each question or at the 2-minute period in the end of the sub-test. Use this time to check that you have clearly answered each question and written your answers for Part A legibly.

OET LISTENING STRATEGIES

Question Type Specific Listening Strategies

Sentence Completion Questions (in part A)

In this type of questions, it is important to look at the question before the speaker starts speaking and identify the key word in the question. It will prepare yourself to listen for the correct answer.

For example:

is unhappy at the care home because of _________

The 'because of' in the question is obviously asking for a reason, and 'because of' usually needs a noun in the answer. This guess will help you to look specifically for a certain reason with a noun.

So, when the recording starts, scan the heading above the questions so you will have an idea about what you are going to listen.

Use your prediction skills wisely– e.g., what vocabulary is likely to come up given this topic. (in this example, the answer is definitely coming from patient's mouth. So, listen carefully for the negative terms like synonyms of unhappy like feel bad or sad, distressed, irritated, not pleased, miserable, pity.. etc)

Multiple Choice Questions (in part B & C)

In this type of questions, you have to look at the question and options carefully to pick out the key words. You should then think of any synonyms or paraphrases that could be used, both in the question and answers provided.

For example:

One drawback of exercise ECGs is that they are_______.

A. *prohibitively expensive*

B. *lacking in precision*

C. *less effective with males*

In this question the keywords are drawback, prohibitively, precision and less effective. You need to think of other ways to say these words, like disadvantage or problem for 'drawback'.

This guess will help you to flag the instances where these key words pop up, and choose which option has the most relevant information according to the question based on your understanding of the content.

General Listening Strategies

Have a spare pen or pencil ready just in case

Fill in the cover page correctly

- Stay relaxed and receptive – ready to listen
- Focus on listening and understanding then recording your answer
- Don’t try to write everything the speakers say – it is not dictation or a memory test
- Don’t be distracted by what is going on around you (e.g., sneezing, a nervous candidate at the next desk)
- Don’t lose your place during the test; remain focused on each question
- Use only the common abbreviations that you hear in the listening extract
- Write clearly; don’t make it difficult for the assessor to read your responses as you may not get all the marks you could
- Keep looking ahead at what is coming up
- Use the pauses in the recordings to finish writing, review, and prepare for the next section
- Make sure your notes communicate what you intend

- Don’t waste valuable time using an eraser to correct a mistake if you make one. Simply cross out any words you don’t want the person marking your paper to accept; this takes a lot less time and you will not be penalized
- Think twice about going back to change something – it may be better to leave what you wrote the first time if you are not sure
- Don’t leave any blanks; have a guess at the answer
- Check the format of each question: e.g., sentence completion or multiple-choice questions.
- Look for any simple spelling errors that may accidentally change the meaning of your answer (‘message’ for ‘massage’, ‘bills’ for ‘pills’, etc.).
- Practice, Practice, Practice! This is the most important aspect of improving your ability to take notes. The more you practice the better you will able to take notes and listen at the same time.
- Build your vocabulary. When you encounter new words, find out the meaning and write them down in a vocabulary booklet.

WEBSITE LINKS TO LISTENING EXTRACTS FOR PRACTICE

There are resources on the web which can help candidates develop the general listening skills involved in a medical context especially on YouTube. You can also check the language style, appropriate use of the language and some medical terms used in the following websites.

ABC Australia Health

• http://www.abc.net.au/health/

(Health Matters)

• http://www.abc.net.au/rn/allinthemind/

(All in the Mind)

• http://www.abc.net.au/rn/healthreport/

(Health Report)

• http://www.abc.net.au/rn/lifematters/

(Life Matters)

• http://www.abc.net.au/health/minutes/

(Health Minutes)

BBC World Service Health

•
http://www.bbc.co.uk/worldservice/programmes/health_check.shtml

(Health Check)

•
http://www.bbc.co.uk/worldservice/programmes/science_in_action.s

(Science in Action)

Newsletters

You could subscribe to the regular health-related newsletters:

- http://www.abc.net.au/health/subscribe/default.htm
- http://www.englishmed.com/