

OET

VOL:III

***Writing
Sub-Test
Exercises
& Answer Key***

FOR NURSES
(2021 EDITION)

MAGGIE RYAN

OET 2.0
WRITING
SUB-TEST

**EXERCISES
& ANSWER KEY
FOR NURSES
VOL. III**

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SECTION. I & SECTION. III are same as in first book of this series (VOL. I) and only included in this book for the sole purpose of revision, whereas the SECTION. II (Exercises & Answers) is different & contains unique 10 OET Writing Sub-test Questions & Sample Answers for practice.

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PREFACE

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How this book is different from other books available in the market?

Unlike paper books and other e books, you don't have to scroll or turn pages back and forth while answering questions. **One-touch navigation links** (with one single touch you will execute the intended action) are available between each questions and their respective answers/ relevant case notes/ custom sentence styles, and vice versa. This will save you a lot of time, and makes your answering easier.

Apart from this, **one-touch reference links** are available for every word in this book (including any words from paragraphs, questions, instructions, or even these words, which you are reading right now).

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1. **Dictionary**:– in-built dictionaries are available for referring any word you touch and hold. This feature helps you save a lot of time by:

- You don't have to search through a paper bind dictionary to find the meaning of the word.
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- There is an **in-built Oxford English dictionary** available for your reference, which shows the meaning in a pop up dialogue box. If you prefer detailed meaning or the meaning of phrases related to the word, then you can easily choose full definition in the pop-up box for further details and pronunciation.
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- b. You can read Wikipedia reference without closing or minimizing the kindle app in which you are reading the book.
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- d. This helps in the better understanding of technical and technological terms.

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Frequent Letter Types & Areas to Focus For Nurses

The writing sub-test is usually a letter of referral but it may also be a letter requesting or giving advice.

Letter to a doctor:

focus on medical history and medication

Discharge to a community nurse:

focus on medical history and ongoing care required

Transfer to palliative care:

focus on medical history and ongoing care required

Psychiatric condition:

focus on social factors & behavioural problems and issues

Discharge to social worker:

focus on social factors rather than medical details. Use lay language rather than abundance of technical terms.

Letter to General Public (Eg: Transfer to patient's home):

provide advice on a medical topic such as first aid for burns

Do not just summarise the medical history. Always consider what the referred to person needs to know and what they will do with information. The social factors are sometimes very significant, hence the need for ongoing care, and are included to make the task more complex and challenging for the

candidate.

Examples for Writing Task Types

Letter Type	Chief Complaint & Purpose of Writing(Examples)	Complicating factors in case notes (Examples)
<ul style="list-style-type: none"> • Referral to admitting doctor in Emergency Department 	<ul style="list-style-type: none"> • throat pain 	<ul style="list-style-type: none"> • Significant medical history • Urgent case
<ul style="list-style-type: none"> • Referral to Community Home Care social worker 	<ul style="list-style-type: none"> • Guillain-Barre syndrome patient 	<ul style="list-style-type: none"> • No family support • Detailed discharge plan • Cannot use medical terminology
<ul style="list-style-type: none"> • Referral to Child Health Nurse 	<ul style="list-style-type: none"> • Discharge of child • Ongoing care 	<ul style="list-style-type: none"> • Complex social factors • Language barrier
<ul style="list-style-type: none"> • Referral to 		<ul style="list-style-type: none"> • Requests no further treatment

<p>Hospice (palliative care)</p>	<ul style="list-style-type: none"> • Stage IV stomach cancer 	<ul style="list-style-type: none"> • Detailed medical history
<ul style="list-style-type: none"> • Referral to school psychiatrist 	<ul style="list-style-type: none"> • Post Traumatic Stress Disorder in child 	<ul style="list-style-type: none"> • Social factors leading to psychiatric problems • Focus on social not medical history
<ul style="list-style-type: none"> • Letter of advice to parents 	<ul style="list-style-type: none"> • Son discharging home after appendectomy 	<ul style="list-style-type: none"> • Letter of advice not referral • Summarise treatment procedure
<ul style="list-style-type: none"> • Referral to nutritionist 	<ul style="list-style-type: none"> • Dietary requirements of a diabetic patient 	<ul style="list-style-type: none"> • Socio-economic situation of patient • Detailed medical history

<ul style="list-style-type: none"> • Referral to GP 	<ul style="list-style-type: none"> • hypertension 	<ul style="list-style-type: none"> • Socio-economic situation of patient • Detailed medical & social history
<ul style="list-style-type: none"> • Referral to physiotherapist 	<p>Rehabilitation after open reduction and internal fixation surgery(ORIF)</p>	<ul style="list-style-type: none"> • Detailed medical history • Social situation
<ul style="list-style-type: none"> • Referral to Lactation Consultant 	<ul style="list-style-type: none"> • Baby not gaining weight 	<ul style="list-style-type: none"> • Complex social factors of mother
<ul style="list-style-type: none"> • Referral to Post-Operative Care Centre 	<ul style="list-style-type: none"> • Discharge after total colectomy 	<ul style="list-style-type: none"> • Detailed medication history

5 Criteria of Assessing Letter Writing

Your writing will be rated by at least 2 examiners who will use the criteria below to determine your writing level. Therefore study this information carefully so that you can develop the skills to write at top levels.

- **Overall task fulfillment** – including whether the response is of the required length.
- **Appropriateness of language** – including the use of appropriate vocabulary and tone in the response, and whether it is organized appropriately.
- **Comprehension of stimulus** – including whether the response shows you have understood the situation and provide relevant rather than unnecessary information to your reader.
- **Control of linguistic features (grammar and cohesion)** – how effectively you communicate using the grammatical structures and cohesive devices of English.
- **Control of presentation features (spelling, punctuation and layout)** – how these areas affect the message you want to communicate.

Overall task fulfillment

- **Write within the word limit between 180 and 200 words** for the body of the letter. This is the basic requirement of OET writing.
- **Don't write over 220 words** because you are being tested on your ability to write a clear concise letter, not a lengthy letter.
- **Don't write below 180 words** as your score may fall below B grade.

- **Don't copy directly from the case notes** without any changes. You should put the information into your own words.
- **Don't** write down all the information from the task sheet, which does not reflect reality. This will make the letter too long, poorly organised and difficult to read.
- **Find the irrelevant information** among the given information, which is not directly relevant to your task **and omit it.**
- Read the task question carefully, and make sure your letter has a clear focus. As a rule, recent case history is more important than older case history.
- **Don't** include information that the intended reader clearly knows already (e.g., if you are replying to a colleague who has referred a patient to you).
- **Avoid** using a 'formulaic' response – if you include elements that do not fit the task, it indicates a lack of flexibility in your writing.
- **Don't** start writing without planning your letter.
- State the purpose of the letter clearly in the introduction and focus on important information and minimise less relevant detail.
- Make your conclusion specific to the situation.
- **You should spend:**
 - 15 minutes reading case notes and planning the letter .
 - 25 minutes writing.
 - 5 minutes at the end of the test to proof read your work and fix up any mistakes.
 - **Don't** submit the letter without proof reading.

Appropriateness of language

- **Organize the information clearly** – the sequence of information in the case notes may not be the most appropriate sequence of information for your letter.
- **Group similar information** in the case notes together which are related such as medication, medical condition.
- **Highlight the main purpose** of your letter at the start – this provides the context for the information you include.
- **Do not overuse medical terminology** .
- **Be clear** about the level of urgency for the communication.
- Always keep in mind the **reason for writing** – don't just summarize the case notes provided.
- Focus on important information and **minimize incidental detail**.
- Consider using **dates and other time references** (e.g., three months later, last week, a year ago) to give a clear sequence of events where necessary.
- **Avoid informal language, slang, colloquialisms and spoken idiom** unless you are sure this is appropriate (e.g., use 'Thank you' rather than 'Thanks a lot').
- **Give the correct salutation:** if you are told the recipient's name and title, use them.
- **Show awareness of your audience** by choosing appropriate words and phrases: if you are writing to another professional, you may use technical terms and, possibly, abbreviations; if you are writing to a parent or a group of lay people, use non-technical terms and explain carefully.

Comprehension of stimulus

- Demonstrate in your response that **you have understood the case notes fully**.
- Be clear what the **most relevant issues for the reader** are.
- Base your **letter from today's perspective**. That means, include all the relevant history, but in summary form, eliminate less important detail and focus your attention on the current situation.
- **Don't let the main issue become hidden** by including too much supporting detail.
- **Show clearly the connections between information in the case notes** if these are made; however, do not add information that is not given in the notes (e.g., a suggested diagnosis), particularly if the reason for the letter is to get an expert opinion.
- If the stimulus material includes questions that require an answer in your response, be explicit about this – **don't hide the relevant information in summary** of the notes provided.

Control of linguistic features

- Show that you can **use language accurately and flexibly** in your writing.
- Make sure you **demonstrate a range of language structures** – use complex sentences as well as simple ones.
- **Split a long sentence** into two or three sentences if you feel you are losing control of it.
- Review areas of grammar such as:
 - **Use articles** (such as **a/an/the** before countable

nouns). This is very important for formal writing. The case notes are written in short form, so they do not follow standard grammatical rules and it is common to omit articles.

- **Use synonyms** so that you can express the information from the case notes in different ways.
- **Countable and uncountable nouns.**
- **Singular/ plural noun and verb agreement**, (e.g. The test result **shows** that ..., There **is** no evidence ..., He lives ..., one of the side effects.)
- **verb forms** especially past simple, present perfect & past perfect.
- **adverbs** that give time references (e.g., previously & ago).
- **prepositions** following other words.
- **Use connecting words and phrases** to link ideas together clearly (e.g., however, therefore, subsequently).
- **Gender agreement**, (e.g. Mr James and his **her** daughter)

Control of presentation features (spelling, punctuation and layout)

- Take care with the **placement of commas and full stops**. Make sure there are enough – separating ideas into sentences.
- **Follow standard letter format** for referral letters.
- **Expand on all acronyms** because you are being tested on your ability to expand on case notes. For example, BP as blood pressure and PR as pulse rate & hx as history.
- **Make sure there are not too many punctuations** – keep elements of the text meaningfully connected together.
- **Leave a blank line between paragraphs** to show clearly the overall structure of the letter.

- **Check for spelling mistakes and for spelling consistency** through your writing (e.g., with a patient's name).
- Remember that many of the words you write are also in the case notes – **check that the spelling you use is the same.**
- **Be consistent in your spelling:** alternative spelling conventions (e.g., American or British English) are acceptable as long as your use is consistent.
- **Don't use symbols as abbreviations** in formal letters.
- **Avoid creating any negative impact** on your reader through the presentation of the letter.
- **Use a clear layout** to avoid any miscommunication.
- **Make sure poor handwriting does not confuse the reader** over spelling and meaning.

Write legibly so the examiner can grade your response fairly using these five criteria.

Planning the Letter

Find answers for the following things while reading the case notes in the question and note them clearly:

- **Who** am I writing to?
- What **information** do **they need to know**?
- What **information** do **they not need to know**?
- What is the **chief purpose/complaint/current condition** of the letter?
- Are there any **significant social factors** which **need to be mentioned**?
- Are there any **trends in medical condition, treatment, medication**?
- What **information can be grouped together**?

3 Important Steps Involved in Letter Writing

1. **Select** the relevant case notes
2. **Organise** the selected case notes
3. **Transform** the organised case notes to sentences.

Relevant Matters Involved in a Standard Letter

- Patient's past medical history.
- Patient's past medications.
- Patient's current medical history.

- Patient's current medications (in detail).
- Necessary social particulars (lives alone).
 - Necessary physical particulars (needs walking frame).
 - What you want done now with the patient.

Introduction of the Letter

Date & Address

The position of the date can be either above the address or below the address. It is normal to leave a blank line space between the date and address. (But don't write both above and below.)

Date (this position is acceptable)

Name of person

Address

Address

Date (this position is also acceptable)

- In formal letters, it is normal for the date at the start to be written in full form e.g. 3rd February 2018 rather than 02/02/18. [Numbers and slashes is fine within the body of the letter]
- The test materials are specifically written for the test date each month so the date to use is also the same date as the test. The test date will also be the date of discharge, most recent consultation etc. within the case notes.
- If you make a mistake in the test and write a different date or use numbers not words, DO NOT PANIC, this cannot fail you. The assessors are looking for your understanding of letter writing convention in English. It is much more important that a date is on the letter than that the date you used is correct.

Salutation

Use shorter for recipient's name as full name is clearly stated above address. This can be followed by a comma.

Dear Ms. Robert,

Subject

The subject is a place where information such as the name & D.O.B of the patient can be included. This can save you words in the body of the letter, but be careful not include too much information here. Use proper punctuation.

- **Re: Margret Milton, D.O.B. 07/09/2000**
- **Re: Margret Milton (aged 17), for discharge from St. Bartholomew Hospital on 28 February 2018**

Contents of Introductory Sentences

1. Background information such as name, age, occupation, marital status and gender of the patient if relevant and not mentioned in the subject line
2. A brief summary of the chief complaint, purpose of writing or your main concern

It will usually be only 1 or 2 sentences long and detailed information about the patient's history and condition should go in the main body of the letter.

Sample Introduction Paragraphs & Examiner's Remarks

Sample Introduction 1

Dear Ms. Alfred,

Re: Mr. Antony Brian

I am writing to request aged care assistance for Mr. Brian, an 73-year-old man who is recovering from pressure ulcer on his left buttock.

Examiner's Remarks

- Includes shorter for a patient name as full name is clearly stated in the subject line.
- Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences.
- States both purpose of writing and chief complaint.

Sample Introduction 2

Dear Mr. Hammed,

Re: Mrs. Catherine Becker

I am writing to request a respite admission for this patient, a 46-year-old married mother of two children who has been receiving personal care from our organisation over the last two months.

Examiner's Remarks

- Includes shorter for a patient name as full name is clearly stated in the subject line.

- Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences.
- Includes relevant biographical detail: age, marital status, mother.

Sample Introduction 3

Dear Ms. Jerome,

Re: Ms. Morgan Meyers, DOB: 02/02/1957

I am writing to request daily home visits by the Blue Nurses to provide care and support for Ms. Meyers, a 61-year-old widow who lives on her own.

Examiner's Reviews

- Includes shorter for a patient name as full name is clearly stated in the subject line.
- Uses relative clause and appositive sentence structures which demonstrate ability to use complex sentences.
- States purpose of writing clearly.

Sample Introduction 4

Dear Ms. Baker,

Re: Mr. Benjamin Parker

I am writing with regard to Mr. Parker, a 63-year-old man who was admitted the hospital on the 4th of January and diagnosed with Non-Small Cell carcinoma of left lung. He underwent a open lobectomy on the 6th of January.

Examiner's Remarks

- Includes shorter for a patient name as full name is clearly stated in the subject line.
- Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences.
- Summarises chief complaint and treatment.

Sample Introduction 5

Dear Parents:

Re: Outbreak of head lice

I am writing to inform you of a recent outbreak of head lice at Green Valley Primary School. Although head lice spread easily and cause several symptoms of itchiness and discomfort, they are easy to diagnose and treat.

Examiner's Remarks

- Purpose of writing stated clearly in the subject line
- Informs parents of main problem
- Summarises symptoms and treatment briefly

Sample Introduction 6

Dear Mrs. Daniel,

Re: Samson Simon (aged 63), for discharge from Newtown Public Hospital on 11 February 2018

I am writing to refer Mr. Samson who was admitted

to our Coronary Care Unit ten days ago with the diagnosis of peripheral vascular disease(PVD). Peripheral angioplasty was done, followed by post-operative treatment and physiotherapy.

Examiner's Remarks

- Does not include patient's full name or age as this is clearly stated in the subject line
- Uses appositive and relative clause sentence structure which demonstrates ability to use complex sentences
- States purpose of writing clearly and summarises recent history
- Summarises chief complaint and treatment and current condition

Introduction - Incorrect and Correct Usages with Explanations

Incorrect Usage	Correct Usage	Explanation
Dear Ms Annie	Dear Ms. Annie,	Punctuation error
I am writing to refer Mr. John, 54 years old man who lives alone.	I am writing to refer Mr. John, <u>a 54-year-old</u> man who lives alone.	Age Error: Rules regarding how to refer to a patient's age are: It must be hyphenated when used before a noun such as man/woman, an article is required.
I am writing to refer Mr. Harry Douglas. He is <u>81 years old</u> . He is a <u>pensioner</u> . He is a <u>widower</u> . He requires dietary advice after undergoing liver transplant.	I am writing to refer Mr. Harry Douglas, a <u>81-year-old widowed pensioner</u> who requires dietary advice after undergoing liver transplant	Appositives Error: Appositives is a noun or a noun phrase that is placed after another noun to explain or identify it, and a comma is required to separate these nouns. It has a very important use in the introductory sentence of referral letters.
I am writing to refer Mr. Mason.	I am writing to refer Mr. Mason	Relative Clauses Error: A relative clause is a useful sentence structure

<p>He is due to be discharged today. He has made a full recovery. I am writing to refer Mr. Mason, 70 years old who lives alone</p>	<p>who is due to be discharged today after making a full recovery. I am writing to refer Mr. Mason who is 70 years old and lives alone.</p>	<p>to use in the introduction. It allows the write to demonstrate the ability to write a complex sentence, which is a basic necessity to get B grade of higher.</p>
<p>Dear Ms. Dan, Re: Mrs Rita Redford I am writing to refer Mrs Redford, an 74 year old woman who is a resident at the Sunrise Retirement Home, who needs urgent admission to your hospital due to severe stomach pain.</p>	<p>Dear Ms. Dan, Re: Mrs. Rita Redford I am writing to refer Mrs. Redford, a 77-year-old woman who is a resident at the Sunrise Retirement Home. She needs urgent admission to your hospital due to severe stomach pain. or I am writing to refer Mrs. Redford, a 77-year-old female resident at the Sunrise Retirement Home who needs urgent admission to your hospital due to</p>	<p>Incorrect sentence structure with two relative clauses.</p>

	severe stomach pain.	
Dear Mr. Sheldon, Re: Aiden Carlson I am writing to refer Carlson a 13-year-old boy, who is a year 7 student at Williams School.	Dear Mr. Sheldon, Re: Alden Carlson I am writing to refer Aiden, a 13-year-old boy who is a year 7 student at Williams State School.	Two errors 1. Use first name when referring to a child. 2. Incorrect punctuation (comma placement)
Re: Mr. Ernest D’cruz DOB: 20/05/1955 I am writing to refer Mr. Ernest D’cruz to you, an 62-year-old widower. He is due to be discharged today. He has made a full recovery from asthma	Re: Mr. Ernest D’cruz DOB: 20/05/1955 I am writing to refer Mr. D’cruz to you, a 62-year-old widower who is due to be discharged today after making a full recovery from asthma.	No grammatical errors, but it lacks sophistication in the use of simple sentences. Also, it repeats the patient name in full which is not necessary and repetitive since it was written directly above in the subject line.
Dear Ms. Jackson, Re: Sandra Stewart Thank you for admitting Mrs.	Dear Ms. Jackson, Re: Sandra Stewart Thank you for admitting Mrs. Stewart, an 70-	Relative pronoun

<p>Stewart, an 70-year-old dementia patient, requires respite care for a period of three months.</p>	<p>year-old dementia patient <u>who</u> requires respite care for a period of three months</p>	<p>missing error.</p>
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Body Paragraphs of the Letter

Most referral letters will contain 3 body paragraphs and each of the paragraphs should have a main idea which the writer needs to convey to the reader. All the sentences with the paragraphs must relate to this main idea.

Topic Sentence

A topic sentence which introduces the reader to the main idea of the paragraph. In many cases it will identify and/or summarise an area of concern regarding the patient. It should be written in original words rather than from words in the case notes.

Supporting Sentences

Supporting sentences may contain the information regarding patient history, details of symptoms, relevant aspects from the treatment record, causes and effects, trends, etc. This information can be taken directly from the case notes, and written as full sentences. So, you will need to paraphrase the information into your own words. This includes:

- Changing verbs to nouns: advise=advice
- Changing adjectives to nouns: Confident = Confidence
- Using synonyms

Paragraph Structure

A good paragraph will contain 5 main elements

1. Topic Sentence
2. Supporting Sentences
3. Signal words/phrases
4. medical collocations
5. Vocabulary

Note: Please check '*Miscellaneous Notes*' section in this book for detailed information on: medical collocations, vocabulary and expansion of medical abbreviations seen in OET Writing Sub-Test Questions.

It's a lengthy section; so, I didn't want to waste the time candidates who have only days to prepare for their exams by not focusing on core sections of OET Writing.

Signal words and phrases

They link sentences together so that the information flows smoothly and is easy to read. Common signal words/phrases which can help you present information clearly and logically include:

- Additional information: *Moreover, Also, In addition, Apart from this, Furthermore*
- Advice: *I recommend that you....., It is important to..., Please ensure that.....*
- Contrast: *Despite, However, Although*
- Emphasis: *My main concern is....., Please note, May I remind you, What concerns me most is.....*
- Location: *Initial examination at my clinic revealed..., During hospitalisation, On examination....*
- Order: *Firstly, Secondly, Thirdly, Finally*
- Result: *As a result, Therefore, Consequently, For this reason...*
- Sympathy: *Unfortunately, Regrettably,*
- Subject: *Based on the test results....., Regarding her medical history....., In terms of her social history..., With regard to her medication....., Her medical history shows..., The risk factors include....., Treatment to date includes...*
- Time: *On review today, On consultation today, On 19/08/10..., At that time, Recently, Over the past 2 weeks...., Three weeks later, On her next visit, During, Since that time, Initial examination...*

Using Passive Voice in Letters

The most simple sentence structure in the English language is:
Noun + verb.

If the noun is doing the action described by the verb, the noun is known as a subject. E. g. The doctor consulted. ('doctor' is the subject of this sentence).

If the action described by the verb is being done to someone or something, the recipient of the action is known as the object. We add this noun after the verb:

E. g. The doctor consulted the patient. ('doctor' is the subject and 'patient' is the object).

This sentence structure is:

Subject + verb + object

Using the passive voice allows us to do two useful things in healthcare letters:

1. Focus on the object of a sentence by putting it first.
2. Save space by leaving out the subject (that is, the noun actually doing the action).

The first type of sentence structure in usage is:

Object + Passive verb + subject

E. g. The patient was consulted by the doctor.

This allows us to focus the reader's attention on the patient, rather than the doctor, by putting them first in the sentence. This is useful in discharge and referral letters, because the patient is the most important focus of the letter.

The second sentence structure in usage is:

The patient was consulted.

This is very useful if the person or thing that did the action isn't as important as the person who received the action. It also allows us to leave out irrelevant information. For example, 'the patient was admitted on 27th January 18' is more concise than 'the patient was admitted on 27th January 18 by a doctor'. It doesn't really matter who admitted the patient, so it's best to leave this information out when doing the OET Writing Test.

A very common error that candidates make in their writing tasks is to use the active form of a verb instead of the passive. Any verb can be 'active' or 'passive', depending on whether the noun it refers to is doing an action or receiving an action. The passive voice is especially useful in healthcare letters. This is because we are mainly writing about a patient, and a patient often receives actions rather than doing things actively.

Frequently Used Verbs		Present Tense	Past Tense	Future tense
Admit	Active	Admits	Admitted	Will admit
	Passive	<i>Is being admitted</i>	<i>Was admitted</i>	<i>Will be admitted</i>
Advise	Active	Advises	Advised	Will advise
	Passive	<i>Is advised</i>	<i>Was advised</i>	<i>Will be advised</i>
Decrease	Active	Decreases	Decreased	Will decrease

	<i>Passive</i>	<i>Is being decreased</i>	<i>Is being decreased</i>	<i>Will be decreased</i>
Discharge	Active	Discharges	Discharged	Will discharge
	<i>Passive</i>	<i>Is being discharged</i>	<i>Was discharged</i>	<i>Will be discharged</i>
Increase	Active	Increases	Increased	Will increase
	<i>Passive</i>	<i>Is being increased</i>	<i>Was increased</i>	<i>Will be increased</i>
Require	Active	Requires	Required	Will require
	<i>Passive</i>	<i>Is required</i>	<i>Was required</i>	<i>Will be required</i>

Here are some examples:

- The patient was admitted on Monday.
- The dose will be increased after discharge.
- She is advised to continue the rehabilitation exercises.

Overall, passive voice can be a very useful tool in improving your letter.

Conversion of Case Notes to

Body Paragraphs with Samples

Sample 1

Case notes

Birth History

Normal vaginal birth at term
Birth weight: 3500gm
Apgar score at 5min: 9
No antenatal or postnatal complications

Feeding

Breast fed for first three weeks after birth.

Baby became unsettled during heat wave at Easter. Mother got sick and had a fever for a few days. Mother-in-law came to visit and advised changing baby to formula feeds. Mother-in-law advised extra powder in formula feeds to improve weight gain. Mother-in-law says her son (Greg Collins) also had feeding problems and difficulty gaining weight as a baby.

Mother says she is worried she does not have enough breast milk and now gives extra formula feeds as well as breast feeding. She wishes she could breast feed properly as she believes it would be the best thing for her son. He hasn't taken to the bottle.

Sample Body Paragraph 1

The patient was born via vaginal birth at term with a birth weight of 3500 grams. During a heat wave at Easter, the baby became unsettled, due to lack of fluids. When the mother became sick for a few days, her mother-in-law visited to help out but has advised her to change to formula feeds and to put more powder in the bottle to improve weight gain. However, the mother believes that breast milk is the best for her baby and would like to breast feed full-time but is worried that she doesn't have enough breast milk for the baby. Therefore, she has been giving extra formula feeds to the baby.

Examiner's Remarks

1. The topic sentence is begins with the baby's birth.
2. Supporting sentences transform case notes into complete sentences.
3. Displays understanding of the long case notes by summarising the main idea. Explains conflicting views of mother and mother-in-law.

4. Signal words/ phrases used: During a heat wave, When, However, Therefore.

Case notes(continuation)

06/05/17

Subjective

Mother and baby attended for routine 6 week check-up. Mother says she is concerned about constipation: once every three days, hard stool. Mother is asking about stool softener or prune juice for baby.

Objective

Reflexes normal
Lethargic
No abdominal tenderness
Heart Rate: 174
Respirations: 56
Temperature: 37.1
Weight: 4200gms
3 wet nappies in last 24 hours.
Urine dark.

Assessment

Mild constipation and dehydration

Sample Body Paragraph 2

At the 6 week check-up, the baby's weight is 4200 grams and his vital signs are in normal limits. However, the baby is suffering from mild constipation, dehydration and lethargy.

Examiner's Remarks

1. Topic sentence is introduced with the phrase: **At the 6 week check up**,
1. Focuses on objective information and final assessment. Omits irrelevant detail.
2. Summarises objective details concisely into 'vital signs in normal limits'

3. Paraphrases adjectives into nouns, (lethargic=lethargy)
4. Signal words/ phrases used: At the 6 week check up, However

Case Notes (continuation)

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.

Sample Body Paragraph 3

Could you please support and advise the mother regarding breastfeeding and correct preparation of formula feeds if required. In addition, advice on how to keep the baby cool in hot weather is necessary. Please note, the patient is due for review on 08/05/2017.

Examiner's Remarks

- Topic sentence is a request of support
- Supporting sentences expand case notes into formal sentences
- Signal words/ phrases used: In addition, Please note, on 08/05/2017

Sample 2

Case Notes

Diagnosis

Right partial rotator cuff tear

Presented to Mater hospital with pain and weakness in the right shoulder, especially when lifting arm overhead. Descending stairs at home and slipped, falling onto outstretched arm. Xray and MRI showed a partial rotator cuff tear. Orthopaedic surgeon discussed surgery. Patient prefers to try non-surgical treatment.

Date of admission: 31-01-2018

Date of discharge: 02-02-2018

Treatment

Ibuprofen orally QID

Cortisone injections

Daily physiotherapy

Sample Body Paragraph 1

Ms. Merkel was admitted to our hospital on the 30th of October with a diagnosis of right rotator cuff tear following a fall while descending stairs. Therefore, surgery has been suggested; however, she prefers non- surgical treatment. She has received ibuprofen and cortisone as prescribed and also daily visits by a physiotherapist.

Examiner's Remarks

1. Topic sentence is introduced with the phrase: **Ms. Merkel was admitted to our hospital on....**
2. Supporting sentences transform case notes into complete sentences
3. Signal words/ phrases used Therefore, However

Case Notes (continuation)

Medical History

Diabetes Mellitus Type 2 Metformin 500mg mane

Nursing Care Needs

Needs blood glucose level monitoring 4 hourly
May be elevated because of cortisone

Needs assistance with shower and housework Orthopaedic review on 18th February

Sample Body Paragraph 2

In terms of her medical history, she suffers from type 2 diabetes mellitus for which she is taking metformin 500mg. However, following her discharge, she will need a regular monitoring on the blood glucose level which may become elevated due to administration of cortisone during hospitalisation. She will also require assistance in showering and home help. As well as this, she needs to review her condition with an orthopaedic surgeon on the 18th of February.

Examiner's Remarks

1. Topic sentence is introduced with the phrase: **In terms of medical history**,
2. Supporting sentences transform case notes into complete sentences.
3. Signal words/ phrases used
However, due to, As well as this

Case Notes (continuation)

Social Background

Marital status: Widow.

No children.

Lives alone

Next of kin: Nancy Song (Niece)

Niece lives with husband in Sydney who works as software engineer for Google Australia.

Sister died recently.

No other relatives.

Sample Body Paragraph 3

Ms. Merkel lives alone and has no children. Her next of kin is her niece, Nancy Song who lives in Sydney. Regrettably, she has no relatives or friends to support her.

Examiner's Remarks

1. There is no topic sentence, but the main idea of social history is clear.
2. Supporting sentences expand the case notes into complete sentences, note the use of verbs, articles and conjunctions (and).
3. Signal words/ phrases used
Regrettably.

Conclusion of the Letter

The conclusion of the letter should be in a standard format. It should be based on the task question which is found mostly at the end of case notes. It may contain usually one or two of the following points:

- a polite request of action required/ a thank you for ongoing support
- an offer of future assistance if required (this may be useful if you plan to omit some details from the case notes)

It is useful to be familiar with some standard formats so that you will be able to conclude your letter quickly, confidently and accurately. However, you should try to ensure that your conclusion is related to your task and not simply a memorised ending.

In conclusions can/ will are considered informal. Therefore, avoid using them. For instance:

- I will be pleased if you can examine, diagnose and treat the patient as you feel appropriate.
- Can you examine and treat the patient as you feel appropriate.
- Can you arrange someone to help this family and provide proper medical support

Also, avoid direct sentence formats such as

- Please examine, diagnose and treat the patient as you feel appropriate.
- Please examine and treat the patient as you feel appropriate.
- Please arrange someone to help this family and provide proper medical support.

Use could/ hope you can / would to write a polite and standard conclusions.

- Could you please examine and treat the patient as you feel appropriate
- I hope you can arrange someone to help this family and provide proper medical support.
- I would be grateful if you could examine, diagnose and treat the patient as you feel appropriate.
- I would appreciate it if you could examine, diagnose and treat the patient as you feel appropriate.

The passive form of sentence is more polite and will make an excellent conclusion.

- It would be greatly appreciated if you could examine, diagnose and treat the patient as you feel appropriate.

Conditional Sentences

- These sentences are also frequently used in the conclusion of a referral letter. For example

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

- If you require any more information, please do not hesitate to contact me.
- If you have any further questions, please do not hesitate to contact me.
- Please do not hesitate to contact me if you have any further questions.

Closer, Name and Designation

Leave a space between the last line of the conclusion and the closer. The closer should be followed by a comma. Then write your name and designation below the closer.

Yours sincerely,

Martina Cammeron
Charge Nurse

Sample Questions, Sample Conclusions and Examiners Remarks

Sample 1

Case Notes

Discharge Plan

Organise social worker and Meals on Wheels. (Niece will visit at weekend to help with housework and shopping) Stitches to be removed and situation to be reviewed at Out Patient Department appointment - 10.30 am 31-05- 09

Writing Task

Using the information in the case notes, write a letter to the Director, Saffron Nursing Service, Wharton Street, Brisbane.

Conclusion

It would be greatly appreciated if you could do daily home visits and provide support and reassurance for Mrs. Cooper. In addition, please organize Meals on Wheels and a social worker for home help. Please note, the patient has an appointment at the Out Patient Department at 10.30 am 31-05-09 for the removal of stitches. Thank you for your ongoing care.

Yours sincerely,

Pamela Peterson
Charge Nurse

Examiner's Remarks

- This is a long conclusion, but incorporates discharge plan into the conclusion which is an effective strategy
- Emphasises a future appointment
- Maintains polite tone through the use of modal verb would & could
- Contains a polite thank you

Sample 2

Case Notes

Writing Task

Mr. Han has requested advice on low fat dietary guidelines and healthy simple recipes. Write a letter to the Community Information Section of the Heart Foundation, Mathew Marlow, Houston on the patient's behalf. Use the relevant case notes to explain Mr. Han's situation and the information he needs. Include Medical History, BMI and lifestyle. Information should be sent to his home address.

Conclusion

In order to maintain a good health condition, Mr. Han has requested advice on low fat dietary guidelines and healthy simple recipes. It would be greatly appreciated if you could send the above mentioned information to Mr. Han at his home address 41B Livingston Apartments, Park Street, Texas.

Yours sincerely,

Manuela Channing
Charge Nurse

Examiner's Remarks

- Uses information from the writing task to formulate conclusion
- Contains a polite request
- Maintains polite tone through the use of modal verbs would and could
- Contains information specific to the task

Sample 3

Case Notes

Writing Task

Write a referral letter to the Dr Tim Pearson, Medical Practitioner at the Heathrow General Practice, requesting assessment of your patient's condition. Give the recent history of events and also the patient's past medical history and condition.

Conclusion

It would be greatly appreciated if you could assess the patient's condition and treat as you feel appropriate.

Yours sincerely,
Stephanie Meyer
Charge Nurse

Examiner's Remarks

- Contains a very polite request using conditional 'if' plus passive form
- Polite tone through the use of modal verbs would & could

Sample 4

Case Notes

Writing Task

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

Conclusion

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,
Michele Anton
Charge Nurse

Examiner's Remarks

- Uses information from the writing task to formulate conclusion
- Contains a request using the polite expression: I hope you will be able to..
- Contains information specific to the task
- Offers future assistance

Sample 5

Case Notes

Writing Task

Write a letter for the admitting doctor of the St. Patrick's Hospital Emergency Department. Give the recent history of events and also the patient's past medical history and condition.

Conclusion

I would appreciate your assessment and emergency management of this patient's condition.

Yours sincerely,
Night Nurse
Morning Star Retirement Home

Examiner's Remarks

- Uses information from the writing task to formulate conclusion
- Maintains polite tone through the use of modal verb would
- Maintains level of urgency appropriate to the situation

Things to Remember While Writing

- Take the time to understand the situation and the requirements of the task.
- Before you begin writing, underline all the information in the notes that you think is relevant to the specialist you are referring to.
- Write in a formal style within the word limit mentioned and avoid using slang language or abbreviations.
- Always remember why you are writing and who you are writing it for.
- Write as neatly as possible. The examiner must be able to clearly read your writing.
- Try to use complex sentences where it is appropriate. If your sentence is too long or complicated, break it down into more simple sentences.

How to Practice Sample Exercises in This Book

1. Read the question thoroughly at least 2 times from top to bottom.
2. Prepare a list of relevant case notes in a sheet of paper. [NB: short hands save time]
3. There is a 'Relevant Case Notes' link after every question. Click the 'Relevant Case Notes' Link below the question and compare it with your own lists.
4. After that start writing the Letter.
5. If you feel starting trouble or need help with sentence structures, click the 'Custom Sentence Styles' Link below the question. [Note: Custom sentences styles are based on sample answer]
6. After finishing the task, click 'Sample answer' Link to read the sample answer, which will give you more orientation in writing.

Relevant Case Notes and Sample answer is provided only for questions 1 to 5.

Questions 6 to 10 doesn't have 'Relevant Case Notes' Links or Sample answer. They only have general 'Custom Sentence Styles' for introduction, body paragraphs and conclusions. These questions are meant for self assessment.

WRITING 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:

You are Roxanne Williams, a senior nurse working with Athlone Health Care Agency. Henry Bastian is a patient under your care. Read the case notes below and complete the writing task, which follows.

Patient Details

Henry Bastian, 53 years old
12 Eastbury Road
Northwood HA6 3AL
Phone: +44 20 3826 5500

Social Background

Married – Wife, Kendra Bastin, aged 48.
They live together Henry Bastian works as an accountant for a company in Northwood.

Medical History

Cerebrovascular accident (CVA) approximately 2 years ago.
Agile, mentally active, speech slightly slurred, complaining of severe illness, walks with a limp, impaired balance

10/4/2018

Experienced a severe headache in the morning, fell down the stairs and badly injured his left knee. GP requested 'Athlone Health Care Agency' to help with dressing and assisting him in taking showers daily.

13/4/2018

Left knee – redressed, no infection noticed.
Henry was able to walk short distances with the help from his wife, Kendra.
He complained of usual pain while walking, apart from this there is nothing different to report and he is making good progress.

17/4/2018

Knee healed well.
Patient was advised to walk with walking sticks.
Patient's wife, Kendra, requested more home visits in order to continually improve his mobility.

Writing task:

Using the information provided in the case notes, write a letter to the Head Nurse, Ms Carol Kopelowit, Northwood Physiotherapy, 14 Hillside Cres, Northwood HA6 1RW on behalf of Kendra, requesting a home visit to help her husband make improvements with his walking.

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.

Relevant Case Notes	<u>“Writing Test 1”</u>
Custom Sentence Styles	<u>“Writing Test 1”</u>
Sample Response Letter	<u>“WRITING TEST 1”</u>

WRITING 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:

You are Linda Denison, a qualified head of nursing, working at Choice Hospital. Elma Lincroft is a patient in your care.

Patient Details

Elma Lincroft, 53 years old
Hanover St, Liverpool L1 3DZ
+44 151 691 4933

Social Background

Widow – lives alone
No children
Femi Lindsey, her neighbor, is very friendly, visits her in hospital daily

Medical History

Underwent an operation for appendicitis (appendix removed) – 1996
Diagnosed as diabetic – 2007
Admitted to the hospital due to severe pain in the stomach- 12 Feb 2018 (Diagnosed as food poisoning – cleared)
Patient was discharged after a week at the hospital – 18 Feb, 2018
12 April, 2018 – Admitted to the hospital due to severe abdominal pain, weakness, nausea
Symptoms went after a course of medication was taken.
Discharged after a week
12 July, 2018 – Admitted to the hospital due to an injury to the left knee and ankle, as well as an injury to the head.
Fell down the stairs.
Not used to wearing spectacles.
Suffered from pain and an intense stinging sensation, and inflammation of the skin
Walks with difficulty now
20 July, 2018 – Shown signs of a successful recovery.
Discharged from the hospital.
Personal nursing care has been requested

Writing task:

Using the information in the case notes, write a letter to Ms Holly Vincent, Head Nurse at Old Age Nursing Home, 1 Clock Tower Park, Longmoor Lane, Liverpool L10 1LD, to request that a nurse is sent to the patient's house to help with her recovery and with personal care.

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.

Relevant Case Notes	<u>“Writing Test 2”</u>
Custom Sentence Styles	<u>“Writing Test 2”</u>
Sample Response Letter	<u>“WRITING TEST 2”</u>

WRITING 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:

Mr. Ned Olin, a 63-year-old, is a patient in the medical ward of which you are Charge Nurse.

Patient details

Ned Olin (Mr.)

Community Retirement Home, Brisbane

Widowed (spouse deceased, 8 months ago)

Next of kins are Vinnie, web designer (27, married, 1 infant)

Ingram, accountant (30, married, working overseas, 2 children <5)

Diagnosis

Pneumonia

Past medical history

Osteoarthritis (mainly fingers) – Voltaren

Social background

Retired school teacher (history, mathematics).

Financially independent.

Lonely since wife died.

Weight loss – associated with poor diet.

Medical background

Admitted with pneumonia – acute shortness of breath (SOB), inspiratory and expiratory wheezing, persistent cough (chest & abdominal pain), fever, rigors, sleeplessness, generalised ache.

On admission – mobilising with pick-up frame, assist with ADLs (e.g., showering, dressing, etc.), very weak, ambulating only short distances with increasing shortness of breath on exertion (SOBOE).

Medical progress

Afebrile.

Inflammatory markers back to normal.

Slow but independent walk & shower/toilet.

Dry cough, some chest & abdom. pain.

Weight gain post r/v by -.dietitian

Nursing management

Encourage oral fluids, proper nutrition.

Ambulant as per physio r/v.
Encourage chest physio (deep breathing & coughing exercises).
Sitting preferred to lying down to ensure postural drainage.

Assessment

Good progress overall

Discharge plan

Paracetamol if necessary for chest/abdom. pain.
Keep warm.
Good nutrition – fluids, eggs, fruit, veg (needs help monitoring diet).

Writing task:

Using the information given in the case notes, write a discharge letter to Ms Riley Casper, Resident Community Nurse at the Community Retirement Home, 34 Park Street, Brisbane.

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.

Relevant Case Notes	<u>“Writing Test 3”</u>
Custom Sentence Styles	<u>“Writing Test 3”</u>
Sample Response Letter	<u>“WRITING TEST 3”</u>

WRITING 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:

Patient Details

Ms Jennifer Michael

DOB: 19/03/1957

New resident of Dementia Specific Unit, Caremark Elderly Care

Single

Under the Australian Guardianship and Administration Council protection

Medical History

Ischemic heart disease (IHD) since 2011, takes Nitroglycerine patch, daily

Stroke – May 2017, after stroke - unsteady gait

In 2017 - diagnosed with severe dementia - able to understand simple instructions only, confused and disorientated

Diabetes mellitus (type 2) since 2006 – on a diabetic diet Osteoarthritis of both knees 15 yrs.

Voltaren Gel to both knees BD

Weight gain 10 kg over the last 5 months, current weight 106 kg (BMI of 30)

Chronic constipation, takes Laxatives PRN

No allergies to medication or food

No teeth – has entire upper or lower dentures, sometimes refuses to wear dentures due to confusion and disorientation

Increased appetite– usually eats full portion of offered meals x 3 times daily and, also, goes into other residents' rooms and eats their food as bananas, biscuits or lollies.

Social History

no friends

lack of interests, but likes colouring and watching TV

emotional dependence on nursing staff

non-smoker, no use of alcohol or illegal drugs

Recent Nursing Notes

15/02/18

Chest infection. Keflex 500mg QID x 7 days

26/02/18

Occasional cough & episodes of SOB with ↑ RR

27/02/18

Sporadic throat clearing after eating yoghurt

20/03/18

1700 hrs

Episode of choking on a piece of food (? food not chewed properly). She suddenly turned blue, grabbed the throat with both hands and coughed. The piece of solid food was removed.

1710 hrs

Nursing assessment after treatment

- Pulse – 88 BPM
- BP – 115/70 mmHg
- RR – 16/min
- T-37.0 ° C.
- BSL – 6.0 mmol/L 1800 hrs
- No complaints.
- Skin: normal colour
- Hospital visit not required

Writing task:

You are a Registered Nurse at the Dementia Specific Unit. Using the information in the case notes, write a letter to Dietician, at Department of Nutrition and Dietetics, Beaumont Hospital, Gold Coast. In your letter explain relevant social and medical history and request the dietician to visit and assess Ms Michael's swallowing function and nutritional status urgently due to a high risk of aspiration.

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.

Relevant Case Notes	<u>“Writing Test 4”</u>
Custom Sentence Styles	<u>“Writing Test 4”</u>
Sample Response Letter	<u>“WRITING TEST 4”</u>

WRITING TEST 5
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 Catherine Currant, a qualified nurse, working with the Willis Care & Nursing, Birmingham. Brenda Chadwick is a patient in your care. Read the case notes below and complete the writing task which follows.

Patient Details

Brenda Chadwick (Mrs.)
Great Charles Street Queensway, Birmingham B3 3LP
+44 333 323 3121
DOB: 2 May 1958

Social Background

Married – husband Mark Chadwick, aged 73. He is a retired teacher. They live together in their own house.

Medical History

Osteoporosis patient – first signs noted in 2015

16 April 2018

Tripped over a loose rug – injured hip

16 April 2018

Admitted at the hospital (time: 12:45 pm)
Diagnosed – hip fracture or broken hip (intracapsular)

17 April 2018

Underwent surgery – successful

18 April 2018

Shifted to specialized geriatric-orthopaedic rehabilitation ward. Rehabilitation treatment initiated.
Offered mobilization (exercises to help promote strength and recovery).

23 April 2018

Patient doing well. Walking, with help. Requires extra care.

25 April 2018

Discharged from the hospital
Her husband wants someone to come to their house to help her with gaining mobility and with

performing exercises to help speed up the recovery process. He is not really able to assist her with walking because he uses a walking stick himself.

Writing task:

Using the information in the case notes, write a letter to Mrs. Gretchen Lockhart, Head Nurse at Fairways Physiotherapy Clinic, Bordesley Green E, Birmingham B9 5SS, UK to request that a physiotherapist is sent to the patient's house to help her with her recovery.

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.

Relevant Case Notes	<u>“Writing Test 5”</u>
Custom Sentence Styles	<u>“Writing Test 5”</u>
Sample Response Letter	<u>“WRITING TEST 5”</u>

Note: This question does not have sample answer.

Writing Task 6

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:

Patient Details

Mrs. Nina Palmer, 71 yrs old

Italian & Catholic, speaks functional English

Diagnosis

Renal failure 2° to dehydration

mild dementia

pneumonia

Social History

Lives with 80 yr old husband/carer, Eugene, in a 4 bdrm unit

Eugene not coping with pt's or his own care needs.

House filthy, both have poor hygiene and nutrition

One son, Derrick, a medical rep, visits Tuesday and Sunday

Interests include knitting, music and gardening.

Medical History and Medications:

See Dr's notes (to be forwarded)

Management and Progress during Hospitalisation:

Initially comatose, ventilated in ICU 7/7

Given dialysis 3/52 which ↓ urea & creatinine, stable now

Hospital acquired pneumonia 2/24 chest physio for 2/52, still

requiring O₂ 2 litres via nasal prongs but non infective for 3/52.

↑ confusion post ICU but now back to usual mild level and is quite settled.

Needs prompting to eat, drink, dress, walk, toilet & tend to personal hygiene but can independently do these

Family conference 25/3/18.

Consensus decision: pt will move to nursing home & Eugene will live in adjoining hostel – nil beds for either till 28/4/18.

Discharge Plan

Transfer to nursing home

Husband will live in hostel next door, both accepting of this

Continue O₂ therapy as per O₂ sats

Encourage independence, pt capable of self-care with ++ prompting

Ensure adequate hydration to prevent ↓ renal function

Repeat electrolyte, urea & creatinine blood test weekly

Writing task:

You are the Charge Nurse on the medical ward where Ms Palmer has spent most of her hospital stay as a patient.

Using the information in the case notes, write a referral letter to the Charge Nurse at Green Valley Nursing Home, Brisbane where Mrs. Nina Palmer will be discharged to from your ward.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Custom Sentence	“Introduction”
	“Medical History”

Styles	<u>“Current Condition”</u>
	<u>“Conclusion”</u>

Note: This question does not have sample answer.

Writing Task 7

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:

Patient Details

Linda Newman, Age: 6 days

Next of Kin: Isabelle Newman (Mother)

Will live with mother at maternal grandmother's house

Diagnosis

Low birth weight & opioid dependence

Family Background

Mother (22 yrs) is a heroin dependent 2 yrs.

She is single and recently worked as a sex worker.

Estranged from father of Linda as alleged domestic violence towards her during pregnancy.

Isabelle's mother supportive.

First child

Department of Community Services involved but approve discharge living situation as long as with grandmother

Medical History and Medications:

See Dr's notes (to be forwarded)

Management and Progress during Hospitalisation:

Both mother and baby completed heroin withdrawal without complications

Baby 2.0kg at birth; 2.3kg 28/4/11
Bottle feeding erratically ? ↓ appetite
Poor bonding between mother and baby.
Isabelle often needs prompting to care for baby.
Drug and alcohol team involved in managing Isabelle’s ongoing addiction issue.

Discharge Plan

Daily visits until pt stable weight and feeding stable
Ensure safe environment for baby and update Department of Community Services if risks present
Monitor mother’s coping and psychosocial state
Educate mother and grandmother on infant care
Liaise with drug and alcohol team to provide integrated support for mother to ↓ risk of heroin use.

Writing task:

You are the Charge Nurse on the maternity ward where Linda Newman was born and need to write a letter to the local community midwifery team outlining relevant information and requesting discharge follow-up. Address the letter to Greenwich Maternal and Child Health Centre, Greenwich.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Custom Sentence Styles	<u>“Introduction”</u>
	<u>“Medical History”</u>
	<u>“Current Condition”</u>

	<u>“Conclusion”</u>	
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Note: This question does not have sample answer.

Writing Task 8

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 Olivia Wilfred, a qualified nurse working with the Oasis Nursing Home Care Agency. Matt Nolan is a patient in your care. Read the case notes below and complete the writing task which follows.

Patient Details

Matt Nolan
141 Montague, West End 4101
(07) 3442 1958
Date of Birth: 25 September 1934

Social Background

Married – wife Betty aged 83.
Lives in own home – Both receive age pensions
Matt is World War II Veteran with Gold Health Card entitlement

Medical History

Cerebrovascular accident (CVA) 4 years ago
Rehabilitation generally successful - Mentally alert, slight speech impairment, - residual weakness left side - walks with limp – balance slightly impaired.

18 /5/18

Had fall descending stairs.

Badly grazed left knee.

GP has requested daily visits by Oasis Nursing Home Care to dress wound and assist with showering.

19/5/18

Grazed knee redressed – no sign of infection

Matt managing to get around the house slowly with aid of his wife.

Reports that apart from “usual aches and pains” he is doing well.

23/5/18

Knee healing well.

Suggested use of a walker or walking stick to assist with mobility.

Bob said he had a walking stick but it was useless.

Wife says he had never learned to use it properly.

She asked if I would contact their local physiotherapist to see if Bob could receive a home visit to assess further assistance to improve his mobility.

Writing task:

Using the information in the case notes, write a letter to Ms Celine Pascal, Highgate Physiotherapy Centre, 60 Grove End Road, London on behalf of Mrs. Betty Nolan requesting a home visit to provide advice and assistance with improving her husband’s mobility.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Custom Sentence Styles	<u>“Introduction”</u>
	<u>“Medical History”</u>
	<u>“Current Condition”</u>
	<u>“Conclusion”</u>

Note: This question does not have sample answer.

Writing Task 9

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:

Mr. Raymond Kendrick is a 73-year-old patient on the ward of North Manchester General Hospital in which you are Charge Nurse.

Patient Details

Widower (8 years)

Lives at Hatfield Nursing Home (5 years)

No children

Employed as a radio engineer until retirement aged 56

Now aged-pensioner

Hobbies: chess, ham radio operator

Sister, Wendy Samson (65), visits regularly; very supportive, plays chess with Mr. Baker on her visits

Diagnosis

Left Total Hip Replacement (THR)

Ongoing high blood pressure

No signs of dementia observed

Medical Background

2015 – Osteoarthritis requiring total hip replacement surgery

1997 – Hypertension (ongoing management)

1986 – Colles fracture, ORIF

Medications

Aspirin 100mg mane (recommenced post-operatively)

Ramipril 5mg mane

Panadeine Forte (co-codamol) 2 qid prn

Nursing Management and Progress

Daily dressings surgery incision site

Range of motion, stretching and strengthening exercises

Occupational therapy

Staples to be removed in two wks

Also, follow-up FBE and UEC tests at North Manchester General Hospital Clinic

Assessment

Good mobility post-operation

Weight-bearing with use of wheelie-walker; walks length of ward without difficulty

Post-operative disorientation requires time and place during recovery, possibly relating to anaesthetic – continued observation recommended

Dropped Hb post-operatively (to 72) requiring transfusion of 3 units packed red blood cells; Hb stable (112) on discharge – ongoing monitoring required for anaemia

Discharge Plan

Monitor medications (Panadeine Forte)

Preserve skin integrity

Continue exercise program

Equipment required: wheelie-walker, wedge pillow, toilet raiser.

Hospital to provide walker and pillow.

Hospital social worker organised 2-wk hire of raiser from local medical supplier.

Writing task:

Using the information in the case notes, write a letter to Ms Mandy Remy, Senior Nurse at Hatfield Nursing Home, 13 Station Road, Hatfield, who will be responsible for Mr. Kendrick's continued care at the Nursing Home.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Custom Sentence Styles	<u>“Introduction”</u>
	<u>“Medical History”</u>
	<u>“Current Condition”</u>
	<u>“Conclusion”</u>

Note: This question does not have sample answer.

Writing Task 10

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 Melanie Hill is an 18 years old woman who has just given birth to her first child at the Royal Mothers' Hospital in Liverpool. You are the nurse looking after her.

Patient Details

Single and has had no contact with father of child for six months.

She does not know his current address.

No family members in Liverpool.

Parents and sister live in Manchester.

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 and has talked about offering the baby for adoption.

Medical History

General health good

Had appendicectomy at 14 years age

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 1900 hrs on 9th September
Contracting 1:10 mins
1st stage of labour: 16 hrs
Mode of delivery: Emergency Caesarean Section
Reason: Fetal distress and failure to progress

Baby Details

DOB: 10th March 2018
Weight: 4.0 kg
Time: 1120 hrs
Sex: Female
Apgar Score: 6 at 1 min, 9 at 5 mins
Resuscitation: O2 only for few minutes

Postnatal Progress

Maternal post partum haemorrhage of 800 mls
Blood loss now minimal
Wound: clean and dry
Haemoglobin on 12/09/os: 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
Baby weight at discharge: 4.3 kg
Feeding well
No jaundice

Writing task:

Write a letter to her social worker, Ms. Margret Grundy, Community Child Health Service, 24 Vincor Street, Liverpool, using the information provided in the case notes.

In your answer:

- Expand the relevant case notes into complete sentences
- Do not use note form
- The body of the letter should not be more than 200 words
- Use correct letter format

Custom Sentence Styles	<u>“Introduction”</u>
	<u>“Medical History”</u>
	<u>“Current Condition”</u>
	<u>“Conclusion”</u>

Miscellaneous Notes

Countable and Uncountable Nouns

There are two types of nouns in the English language: Countable and uncountable. This is important to understand because when a noun is countable and singular (rather than plural), it must have a determiner in front of it (e.g. a, the, his or her).

For example:

'Patient will need regular checking of blood sugar level' is a grammatically incomplete sentence.

The correct version is:

'The patient will need regular checking of her blood sugar level.'

The nouns 'patient' and 'level' are singular and countable, so they need to have determiners in front of them.

To work out if a noun is countable, all yourself: 'Can I have 2 or 3 of these in a patient or anywhere else?' If the answer is yes, then it's countable.

Some examples of countable nouns are:

Ward, Condition, Bed, Floor, Risk

On the other hand, uncountable nouns can't be counted. They are either present or absent, but they are never present in a particular number. Some examples of common uncountable nouns in healthcare are:

Health, Progress, Information, Advice, Equipment

These nouns have no plural form — if we can't count them, then how can we say there's more than one?

Therefore, there is no such thing as 'advices' or 'equipments' (this is a common error most make). Importantly, uncountable nouns don't need to have a determiner in front of them.

However, they can use one if we want to be more specific. For example, you might say 'her/his progress' instead of just 'progress' if you want to make it clear that you're talking about the patient.

Determiners

The mistake made most often by candidates in the writing test is incorrect use or no use at all, of determiners.

Determiners are

- **articles (a/an, the),**
- **possessive pronouns (his, her),**
- **qualifiers (this, that) and**
- **quantifiers (one, any).**

They must be used in certain situations in order to make a sentence grammatically correct.

Follow these three simple rules to avoid leaving out determiners by mistake or using them incorrectly:

1. Use a determiner for all singular, countable nouns.
2. Use any determiner for uncountable nouns except a, an or one. These three determiners mean 'singular' by definition, which is why we can't use them for nouns that we can't count (that is, we can't say that these nouns are singular).
3. If you're not sure whether a noun must have a determiner or not, just use the, while referring to them from the second time onwards. 'The' is a useful determiner, because it can be used for both countable and uncountable nouns.

Confusing Pairs of Words in Letter Writing

The English language is governed by rules. However, there are also many exceptions to these rules and words which do not follow the normal or expected pattern are those which often cause problems. Study this list carefully so that you can improve your grammatical accuracy and knowledge.

Complain vs. Complaint

Complain is a verb

- The patient complained of severe headache.

Complaint is a noun

- The patient presented with a complaint of severe headache.

Note: *Complaint is a countable noun. so it can be used in the plural form or singular with an article.*

The two main prepositions used with complain are: complain of & complain about.

Mr. Gilbert presented with complaints of headache, giddiness and vomiting. (plural)

Mr. Gilbert presented with a complaint of dyspnea. (singular with article)

Incorrect Usage	Correct Usage
The patient complaints of diarrhea and her temperature is high.	The patient <u>complains</u> of diarrhea and her temperature is high.(verb)
The patient presented with a complain of diarrhea.	The patient presented with a <u>complaint of diarrhea</u> .(noun)
The patient presented with complaint of diarrhea.	The patient presented with <u>a</u> complaint of diarrhea. (article required)
He presented to my office on 23/03/2008 complaining on severe pain associated with the lower left first molar	He presented to my office on 23/03/2008 complaining <u>of</u> severe pain associated with the lower left first molar

Suggest or Recommend vs. Advise

Suggest, recommend and advise are all words commonly used in referral letters to report information were given to the patient. The words suggest & recommend cannot be followed by an object pronoun such as him/her whereas advise can..

Incorrect Usage	Correct Usage
I have suggested him to see you next day.	I suggested that he see you next day. Or, I advised him to see you next day.
I suggested her to return in morning as she required further blood test and assessment.	I suggested that she return in morning as she required further blood test and assessment. Or, I advised her to return in morning as she required further blood test and assessment.
I recommended him to rest for 5 days.	I recommended (that) he rest for 5 days.

Explain vs. Tell

The word explain cannot be followed by a pronoun or noun without the preposition to whereas tell can.

Incorrect Usage	Correct Usage
I explained them that unsuccessful conception was not unusual in their case	I explained to them that unsuccessful conception was not unusual in their case. Or, I told them that unsuccessful conception was not unusual in their case.
I have already explained the couple the basic advice regarding conception	I have already explained to the couple basic advice regarding conception. Or, I have already told the couple basic advice regarding conception.

Advise vs. Advice

Advise is a verb.

- We advise patients on how to take their medication.

Advice is a noun.

- We give advice or provide advice to patients on how to take their medication.

Note: The noun advice is uncountable so it cannot be used in plural form. This means advices/a advice/ an advice is incorrect.

- I gave some advice to the patient regarding her medication.

Incorrect Usage	Correct Usage
It would be greatly appreciated if you could make a visit to this family and advice his parents regarding the recommended vaccines for both children.	It would be greatly appreciated if you could make a visit to this family and <u>advise</u> his parents regarding the recommended vaccines for both children. (verb)
Please advice the patient on how and when to take their medication.	Please <u>advise</u> the patient on how and when to take their medication. (verb)
I gave a advice to the patient regarding her medication. Or, I gave an advice to the patient regarding her medication. Or, I gave advices to the patient regarding her medication.	I gave <u>some advice</u> to the patient regarding her medication.(noun) Or, I gave <u>advice</u> to the patient regarding her medication.(noun)
I am writing to refer this patient to you for an advice regarding the management of his bilateral inguinal hernia.	I am writing to refer this patient to you for <u>advice</u> regarding the management of his bilateral inguinal hernia. (noun)

Request Verb vs. Noun

Request as a verb

- The patient requested painkillers. (verb form)

Request as a noun

Request + for : noun form

- The patient made a request for painkillers. (noun form: request+for)

Incorrect Usage	Correct Usage
Mr. Martin requested for new dentures.	Mr. Martin <u>requested</u> new dentures. (verb) Or, Mr. Martin <u>made a request for</u> new dentures. (noun)
The client requested about IVF treatment.	The client <u>requested</u> IVF treatment.(verb) Or, The client <u>made a request</u> for IVF treatment. (noun).

Affect Vs Effect

Affect is a verb

- The patient has not been affected by the treatment

Effect is a noun

- The treatment has had no effect.

Incorrect Usage	Correct Usage
He has also been <u>effected</u> by cataract for the past 3 years.	He has also been <u>affected</u> by cataract for the past 3 years. (verb)
The side <u>affects</u> of this medication are unknown.	The side <u>effects</u> of this medication are unknown. (noun).

Widow or Widower

Widower (noun) refers to a man whose wife has died and who has not remarried.

Widow (noun) refers to a woman whose husband has died and who has not remarried.

Widowed (adjective) refers either a man or woman whose spouse has died and has not remarried

Incorrect Usage	Correct Usage
I am writing to refer Mrs. Simon, a 58-year-old widowed who admitted with cough, fever and dyspnea.	I am writing to refer Mrs. Simon, a 58-year-old <u>widow</u> who admitted with cough, fever and dyspnea. (noun) Or, I am writing to refer this patient a 58-year-old <u>widowed woman</u> who admitted with cough, fever and dyspnea. (noun)
I am writing to refer Mr. Thomas, a 60-year-old widow who complained of severe back pain.	I am writing to refer Mr. Thomas, a 60-year-old widower who complained of severe back pain. (noun).

History

History is always present, never past as you can't change it. Therefore you need to use simple present tense not past tense when using this expression.

- George has no known allergies. (plural)
- George has a seafood allergy. (singular)

Allergic is an adjective

- Michael is allergic to seafoods.

Incorrect Usage	Correct Usage
In addition, he is known allergic to seafood for which he was admitted to hospital with anaphylaxis 1 year ago.	In addition, he has a <u>known allergy to seafoods</u> for which he was admitted to hospital with anaphylaxis 1 year ago.(noun) Or, In addition, he is known <u>to be allergic to seafoods</u> for which he had been admitted in the hospital with anaphylaxis 1 year ago.(adjective)
Regarding his medical history she is allergy to penicillin drugs.	Regarding his medical history she <u>has an allergy to penicillin drugs</u> .(noun) Regarding his medical history she <u>is allergic to penicillin drugs</u> .(adjective).

Confident Vs Confidence

Confident is an adjective

- The patient is not confident in her ability as a mother.

Confidence is a noun

- The patient lacks confidence in her ability as a mother.

Incorrect Usage	Correct Usage
Mr. Milton has not confident social situations.	Mr. Milton has no <u>confidence</u> in social situations. (noun form)
Mr. Milton is not confidence in social situations.	Mr. Milton is not <u>confident</u> in social situations. (adjective form)

a few or few and a little or little

Few/ a few is used with plural nouns, and little/a little is used with uncountable nouns.

Incorrect Usage	Correct Usage
The patient has reduced speech output and a little eye contact.	The patient has reduced speech output and <u>little</u> eye contact.(negative connotation required here)
There are few ways to help identify the possibility of threadworms such as checking the anus of your children at night and frequent scratching.	There are <u>a few</u> ways to help identify the possibility of threadworms such as checking the anus of your children at night and frequent scratching. (positive connotation required)

During or While

During is followed by a noun

- During hospitalisation the patient made a full recovery.
- The patient had many visitors during his stay in hospital.

While is followed by a phrase/ gerund (-ing form)

- While in hospital, the patient made a full recovery.
- The patient had many visitors while recovering in hospital.

Incorrect Usage	Correct Usage
He twisted his ankle during playing badminton 2 months ago.	He twisted his ankle <u>during a game of</u> badminton 2 months ago. Or, He twisted his ankle <u>while playing</u> badminton 2 months ago.

following or followed by

Incorrect Usage	Correct Usage
He was admitted to our hospital followed by a collapse at home with fever and severe pain.	He was admitted to our hospital following a collapse at home with fever and severe pain.

Collocations

Collocations are great to add to your vocabulary, because native English speakers use them often. This also means that you will sound more fluent if you use them, too. Technically, collocations are 2 or more words that are commonly used together. For example, 'fast food' is commonly used to refer to food that can be purchased quickly, eaten while you are walking/working and is usually not very healthy. Have a look at the following collocations that are often used in healthcare, and practice writing sentences using them.

Combinations of verbs and prepositions:

- To 'complain of': to report, experience.

E.g. She complained of nausea, vertigo and trouble sleeping.

- To 'be associated with': to be found together, accompanied by.

E.g. The headaches are associated with memory loss and personality changes.

- To 'be admitted to': to be processed for admission to an institution.

E.g. Mr Smith, who was admitted to our facility on 3 April, will go home today.

- To 'be discharged from': to be released from an institution.

E.g. He was recently discharged from hospital.

- To 'put up with': to endure, suffer from, cope with.

E.g. She has been putting up with a dry cough for the last few months.

Combinations of nouns and prepositions:

- 'In regards to': in relation to, on the subject of.

E.g. In regards to his medical history, the patient has type 2 diabetes and Crohn's disease.

- 'In spite of': despite.

E.g. In spite of the complications, she has made a full recovery.

Descriptive collocations:

- 'Incontinent of urine/faeces': unable to control urine or stool output.

E.g. The patient became incontinent of urine after prostate reduction surgery.

- 'Hearing/vision impaired': having a medical condition affecting the hearing or vision.

E.g. The patient is vision impaired due to cataracts, which will require removal.

- 'Developmentally delayed': having a medical condition that resulted in poor cognitive ability.

E.g. The patient is developmentally delayed, and hence, he needs a full time career.

Adverb – Verb

also ... have
also ... find
commonly ... use
also ... show
sexually ... transmit
also ... include
significantly ... reduce
widely ... use
significantly ... increase
also ... provide
also ... know
previously ... report
well ... know
randomly ... assign
also ... use
often ... have
also ... report
still ... have
also ... help
also ... suggest
well ... understand
often ... use
previously ... describe...
also ... increase
et al ... find
well ... tolerate
randomly ... select
also ... need
also ... call
also ... occur
et al ... report
already ... have
also ... note
now ... have
significantly ... decrease
also ... associate
usually ... occur
strongly ... associate
poorly ... differentiate
newly ... diagnose
significantly ... correlate

Noun – Subject – Verb

patient ... have
study ... show
child ... have
patient ... receive
study ... find
study ... suggest
% ... have
woman ... have
people ... have
researcher ... find
research ... show
study ... demonstrate
patient ... undergo
patient ... take
study ... report
patient ... experience
data ... suggest
study ... use
study ... examine
study ... indicate
% ... report
patient ... need
patient ... develop
finding ... suggest
patient ... die
patient ... report
patient ... require
symptom ... include
study ... compare
patient ... present
infection ... cause
patient ... use

Adverb – Adjective

statistically ... significant
significantly ... high
significantly ... low
significantly ... different
so ... many
very ... important
very ... low
as ... opposed
very ... high
too ... much
critically ... ill
significantly ... great
very ... good
as ... high
as ... effective
much ... high
very ... different
very ... small
relatively ... small
very ... difficult
as ... possible
as ... likely
very ... similar
too ... many
relatively ... low
commercially ...
available
minimally ... invasive
significantly ... related

Verb – Part

follow ... up
carry ... out
go ... on
point ... out
find ... out
set ... up
rule ... out
make ... up
pick ... up
turn ... out
come ... up
end ... up
give ... up
take ... up
grow ... up
break ... down
come ... in
work ... out
build ... up
come ... out

X to V

likely ... to ... have
use ... to ... treat
find ... to ... have
use ... to ... assess
have ... to ... do
use ... to ... determine
appear ... to ... have
want ... to ... know
likely ... to ... develop
need ... to ... treat
show ... to ... have
intention ... to ... treat...
likely ... to ... report
show ... to ... reduce

Common mistakes while using medical Collocations

Incorrect	Correct
I am writing in regards of + [noun]	I am writing in regards to +[noun] Or, I am writing regarding + [noun]
admitted in hospital	admitted to hospital
due to + [sentence] e.g. 'due to he is still not well.'	due to + [noun] e.g. 'due to his illness'
diagnosed of + [name of disease]	diagnosed with + [name of disease]

Sample Collocations of 'diagnosis'

1. until seven years after the initial diagnosis, although she had local and distant recurrences.
2. diagnosis rate in the hand region is not known
3. led the first treating physicians to a false diagnosis of a regular carpal tunnel syndrome
4. The differential diagnosis between
5. gave the correct diagnosis
6. Differential diagnosis
7. Make diagnosis
8. Confirm diagnosis
9. Clinical diagnosis
10. Tentative diagnosis
11. Prenatal diagnosis
12. Histologic diagnosis
13. pathological diagnosis
14. a sound original diagnosis
15. standard technique for the diagnosis
16. We made the diagnosis of rcvs and began treatment with
17. of cerebral vasoconstriction, confirming the diagnosis of rcvs
18. or endoscopy are essential for the correct diagnosis of
19. and colonoscopy have been recommended for the diagnosis of
20. is insufficient to the rule out a diagnosis of
21. is diagnosed incidentally with prenatal diagnosis
22. Diagnosis is confirmed by
23. Diagnosis is usually delayed more than
24. Three years after the initial diagnosis, she had no clinical symptoms.
25. was treated under a tentative diagnosis of
26. A differential diagnosis of
27. suggested exclusion diagnosis of
28. importance in determining the correct clinical diagnosis.
29. Histologic diagnosis of
30. with a prenatal diagnosis of
31. at lymphoma diagnosis of
32. was performed to make a definite pathological diagnosis which revealed

Sample Collocations of ‘treatment’

1. a good response to treatment
2. receiving locoregional treatment
3. systemic treatment.
4. the treatment was continued
5. Definitive treatment was performed
6. continuing nimodipine treatment
7. rcvs treatment
8. conservative treatment,
9. a cognitive behavioral treatment
10. refusing rehabilitative treatment
11. rehabilitative treatment
12. locoregional treatment
13. anti-tuberculosis treatment
14. length of treatment
15. conservative treatment
16. nimodipine treatment
17. definitive treatment
18. hormonal treatment
19. systemic treatment
20. surgical treatment
21. additional treatment
22. introduction treatment
23. calcium channel blocker treatment
24. cognitive behavioral treatment
25. treatment modalities
26. prompt surgical treatment,
27. hormonal treatment.
28. medical treatment was administered.
29. underwent standard treatment
30. put on treatment
31. The length of treatment
32. medical drug treatment in the patient included
33. Treatment modalities include
34. Introduction treatment with a
35. to improve in patients with prolonged infliximab treatment
36. was not adequately controlled, additional treatment with
37. 10 months after initiating treatment. So, overall, she developed
38. One report showed that chronic treatment with
39. Therefore, primary treatment should be targeted towards addressing
40. Treatment options in this case include close observation

Sample collocations of 'blood'

1. blood relatives with an identical genetic ancestor
2. swabs from the lesions and blood cultures were positive fo
3. blood urea nitrogen of
4. given her normal to low blood pressures
5. white blood cells (wbc),
6. red blood cells (rbc),
7. her systolic blood pressures ranged from the high 80s to low 100s
8. Therefore, she was advised to measure her blood pressure at home and take
9. Blood tests did not indicate infection or
10. The operation duration was 260 minutes and the blood loss was 50 g. Pathology results revealed no evidence of
11. is present, there is increased blood flow into the
12. which was confirmed by peripheral blood mononuclear cells
13. Development of low blood glucose reading
14. exclusion of all other possible causes of low blood glucose readings.
15. Lastly, the threshold for low blood glucose levels
16. low blood glucose concentration measured with a precise
17. and symptom alleviation upon correction of blood glucose. Thus, it may be undermining the
18. However, a threshold of blood glucose level of less than
19. proposed mechanism for the development of low blood glucose readings observed in the case.
20. patient developed episodes of low blood glucose readings after treatment with
21. closer monitoring of blood glucose levels should be rendered
22. isolation of immune cells from her peripheral blood, as described

Sample Collocations of 'abdominal'

1. patient have a history of major abdominal surgery. However,
2. but before that occurred she presented with left abdominal tenderness with
3. pain was experienced with increased intra-abdominal
4. developed abdominal distention.
5. He developed severe abdominal distention on the second day of
6. with a one-week history of right upper quadrant abdominal pain, nausea, vomiting, and jaundice
7. She presented with jaundice, abdominal distension with a
8. and a large midline abdominal wall defect with dullness upon percussion
9. and the previous abdominal surgery are likely to have contributed to
10. and a large abdominal wall defect suggestive of a
11. He presented with confusion and progressive upper abdominal pain and swelling for the previous three months.
12. had a six-month evolution of right upper quadrant abdominal pain, nausea, and dyspnea
13. through the rectus muscle presented as persistent abdominal pain.
14. Back, flank, or abdominal vague pain with or without a palpable mass and
15. The decision to perform an abdominal wall reconstruction should be made on an
16. likely to have contributed to an increased intra-abdominal pressure, which was exerted over a
17. which was exerted over a previously operated abdominal wall, with subsequent
18. At 37 weeks, the maternal abdominal girth exceeded the expected range, and
19. during a physical examination, she was noted to have abdominal distention and tenderness.

Sample collocations of 'lymphoma'

1. presented with cerebral lymphoma,
2. was complicated by a non-hodgkin lymphoma and probably by
3. relapsing lymphoma was suspected on the basis of
4. lymphoma presenting as
5. Only one case of burkitt's lymphoma presenting with
6. large b-cell lymphoma as the etiology of
7. cutaneous t cell lymphoma
8. unclassified lymphoma
9. malignant lymphoma
10. propagation of lymphoma
11. risk of lymphoma development in

Vocabulary-Building Strategy

Word families

Recognising word families and using them to build your vocabulary more effectively can be extremely helpful for all parts of the OET, especially the writing test. Word families are groups of words formed from a base or 'root' word.

For example, let's look at the root word 'infect'. This root is used to create many other words with similar meanings (the word family)

- Noun: infection
- Adjective: infectious
- Verb: to infect
- Adverb: infectiously

By looking up each of the members of this word family in the dictionary can help you extend and solidify your understanding of each of them, as well as more clearly understanding the meaning of texts in general. Use a dictionary such as the Oxford Learner's Dictionary available from available list of dictionaries to find other members of that word family.

Here are some more examples:

Root: admit

- Noun: admission
- Adjective: admissible
- Verb: to admit

Root: use

- Noun: use
- Adjective: useful
- Verb: to use
- Adverb: usefully

Root: decide

- Noun: decision
- Adjective: decisive
- Verb: to decide

Capitalisation in OET Writing

Correct use of capitals is an important area to master when writing letters. Study the rules of usage below to ensure you use capital letters correctly in the OET Writing Subtest!

Rules of Usage

1. Medications and Diseases

Capitals are required for proper nouns. Proper nouns include the brand name of a drug or registered trademark of the manufacturer.

- Ritalin
- Voltaren
- Zocor

The chemical constituent should be written in lower case.

- penicillin
- amoxicillin

Names of diseases should always be lower case.

- bowel cancer
- high blood pressure
- diabetes
- epilepsy

Eponyms: Some medical conditions are named after the person who discovered it. In this case the first word should be capitalised (this is the name of a person).

- Parkinson's disease
- Bell's palsy

Names of medical procedures do not require capitals.

- orthopantomogram
- x-ray
- caesarian section

Body parts should always be lower case

- heart
- adrenal gland
- knee

2. Proper Nouns

Proper nouns name something specific as in the examples below. These words must always be capitalised.

Job titles

- The Lactation Consultant, Green's Public Hospital
- The Veterinary Eye Specialist, University of Virginia

Institutions

- Mr. Pippins was admitted to Sacred Heart Hospital.
- Ms. Geller works at Aster Medical Centre.

Places including addresses

- 168 Mount Road, Summer Hills
- 12 Gretchen Road, Silent Park
- 36 Gilmore Street, Holing Mt

Titles when they precede the name of a person

- The patient was seen by Doctor Sam.
- Nurse Gaines is in charge of the patient's care.

3. Common Nouns

Common nouns do not name any specific institution, place, person or profession. These words do not need to be capitalised.

- The patient was admitted to hospital.
- The patient does not have a family doctor.
- Greg is a teacher.
- Yakub is a doctor.
- Riza is a dentist.

4. Holidays, months, days

Holidays, months, days of the week all need to be capitalised. However seasons do not.

- The baby was born on St Patrick's Day.
- The patient was admitted to hospital on February 16.
- Please come and see me on Monday.
- The vaccination will be available in summer.

5. I

The pronoun 'I' must always be capitalised.

- It was I who treated the patient.

6. First word of a salutation

Capitalise the first word of a salutation and the first word of a complimentary close.

- Dear Dr. Robert,
- Yours sincerely,

Common Abbreviations in Case Notes

Tx = treatment

Dx = diagnosis

Thx = therapy

Sx = surgery

Rx = pharmacy or prescription

d/t = due to

s/t = secondary to

r/t = related to

s/p = status post

r/o = rule out

c/o = complains of

Δ = change

+/- = with or without / maybe or may be not possible

ac = before meals

pc = after meals

hs = hour of sleep bedtime

ad lib = as desired

Abx = antibiotics

VSS = vital signs stable

S/S = signs and symptoms

WA = while awake

NOC = night shift

EOS = end of shift

Commonly Used Medical Abbreviations [Extended Version]

AA - Alcoholics Anonymous; African American

A-a - Alveolar Arterial gradient

AAA - Abdominal Aortic Aneurysm

AB - Antibody; also Abortion

ABD - Abdomen

ABG - Arterial Blood Gas

ABI - Ankle Brachia!Index

ABPA - Allergic Broncho Pulmonary Aspergillosis

ABX - Antibiotics

AC - Anterior Chamber; also Acromio-Clavicular and Before Meals
ACE-I - Angiotensin Converting Enzyme Inhibitor
ACL - Anterior Cruciate Ligament
ACLS - Advanced Cardiac Life Support
ACS - Acute Coronary Syndrome
AD LIB - As Desired
ADA - American Diabetes Association
ADD - Attention Deficit Disorder
ADE - Adverse Drug Effect
ADHD - Attention Deficit Hyperactivity Disorder
ADL - Activities of Daily Living
ADR - Adverse Drug Reaction
ADTP - Alcohol and Drug Treatment Program
AED - Automatic External Defibrillator ; Anti-Epileptic Drug
AF - Atrial Fibrillation; Afebrile
AFB - Acid Fast Bacterium
AFP - Alpha Fetoprotein
AGN - Antigen
AI - Aortic Insufficiency
AIDS - Acquired Immuno-Deficiency Syndrome
AIN - Acute Interstitial Nephritis
AK - Actinic Keratosis
AKA - Above Knee Amputation
ALL - Allergies; also Acute Lymphocytic Leukemia
ALS - Amyotrophic Lateral Sclerosis; also Advanced Life Support
AMA - Against Medical Advice; American Medical Association
AMD - Aging Macular Degeneration
AMI - Acute Myocardial Infarction; Anterior Myocardial Infarction
A-MIBI - Adenosine MIBI
AML - Acute Myelogenous Leukemia
AMS - Altered Mental Status; Acute Mountain Sickness
ANC - Absolute Neutrophil Count
AND - Axillary Node Dissection
ANGIO - Angiography
A&O - Alert And Oriented
AP - Anterior-Posterior

AIP - Assessment and Plan
APC - Atrial Premature Contraction
APD - Afferent Pupillary Defect
APPY - Appendectomy
APS - Adult Protective Services
ARB - Angiotensin Receptor Blocker
ARDS - Adult Respiratory Distress Syndrome
ARF - Acute Renal Failure
AS - Aortic Stenosis; also Ankylosing Spondylitis
ASA - Aspirin
ASD - Atrial Septal Defect
ASU - Ambulatory Surgery Unit
ATN - Acute Tubular Necrosis
AN Nicking - Arteriolar Venous Nicking
AN Ratio - Arteriolar/Venous Ratio
AVF- Arterio-Venous Fistula
AVM - Arterial Venous Malformation
AVN - Avascular Necrosis; Atrio-Ventricular
AVNRT - Atrio-Ventricular Nodal Reentrant Tachycardia
AVR - Aortic Valve Replacement
AVSS - Afebrile, Vital Signs Stable
B - Bilateral
B&C - Board and Care
BAE - Barium Enema
BBB - Bundle Branch Block
BCC - Basal Cell Carcinoma
BCG - Bacille Calmette-Guerin
BDR - Background Diabetic Retinopathy
BE - Bacterial Endocarditis; also Barium Enema
BET - Benign Essential Tremor
BIB - Brought In By
BID - Twice a Day
BIPAP - Bi-Level Positive Airway Pressure
BIVAD - Bi-Ventricular Assist Device
BK.A - Below Knee Amputation
BL CX - Blood Culture

BM - Bone Marrow; also Bowel Movement
BMI - Body Mass Index
BMT - Bone Marrow Transplant
BP - Blood Pressure
BPD - Borderline Personality Disorder; also Bi-Polar Disorder and
Broncho-Pulmonary Dysplasia
BPV - Benign Positional Vertigo
BR - Bed Rest
BRAO - Branch Retinal Artery Occlusion
BRB - Bright Red Blood
BRBPR - Bright Red Blood Per Rectum
BRP - Bathroom Privileges
BRVO - Branch Retinal Vein Occlusion
BS - Bowel Sounds; also Breath Sounds and Blood Sugar
BSA - Body Surface Area
BUN - Blood Urea Nitrogen
BX - Biopsy
C - With
CABG - Coronary Artery By-Pass Graft
CAD - Coronary Artery Disease
CAP - Prostate Cancer; Community Acquired Pneumonia
CARDS - Cardiology
CAT - Cataract
CATH - Catheterization
CB - Cerebellar
C/B - Complicated By
CBC - Complete Blood Count
CBD - Common Bile Duct; Closed Bag Drainage
CBI - Continuous Bladder Irrigation
CC - Chief Complaint
CCB - Calcium Channel Blocker
CCC - Central Corneal Clouding
CCK - Cholecystectomy
CCE - Clubbing, Cyanosis, Edema
CID - Cup to Disk ratio
CDI - Clean Dry Intact

C DIF - Clostridium Difficile
CEA - Carcinoembryonic Antigen Chemo - Chemotherapy
CHI - Closed Head Injury
CHF - Congestive Heart Failure Choly - Cholecystectomy
CI - Cardiac Index
CIC - Clean Intermittent Catheterization
CIDP - Chronic Inflammatory Demyelinating Polyneuropathy
CK - Creatinine Kinase
CL - Chloride
CLL - Chronic Lymphocytic Leukemia
CM - Cardiomegaly
CML - Chronic Myelogenous Leukemia
CMP - Cardiomyopathy
CMR - Chief Medical Resident
CMT - Cervical Motion Tenderness ; Charcot Marie Tooth
CMV - Cyto-Megalo Virus
CN - Cranial Nerves
CNIS - Carotid Non-Invasive Study
CNS - Central Nervous System
CO - Cardiac Output
C/O - Complains Of
COPD - Chronic Obstructive Pulmonary Disease
COX 2 - Cyclooxygenase 2
CPAP - Continuous Positive Airway Pressure
CPP - Cerebral Perfusion Pressure
CPPD - Calcium Pyrophosphate Disease
CPR - Cardiopulmonary Resuscitation
CPS - Child Protective Services
CPU - Chest Pain Unit
CRAO - Central Retinal Artery Occlusion
CRFs - Cardiac Risk Factors
CRI - Chronic Renal Insufficiency
CRP - C Reactive Protein
CRVO - Central Retinal Vein Occlusion
CSF - Cerebral Spinal Fluid
CT - Cat Scan; also Chest Tube and Cardio-Thoracic

CTA - Clear To Auscultation
CVA - Cerebral Vascular Accident
CVL - Central Venous Line
CVP - Central Venous Pressure
C/W - Consistent With; Compared With
CX - Culture
CXR - Chest X-Ray
C/W - Consistent With
D - Diarrhea; also Disk
D5W - Dextrose 5% in Water
DB- Direct Bilirubin
DBP - Diastolic Blood Pressure
DC - Discharge; Discontinue ; Doctor of Chiropractics
D&C - Dilatation and Curretage
DCIS - Ductal Carcinoma In Situ
DDX - Differential Diagnosis
DF - Dorsiflexion
DFA - Direct Fluorescent Antibody
DFE - Dilated Fundus Examination
DI - Diabetes Insipidus; Detrusor Instability
DIC - Disseminated Intravascular Coagulopathy
DIF - Differential
DIP - Distal Inter-Phalangeal
DJD - Degenerative Joint Disease
DKA - Diabetic Ketoacidosis
DM - Diabetes Mellitus
DNI - Do Not Intubate
DNR - Do Not Resusitate
DO - Doctor of Osteopathy
DIO - Disorder
DOT - Directly Observed Therapy
DOU - Direct Observation Unit
DP - Dorsalis Pedis
DPL - Diagnostic Peritoneal Lavage
DPOA - Durable Power Of Attorney
DR - Diabetic Retinopathy

DRE - Digital Rectal Exam
D/T - Due To
DTs - Delirium Tremens
DTR - Deep Tendon Reflex
DVT - Deep Venous Thrombosis
DX - Diagnosis
DU - Duodenal Ulcer
EBL - Estimated Blood Loss
EBM - Evidence Based Medicine
EBRT - External Beam Radiation Therapy
EBV - Epstein Barr Virus
ECG - Electrocardiogram (also known as EKG)
ECHO - Echocardiography
ECMO - Extra-Corporeal Membrane Oxygenation
ECT - Electro-Convulsive Therapy
ED - Erectile Dysfunction EEG - Electroencephalogram
EF - Ejection Fraction (in reference to ventricular function)
EGD - Esophago-Gastro Duodenoscopy
EiC - Epidermal Inclusion Cyst
EJ - External Jugular
EKG - Electrocardiogram (also known as ECG)
EM - Electron Microscopy
EMG - Electromyelogram
EMS - Emergency Medical System
EMT - Emergency Medical Technician
E/O - Evidence Of
EOMI - Extra Ocular Muscles Intact
Eos - Eosinophils
EPO - Erythropoeitin
EPS - Electro-Physiologic Study
ER - External Rotation; also Emergency Room
ERCP - Endoscopic Retrograde Cholangio-Pancreotography
ES - Epidural Steroids
ESI - Epidural Steroid Injection
ESLD - End Stage Liver Disease
ESR - Erythrocyte Sedimentation Rate

ESRD - End Stage Renal Disease
ESWL - Extracorporeal Shock Wave Lithotripsy
ETOH - Alcohol
ETT - Exercise Tolerance Test; also Endotracheal Tube
EWCL - Extended Wear Contact Lens
EX LAP - Exploratory Laparotomy
EX FIX - External Fixation
EXT - Extremities
FB - Foreign Body
F/B - Followed By
FBS - Fasting Blood Sugar
FE - Iron
FEM - Femoral
FENA - Fractional Excretion of Sodium
FEV1 - Forced Expiratory Volume 1 Second
FFP - Fresh Frozen Plasma
Flex Sig - Flexible Sigmoidoscopy
FLU - Influenza
FMG - Foreign Medical Graduate
F&N - Febrile and Neutropenic
FNA - Fine Needle Aspiration
FOOSH - Fall On Outstretched Hand
FOS- Full of Stool; Force Of Stream
FP - Family Practitioner
FRC - Functional Residual Capacity
FSG - Finger Stick Glucose
FSH - Follicle Stimulating Hormone
FTT - Failure To Thrive
F/U - Follow-Up
FUO - Fever of Unknown Origin
FX - Fracture
G - Guaiac (followed by + or -)
GA - General Anesthesia
GAD - Generalized Anxiety Disorder
GAS - Group A Strep; Guaiac All Stools
GB - Gall Bladder; also Guillain Barre

GBM - Glioblastoma Multiforme
GBS- Group B Strep
GC - Gonorrhea
GCS - Glasgow Coma Scale
GCSF - Granulocyte Colony Stimulating Factor
GERD - Gastroesophageal Reflux
GERI- Geriatrics
GET - General Endotracheal
GI - Gastrointestinal
GIB - Gastrointestinal Bleeding
GLC - Glaucoma
GMR - Gallups, Murmurs, Rubs
GN - Glomerulonephritis
GNR - Gram Negative Rod
GOO - Gastric Outlet Obstruction
GP - General Practitioner
G#P# - Gravida # Para #
GP 2b/3a - Glycoprotein 2b/3a Inhibitor
GPC - Gram Positive Coccus
GS - Gram Stain
GSW - Gun Shot Wound
GTT - Glucose Tolerance Test
G-Tube - Gastric Feeding Tube
GU - Genito-Urinary; also Gastric Ulcer
GVHD - Graft Versus Host Disease
H FLU - Haemophilus Influenza
HA - Headache
HAART - Highly Active Anti-Retroviral Therapy
HACE - High Altitude Cerebral Edema
HAPE - High Altitude Pulmonary Edema
H2 - Histamine 2
HCC - Hepatocellular Carcinoma
HCG - Human Chorionic Gonadotropin
HCL - Hard Contact Lens
HCM - Health Care Maintenance
HCT - Hematocrit

HCV - Hepatitis C Virus
HD - Hemodialysis
HDL - High Density Lipoprotein
HEENT - Head, Ears, Eyes, Nose, Throat
HELLP - Hemolysis Elevated Liver tests Low Platelets
HEME/ONC - Hematology/Oncology
HGB - Hemoglobin
HH - Hiatal Hernia
H&H - Hemoglobin and Hematocrit
HI - Homicidal Ideation
HIB - Haemophilus Influenza B vaccine
HIT - Heparin Induced Thrombocytopenia
HIV - Human Immunodeficiency Virus
HL - Heparin Lock
HOB - Head Of Bed
HOCM - Hypertrophic Obstructive Cardiomyopathy
HOH - Hard Of Hearing
HONK - Hyperosmolar Non-Ketotic State
HPI - History of Present Illness
HPV - Human Papilloma Virus
HR - Heart Rate
HRT - Hormone Replacement Therapy
HS - At Bedtime
HSM - Holo-Systolic Murmur; also Hepato-Splenomegaly
HSP - Henoch Shonlein Purpura
HSV - Herpes Simplex Virus
HTN - Hypertension
HU - Holding Unit
HUS - Hemolytic Uremic Syndrome
HX - History
I+ - With Ionic Contrast (in reference to a CAT Scan)
I- - Without Ionic Contrast (in reference to a CAT Scan)
IA - Intra-Articular
IABP - Intra-Aortic Balloon Pump
IBD - Inflammatory Bowel Disease
JBS - Irritable Bowel Syndrome

IBW - Ideal Body Weight
ICD - Implantable Cardiac Defibrillator
ICH - Intra-Cranial Hemorrhage
ICP - Intra-Cranial Pressure
ID - Infectious Diseases
I&D - Incise and Drain
IDDM - Insulin Dependent Diabetes Mellitus
IFN - Interferon
IH - Inguinal Hernia (usually preceded by L or R)
IJ - Internal Jugular
IL- Interleukin; Indirect Laryngoscopy
ILD - Interstitial Lung Disease
IM - Intramuscular also Intramedullary
IMI - Inferior Myocardial Infarction
IMP - Impression
INR - International Normalized Ratio
I&O - Ins and Outs
IOL - Intra-Ocular Lens
IOP - Intra-Ocular Pressure
IP - Inter-Phalangeal
IPF - Idiopathic Pulmonary Fibrosis
IR - Interventional Radiology; Internal Rotation
IRB - Indications Risks Benefits; Institutional Review Board
IT - Intrathecal; Information Technology
ITP - Idiopathic Thrombocytopenia
IUD - Intrauterine Device
IUP - Intrauterine Pregnancy
IV - Intravenous
IVC - Inferior Vena Cava
IVDU - Intravenous Drug Use
IVF - Intravenous Fluids; also In Vitro Fertilization
IVP - Intravenous Pyelogram
JP - Jackson Pratt
J-Tube - Jejunal Feeding Tube
ND - Jugular Venous Distention
N P - Jugular Venous Pressure

K - Potassium
KCAL - Kilocalories
KUB - Kidneys Ureters and Bladder
KVO - Keep Vein Open
L - Left
LA - Left Atrium
LAC - Laceration
LAD - Left Anterior Descending (coronary artery); Left Axis Deviation
LAP - Laproscopic; also Laparotomy
LAR - Low Anterior Resection
LBBB - Left Bundle Branch Block
LBO - Large Bowel Obstruction
LBP - Low Back Pain
LCL - Lateral Collateral Ligament
LCX - Left Circumflex (coronary artery)
L&D - Labor and Delivery
LDH - Lactate Dehydrogenase
LDL - Low Density Lipoprotein
LE - Lower Extremity (usually preceded by R or L); Leukocyte Esterase
LENIS - Lower Extremity Non-Invasive Study
LFT - Liver Function Test
LH - Leutinizing Hormone; Left Handed; Light Headed
LHC - Left Heart Cath
LHRH - Leutinizing Hormone Releasing Hormone
LIMA - Left Internal Mammary Artery
LLE- Left Lower Extremity
LLL - Left Lower Lobe; Left Lower Lid
LLQ - Left Lower Quadrant
LM - Left Main Coronary Artery
LMA - Laryngeal Mask Airway
LMD - Local Medical Doctor
LMN - Lower Motor Neuron
LMP - Last Menstrual Period
LN - Lymph Node also Liquid Nitrogen
LND - Lymph Node Dissection

LOA - Lysis Of Adhesions
LOC - Loss Of Consciousness
LP - Lumbar Puncture
LPN - Licensed Practical Nurse
LR - Lactated Ringers
LS - Lumbro-Sacral
LT - Light Touch
LUE - Left Upper Extremity
LUL - Left Upper Lobe; also Left Upper Lid
LUTS - Lower Urinary Tract Symptoms
LUQ - Left Upper Quadrant
LV FXN - Left Ventricular Function
LVAD - Left Ventricular Assist Device
LVEDP - Left Ventricular End Diastolic Pressure
LVH - Left Ventricular Hypertrophy
LVN - Licensed Vocational Nurse
LMWH - Low Molecular Weight Heparin
LYTES- Electrolytes
MAC - Monitored Anesthesia Care
MCL - Medial Collateral Ligament
MCP - Metacarpal-Phalangeal
MCV - Mean Corpuscular Volume
MDRTB - Multi-Drug Resistant Tuberculosis
MEDS - Medicines
MFM - Maternal-Fetal Medicine
MI - Myocardial Infarction
MICU - Medical Intensive Care Unit
MIDCAB - Minimally Invasive Direct Coronary Artery Bypass
MM - Multiple Myeloma
M&M - Morbidity and Mortality
MMP - Multiple Medical Problems
MMR - Measles, Mumps and Rubella vaccine
MOM - Milk Of Magnesia
MR - Mitral Regurgitation
MRCP - Magnetic Resonance Cholangio Pancreatography
MRI - Magnetic Resonance Imaging

MRSA - Methicillin Resistant Staph Aureus
MS - Mental Status; also Mitral Stenosis, Multiple Sclerosis and Morphine Sulfate
MSSA - Methicillin Sensitive Staph Aureus
MTP - Metatarsal- Phalangeal
MVP - Mitral Valve Prolapse
MVR - Mitral Valve Replacement
N - Nausea
NA - Not Available; also Sodium
NAD - No Apparent Distress; No Acute Disease
NABS - Normal Active Bowel Sounds
NCAT - Normocephalic Atraumatic
NCS - Nerve Conduction Study
NEB - Nebulizer
NGT - Naso-Gastric Tube
NGU - Non-Gonococcal Urethritis
NH - Nursing Home
NHL - Non-Hodgkin's Lymphoma
NICU - Neonatal Intensive Care Unit
NIDDM - Non-Insulin Dependent Diabetes Mellitus
NIF - Negative Inspiratory Force
NKDA - No Known Drug Allergies
NMS - Neuroleptic Malignant Syndrome
NOS - Not Otherwise Specified
NP - Nurse Practitioner
NPO - Nothing By Mouth
NS - Normal Saline
NSBGP - Non-Specific Bowel Gas Pattern
NSCLCA - Non-Small Cell Lung Cancer
NSR - Normal Sinus Rhythm
NT - Non-Tender
NTD - Nothing To Do
NUCS - Nuclear Medicine
NYHA - New York Heart Association
OA - Osteoarthritis
OB - Occult Blood (followed by '+' or '-')

OCD - Obsessive Compulsive Disorder
OCP - Oral Contraceptive Pill
OD - Right Eye
OE - Otitis Extrema
OLT - Orthotopic Liver Transplant
OM - Otitis Media
ON - Optic Nerve; Over Night
OOB - Out Of Bed
OP - Opening Pressure
O/P - Oropharynx
O&P - Ovum and Parasites
ORIF - Open Reduction with Internal Fixation
ORL - Oto-Rhino Laryngology
OS - Left Eye
OSA - Obstructive Sleep Apnea
OT - Occupational Therapy
OTC - Over The Counter
OTD - Out The Door
OU - Both Eyes
O/W - Otherwise
P - Pulse
P - Pending
P - After
PA - Posterior-Anterior; also Physician's Assistant
PACU - Post Anesthesia Care Unit
PAD - Peripheral Arterial Disease
PALS - Pediatric Advanced Life Support
PBC - Primary Billiary Cirrhosis
PC - After Meals
PCA - Patient Controlled Analgesia
PCI - Percutaneous Coronary Intervention
PCKD - Polycystic Kidney Disease
PCL - Posterior Cruciate Ligament
PCM - Pacemaker
PCOD - Poly-Cystic Ovarian Disease
PCP - Primary Care Physician; also Pneumocystis Pneumonia

PCR - Polymerase Chain Reaction
PCWP - Pulmonary Capillary Wedge Pressure
PD - Parkinson's Disease; also Personality Disorder and Peritoneal Dialysis
PDA - Patent Ductus Arteriosus
PE - Physical Exam; also Pulmonary Embolism
PEG - Percutaneous Endoscopic Gastrostomy
PERRL - Pupils Equal, Round, Reactive to Light
PET - Positron Emission Tomography
PF - Peak Flow; also Plantar Flexion
PFO - Patent Foramen Ovale
PFTs - Pulmonary Function Tests
PH - Pin Hole
PICC - Peripherally Inserted Central Catheter
PICU - Pediatric Intensive Care Unit
PID - Pelvic Inflammatory Disease
PIH - Pregnancy Induced Hypertension
PIP - Proximal Inter-Phalangeal
PLT - Platelets
PMD - Primary Medical Doctor
PMH - Past Medical History
PMI - Point of Maximum Impulse
PMN - Polymorphonuclear Leukocytes
PMRS - Physical Medicine and Rehabilitation Service
PN - Progress Note
PNA - Pneumonia
PNBX - Prostate Needle Biopsy
PND - Paroxysmal Nocturnal Dyspnea also Post Nasal Drip
PNS - Peripheral Nervous System
PO - By Mouth
POP - Popliteal
PP - Pin Prick
PPD - Purified Protein Derivative
PPH - Primary Pulmonary Hypertension
PPI - Proton Pump Inhibitor
PPN - Peripheral Parenteral Nutrition

PPTL- Post Partum Tubal Ligation
PR - Per Rectum
PRBCs - Packed Red Blood Cells
PRN - Refers to treatments which patient can receive on an “as needed” basis
PSA - Prostate Specific Antigen
PSC - Primary Sclerosing Cholangitis
PSH - Past Surgical History
PT - Physical Therapy; Posterior Tibial; Prothrombin Time; Patient
PTA - Prior To Admission; Peritonsillar Abscess
PTCA - Percutaneous Transluminal Coronary Angioplasty
P-Thal - Persantine Thallium
PTSD - Post-Traumatic Stress Disorder
PTT - Partial Thromboplastin Time
PTX - Pneumothorax
PUD - Peptic Ulcer Disease
PV - Polycythemia Vera; Portal Vein
P VAX - Pneumococcal Vaccination
PVC - Premature Ventricular Contraction
PVD - Peripheral Vascular Disease; Posterior Vitreous Detachment
PVR - Post Void Residual
Q - Every (refers to a time interval...eg. if followed by 6, means “Every 6 Hours”; if followed by AM, D, W, or M =s “Every Morning Day, Week, or Month” respectively)
QHS - Every Night
QID - Four times per day
QNS - Quantity Not Sufficient
QOD - Every Other Day
R - Right
RA - Right Atrium
RAD - Right Axis Deviation; also Reactive Airways Disease
RIB - Referred By; Relieved By
RBBB - Right Bundle Branch Block
RBC - Red Blood Cell
RCA - Right Coronary Artery
RCC - Renal Cell Cancer

RCT - Randomized Controlled Trial; Rotator Cuff Tear
RD - Retinal Detachment; also Registered Dietician
RDI - Respiratory Disturbance Index
RF - Rheumatoid Factor; also Risk Factor
RFA - Radio Frequency Ablation; Right Femoral Artery
RHC - Right Heart Cath
RHD - Rheumatic Heart Disease Rheum - Rheumatology
R/I - Rule In
RIG - Rabies Immunoglobulin
RIMA - Right Internal Mammary Artery
RLE - Right Lower Extremity
RLL - Right Lower Lobe; also Right Lower Lid
RLQ - Right Lower Quadrant
RML - Right Middle Lobe
RNEF - Radionuclide Ejection Fraction
RIO - Rule Out
ROM - Range Of Motion
ROMI - Rule Out Myocardial Infarction
ROS - Review Of Systems
RPGN - Rapidly Progressive Glomerulonephritis
RPLND - Retroperitoneal Lymph Node Dissection
RPR - Rapid Plasma Reagin
RR - Respiratory Rate
RRP - Radical Retropubic Prostatectomy
RRR - Regular Rate and Rhythm
RSD - Reflex Sympathetic Dystrophy
RSV - Respiratory Syncytial Virus
RT - Respiratory Therapy
RTC - Return To Clinic
RUE - Right Upper Extremity
RUG - Retrograde Urethrogram
RUL - Right Upper Lobe; Right Upper Lid
RUQ - Right Upper Quadrant
RV - Right Ventricle ; Residual Volume
RVAD - Right Ventricular Assist Device
RVG - Right Ventriculogram

RVR- Rapid Ventricular Response
RX - Treatment
S - Without
212 - Secondary To
SA - Sino-Atrial; Staph Aureus
SAAG - Serum Ascites Albumin Gradient
SAB - Spontaneous Abortion
SAH - Sub-Arachnoid Hemorrhage
SBE - Subacute Bacterial Endocarditis
SBO - Small Bowel Obstruction
SBP - Spontaneous Bacterial Peritonitis; Systolic Blood Pressure
SC - Subcutaneous
SCCA - Squamous Cell Cancer
SCL - Soft Contact Lens
SCLCA - Small Cell Lung Cancer
SEM - Systolic Ejection Murmur (with reference to cardiac exam)
SFA - Superficial Femoral Artery
SFV - Superficial Femoral Vein
SI - Suicidal Ideation
SIADH - Syndrome of Inappropriate Anti-Diuretic Hormone secretion
SICU - Surgical Intensive Care Unit
SIDS - Sudden Infant Death Syndrome
SIRS - Systemic Inflammatory Response Syndrome
SK - Seborrhic Keratosis; also Streptokinase
SL - Sublingual
SLE - Systemic Lupus Erythematosus; also Slit Lamp Exam
SLR - Straight Leg Raise
SNF - Skilled Nursing Facility
SIP - Status Post; also Supra Pubic
SPEP - Serum Protein Electro-Pheresis
SPF - Sun Protection Formula
SQ - Subcutaneous
SSI - Sliding Scale Insulin
SSRI - Selective Serotonin Reuptake Inhibitor
STAT - Immediately
STD - Sexually Transmitted Disease

STS - Soft Tissue Swelling
STX - Stricture
SVC - Superior Vena Cava
SVG - Saphenous Vein Graft
SW - Social Work; Stab Wound
SX - Symptoms
SZR - Seizure
T - Temperature
T&A - Tonsillectomy and Adenoidectomy
TAA - Thoracic Aortic Aneurysm
TAB - Threatened Abortion; also Therapeutic Abortion
TAH - Total Abdominal Hysterectomy
TB - Tuberculosis; Total Bilirubin
T&C - Type and Cross
TCA - Tricyclic Antidepressant
TC - Current Temperature
TCC - Transitional Cell Cancer
TD - Tetanus and Diphtheria Vaccination; Tardive Dyskinesia
TDWBAT - Touch Down Weight Bearing As Tolerated
TEE Trans-Esophageal Echocardiogram
TFs - Tube Feeds
TG - Triglycerides
THA - Total Hip Arthroplasty
THR - Total Hip Replacement
TIA - Transient Ischemic Attack
TIBC - Total Iron Binding Capacity
TID - Three times per day
TIPS - Transvenous Intrahepatic Porto-Systemic Shunt
TKA - Total Knee Arthroplasty
TKR - Total Knee Replacement
TLC - Triple Lumen Catheter; Total Lung Capacity
TM - Tympanic Membrane ; Maximum Temperature
TMJ - Temporo-Mandibular Joint
TMN - Tumor Metastases Nodes (universal tumor staging system)
TNF - Tumor Necrosis Factor
TOA - Tubo-Ovarian Abscess

TOX - Toxicology
TOXO - Toxoplasmosis
TP - Total Protein
TPA - Tissue Plasminogen Activator
TPN - Total Parenteral Nutrition
TR - Tricuspid Regurgitation
TRUS - Transrectal Ultrasound
T&S - Type and Screen
TSH - Thyroid Stimulating Hormone
TTE - Trans-Thoracic Echocardiogram
TTP - Tender To Palpation; Thrombotic Thrombocytopenic Purpura
TURBT - Transurethral Resection Bladder Tumor
TURP - Transurethral Prostatectomy
TV - Tidal Volume
TVC - True Vocal Cord
TX - Transfusion; Treatment
UA - Urine Analysis; also Uric Acid
UC - Ulcerative Colitis
UCC - Urgent Care Center
UCX - Urine Culture
UDS - Urodynamic Study
UE - Upper Extremity (usually preceded by R or L)
UF - Ultra Filtration
UFH - Unfractionated Heparin
UMBO - Umbilical
UMN - Upper Motor Neuron
UNSA - Unstable Angina
UO - Urine Output
UPEP - Urine Protein Electro-Pheresis
UPPP - Uvulopalatopharyngeoplasty
URI - Upper Respiratory tract Infection
US - Ultrasound
UTD - Up To Date
UTI - Urinary Tract Infection
UV - Ultraviolet
V - Vomiting

VA - Visual Acuity
VATS - Video Assisted Thoracoscopic Surgery
VAX - Vaccine
VBAC - Vaginal Birth After Cesarean Section
VBG - Venous Blood Gas
VC - Vital Capacity; Vocal Cord
VCUG - Voiding Cysto-Urethrogram
VF - Ventricular Fibrillation
VIP - Vasoactive Intestinal Peptide
VP - Ventriculo-Peritoneal
V&P - Vagotomy and Pyloroplasty
VS - Vital Signs
VSD - Ventricular Septal Defect
VSS - Vital Signs Stable
VT - Ventricular Tachycardia
VWF - Von Willebrand Factor
WBAT - Weight Bearing As Tolerated
WBC - White Blood Cells
WDWN - Well Developed, Well Nourished
WNL - Within Normal Limits
W10 - Without
W/U - Work-Up
X - Except
XLR - Crossed Leg Raise
XRT - Radiation Therapy
ZE - Zollinger Ellison

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: NURSING
SAMPLE RESPONSE: LETTER
WRITING TEST 1

Sample Letter

Note: *This is just a sample letter. Information given in below can be presented in a different way as well, as long as it is written in a proper letter format.*

Ms Carol Kimmel
Head Nurse
Northwood Physiotherapy
14 Hillside Cres
Northwood HA6 1RW

(Today's date)

Dear Ms Kimmel

Re: Mr. Henry Bastian (53 years old), Left knee injury

Mr. Henry Bastian is being discharged from 'Athlone Health Care Agency' into your care today.

The patient fell down a staircase and badly injured his left knee. It was profusely bleeding and he was unable to walk properly. On the 10th of April, as per the guidelines from the local area general physician, his wife, Kendra, contacted us and asked for daily home visits (for assisting her husband with dressing and taking showers daily).

The patient's left knee was dressed for the first time after he had showered on the 10th of April and then again on the 13th of April. No infection was noticed on the 15th of April and, as the wound was healing, the patient was able to make movements as well. The patient has been able to walk short distances with help from his wife, Kendra.

The patient has complained about pain whilst walking (which was in fact normal in the beginning due to the pressure on the injured area). Apart from this usual pain, there is nothing significant to report. By

the 17th of April, the knee had healed well. The patient was advised to walk with the help of his walking sticks. His wife, Kendra, requested a greater number of visits in order to help speed up his recovery.

Please, get in touch with Kendra on her number: +44 20 3826 5500 to assist her with helping her husband recover.

Please contact me with any queries.

Yours sincerely
Roxanne Williams
Charge Nurse

Back To Question	<u>"WRITING TEST 1"</u>
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Writing Test 1

Custom Sentence Styles

- *[Mr/Mrs. Last Name of the Patient]* is being discharged from *[Name of the Medical Institution]* into your care today.
- The patient *[details of accident]* and badly injured *[his/her]* *[location]*.
- It was profusely bleeding and *[he/she]* was unable to *[activity]* properly.
- On *[date]*, as per the guidelines from the local area general physician, *[his/her]* *[relative]*, *[Name of relative]*, contacted us and asked for *[time period]* home visits (for assisting the patient with *[type of medical care]* *[time period]*).
- The patient's *[Location]* was *[type of medical care given]* for the first time after he had *[activity]* on *[date]* and then again on *[date]*.
- No infection was noticed on *[date]* and, as the wound was healing, the patient was able to make movements as well.
- The patient has been able to walk short distances with help from *[his/her]* *[relative]*, *[Name of relative]*.
- The patient has complained about *[symptoms]* whilst *[activities]* (which was in fact normal in the beginning due to *[reason]*).
- Apart from this usual *[symptom/s]*, there is nothing significant to report.
- By *[date]*, the *[location]* had healed well.
- The patient was advised to *[activities]* with the help of *[type of assistance]*.

- ***[His/her] [relative], [Name of relative]***, requested a greater number of visits in order to help speed up ***[his/her]*** recovery.
- Please, get in touch with ***[Name of relative]*** on ***[his/her]*** number: ***[phone number]*** to assist ***[him/her]*** with helping ***[his/her] [relative]*** recover.
- Please contact me with any queries.

Back To Question	<u>“WRITING TEST 1”</u>
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Writing Test 1

RELEVANT CASE NOTES

- discharged from 'Athlone Health Care Agency'
- patient fell down a staircase
- badly injured left knee
- was bleeding and unable to walk properly
- on April 10, as per the guidelines from the local area GP, wife, Kendra, contacted us
- asked for daily home visits
- for assist in dressing and showers daily
- patient's left knee was dressed on April 10 and again on April 13
- no infection noticed on April 15
- wound was healing
- patient able to make movements
- able to walk short distances with help of wife
- patient complained about pain while walking
- nothing significant other than that
- on April 17, knee healed well
- advised to walk with the help of walking sticks
- wife requested a greater number of visits to speed up his recovery.
- contact number: +44 20 3826 5500

Back To Question	"WRITING TEST 1"
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OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: NURSING
SAMPLE RESPONSE: LETTER
WRITING TEST 2
Sample Letter

Note: *This is just a sample letter. Information given in below can be presented in a different way as well, as long as it is written in a proper letter format.*

Ms Holly Vincent
Head Nurse
Old Age Nursing Home
1 Clock Tower Park
Longmoor Lane
Liverpool L10 1LD

(Today's date)

Dear Mrs. Vincent

Re: Mrs. Elma Lincroft, 53 years old

Mrs Lincroft was admitted into our hospital on 12th July, 2018 due to injuries to her left knee, ankle and to the head (fell from the stairs and injured herself badly).

At the time of admission, the patient was complaining of pain and intense stinging sensation of the inflammation of the skin. The patient was facing difficulty in walking because of the injury to the knee. It took almost 8 days for the patient to return to the normal condition. The patient showed signs of recovery and was given discharge on 20 July, 2018. She has got spectacles but she is not used to wearing that. The patient requested for personal care by the nurse too.

Please, take a note that Mrs Lincroft is a patient of BP as well. She has been suffering from BP problems since 2007. Strict post medical treatment is required.

Please, do let me know if you require any more information about the patient or have any further queries.

Yours sincerely
Linda Denison
Head of nursing
Choice Hospital

Back To Question	“<u>WRITING TEST</u> 2”
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Writing Test 2

Custom Sentence Styles

- **[Mr/Mrs. Last Name of the Patient]** was admitted into our hospital on **[date]** due to injuries to **[his/her] [location/s]** (fell from the stairs and injured **[himself/herself]** badly).
- At the time of admission, the patient was complaining of **[symptom/s]**.
- The patient was facing difficulty in **[activity]** because of the injury to the **[location]**.
- It took almost **[time period]** for the patient to return to the normal condition.
- The patient showed signs of recovery and was given discharge on **[date]**.
- **[He/She]** has got spectacles but **[he/she]** is not used to wearing that.
- The patient requested for personal care by the nurse too.
- Please, take a note that **[Mr/Mrs. Last Name of the Patient]** is a patient of **[Medical condition/s]** as well.
- **[He/She]** has been suffering from **[Medical condition/s]** problems since **[year]**.
- Strict post medical treatment is required.
- Please, do let me know if you require any more information about the patient or have any further queries.

Back To Question	“WRITING TEST 2”
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Writing Test 2

RELEVANT CASE NOTES

- admitted on 12th July, 2018
- injuries to left knee, ankle and to the head
- fell from stairs and injured badly
- at the time of admission complained of pain and intense stinging sensation of the inflammation of the skin
- faced difficulty in walking because of the injury to the knee
- took almost 8 days to get well
- showed signs of recovery and given discharge on 20 July, 2018
- got spectacles but not used to wearing that
- patient requested for personal care by the nurse
- patient of BP, since 2007
- strict post medical care or treatment is required

Back To Question	“WRITING TEST 2”
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OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: NURSING
SAMPLE RESPONSE: LETTER
WRITING TEST 3
Sample Letter

Note: *This is just a sample letter. Information given in below can be presented in a different way as well, as long as it is written in a proper letter format.*

Ms. Wilma Osmond
Head Nurse
South Park Nursing Agency
Gale Ln, Acomb, York YO24 3HX

(Today's date)

Dear Ms. Osmond

Re: Mrs. Hannah Keller, 43 years old

Mrs. Keller was admitted into our 'Fulford Health Agency' on 17th May 2018 on complaints of nausea, vomiting and quadrant abdominal pain. On examination it was noted that the patient was suffering from cirrhosis (early stage and there were no complications). The patient complained of weight loss too (lost approx. 3 Kg of body weight).

The patient was kept in the hospital for 20 days. During this time, the patient did not complain of any pain and no surgery was performed as there was no need for it.

The patient's condition was normal at the time of discharge from the hospital on 8th of June. Her husband requested for a nurse to come to their house for her personal care too.

Please, take a note of this too that Mrs. Keller is a patient of high BP. She has been suffering from BP problems for about 6 years now. Strict post medical care is required.

Please, contact me with any queries.

Yours sincerely
Tirana Denis
Charge Nurse

Back To Question	<u>“WRITING TEST 3”</u>
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Writing Test 3

Custom Sentence Styles

- ***[Mr/Mrs. Last Name of the Patient]*** was admitted into our ***[Name of Medical Institution]*** on ***[Date of Admission]*** on complaints of ***[Medical Condition/s on Admission of the Patient]***.
- On examination it was noted that the patient was suffering from ***[Medical Condition/s]*** (***[type of stage]*** stage and there were ***[type of complications]*** complications).
- The patient complained of weight loss too (lost approx. ***[Quantity]*** of body weight).
- The patient was kept in the hospital for ***[time period]***.
- During this time, the patient did not complain of any ***[symptom/s]*** and no ***[Medical procedure/s]*** was performed as there was no need for it.
- The patient's condition was normal at the time of discharge from the hospital on ***[date]***.
- ***[His/Her relative]*** requested for a nurse to come to their house for her personal care too.
- Please, take a note that ***[Mr/Mrs. Last Name of the Patient]*** is a patient of ***[medical condition]***.
- ***[He/She]*** has been suffering from ***[medical condition]*** for about ***[time period]*** now.
- Strict post medical care is required.
- Please, contact me with any queries.

[Back To](#)

["WRITING TEST"](#)

Question	3"
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Writing Test 3

RELEVANT CASE NOTES

- admitted on 17th May 2018
- on complaints of nausea, vomiting and quadrant abdominal pain
- was suffering from cirrhosis
- early stage and there were no complications
- complained of weight loss, lost approx. 3 Kg
- kept in the hospital for 20 days
- during this time did not complain of any pain
- no surgery performed
- condition normal at discharge on June 8
- husband requested for a nurse to come to their house for her personal care
- Mrs. Keller has high BP since 6 years
- strict post medical care or treatment required.

Back To Question	<u>“WRITING TEST 3”</u>
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OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: NURSING
SAMPLE RESPONSE: LETTER
WRITING TEST 4
Sample Letter

Note: *This is just a sample letter. Information given in below can be presented in a different way as well, as long as it is written in a proper letter format.*

Dietician
Department of Nutrition and Dietetics
Beaumont Hospital
Gold Coast

(Today's Date)

Dear Dietician

Re: Ms. Jennifer Michael

Thank you for seeing this patient, a 61-year-old single female resident of our Dementia Specific Unit, who had an episode of choking on a piece of food on 20/03/18. She requires an urgent swallowing and nutritional assessment due to a high risk of aspiration and chest infection.

Ms. Michael's condition has been deteriorating since May, 2017, when she suffered a stroke. Over the last year, she has developed advanced dementia and is now confused and disorientated. Apart from this, she is edentulous for both upper and lower teeth and sometimes refuses to wear dentures due to her confusion. In addition, her appetite has increased recently (gained 10 kg over the last 5 months) and her current weight is 106 kg (BMI of 30). Ms. Michael also complains of chronic constipation. She has no allergies to medication or food. Her vital signs and blood sugar level were all within normal limits.

In regards to her medical history, Ms Michael has been living with type 2 diabetes since 2005, which has been managed by a diabetic diet

only. She was also diagnosed with ischaemic heart disease in 2010 and has had osteoarthritis for the past 15 years.

If you require any more information, please do not hesitate to contact me.

Yours sincerely,
Macy Darwin
Registered Nurse
Dementia Specific Unit
Caremark Elderly Care

Back To Question	“WRITING TEST 4”
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Writing Test 4

Custom Sentence Styles

- Thank you for seeing this patient, a **[age]**-year-old **[marital status] [female/male]** resident of our **[name of facility/unit]**, who had an episode of **[medical condition/accident]** on **[date]**.
- **[He/She]** requires an urgent **[type of assessment]** assessment due to a high risk of **[probable medical condition/s]**.
- **[Mr/Mrs. Last Name of the Patient]** condition has been deteriorating since **[date]**, when **[he/she]** suffered **[Medical condition/s]**.
- Over the **[time period]**, **[he/she]** has developed advanced **[Medical condition/s]** and is now **[symptoms]**.
- Apart from this, **[he/she]** is edentulous for both upper and lower teeth and sometimes refuses to wear dentures due to **[his/her]** confusion.
- In addition, **[his/her]** appetite has increased recently (gained **[quantity]** over the last **[time period]**) and **[his/her]** current weight is **[quantity]** (BMI of **[value]**).
- **[Mr/Mrs. Last Name of the Patient]** also complains of **[physical condition/s]**.
- **[He/She]** has no allergies to medication or food.
- **[His/Her]** vital signs and blood sugar level were all within normal limits.
- In regards to **[his/her]** medical history, **[Mr/Mrs. Last Name of the Patient]** has been living with **[medical condition/s]** since **[year]**, which has been managed by a **[type of treatment]** only.

- ***[He/She]*** was also diagnosed with ***[medical condition]*** in ***[year]*** and has had ***[medical condition]*** for the past ***[time period]***.
- If you require any more information, please do not hesitate to contact me.

Back To Question	<u>“WRITING TEST 4”</u>
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Writing Test 4

RELEVANT CASE NOTES

- single female resident of Dementia Specific Unit
- had an episode of choking on a piece of food on 20/03/18
- requires an urgent swallowing and nutritional assessment
- high risk of aspiration and chest infection.
- May, 2017, suffered a stroke
- over the last year, developed advanced dementia
- now confused and disorientated
- edentulous for both upper and lower teeth
- refuses to wear dentures due to confusion
- appetite has increased recently
- gained 10 kg over the last 5 months
- current weight is 106 kg
- BMI 30
- complains of chronic constipation
- no allergies to medication or food
- vital signs and blood sugar level within normal limits
- has type 2 diabetes since 2005, managed by a diabetic diet only
- had ischaemic heart disease in 2010
- has osteoarthritis for the past 15 years

Back To Question	“WRITING TEST 4”
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OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: NURSING
SAMPLE RESPONSE: LETTER
WRITING TEST 5
Sample Letter

Note: *This is just a sample letter. Information given in below can be presented in a different way as well, as long as it is written in a proper letter format.*

Mrs. Gretchen Lockhart
Head Nurse
Fairways Physiotherapy Clinic
Bordesley Green E
Birmingham B9 5SS, UK

(Today's date)

Dear Mrs. Lockhart

Re: Mrs. Brenda Chadwick, 60 years old

Mrs. Chadwick, who underwent hip fractured surgery on 17th of April, is being discharged into your care. On 16th of April, she tripped over and fell down, badly injuring her hip. On diagnosis, broken pieces were noted which called for immediate action. Surgery was performed successfully and the patient was shifted to a specialized geriatric-orthopedic rehabilitation ward on 18th of April, when the condition was noted to be normal.

Rehabilitation treatment was initiated and was offered mobilization (the patient was encouraged to do exercises which promote strength and recovery). By April 23, the patient was able to walk short distances with the help from her husband. Since, she requires extra help; her husband wants a physiotherapist to come to their house to assist her in gaining much more mobility (for her speedy recovery). Her husband is not able to assist her as he himself walks with a walking stick.

Please, send a physiotherapist from your agency to the patient's house

to help the patient recover sooner. Please, contact her husband on the number: +44 333 323 3121, and their address is: Great Charles Street Queensway, Birmingham B3 3LP.

Mrs. Chadwick has been a patient of Osteoporosis too since 2015.

Please, contact me with any queries.

Yours sincerely

Catherine Currant

Charge Nurse

Back To Question	<u>“WRITING TEST 5”</u>
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Writing Test 5

Custom Sentence Styles

- **[Mr/Mrs. Last Name of the Patient]**, who underwent **[type of medical procedure]** on **[date]**, is being discharged into your care.
- On **[date]**, **[he/she]** tripped over and fell down, badly injuring **[his/her] [body location]**.
- On diagnosis, **[observation/s]** were noted which called for immediate action.
- **[Type of medical procedure]** was performed successfully and the patient was shifted to a specialized **[type of ward]** rehabilitation ward on **[date]**, when the condition was noted to be normal.
- Rehabilitation treatment was initiated and was offered mobilization (the patient was encouraged to do exercises which promote strength and recovery).
- By **[date]**, the patient was able to walk short distances with the help from **[his/her] [relative]**.
- Since, **[he/she]** requires extra help; **[his/her] [relative]** wants a **[type of medical professional/specialist]** to come to their house to assist **[his/her]** in gaining much more mobility (for **[his/her]** speedy recovery).
- **[His/Her] [relative]** is not able to assist **[him/her]** as **[he/she] [himself/herself]** walks with a walking stick.
- Please, send a **[type of medical professional/specialist]** from your agency to the patient's house to help the patient recover sooner.
- Please, contact **[his/her] [relative]** on the number: **[number]**, and their address is: **[address]**.

- ***[Mr/Mrs. Last Name of the Patient]*** has been a patient of ***[medical condition]*** too since ***[year]***.
- Please, contact me with any queries.

Back To Question	<u>“WRITING TEST 5”</u>
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Writing Test 5

RELEVANT CASE NOTES

- patient underwent hip fractured surgery on 17 April
- On 16 April, tripped over and fell down, badly injuring hip.
- broken pieces noted
- surgery performed successfully
- shifted to a specialized geriatric-orthopedic rehabilitation ward on 18 April, when normal.
- rehabilitation treatment initiated and offered mobilization
- encouraged to do exercises which promote strength and recovery
- April 23, able to walk short distances with the help from husband
- requires extra help; husband wants a physiotherapist to come to house to assist in gaining more mobility
- husband not able to assist as he himself walks with a walking stick.
- send a physiotherapist
- contact: +44 333 323 3121
- address: Great Charles Street Queensway, Birmingham B3 3LP.
- patient of Osteoporosis since 2015.

Back To Question	<u>“WRITING TEST 5”</u>
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Letter Writing

Custom Sentence Styles

Introduction

- ***[Mr/Mrs. Last Name of the Patient]*** is a patient who is in receipt of health care services from our agency.
- ***[Mr/Mrs. Last Name of the Patient]*** is a patient who was admitted into our hospital on ***[Date of Admission]*** due to problems with ***[Medical Conditions on Admission of the Patient]***.
- ***[Mr/Mrs. Last Name of the Patient]*** is a patient who is being discharged from our hospital into your care today.
- ***[Mr/Mrs. Last Name of the Patient]*** is a patient who was admitted into our hospital on the ***[Date of Admission]***.
- ***[Mr/Mrs. Last Name of the Patient]*** is being discharged from our hospital into your care today according to doctor's recommendation, in view of ***[Current Medical Condition/s of the Patient]***.
- ***[He/She]*** is a patient of ***[Medical Condition/s of the Patient]***
- ***[He/She]*** was not able to ***[name of function]*** properly at ***[place]*** so ***[he/she]*** was rushed into hospital.
- ***[He/She]*** was admitted into our hospital on ***[Date of Admission]***, following complaints of ***[Medical Conditions during Admission of the Patient]***.
- The symptoms ***[he/she]*** was presenting were ***[Medical Conditions during Admission of the Patient]***.

- ***[Mr/Mrs. Last Name of the Patient]*** is being discharged from ***[Name of the Medical Institution]*** into your care today.
- The patient ***[details of accident]*** and badly injured ***[his/her]*** ***[location]***.
- It was profusely bleeding and ***[he/she]*** was unable to ***[activity]*** properly.
- ***[Mr/Mrs. Last Name of the Patient]*** was admitted into our ***[Name of Medical Institution]*** on ***[Date of Admission]*** on complaints of ***[Medical Condition/s on Admission of the Patient]***.
- ***[Mr/Mrs. Last Name of the Patient]***, who underwent ***[type of medical procedure]*** on ***[date]***, is being discharged into your care.
- On ***[date]***, ***[he/she]*** tripped over and fell down, badly injuring ***[his/her]*** ***[body location]***.
- Thank you for seeing this patient, a ***[age]***-year-old ***[marital status]*** ***[female/male]*** resident of our ***[name of facility/unit]***, who had an episode of ***[medical condition/accident]*** on ***[date]***.
- ***[He/She]*** requires an urgent ***[type of assessment]*** due to a high risk of ***[probable medical condition/s]***.
- ***[Mr/Mrs. Last Name of the Patient]*** was admitted into our hospital on ***[date]*** due to injuries to ***[his/her]*** ***[location/s]*** (fell from the stairs and injured ***[himself/herself]*** badly).
- ***[Mr/Mrs. Last Name of the Patient]***, who was admitted into our hospital, was diagnosed with ***[Current Medical Condition of the Patient]***.
- ***[Priority Medical Condition of the Patient]*** was noted which required immediate attention.
- ***Mr/Mrs. Last Name of the Patient]*** was admitted into our ***[Name of Medical Institution]*** due to ***[Medical Conditions during Admission of the***

Patient] on ***[Date of Admission]***.

- ***[Name of the Baby]***, a ***[time period]*** old baby, is being discharged from our Maternity Hospital into your care today.
- ***[Mr/Mrs. Last Name of the Patient]*** is being discharged from our hospital into your care today.
- ***[Mr/Mrs. Last Name of the Patient]*** was admitted into the hospital due to ***[Medical Conditions on Admission of the Patient]*** on ***[Date]***.

Back To Question	<u>“Writing Task 6”</u>
	<u>“Writing Task 7”</u>
	<u>“Writing Task 8”</u>
	<u>“Writing Task 9”</u>
	<u>“Writing Task 10”</u>

Medical History

- The patient has a history of ***[Past Medical Condition/s of the Patient]*** and has been attending our hospital for various ailments since ***[Year]***.
- ***[She/He]*** was prescribed ***[Medication]*** for ***[Past Medical Condition/s of the Patient]*** due to ***[Lifestyle of the Patient]***.
- ***[Time Period]*** later, ***[his/her]*** symptoms were unchanged and ***[Medical Condition]*** was suspected.
- In addition, ***[he/she]*** was treated with ***[Medication]*** for ***[Medical Condition]***.
- On review ***[Time Period]*** later, ***[Medications]*** were commenced due to the side effects of ***[Medication/s]***.

- After returning from *[Place]* in *[Year]*, *[he/she]* experienced features of *[Medical Condition]*, which was aggravated by close contact with *[trigger]*.
- Subsequently, *[he/she]* was prescribed *[Medication]* and also referred to an *[type of Specialist]*.
- *[Time Period]* later, *[he/she]* was commenced on a course of *[Medication]* for *[his/her] [Medical Condition]*.
- *[Time Period]* ago, *[he/she]* complained of failed *[Medication]*.
- *[His/Her]* symptoms have not resolved even though *[he/she]* followed *[Medication]*.
- Moreover, *[New Medication]* was trialed to help *[him/her] [type of function]* for *[Time Period]*.
- Initially, *[he/she]* was presented on *[Date]* with *[Physical Conditions of the Patient]*, especially during *[activity]*.
- After *[his/her] [type of state]*, *[he/she]* noticed *[observation]*.
- Examination revealed *[Medical Condition/s of the Patient]*.
- *[He/She]* was advised to use *[aid/s]* and *[Medical Procedure/s]* in future, if the conditions further deteriorate.
- *[Mr/Mrs. Last Name of the Patient]* again visited on *[Date]* in a *[type of state]* condition, complaining of *[symptom]* in *[Location]* for *[Time Period]* and *[medications]* were not helpful.
- Examination showed that *[his/her]* temperature was *[value]* °C, pulse *[value]* bpm and BP *[value]*.
- *[Body Part]* were infected up-to *[Location]* and *[type of change]* in *[Location]*.
- *[He/She]* first admitted in our clinic on *[Date]*

- complaining of **[Symptom]** for **[Time Period]**.
- The patient was given **[Medication]** (**[number]** times a day) and advised to stop taking **[Past Medication]**.
 - While reviewing **[Time Period]** later, **[his/her]** **[symptom]** was persistent all the time, especially at **[time of a day]**, however, it resolves by **[type of treatment]**.
 - In addition, **[he/she]** reported loss of **[value]** kg over **[Time Period]** and was **[feeling of the Patient]**.
 - The patient was initially admitted on **[Date]** with **[Time Period]** history of **[symptom/s]**.
 - **[He/She]** had no **[symptom/s]** and did not have any kind of significant past or family history.
 - Since, there were no abnormalities detected; doctor advised **[him/her]** to take **[Medication]** on **[number]** hourly basis.
 - The patient visited again on **[Date]** with distressing **[symptom]** associated with **[symptom/s]**.
 - Examination showed that pulse **[value]** bpm, BP **[value]** and no **[type of abnormality]**.
 - A stat dose of **[medication]** injection was given and doctor advised to review after **[Time Period]** if there was no improvement.
 - The patient was diagnosed with **[Past Medical Condition/s of the Patient]** in **[Year]**, for which **[he/she]** underwent **[Medical Procedure]** in **[Year]** after **[Medical Procedure]**.
 - **[He/She]** was in remission from **[Year]** to **[Year]** until a **[symptom]** in **[his/her]** **[Location]** was detected with **[Additional Details]**.
 - **[His/Her]** medical history shows the presence of **[Past Medical Condition/s of the Patient]** (which has been progressing since **[Year]**, as per

[his/her] MD).

- *[He/She]* is also a patient of *[Medical Condition of the Patient]* (noted in the year *[Year]*) and *[Medical Condition of the Patient]* (noted in the year *[Year]*).
- In addition, *[he/she]* is suffering from *[Current Medical Condition/s of the Patient]*, and *[he/she]* is allergic to *[allergen]*.
- The patient ambulates with a cane and contact guard.
- It has been observed that *[he/she]* is often *[Current Observation/s regarding the Patient]*; this could be linked to *[his/her]* *[Current Medical Condition/s of the Patient]*.
- Just recently, *[he/she]* complained of a severe *[Medical Condition of the Patient]* and, since then, it has been recurring episodically.
- The *[Medical Condition of the Patient]* began approximately *[Time Period]* ago and it is localized to both *[Location]* areas.
- Apart from this, patient had *[Number]* episodes of *[Medical Condition of the Patient]* during *[activity]*.
- *[His/Her]* medical history reveals that *[he/she]* has been suffering from *[Past Medical Condition/s of the Patient]* since *[Year]*.
- Also, *[Past Medical Condition of the Patient]* was noted in the year *[Year]*.
- I am pleased to report that *[type of change/s]* in *[his/her]* *[Condition of the Patient]* have been noted and there is *[type of history]* of similar *[Medical Condition of the Patient]*.
- Neither is there any family history of *[Medical Condition]*.

- However, the patient has suffered **[Number]** episodes of **[Medical Condition of the Patient]**, during the **[Time Period]**.
- The first one happened while **[he/she]** was **[activity]** (this was around **[Time period]** ago) and the second while **[he/she]** was **[activity]** (just **[Time period]** ago).
- During these episodes, no **[Physical Condition]** occurred and neither did any **[Other Physical Condition]**.
- Please note that **[Mr/Mrs. Last Name of the Patient]** is a **[Medical Condition of the Patient]** patient as well.
- The general condition of the patient can be stated as follows: **[Physical Conditions of the Patient]**.
- **[He/She]** also wears **[apparel]**; **[he/she]** is continent of **[urination/defecation]**, but incontinent of **[urination/defecation]**.
- **[His/her]** medical history reveals the following information: **[Past Medical Conditions of the Patient]**.
- For several years, the patient has been suffering from **[Medical Conditions of the Patient]** related problems as well.
- **[Medical Condition of the Patient]** is also a part of **[his/her]** medical history which seems to be prevailing.
- **[Mr/Mrs. Last Name of the Patient]** is able to move around with **[his/her]** walker, although **[Current Medical Condition/s of the Patient]**.
- On **[date]**, as per the guidelines from the local area general physician, **[his/her] [relative]**, **[Name of relative]**, contacted us and asked for **[time period]** home visits (for assisting the patient with **[type of**

medical care *[time period]*).

- The patient's *[Body location]* was *[type of medical care given]* for the first time after he had *[activity]* on *[date]* and then again on *[date]*.
- No infection was noticed on *[date]* and, as the wound was healing, the patient was able to make movements as well.
- Please, take a note that *[Mr/Mrs. Last Name of the Patient]* is a patient of *[medical condition]*.
- Please, take a note that *[Mr/Mrs. Last Name of the Patient]* is a patient of *[Medical condition/s]* as well.
- *[He/She]* has been suffering from *[medical condition]* for about *[time period]* now.
- *[Mr/Mrs. Last Name of the Patient]* has been a patient of *[medical condition]* too since *[year]*.
- In regards to *[his/her]* medical history, *[Mr/Mrs. Last Name of the Patient]* has been living with *[medical condition/s]* since *[year]*, which has been managed by a *[type of treatment]* only.
- *[He/She]* was also diagnosed with *[medical condition]* in *[year]* and has had *[medical condition]* for the past *[time period]*.
- *[He/She]* has been suffering from *[Medical condition/s]* problems since *[year]*.
- Apart from a problem related to *[Medical Condition/s of the Patient]*, which occurred once and *[another Medical Condition/s of the Patient]*, *[Mr/Mrs. Last Name of the Patient]* has no previous medical history.
- Also, note that *[Mr/Mrs. Last Name of the Patient]* has *[medical conditions]* problems too.
- There is no history of *[Medical Condition/s]* in *[his/her]* family.

- Prior to this diagnosis, **[Mr/Mrs. Last Name of the Patient]** had always been in good health and **[he/she]** had no medical history; this is the first time that **[he/she]** has ever been admitted into hospital.
- **[He/She]** has been drinking alcohol excessively for approximately **[time period]** and **[he/she]** is also a chain smoker; it has been suggested that **[he/she]** should avoid smoking and drinking completely whilst **[he/she]** is in recovery.
- **[He/She]** suffered from **[symptoms]** for about **[time period]** and complained of **[physical conditions]**.
- **[He/She]** denied any family history of **[Medical Condition/s]**.
- **[He/she]** also had an **[medical condition]** that was associated with **[other medical condition]**.
- **[He/she]** has been **[type of addiction/drug abuse]** for the past **[number]** years and was advised to quit **[type of addiction/drug abuse]**.
- Please note that, **[high risk factors of the patient]**.
- I have to mention, the patient was recently diagnosed with **[medical condition/s]**.
- The patient had a **[time period]** history of **[Medical Condition/s]** which was not responding to **[medication]**.

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Current Condition

- This **[Medical Condition of the Patient]** is not associated with **[Other Medical Condition of the Patient]** and often goes away after the patient takes **[Medication]**.
- Upon recommendation from the doctor, the patient underwent a **[type of examination/s]**; **[he/she]** also underwent necessary lab tests.
- The **[Observation/s regarding the Patient]** noted at the time of admission was **[units]**.
- On assessment of the problem, the doctor prescribed the use of **[Medication]**.
- **[His/Her]** condition soon became normal and **[he/she]** was able to **[name of function]** without a struggle.
- The patient’s **[left/right]** foot turns out on ambulation.
- The patient is taking a prescription for **[Current Medical Condition/s of the Patient]** and the doctor has recommended the same prescription for **[his/her]** new symptoms.
- As the patient’s health and symptoms have been improving, **[he/she]** has been discharged early.
- **[Observation regarding the Patient]** was noted at the time of discharge as **[units]** and **[his/her]** **[Current Observation/s regarding the Patient]** levels were normal.

- **[He/She]** was advised to take **[Medication]** (**[Quantity]**- **[Number]** times in a day) and the option of **[Medication]** was discussed with **[him/her]** (**[Quantity]** - to be given if there is an increase in pain levels).
- It has been observed that **[he/she]** is often **[Current Observation/s regarding the Patient]**; this could be linked to **[his/her]** **[Current Medical Condition/s of the Patient]**.
- The **[Observation regarding the Patient]** noted at the time of admission was **[units]** and the patient showed signs of **[Medical Condition of the Patient]**.
- After a thorough assessment, the condition was confirmed (**[Name of the Test]** confirmed the diagnosis of **[Medical Condition of the Patient]**).
- Without any further delay, an operation was performed on **[Date Operation was done]**.
- I would like to make a request for your agency to appoint someone for personal care of the patient, as **[she/he]** cannot take care of **[him/her]**self.
- **[She/he]** can be contacted on the following number: **[Contact Number of the Patient]**.
- On **[Date]**, **[his/her]** condition was improved, examination revealed no abnormality and **[symptom]** was also reduced..
- On reassessment today, **[Mr/Mrs. Last Name of the Patient]** is suffering from **[symptom]** and reports that **[he/she]** is **[details of drug abuse]**.
- After examination, **[his/her]** BP was **[value]** and **[his/her]** pulse was **[value]**.
- **[Tests]** were ordered and these confirmed the diagnosis of **[Medical Condition/s of the**

Patient].

- As a divorced elderly ***[gender]***, who lives alone with no one to take care after ***[him/her]***, I believe that ***[he/she]*** needs to be visited ***[number]*** times a ***[Time Period]*** to monitor ***[his/her]*** compliance with the diet plan and medication (***[medication]*** - ***[value]*** mg, ***[number]*** times a day). .
- On ***[Date]*** after ***[Time Period]*** of distressing ***[symptoms]***, ***[he/she]*** was found in a ***[type of state]*** on urgent home visit, complaining of weakness in ***[Location]***, impaired level of ***[senses]***.
- On examination pulse ***[value]*** bpm, BP ***[value]***, increased ***[symptom]*** and reflexes were normal.
- ***[Mr/Mrs. Last Name of the Patient]*** wishes to die at home with ***[his/her]*** ***[Friends and Family]*** who also live in ***[place]***.
- Upon discharge, the patient and ***[his/her]*** family need your help in ***[type of special care]*** on ***[number]***-hourly basis, daily ***[type of special care]*** and assistance with care.
- ***[He/She]*** also requires ***[Additional need/s of Patient]***.
- The family needs your help in explaining ***[nutrition]*** that ***[Mr/Mrs. Last Name of the Patient]*** can tolerate.
- As you know, in ***[his/her]*** case the most important treatment is psychological support for ***[him/her]*** and ***[his/her]*** family, and ***[religious/ friendly]*** care from ***[his/her]*** ***[local religious head/ peer group]***, as ***[he/she]*** has strong links with ***[his/her]*** ***[local religious center/peer group]***.
- The patient has been able to walk short distances with help from ***[his/her]*** ***[relative]***, ***[Name of***

relative].

- The patient has complained about ***[symptoms]*** whilst ***[activities]*** (which was in fact normal in the beginning due to ***[reason]***).
- Apart from this usual ***[symptom/s]***, there is nothing significant to report.
- By ***[date]***, the ***[location]*** had healed well.
- The patient was advised to ***[activities]*** with the help of ***[type of assistance]***.
- ***[His/her]*** ***[relative]***, ***[Name of relative]***, requested a greater number of visits in order to help speed up ***[his/her]*** recovery.
- Please, get in touch with ***[Name of relative]*** on ***[his/her]*** number: ***[phone number]*** to assist ***[him/her]*** with helping ***[his/her]*** ***[relative]*** recover.
- On examination it was noted that the patient was suffering from ***[Medical Condition/s]*** (***[type of stage]*** stage and there were ***[type of complications]*** complications).
- The patient complained of weight loss too (lost approx. ***[Quantity]*** of body weight).
- The patient was kept in the hospital for ***[time period]***.
- During this time, the patient did not complain of any ***[symptom/s]*** and no ***[Medical procedure/s]*** was performed as there was no need for it.
- The patient's condition was normal at the time of discharge from the hospital on ***[date]***.
- ***[His/Her relative]*** requested for a nurse to come to their house for her personal care too.
- On diagnosis, ***[observation/s]*** were noted which called for immediate action.

- **[Type of medical procedure]** was performed successfully and the patient was shifted to a specialized **[type of ward]** rehabilitation ward on **[date]**, when the condition was noted to be normal.
- Rehabilitation treatment was initiated and was offered mobilization (the patient was encouraged to do exercises which promote strength and recovery).
- By **[date]**, the patient was able to walk short distances with the help from **[his/her] [relative]**.
- Since, **[he/she]** requires extra help; **[his/her] [relative]** wants a **[type of medical professional/specialist]** to come to their house to assist **[his/her]** in gaining much more mobility (for **[his/her]** speedy recovery).
- **[His/Her] [relative]** is not able to assist **[him/her]** as **[he/she] [himself/herself]** walks with a walking stick.
- Please, send a **[type of medical professional/specialist]** from your agency to the patient's house to help the patient recover sooner.
- Please, contact **[his/her] [relative]** on the number: **[number]**, and their address is: **[address]**.
- **[Mr/Mrs. Last Name of the Patient]** condition has been deteriorating since **[date]**, when **[he/she]** suffered **[Medical condition/s]**.
- Over the **[time period]**, **[he/she]** has developed advanced **[Medical condition/s]** and is now **[symptoms]**.
- Apart from this, **[he/she]** is edentulous for both upper and lower teeth and sometimes refuses to wear dentures due to **[his/her]** confusion.
- In addition, **[his/her]** appetite has increased recently (gained **[quantity]** over the last **[time period]**) and **[his/her]** current weight is **[quantity]** (BMI of

[value]).

- **[Mr/Mrs. Last Name of the Patient]** also complains of **[physical condition/s]**.
- **[He/She]** has no allergies to medication or food.
- **[His/Her]** vital signs and blood sugar level were all within normal limits.
- The patient was facing difficulty in **[activity]** because of the injury to the **[location]**.
- It took almost **[time period]** for the patient to return to the normal condition.
- The patient showed signs of recovery and was given discharge on **[date]**.
- **[He/She]** has got spectacles but **[he/she]** is not used to wearing that.
- The patient requested for personal care by the nurse too.
- Strict post medical treatment is required.
- The patient is a **[widow/widower]** and has **[Details of the Patient's relative]**, the one who brought **[him/her]** to the hospital.
- **[He/She]** also has **[Details of the Patient's relative]** who visits regularly.
- The patient was prescribed **[Medication]** (**[Quantity]**) and advised to continue the use of **[other medications]**.
- There will strictly be no contact with **[hazardous interactions]** and dressing on the **[Location]** site is requested to be done **[time period]**.
- Follow-up **[name]** tests are recommended as well.
- It is suggested that the patient should not perform **[activity]** and that the patient should avoid **[other activities]** until they have made a full recovery.
- The patient was suffering from **[symptom/s]** (**[assumption]**).

- Other changes that which were noted include **[other symptom/s]**.
- The patient had difficulty in **[activities]** for **[time period]**.
- It took more than **[time period]** for the patient to get recovered to a certain extent.
- By **[Date]**, the patient began to show some signs of improvement.
- **[He/She]** was able to walk with the help of **[his/her relative]** who used to come regularly to see **[him/her]**.
- **[Mr/Mrs. Last Name of the Patient]** was discharged from the hospital on **[Date]**.
- The patient was doing well.
- Apart from casual complaints of **[symptoms]**, there were no problems.
- **[His/Her relative]** needs someone to come to their house to care for **[him/her]** personally.
- **[His/Her]** delivery was normal.
- No health related problem was observed.
- The baby was perfectly alright with no disease or weakness of any kind at all.
- **[He/She]** is **[his/her]** mother's **[number]** **[son/daughter]** (**[Mother]** also has got another **[son/daughter]** **[details]**).
- **[His/Her]** mother, **[Mr/Mrs. Last Name of the Mother]**, has regularly been breastfeeding the baby as required or suggested by the doctors.
- The weight of the baby taken at the time of the birth was about **[Quantity]** and the weight of the baby at the time of discharge was about **[Quantity]**.
- This considerable increase in weight was normal as because of the suggestive care provided by the mother.

- No complications were noted or reported.
- The baby and the mother were healthy and have been performing well.
- The regular medicine regime is suggested.
- It is requested that the care shall be taken when the baby is there with you.
- The patient has made no complaints about any pain and **[he/she]** was well at the time of discharge from the hospital.
- Daily observation is needed and the prescribed medicine should be taken for **[time period]** as well.
- **[He/She]** has been diagnosed with **[Current Medical Condition/s of the Patient]** and **[his/her] [Location]** region is the most affected area.
- **[He/She]** stayed at the hospital for observation for about **[time period]** but **[he/she]** is doing perfectly well now and **[his/her]** condition is improving.
- **[He/She]** was given **[Medication] ([Quantity])** whilst **[he/she]** was here and it is requested that **[he/she]** continues to take the same medication for **[time period]**.
- **[His/Her] [vital sign]**, during **[his/her] [number]** day at the hospital, was noted as **[value]**.
- **[He/She]** was given **[medication/s]** and was told to take bed rest for **[time period]**.
- On **[Date]**, **[he/she]** again complained of the **[symptoms]**.
- **[He/She]** also vomited **[five]** times and complained of **[physical conditions]**.
- **[His/Her] [vital sign]** also showed a slight increase from **[value]** to **[value]** and the condition was assessed as **[medical condition/s]**.
- **[Medication/s] [Quantities]** were prescribed.

- The patient did not stay at the hospital due to personal reasons but the next day **[he/she]** was brought to the hospital again.
- **[He/She]** had fallen down and become unconscious due to the same **[medical condition/s]**.
- Urgent examination of the patient is requested at the **[name of department]** department.
- On review today, investigation showed a **[observation/s]**, a significantly **[significant observation/s]**, whereas no abnormal changes noted in **[test/s]**.
- Patient's **[vital sign]** also has **[increased/decreased]** to **[value]**.
- I believe the patient has **[assumption]** and that **[he/she]** is at risk of developing **[medical condition/s]**.
- **[Time period]** later, **[he/she]** came with complaints of **[symptom/s]** for **[time period]** and appeared to be very **[physical appearance]**.
- Patient's **[relative]** reported that **[he/she]** refuses to **[activity]** and has **[symptom/s]** since **[time period]**.
- Examination was unremarkable; **[he/she]** had **[medical condition/s]**, **[vital sign/s - value/s]** and **[test/s]** confirmed significant **[observation/s]**.
- Unfortunately, **[his/her]** **[symptom/s]** has continued to worsen and the change in **[type of treatment]** was not helpful.
- At first, **[his/her]** response was good but unfortunately, **[he/she]** suffered a further **[symptom/s]** on **[date]**.
- **[Medication]** was recommenced at this time but caused significant **[medical condition]**.

- **[She/He]** found it difficult to **[physical activity]** and had a decreased range of movement on **[his/her]** **[body location]**; apart from that, the examination was normal.
- At this time, **[medical tests]** showed **[symptoms]** consistent with **[Medical Condition]**.
- The **[test/s]** shows a well-defined **[result/s]**.
- Today the patient presented with a **[symptom/s]** on the **[body location]**.
- On **[date]**, the above patient presented with **[symptom/s]** on the **[body location]**.
- On **[his/her]** first visit, **[he/she]** complained of **[symptoms]** and whilst examination, **[test/s]** showed **[results]**.
- The patient has visited our hospital **[number]** times, and all were emergencies.
- Today, the patient is asymptomatic and wishes to stop **[his/her]** medications.
- **[Mr/Mrs. Last Name of the Patient]** was diagnosed to have a **[medical condition/s]** and was commenced on **[medication/s]**.
- **[He/she]** was also advised regarding the possibility of **[type of medical procedure]** if the repeat **[test/s]** suggested **[medical condition]**.
- At that time, **[type of test/s]** were done which indicated **[medical condition/s]** and **[discovery]** at **[body location]**.
- The patient was re-presented on **[date]** with complaints of persistent worsening of **[his/her]** symptoms along with **[significant symptom/s]**.
- **[He/she]** was concerned about **[his/her]** **[physical condition]** (**[specifics]**).
- While **[his/her]** review on **[date]**, **[he/she]** reported

- [symptom/s]*** at ***[time of day]***.
- ***[He/she]*** was given ***[medications]*** and advised to ***[type of treatment]***.
 - Today ***[he/she]*** was brought in by ***[his/her]*** ***[relative]*** who reports that the patient had a ***[medical condition/s]***.
 - On ***[Date]***, ***[he/she]*** was brought at first by ***[person who admitted the patient]*** with complaints of ***[chief symptom/s]*** in ***[his/her]*** ***[body location]*** of ***[time period]*** duration, ***[other symptom/s if any]***.
 - The ***[person who admitted the patient]*** reported that ***[Mr/Mrs. Last Name of the Patient]*** has a poor ***[living situation/s]***.
 - ***[He/she]*** was diagnosed to have ***[medical condition/s]*** and prescribed ***[medication/s]*** along with advice about healthy life style was also given.
 - After ***[time period]*** ***[he/she]*** came back for a follow up.
 - The patient was still complaining of the same symptoms plus ***[additional symptom/s]***.
 - ***[Type of disorder]*** disorder was suspected and the plan was ***[treatment]***.

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Conclusion

- Reports on the medical history of the patient and the results of the tests conducted are attached to this letter for your reference.
- The patient was well at the time of discharge and the reports on the tests that were conducted here (**[name/s]** test), medical history of the patient and the prescribed medicine are attached to this letter for your perusal.
- I would like to request that you look into this case.
- Please, do let me know if you require any further details about the patient.
- Please, do let me know if you would like to know any further details about the patient.
- Reports on **[his/her]** medical history are attached here.
- Please, do let me know if you require any more information about the patient or have any further queries.
- The patient was well at the time of discharge.
- Reports on the medical history of the patient and the prescribed course of medicine are attached here with this letter.
- Reports detailing **[his/her]** medical history and a list of **[his/her]** prescriptions are attached to this letter for your information.
- Please, do let me know if you require any further information or have any queries.
- Please do not hesitate to contact me if you require any further information.
- I would appreciate your assessment and management of **[Mr/Mrs. Last Name of the Patient]**.
- I would be grateful if you take over further management of **[Mr/Mrs. Last Name of the**

Patient].

- Therefore, I would be grateful if you could visit *[him/her]* at home to monitor *[his/her]* compliance with the diet plan and medication.

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