OET EXPRESS WRITING

100 ERRORS OET WRITING

BIJU JOHN

BEFORE YOU BEGIN

Have you written OET exam once? Those who have written the exam say that they feel like disarmed, weak, numb, blind, unable to decide and their IQ drained and reduced by half in the exam hall! They only wish if they could organize the letter, decide what is relevant, what is irrelevant, where to start, if the patient is known to the recipient, what the purpose is, what the requests are, etc.

80% of OET candidates fail at least 5 times before they cleared OET!

Introducing a set of 100% effective and tested methods to help you write your OET letters that can score 350+.

Here are those Methods and Orders:

PPRRRAADDDWK Method,
DADS Order,
PRPDD Order,
Diving and Rising Order.

Sample Letter

Below you can see a sample letter written by a pregnant woman's care nurse to her Obstetrician for immediate care and diagnosis. Read carefully:

04th September, 2021

Dr Arnold Woods
Obstetrician
New Orleans Mother and Baby Care Hospital
Sydney

Dear Dr Woods,

Re: Ms Maggie Stilton, 28 years

This is to request an updation of the foetal wellbeing of Ms Maggie Stilton who has been transferred to your care. She is suspected to have still birth or similar conditions.

Under my care for the last three weeks at her home, Ms Stillton's recent developments have not been promising. On assessment today, it was also noted that the heart beat

was nil nor was there any pulsations felt in the umbilical cord. Additionally, there were no voluntary movements for a duration of 1 hour. At 01:10 PM, on finding that she had developed fever with chills, paracetamol was administered and she was transferred.

In view of the promising prognosis that Ms Stilton has at present and considering the expected improvement in her condition, it would be greatly appreciated if you could....

In view of the deteriorating condition that Ms Stilton has at present, it would be appreciated if you could update her foetal wellbeing and commence the management of her condition.

Yours sincerely,

Ms Alexa W Gomes
Obstetrics Nurse.

WHAT DID YOU NOTICE?

- A letter has around 200 words.
- A letter has a date, address, salutation and subject like (Re:)
- The first paragraph introduces the patient, the purpose of writing, the word “requires”, discharge time and discharge condition.
- In the second and third paragraphs, there is information about the patient’s admission / presenting, complaints, assessment, tests, results, diagnosis, management, medication and finally, the present condition of the patient.
- There may / may not be a small paragraph about the patient’s family and social background.
- The final paragraph is request paragraph and the letter ends with the usual closing as you see above!

NB: To write a letter most effectively, try to imagine a reply sent by the

recipient! Look at a sample reply to the sample letter like:

"Dear Ms Rita, you can transfer Mr Parker to our facility. We are glad to admit him and provide treatment. Thank you;" Or:

"Dear Ms Rita, we are sorry to inform you that we cannot admit Mr Parker to our facility due to acute shortage of staff. We advise you to transfer him to another facility. Thank you!"

PPRRRAADDDWK

We introduced “PPRRRAADDDWK” in 2020 but we updated the same several times before Feb 2022. Well, why is PPRRRAADDDWK very important for all OET candidates?

If you follow this method, you will not commit any errors while writing your letters.

Also, you will not miss anything while studying the case notes, nor will you accidently include any information that is not relevant.

You will be very sure about the scenario, so, you will not have to read the case notes several times.

For example, look at D3 (Diagnosed or not); if the patient’s condition is already diagnosed, do you need include her father’s or mother’s medical history to the doctor? No, because, since the diagnosis is done (the patient has colon cancer), you needn’t inform the doctor about her family / past history.

You will understand more about this only when you have a close look at a case notes (the writing-question-paper) which we will discuss after PPRRRAADDDWK.

PPRRRAADDDWK In Short

Before we have a closer look at PPRRRAADDDWK, here is a glimpse. Learn well. Oh, wait! If you are not good at remembering short forms like P1, P2, R1, R2, R3, etc, do not worry! Just learn Patient, Purpose, Recipient, Requests, Relevance, etc.

P1 Patient
P2 Purpose

R1 Recipient
R2 Requests
R3 Relevance

A1 Admitting Condition
A2 Admitting Date / Time

D1 Discharge Condition
D2 Discharge Date
D3 Diagnosed / Not Diagnosed

W Writer (Your role)
K Known / Not Known?

Critical! Do not Ignore!

You have to spend 5 minutes performing the PPRRRAADDDWK tasks before starting the letter writing.

P1 PATIENT

P1 stands for patient. As you can guess, every letter moves around a patient, so, identifying the patient is the first step. Although finding the patient is easy, you may be struck by doubt when there is an accompanying patient.

Who is an accompanying patient? Look at the example:

- Patient: Ron, 1 year
- Problems: Constipation (hard stool); breastfeeding nil
- Mother: Ms Remie, 28 years
- Condition: Insufficient breast milk
- Purpose: Needs advice on breastfeeding

How do you decide the P1 – Patient in this situation?

Ron is the patient here because, in the case notes, you find Ron's name against "Patient Details / Name."

Well, then, who is Ms Remie?

We can see that it is Ms Remie who needs advice but she is not the patient.

NB: You can find the patient's name at the starting of the case notes!

P2 PURPOSE

P2 is the Purpose of writing a letter. Remember, you will see 1 or 2 purposes in each letter. You can see a number of purposes in some letters.

Common Purposes

- Continuity of care
- Emergency Admission
- 24 hours monitoring / care
- Palliative Care
- Rehabilitative Care
- Physiotherapy Sessions
- Dietary Management
- Lactation Consultation
- Child Care
- Home visit
- Update health status
- Social worker's assistance
- Occupational Therapy
- Psychologist's Assessment
- Psychiatrist's Management
- Information Letter (Rare)

NB: There are more purposes. You have to be careful with identifying the purposes because many candidates get confused with purposes and requests. The main request is the purpose!

R1 RECIPIENT

R1 is the Recipient of the letter. Remember, there is always a recipient on the other end, so, be aware of that. You have to always keep this in mind because you may tell an emergency doctor information he may not require. Suppose you are writing to a psychiatrist, will you mention the patient's current treatment for constipation, diabetes? Will you tell the emergency doctor about the patient's reading habits or profession? No. No!

Before you pick any information from the case notes, ask:

- Is this information helpful for the recipient?
- If I tell the recipient about the patient's 2-year-old history (for example, resection, appendectomy, colostomy, fall, etc.), will that help the recipient in some way?

NB: Usually the “recipient” details are found at the end of the letter, that is, in the “Writing Task” area. However, you may find that some case notes provide the recipient details at the start of the case notes.

R2 REQUESTS

R2, or, Requests is another important area of information. You find the “requests” at the end of the case notes, mostly in the Discharge Plan Area. Unlike “Purpose”, there are multiple requests in a case-notes. In more clear words, any requests to the recipient other than the main purposes are the requests. Suppose the main purpose is home care, the recipient will have to fulfil a few requests.

Look at the difference:

Purpose

- Home Care (main)

Requests

- Administration of Medication
- Monitoring of the Progress
- Diet Monitoring
- Arranging follow up visits
- Contacting Social Worker

- Encouraging the patient to quit smoking

NB: Make sure that you mention only the main purpose (P2) in the first paragraph and all the requests (R2) in the last paragraph. However, you will have to repeat the Purpose in the last paragraph, as well!

R3 RELEVANCE

Suppose you are writing a letter to transfer Mr Parker to Dr Sinha, his GP. He underwent angioplasty three months ago while he was under his treatment and was transferred to your care for home care. Will you tell Dr Sinha about the angioplasty when you transfer Mr Parker to a hospital where Dr Sinha works?

Your answer must be NO because the angioplasty-related information is known to Dr Sinha!

This is called relevance!

- Do not tell the recipient anything he already knows about the patient.
- Do not tell the recipient anything about the patient that he can easily guess.
- Do not tell the recipient anything about the patient that is not going to help him / her.

NB: “Relevance” is one of the hardest challenges for many OET candidates. Relevance is all about “what is worth a mention” and “what is not worth a mention.”

You will learn more about R3 shortly!

A1 ADMITTING CONDITION

The Admission Condition of the patient is very important, because, in most letters, the second paragraph starts like, “Mr Parker was admitted on 2nd June, 2022, with symptoms suggestive of myocardial infarction…”.

The following are some of the admitting conditions:

- Mr Parker was admitted following a fall.
- Mr Parker was admitted with signs of myocardial infarction.
- Ms Shirley was admitted following the completion of postoperative care.
- Baby Ryan was admitted after three days of extended vomiting and nausea.

Admitting / Presenting Condition

If you cannot find the “admitting condition,” look for “presenting

condition." Both, admitting condition and presenting condition are somewhat the same but, remember, every patient presented is not admitted!

NB: "Mr Parker comes to a clinic" does not mean he is admitted. "Mr Parker comes to a hospital" also does not mean he is admitted, because, every patient needn't be admitted.

A2 ADMITTING DATE

Admitting Date / Time is another important piece of information you have to find out in the case notes.

There are two uses of Admitting Date:

To begin the second paragraph:

The admitting / presenting date is a very important information in the second paragraph:

"Mr Parker was admitted on 2nd June, 2022, with symptoms suggestive of myocardial infarction…".

To find out the Discharge Date

In rare cases, you may not find the discharge date. In such cases, a little calculation can reveal the discharge date. Study this scenario:

- Mr Parker was admitted on 1st May.

- Diagnosis on 2nd May.
- Surgery on 03rd May

If you discharge him on the third postoperative day, what is the date of discharge? *Well, find that out!*

D1 DISCHARGE CONDITION

You cannot write the first paragraph without the patient's condition at the time of discharge.

Discharge Condition

- He is recuperating after a fall.
- She has been transferred via ambulance

She was discharged (Sometime in the past) on 22nd last month but she requires readmission...

She has been discharged (Patient is not with you)

She is being discharged (the pt is still with you, paying bills, packing)

She will be discharged (pt is still with you, in bed)

- Treatment Status
- She has been admitted
- She has been diagnosed
- If the treatment has not been started
- She has been treated
- Postop
- She is recovering

NB: It is the discharge condition that you mention in the first paragraph – not the admitting condition.

D2 DISCHARGE TIME / DATE

Just like the discharge condition of the patient, you cannot write the first paragraph of your letter without the patient's condition at the time of discharge.

Sample Discharge Time / Date

- She was discharged ten days ago.
- She has been discharged.
- She is being discharged tonight.
- She is being discharged.
- She will be discharged tomorrow.
- Her discharge has been scheduled.
- She will be discharged based on tomorrow's review.

NB: Have a clear understanding about the three lines in green (above):

She has been discharged
(Discharged but she is still in touch with the same hospital)

She is being discharged tonight.
She is not yet discharged. The process is going on!

She is being discharged.
She is still in the hospital but will be discharged very soon, like, in less than 30 minutes.

D3 DIAGNOSED OR NOT

D3 is a very important information because it is directly connected to R3 of Relevance. That is, if a case is D3 (Diagnosed), then you can exclude much of the information about the patient's past medical and family history.

D3 is most beneficial when you write a letter to a doctor. As you know, doctors do "diagnosis" and "treatment" whereas nurses do care and management.

Next time you write a letter to a doctor, do not include any of the patient's past, recent medical history if the diagnosis is already done!

Diagnosed Cases

- Skip vital details
- Skip past med history
- Skip recent tests and results
- Exclude tests whose results are being awaited.

Undiagnosed Cases

- Include vital details
- Include past med history
- Include recent tests and results
- Include tests whose results are being awaited.

W – WRITER (YOUR ROLE)

Do you think the "writer" is not important because it is always you?

Wait a minute because many of you take it for granted!

You have to understand the "writer" is a more personal way. That means, you have to become the writer!

How to become the writer?

It is easy to write the last two lines as follows:

Yours sincerely,
Charge Nurse.

Believe it or not, most nurses cannot "feel" like a "Charge Nurse" while writing the letter. They feel like an OET candidate who has to pass the exam!

If your own dear baby is in pain, how well you can write a referral letter for her / him? However, you mess up when the patient is not your dear one.

What is the solution?

Write with empathy! Feel concern for the patient!

K – KNOWN CASE

The last thing you have to check is whether the patient is known to the recipient or not.

Not Known Cases

- Patient: Mr Parker.
- Recipient: A doctor / a nurse
- The recipient has never treated / cared for the patient

Known Cases

- Patient: Mr Parker
- Recipient: A doctor / a nurse
- The recipient has already treated / cared for the patient.

How to decide?

You can decide if a patient is known to the recipient if:

- The recipient is the patient's GP
- The recipient is a community nurse who has already

attended to the recipient's case.

- Any medical professional who has already treated, cared, known the patient.

PPRRRAADDDWK

COMPLETED

NEXT

R3

RELEVANCE CHECK

Relevance Check is the process of removing the irrelevant information from a case-notes.

CASE NOTES - RELEVANCE

Below, we are going to remove the irrelevant (unimportant) information from the case notes. The relevant pieces of information are in black whereas **red** indicates irrelevant information.

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

TIME ALLOWED:

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

Notes:

You are an obstetrics nurse who visits the patient, a 20-week-pregnant woman who has difficulty traveling for routine visits. Today, during visit at noon, you detected symptoms of stillbirth / miscarriage (?) / placental abruption (?).

Today's date: 04/09/2021

Patient Details:

- Ms Maggie Stilton, 28 years.

- ❖ Ethnicity: African-American
- ❖ Husband: Eric Stilton, 30 years.
- ❖ No other babies.

Social & Habits

- ❖ Smokes and drinks alcohol (Very high till conception but then reduced to half)
- ❖ No recreational drug uses.
- ❖ Husband is very caring
- ❖ Mother-in-law stayed with her for short periods till January
- ❖ Did not receive good prenatal care for a month.

Past History

- Mildly preeclamptic.
- Malnourished in the second month
- Diabetic
- Slightly obese (BMI 29).
- Thyroid replacement therapy (2009)
- No infection diagnosed

- Foetus response today (04/09/2021
- No heartbeat
- Has no pulsations (in the umbilical cord
- No voluntary movements for a duration of 1 hour (11.35 am – 12.40 pm)

01:10 PM

- Fever and chills (Given paracetamol)
- Patient transferred to Mother and Baby Care Hospital, Sydney
- The recipient has been informed over phone.

Writing Task

You are Ms Alexa W Gomes, Ms Stilton's obstetrics nurse home-visiting her in the last three weeks. Write a letter to Dr Arnold Woods, obstetrician / gynaecologist, New Orleans Mother and Baby Care Hospital, Sydney, requesting the

confirmation of foetal wellbeing and to proceed to further procedures.

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.

WHAT DID YOU NOTICE?

The following information are removed from the case notes because they will not help the recipient in any way. Check it yourself!

Why something is Irrelevant?

- Ethnicity: African-American (so what?)
- Husband: Eric Stilton, 30 years (so what?)
- No recreational drug uses (that's good!)
- Husband is very caring (let him care)
- Mother-in-law stayed with her for short periods till January (why is that important?).

Why some information is Relevant

You can see that all the relevant information is someway connected to the patient's present condition and management.

- Mildly preeclamptic (relevant to her present condition)
- Malnourished in the second month (that may have resulted in her condition)
- Diabetic (Diabetes and her present condition are connected)
- Slightly obese, BMI 29 (Obesity and her condition are related)

RELEVANCE CHECK

COMPLETED

NEXT

ORGANIZATION

English Melon Introduced the 4 organization methods in October, 2021 to ease organization. Very simple, these 4 methods will easily control your letter format.

Let's see how we organize letters with our special methods called DADS, PRPDD, Diving and Rising!

DADS

DADS stand for Date, Address, Dear and Subject (Re:). You may think it is not very important, but, in reality, many candidates forget to write all the first four elements of a letter.

NB: The first lines will earn you the highest score. Be careful to follow DADS so that you will not miss out any one of them.

Incorrect!

04th Sept, '21

Dr Arnold (first name required)
Woods
Obstetrician
Mother and Baby care Hospital
Sydney, Australia (Country not needed)

Dear Dr Arnold Woods,

Re: Ms Maggie Stilton, aged 28 years old

NOW, LOOK AT DADS IN DETAIL.

D1 Date

04th September, 2021 (Date)

A Address

Dr Arnold Woods (Address)
Obstetrician
Mother and Baby Care Hospital
Sydney

DEAR MS FIRST NAME OR LAST NAME?

The third element of a letter is salutation or "Dear Line." We do not write the full name of the recipient in this line:

Incorrect: Dear Mr Franklin Rousseau,
Correct: Dear Mr Rousseau,

YEAR OF DIAGNOSIS

Is it important to tell the recipient the exact date or year of diagnosis?

What is the benefit of informing the recipient that Mr Parker was diagnosed with diabetes in 2010?

COUNTRY NAME IN ADDRESS

We do not include the country name in the address element because most letters are sent between two places of the same country.

Incorrect Address: Charge Nurse
City Hospital
Pink Street
Sydney, Australia

Correct Address: Charge Nurse
City Hospital
Pink Street
Sydney

Why? Because anyone in Sydney knows that Sydney is in Australia!

D2 Line - Dear

If you know the name of the recipient, you can write Dear + Name.

- Dear Dr Miller,
- Dear Ms Anderson,

If you do not know the name, you write the designation:

- Dear Dr Woods,
- Dear Nurse,

Except for Doctor and Nurse, you can write Sir /Madam for the following professionals.

Dear Sir /Madam,

- Pharmacist
- Physiotherapist
- Admission Officer
- Director
- Manager
- Social Worker
- Registrar
- Dietitian
- Psychologist

S Subject

Do not forget to write the full name of the patient here.

- Re: Mr Herbert Edison; 39 years
- Re: Ms Lee Robs, 88 years

In case of an information letter, you don't write "Re:". It is "Subject:"

- Subject: Regarding your daughter's further treatment
- Subject: Information about treating tapeworm infestation.

NB: Information letters are very rare.

NB: There is a little confusion regarding Master / Miss / Ms / Mrs / Mr. Yes, we should include Mr, Ms and Mrs for adults (18+, that is, including 18). However, OET do not mandate using **Baby**, **Master** and **Miss** before patients of 17 years and below.

What should you do?

On the "Re: line:

Write Baby (0 – 1 years), Miss (girls) and Master (boys), Ms (women) and Mr (men)

In the Paragraphs

Write Ms (women) and Mr (men) before the names but better not to write Baby, Miss and Master for other age-groups.

Why?

Mrs, Ms and Mr are prefixes that show "respect." We do not respect babies, girls and boys. We love them! Nothing formal!

PRPDD / UPDATE

English Melon introduced the PRPDD Method in 2021. The main purpose of this method is to present the first paragraph of the letter without errors and without a customary “who” that was a fashion at that time.

PRPDD (Best style)

Mr. John Williams (P) requires (R) continuing care and management (P) following his discharge tomorrow (D2). He is recovering from angina (D1).

Known Case (“update”)

This is to request an updation of the foetal wellbeing of Ms Maggie Stilton who has been transferred to your care. She is suspected to have still birth or similar conditions.

Older Style

This letter will introduce Mr. John who is recuperating from angina and is due to be discharged tomorrow. He requires further care and management.

Very Old Style

I am writing regarding Mr. John Williams who is recovering from angina. He requires further care since he is going to be discharged tomorrow.

"Who" in PRPDD...

You know, in 95% cases, we do not write "who" in the first paragraph (PRPDD)

Mrs Judit Dyer (P) requires (R) continued care to manage her condition....

This is to "update" the health status of Ms Maggie Stilton, a 20-week pregnant woman, who requires

emergency obstetric assessment and care…

This is to update the health status of Mr Stapleton Moore who requires continuity of care and support. He has been recuperating after total hip replacement surgery and is ready for discharge.

DIVING AND RISING

"Diving and Rising" is in fact a magic method for safe organization of your letter. With this method, you will be trained to start your second paragraph (admission) in:

- Past tense (was and did);
- Then "dive deep" with "had, had had";
- Slowly come up with "has had";
- Come up with "has been";
- Reach has, is and can (present tense)
- Go to future tense with "will" and "would…" (would be appreciated)

One remarkable fact is, most letters have just one Diving and Rising, that means, you do not go back to past tense after reaching present! That means, once you reach present tense (is, has, can), you usually cannot go back to the past (was / did / had). However, some letters,

in which the patent is not diagnosed (D3), you will need 2 Diving and Rising.

Let's look at two different letters. The first letter has a single diving and single rising while the second one has "DRDR" or one diving, one rising, second diving and second rising.

DR TYPE LETTERS

In this kind of letters, there is a single DR – one diving and one rising. Look at this example:

Paragraph 2

Look carefully, you can see that there is perfect diving into the past and then rising to the present tense! The blue area indicates past while the green area indicates present.

During the last 14 days for the management of lacerated left arm, Mr Patterson's wound was cleaned, sutured and dressed. Additionally, prophylactic antibiotics were initiated. On subsequent days, his blood pressure became elevated which was higher in supine than sitting position. Currently, although he has a good prognosis with well healing wound, his blood pressure has been higher than normal range. On today's assessment, Mr Patterson's blood pressure has been found still elevated which is 196/96.

NB: In this kind of letters, you will not have anything to write in past tense after this point!

Paragraph 2

Look out for the diving (past) and rising (present) in this paragraph. Diving are in blue while rising are in green:

Under my care at her home for the last three weeks, Ms Stilton's recent developments have not been promising. During today's home-visit, there was no pulsation in the umbilical cord nor was there any heartbeat. Additionally, no voluntary movement was noted for a duration of an hour. At 1.10 pm, she developed fever with chills for which paracetamol was administered. Please note, she has not received a good prenatal care for a month. Ms Stilton is mildly preeclamptic and diabetic. Her BMI has been noted 29.

NB: Remember, ***have been*** *is not fully present tense. We consider have been*

/ has been more like past tense than present tense.

Paragraph 3

Ms Stilton underwent a thyroid replacement therapy in 2009. She used to smoke and drink in excess till conception; however, it has been reduced now. Please note that she has no other babies.

Paragraph 4

Look for the "would" (future) and "will" in this paragraph:

In view of the above, it **would** be appreciated if you could provide further evaluation and treatment for Ms Stilton. Please note, she **will** have to visit her dietician twice every month.

Closing Paragraph

Should you have any queries, please feel free to contact me.

Closing

Yours sincerely,

Ms Alexa W Gomes, Obstetric Nurse.

ORGANIZATION

COMPLETED

NEXT

100 ERRORS

Congratulations! You have completed the art of writing an OET letter but you are bound to commit a number of errors while writing.

So, what's Next?

The following 100 errors will help you polish your language!

We are now going to look at some highly notable errors we commit in our letters. They are grammatical, organizational, relevance-related, style-related, connecting, etc.

Be sure, you will find it hard to believe that some expressions and words are really incorrect. Trust me, it is very difficult to reach the villains in our life. People who you always trusted can be your dire enemies!

Adjectives

Adjectives are words that are added before nouns.

- Noun: Lifestyle.
- Adjecting: Sedentary.

In a sentence, we write, “She leads a sedentary lifestyle,” OR, “She has a strong aversion to food during her menstrual cycle.” Did you notice, “strong” is the adjective in the second sentence.

The family of adjective includes articles (a, an, the) and determiners (little, few, a little, some, much, more, each, every, etc.)

Below are some of the adjective-related issues:

A + DISEASE

Do you write “an” or “an” before a disease name? Well, you needn’t!

Incorrect: Five days ago, Mr Woods was admitted to the ICU due to a coronary artery disease.

Correct: Five days ago, Mr Woods was admitted to the ICU due to coronary artery disease.

NB: We hardly use "a" before very few disease names, such as, "a fever" or "a flu."

A + PROCEDURE

Do we really have to write a / an before a procedure?

- She has undergone colostomy, OR
- She has undergone a colostomy?
- Mr James is recovering after angioplasty, OR
- Mr James is recovering after an angioplasty?

Well, how many angioplasties can a patient undergo during one admission? More than 1? By all

means, it is a single angioplasty or a single colostomy or appendectomy. So, since "a" and "an" mean "one," we needn't add these two words before procedures, too.

AN / A?

Many of you still think that "an" is prefixed to words that start with AEIOU, but, this is not a safe rule!

Do you think the usage of "an" and "a" are correct in the following sentences?

1. An operation was performed
2. She ate an orange.
3. An MRI was performed.
4. He has to undergo an X Ray.
5. The patient is a European native.
6. She studies in a university.

While sentence 1 and 2 are correct, the others are hard to agree with.

To help you, use "an" and "the" in the following situations:

1. If the word is singular (medicine)
2. If the first sound of the word is uttered with:
    a. Lips apart
    b. Tongue straight
    c. Teeth ridges are open

Examples for "an"

- An MRI (em-aar-ai)
- An admission (ad…)
- An outpatient admission (aut…)
- An eight-year-old child
- An eighty-year-old…

Examples for "a"

- A university (yoo-ni) student…
- A one-pound (van- pound) reduction
- A youth festival …

Important: It is not AEIOU, but the first sound of the word!

THE + "ANYTHING ALREADY MENTIONED"

When you mention something for the first time in the letter, like, "pain in the chest," do not write "the" before it.

However, do not miss "the" when you refer to the same chest pain the second, third, fourth, fifth times.

First Time: She was brought to the clinic with chest pain. (No "the")

After the First Time: "It was found that **the** pain was radiating to the right side. ("the pain" refers to the chest pain mentioned before)

THE + BODY PARTS

Do not miss the article "the" before all body parts – internal or external.

- The hand (singular)
- The tooth (singular)
- The teeth (plural)
- The hair (singular)
- The toes (plural)

However, if it is a disease condition like "hip fracture", we do not write "the" before hip fracture. You can write, fracture of the hip.

IN THE LIGHT OF THE / IN THE VIEW OF THE

In the light of the...

"The" is mandatory before "light":

*In **the** light of the above, it would be appreciated if you could refer Mr Taylor to a dietitian as he has lost five kilograms of weight due to chemo.*

In view of the...

At the same time, we do not use "the" before "view":

In view of the above, it would be appreciated if you could refer Mr Taylor to a dietitian as he has lost five kilograms of weight due to chemo.

AGED AND OLD IN SUBJECT LINE

Do not include “aged” and “years” in the “Re:” line.

1. Incorrect: Re: Mr Parker, age 22 years old
2. Incorrect: Re: Mr Parker, aged 22 years old
3. Correct: Re: Mr Parker, 22 years

Why are they incorrect?

“22 years” simply means that it is someone’s age or someone is 22 years old. We do not repeat in OET.

Connectors

ADDITIONALLY (IN ADDITION TO THIS)

Use “additionally” to begin a sentence only if the previous sentence has a similar information

Look at these two sentences:

1. She has been able to tolerate light meals at present… (progress)
2. I addition to this, she can walk short distances… (progress)

You can see that the first sentence is about a patient’s progress. What about the second sentence? That is progress, too!

AND / ALONG WITH…

“And” and “along with” are not the same. They are slightly different!

- And is used to connect A and B (two information of the same type)
- Along with is used to connect A and 2 (two information of the same category but slightly different)

Example with "along with"

She was managed thereafter with medication along with diet change.

This sentence is correct because medication and diet change are part of management (same) but they are slightly different.

Example with "and"

She was thereafter treated with metformin and amoxicillin

Incorrect: She requires medication and a meal programme.

Correct: She requires medication along with a meal programme.

FOR WHICH / FOR THIS

"For which" is used to connect two parts of a sentence. However, "For this" is used to start a new sentence.

For which

Correct: She exhibited symptoms of myocardial infarction at 11 pm for which she was transferred to….

Important – Do not use a comma before or after *for which*.

For this +,

She exhibited symptoms of myocardial infarction after the evening meal. For this, she was transferred to….

NB: Do not miss the **comma** (,) after "For this"

ALSO / IN ADDITION TO THIS, +

You cannot use “Also” to start a new sentence. However, it is a good practice to start a sentence with “In addition to this, …”

- Incorrect: Also, his haemoglobin level has dropped to 71.
- Correct: In addition to this, his haemoglobin level has dropped to 71.

THOUGH / HOWEVER

These two have almost the same meaning.

Though / Although

Currently he ambulates short distances with the help of a wheelie walker; however, he needs assistance with activities of daily living.

NB: If the first part of the sentence is over 20 words, you can full-stop and start the next sentence with However:

Currently he ambulates short distances with the help of a wheelie walker for long distances, or a stick, for shorter distances. However, he needs assistance with activities of daily living.

ON ASSESSMENT + PAST MEDICAL CONDITION

Always use past tense after "on assessment" and "upon admission."

On admission, Ms Reeta had high blood pressure and symptoms of myocardial infarction.

Do not forget the comma (,) before the patient's name.

PLEASE NOTE + THAT

You can use "please note" followed by a comma or a "that" as a connective when the current sentence is not well

connected to the previous sentence. Suppose the previous sentence is about the discharge medication but the current sentence is about a drug allergy.

Mr Pious has recently recovered from an acute episode of coronary artery disease. Please note that he consumes alcohol in excess.

NB: Do not use a comma and "that" together. You need only one of them:

- Incorrect: Please note that, he consumes alcohol in excess.
- Correct: Please note, he consumes alcohol in excess.
- Correct: Please note that he consumes alcohol in excess.

AND / BUT / HOWEVER

We use "but" if the information on its both sides are opposite:

- She was admitted on 22nd March and was diagnosed as…

- Her dietitian made her shift to a Mediterranean diet plan; however, she did not show any progress.
- Although her dietitian had made her shift to a Mediterranean diet plan, she did not show any progress.

FOLLOWING / FOLLOWED BY

The more you think of "following" and "followed by," your confusion increases. So, before you cannot deal with it, "he was admitted following a fall" means fall happened first.

- Following the diagnosis = Dx first
- Followed by diagnosis = Dx after

Incorrect: Mrs Price was admitted 2 days ago with mild concussion followed by a fall.

Correct: Mrs Price was admitted 2 days ago with mild concussion following a fall.

The first is incorrect because fall happened first! Following a fall = Fall happened first!

CONNECTORS – DOS AND DON'TS

Do not begin a sentence with these connectors:

- Also,
- So,
- And,
- But

NB: You can use these connectors inside any sentence.

Start your sentences with the following connectors instead of and, also, so, but.

- And / Also → Additionally,
- So → Therefore,
- But → However

What connectors should I avoid?

These include:

- Furthermore,
- Moreover
- Besides,
- Meanwhile,
- Apart from that,
- Later on
- Hence,
- Thus,
- Thereafter

Other connectives:

- Please note / that
- This may be worth noting
- This is worth noting

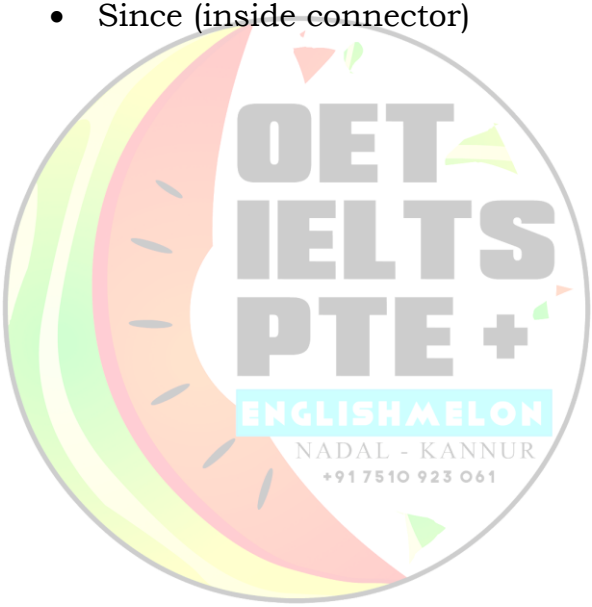
Ms Sonia, I understand the severity of you pain that you are suffering….

Important:

OET was found okaying the use of the following connectors but it is

advised that you be careful with these connectors:

- So (inside connector)
- As (inside connector)
- Because (inside connector)
- Since (inside connector)



APOSTROPHE

Apostrophe is the 'mark we place to show some's possession / ownership.

- Sara's dressing (whose dressing?)
- Ms Lee's wound (whose wound?)
- Mr Parker's transfer (whose transfer?)

You have noticed that the apostrophe is placed just before the S (Sara's, Lee's, Parkers)

However, if the word ends with s, ce, z sounds, there will be no S after the apostrophe:

- Jesus' teachings
- Moses' Laws
- Alice' Wonderlands
- Alex' mother

Be careful with words / names that may or may not end with S.

- Mr Williams' daughter.
- Mr William's daughter.

You can see that one is **Williams** (Williams') and the other is William (William's). They are different but both are correct.

FULL STOP (.)

Each sentence is like a glass, so, do not fill the glasses to the brink! You need to start a new sentence either before it is loaded with 30 words or three lines!

Look at this example:

Kindly link him with a psychotherapist to give up smoking since he needs to undergo CT scan after three months, after which annually, and, his chest X ray needs to be done three times in a year.

Where to full stop?

Kindly link him with a psychotherapist to give up smoking since he needs to undergo CT scan after three months, and, annually thereafter. Please note, his chest X ray need to be done three times in a year.

WHO IS THE PROBLEM?

Do not use "who" in most sentences.

Incorrect: Mrs Price who is being discharged and sent back to her home.

Correct: Mrs Price is being discharged and sent back to her home.

Use "who" in long sentences where you provide an additional information about Mr Parker.

Mr Parker, who has been recuperating from mild concussion, requires twice weekly home visits for assistance with general hygiene, medication monitoring and management for the infected right toes.

NB: There is always a who in the first sentence of the first paragraph of a known-case letter that includes "update".

Correct Words

If you know the correct usage of the following words, your letters will have a standard look and feel. Learn these errors carefully!

ANTIBIOTICS / ANTIBIOTIC

Antibiotics are a group of medicines while antibiotic is an adjective, which means, you can use “antibiotic” before a noun:

Correct

- Antibiotic therapy
- Antibiotic medicines

You can use “antibiotics” as a noun, means, do not use a noun after “antibiotic.”

Incorrect

- Antibiotics therapy
- Antibiotics medicines

DIABETES / DIABETIC

The same rule as above.

Correct

- She is diabetic…
- He is hypertensive
- She has had diabetes / hypertension

Incorrect

- She is diabetes…
- He is hypertension
- She has had diabetic / hypertensive

REFERRED BACK / REFERRED BACK

Refer is the process of referring a patient to a medical professional for the first time. So, in this sense, “refer back” is an incorrect expression.

Mr Benjamin is being referred / transferred back into your care today for continued care and management.

HISTORY

We always write “she has a history,” but many still write “she had a history. Although history refers to the past, yet, you still have the history!

Correct

- She has a history
- She has a history of serious coronavirus infection
- She has a history of hypertension.

Incorrect

- She has had a history
- She had a history of serious coronavirus infection
- She had a history of hypertension.

COMPLAINTS / COMPLAINS

- Complaints (plural of complaint)
- Complains (verb)

COMPLAINTS OR / SYMPTOMS OF

On 05 March, 2018, Mr Taylor was admitted with complaints / symptoms / symptoms suggestive of respiratory infection and rust-coloured sputum.

EDUCATED & ADVISED

- He was educated / advised
- He has been educated / advised

IF YOU HAVE + ANY QUERIES / ANYMORE QUERIES / MORE QUERIES

Look carefully! You have always been committing this error! Is it correct to

say, “Kindly contact me if you have any more queries?”

RE-PRESENTED / REPRESENTED

“Ms Maria re-presented” means she visited again whereas “Maria represented” means she visited the hospital for someone else, like her husband.

- Dr Sam will represent our hospital at the WHO Conference at Doha.

Example:

Today, when Mrs Marshal re-presented, she appeared generally weak, pale, sweaty and distressed.

WAS / WAS FOUND

On assessment, her blood pressure was found elevated.

CAN / IS ABLE TO / CAN BE ABLE TO

Incorrect: She can be able to walk slowly.
Correct: She can ambulate short distances.
Correct: She is able to eat and drink.

CONSULTED / REVIEWED

Many of us think that a doctor consults a patient. No – it is the patient who consults a doctor!

Consulted

Patient consulted → Doctor

1. Incorrect: A doctor has consulted
2. Correct: He has consulted a doctor.
3. Correct: A doctor has been consulted.

On the other side, “review” is an action done by the doctor or nurse.

Reviewed

Doctor reviewed → Patient

1. **Incorrect**: A nutritionist has been reviewed…
2. Correct: A nutritionist reviewed his progress.
3. Correct: His progress was reviewed by a nutritionist
4. Uncommon: He was reviewed by a nutritionist

Uses of H Words

H words are: has, have and had.

HAS – (PRESENT)

Has points to the present time, past time and future time. When you say "Ms Reeta has pain at the incision site," does it mean she has the pain only now? No – she has it now, well, but she had it five minutes ago and she will have the pain even after five minutes!

There are past and future tenses in all present tenses.

- She has a car (she bought it last year).
- She has a scar on the face (she will have it tomorrow, too).
- She has pain in the abdomen (she had it 10 minutes ago and will have it for another 2 hours).

HAD (PAST)

Had indicates something you had in the past but not present now.

- She had a car (but she does not have it now).
- She had a scar on the face (but she got it removed).
- She had pain in the abdomen (but not now).

HAS HAD (FOR CHRONIC CONDITIONS)

Has + had combination is used for describing a chronic condition, because a chronic condition does not disappear.

- She has (now) had (in the past) diabetes mellitus
- He has had hypertension
- She has had hepatitis B

HAD HAD (RARELY USED)

Had + had point to a past time that is not connected to the present.

- She had had pneumonia three years ago.
- I had had breakfast.

Note! The second “had” in the second sentence means “ate food.”

HAS / HAD A HISTORY

With history, never use had! We always say “she has a history of back pain and dysphasia both of which were treated.

Mr Woods has a history of coronary artery disease, hypertension, high cholesterol and arthritis. He has been taking medications including perindopril, atorvastatin and paracetamol.

RECUPERATING AFTER / FROM

Patients recuperate (recover) after a surgery and from a disease condition. Hard to see the difference?

- After + procedure
- From + disease condition

Procedure

Incorrect: She has been recuperating from angioplasty.
Correct: She has been recuperating after angioplasty.

Incorrect: She has been recuperating from Covid 19.
Incorrect: She has been recuperating after Covid 19.

UNDERWENT / UNDERGONE

Both words mean the same but the first is used just after the patient's name:

Incorrect

- He was undergone a surgery….
- He has underwent the surgery
- He undergone the surgery

Correct

- Ms Smith underwent the surgery.
- He underwent colostomy.
- He underwent the surgery.
- He has undergone a surgery….

SMALL OR SHORT?

Use “short” for distances and “small” for sizes:

Correct: Currently, he ambulates short distances with the help of a wheelie walker.

Correct: Additionally, she need to be encouraged to eat *small meals* during the day.

RECUPERATE FROM / AFTER

Recuperate is just another word for “recover” but, whether you use recuperate or recover, be careful with “from” and “after. Do we recover from a surgery? No, because, surgery is not a disease condition.

From + a disease condition

- She is recovering from Covid 19…
- She is recovering from food poisoning

After + procedure

- He is recuperating after coronary artery bypass graft…
- He is recovering after a total hip replacement…

DURING / ON

Both “on admission” and “during hospital stay” are very common but some of you write “during admission” in the incorrect sense.

- On + the starting point
- During + between starting and ending time.

Examples:

During his uneventful postoperative days, Mr Wood’s chest tubes were removed and his surgical site was cleaned and dressed.

On admission, she complained of recurrent episodes of vomiting for the last three days.

WHAT TO DO WITH “TO BE”?

In most case-notes, you will find notes like:

- Oxygen saturation to be monitored…

- Pt to be advised…
- BP to be kept under control…
- Social interaction to be maintained…

In most cases, we add one of the M Words (modal verbs) such as need, can,

NB: We generally do not use “should” and “must” in OET, especially with “you”. The best “to be” filler is “need” and “needn’t.”

NEED TO BE / NEEDS TO BE / NEED BE

More difficult to answer this than to understand. Anyway, here is how you need to understand the uses of need, need to be, need be.

Need as a verb:

- I need treatment.
- We need a change.
- You need advice.
- She needs a transfer.

- He needs a pillow.

Need is a modal verb (like may, might, can, could, should, would, must):

- Medicine need to be continued for three weeks.
- She need quit smoking.
- You needn't get admitted.
- She needn't consult a doctor.

CONTINUED / CONTINUOUS / CONTINUING / ONGOING

- Continued care – the care that you started from your facility.
- Continuous care – the care the recipient has to start at his / her facility.
- Ongoing care – Same as "continued care."

NB: We generally do not write “continuing care” which is same as “ongoing care.”

TRANSFERRED & DISCHARGED

Transferred

There are different states of transfers and discharges:

- He is being transferred today.
- He is being transferred.
- He is transferred today.
- He has been transferred.
- He was transferred.
- He will be transferred.

Process is going on

The ambulance is on the way…

3. He has been transferred. (open)

The ambulance is on the way

He has reached the destination

Discharged

Like “transferred,” discharged also have similar “states.”

- He is being discharged today.

- He is being discharged.
- He is discharged today.
- He has been discharged.
- He was discharged.
- He will be discharged.

NB: “She is being transferred to your facility” is technically incorrect. It is understood that the transfer is to the recipient’s facility.

Didn’t get that? Attend our one month’s group training. To get admitted, message “Melons” to this telegram contact: +917510923061

SCHEDULED ON / FOR

Incorrect

Please note, his next follow-up visit is scheduled on 07/06/2021 07th June, 2021.

Correct

Please note, his next follow-up visit is scheduled for 07/06/2021 07th June, 2021.

Common Sense Issues

You can pass OET with your common sense. Look at the sentences.

She returned back.
(Can you return forward?)

Master Ryan, a 3rd class student, has childhood asthma.
(Do children get adult asthma?)

Mr John may need diapers for incontinence
(Well, Mr John is an adult. Can he use Snuggies?)

She underwent the tests which revealed.
(Oh! Can her tests reveal results without undergoing the tests?)

Her past medical history reveals that she has had hypertension.
(So, she has no hypertension now? Does a chronic condition disappear?)

HER MEDICAL HISTORY….

- She has undergone appendectomy.
- She underwent (closed) appendectomy
- She had an injury / a fall
- She has a history of appendectomy.
- She has had hypertension.

ON BEHALF LETTERS

There is nothing like "on behalf letters." Never start a letter with "This is on behalf of…" because every medical letter is written on behalf a hospital, a medical professional, etc.

PATIENT NAME AT THE STARTING…

This is regarding the transfer of Mr Jeremy Taylor who needs to be transferred into your care today for follow- up care and management. He is recovering after a stage 2A non-small cell lung cancer.

Mr Taylor was admitted on 05 March, 2018 with complaints of respiratory infection and rust-coloured sputum. Consequently, he underwent a series of investigations that confirmed the diagnosis. Also, his VATS procedure was uneventful along with which conservative management was done for his pain. After three days, he was discharged under the care of his daughter.

WEIGHT LOSS (LOST / HAS LOST)

Weight loss and gain are an open actions, which means, the

- She lost 5 kilograms in the last one week.
- She has lost 5 kilograms in the last one week.
- She has gained 5 kilograms in the last one month.

WHO REQUIRES YOUR CARE – WHOSE CARE?

Incorrect: *Ms Reeta (patient) requires your (the recipient's) care and management.*

Remember, "your care" means the recipient's care. Why does the patient require the recipient's care!

Correct: *Ms Reeta requires care and management.*

ON MEDICATION + NAME (REPETITION)

Below, just remove the word "medication" because the recipient knows that Sinemet is a medicine.

Incorrect: Mr White has had Parkinson's disease since 2014 and is on medication Sinemet, 8 tablets per day…

Correct: Mr White has had Parkinson's disease since 2014 and is on Sinemet, 8 tablets per day…

TEST + CONDUCTED + REVEALED

Look at this sentence. Do you think it is important to mention “was performed?”

Incorrect: An X Ray was performed which revealed a non-displaced process of the ulna.

In fact, no, there is no need for “was conducted” because, if the X Ray is not conducted, how can it “reveal?” In more simple words, we needn’t write “I wrote OET and passed” because, when you “pass”, it means you “wrote OET.” How can anyone pass without writing the exam?

THE 2 "SCHEDULED" PROBLEMS

Problem 1

Remember, you cannot schedule a person (he / she). Can you? So, it is not he or she who has been scheduled but his / her appointment.

- Incorrect: He was scheduled for bunion surgery.
- Correct: Bunion surgery was scheduled
- Correct: Bunion surgery has been scheduled.

Problem 2

The second problem is with the correct preposition – on or for. Which one is correct?

- His next appointment has been scheduled on 2nd June.
- His next appointment has been scheduled for 2nd June.

In fact, “scheduled for” is always correct. “Scheduled on” has no relevance because “scheduled on” refers to the date of scheduling the appointment.

Feeling like you never realized these errors? Don’t worry! Come after me! We have many other villains to encounter and kill!

ACCURACY

As a nurse / doctor, your language should be very accurate. The recipient should have clear understanding of what you report.

- She looked weak
- She was weak

"She was weak" is more conclusive than "She looked weak" because, the speaker is not sure if she was weak or just appeared weak.

Metformin was administered" is more informative than "Metformin was prescribed" because the second sentence does not specify if the patient has started taking the medicine or not.

ELEVATED (BP)

“BP was elevated” means “BP was raised” which means, the nurse “raised the patient’s BP intentionally!”

Incorrect: On subsequent days, his blood pressure became elevated which is higher in supine than sitting position.

Correct: On subsequent days, his blood pressure was found elevated in supine position than in sitting position.

Incorrect: On today's assessment, Mr Patterson's blood pressure has still elevated which is 196/96.

Correct: On today's assessment, Mr Patterson's blood pressure was still found elevated.

POSITION OF ADVERBS

Be careful with the position of the word “only.” Any misplacement of “only” can change the meaning of the sentence. Look at these examples and observe the different meanings:

- She only has to refrain from driving for a year.
- She has only to refrain from driving for a year.
- She has to refrain only from driving for a year.
- She has to refrain from driving only for a year.
- She has to refrain from driving for a year only.

There are several words in English that can alter the meaning of a sentence. Also is another example.

PRN (PRO RE NATA)

If / as / when needed

PRN refers to a medicine's time of administration. However, PRN has three different shades. Look at each of them:

If needed (future)

You can administer Panadeine Forte if needed.

Panadeine Forte can be administered if needed.

As needed (past)

Panadeine Forte was administered as needed.

When needed (Any time)

Panadeine Forte can be administered when needed.

Panadeine Forte was administered when needed / required.

NB: If you are unsure, translate PRN into "when needed" because that means if and as needed.

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ALONG WITH / AND

He has been taking thyroid support 60 mg daily along with diet plan.

He has been taking thyroid support 60 mg daily and multivitamins.

- Metformin along with physiotherapy
- Metformin and Warfarin…

EXPERT / APPROPRIATE / EXPERTISE

Expert and expertise are slightly different while "expert" and "appropriate" are same. For safety, do not write "expert care" or "appropriate management" because they are judgmental. Every doctor / nurse thinks that he / she is an expert, so, do not remind them to provide expert care or "appropriate care".

Correct:

In view of the above information, it would be appreciated if you could provide Mr Chien the care he needs to improve his condition.

Incorrect:

In view of the above information, it would be appreciated if you could provide your expertise to improve Mr Chien's condition.

FOR INFORMATION / HAVE QUERIES

- Please do not hesitate to contact me if you have further queries.
- Please do not hesitate to contact me if you require further information.
- Please contact me if you require further information.
- Please contact me if you have further queries.

Passive Voice

Around 40% of an OET letter is written in passive voice.

Active: Nurses admitted her.
Passive: She was admitted.

Active: Doctor prescribed Metformin.
Passive: Metformin was prescribed.

You can easily see that we never write only active forms in letters.

When should we write in passive voice?

1. When an action is done by someone else (not always)

- She was brought to the clinic (by someone)
- He was advised to stop smoking (by someone)

2. When we know by whom an action was done:

- "She was admitted" (by nurses / doctors)

- “Metformin was prescribed.” (by a doctor)

Remember, only transitive verbs can be converted into passive voice.

TRANSITIVE & INTRANSITIVE

You may not be knowing what transitive verbs are. Simple – if an action’s effect passes on to someone else, it is a transitive verb.

Transitive: She admitted me.
Intransitive: She recovered.

- In the first sentence, “she admitted whom?” The answer is “me.”
- In the second sentence, “she recovered whom?” No answer for that, which mean, the action “recovered” is coming back to “She.”

Incorrect: During hospitalisation, deep breathing and walking exercises initiated for Mr Woods.

Correct: During hospitalisation, deep breathing and walking exercises were initiated for Mr Woods.

Incorrect: Additionally, his haemoglobin level has been dropped to 71.

Correct: Additionally, his haemoglobin level has dropped to 71.

SOME CORRECT PASSIVE SENTENCES

A. The nurses and doctors admitted Mr Parker.
P. Mr Parker was admitted.

A. Dr Ahmed **prescribes** my medicines.
B. My medicines are prescribed by Dr Ahmed.

A. Dr Ahmed has **prescribed** my medicine.
P. My medicine has been prescribed by Dr Ahmed.

NB: You need a very strong Passive Voice. It is highly recommended that you attend our 02.00 PM Grammar

Sessions or the MELONS Program (20 Days, 100 Hours)

INCORRECT PASSIVES

Here are the most unacceptable passive forms in medical communication:

Incorrect:

- She was prescribed Metformin
- She was administered Amoxicillin
- She was commenced antibiotics
- She was recommended exercise program.

Correct

- Metformin was prescribed…
- Amoxicillin was administered…
- Her medication commenced on antibiotics / She commenced antibiotics

- An exercise program was recommended…

Why are they incorrect?

It is very hard to explain why the following passive forms are incorrect. However, it is worth taking time:

- She was prescribed Metformin
- She was administered Amoxicillin
- She was commenced antibiotics
- She was recommended exercise program.

Look at the first sentence – "she was prescribed Metformin." Well, what was prescribed – she or Metformin?

She was prescribed is incorrect because "she" is not a medicine that the doctor prescribes. The doctor can prescribe Metformin but no doctor can prescribe "her" because, I repeat, "she" is not a medicine!

The funny thing is “She was commenced!”

- Commenced – Started
- She was commenced – She was started!
- She was started? Is she a machine that you can “start her?”

Still not convinced? Attend my live sessions. Join our telegram group NOW.

Letter Closing

REQUEST

Requests are very important elements of an OET letter. In fact, you include medical, social details only to make a couple of requests to the recipient!

Request expressions

- Kindly
- Please
- It will be appreciated

Incorrect: He should not lift heavy weights.

Correct: Kindly advise him to refrain from heavy lifting.

Too many “please” and “kindly”:

Do not start every sentence with a please or kindly. One way to avoid the repetition of “please” and “kindly” is writing in passive voice.

- Kindly advise him to refrain from heavy lifting…
- He need to be advised to refrain from lifting heavy objects…

YOURS SINCERELY / FAITHFULLY

You decide “Yours sincerely” or “Yours faithfully depending on how you had addressed the recipient. If you had addressed the recipient Dear + Name, you close the letter “Yours sincerely,”. If you had addressed the recipient “Dear + Sir / Madam,” you end the letter “Yours faithfully,”.

After Dear + Name

Yours sincerely,

Charge Nurse.

After Dear + Designation

Yours faithfully,

Charge Nurse.

NB: As per OET’s recent update, do not forget a line-gap between the two lines.

Pronouns

Here are some incorrect and correct usage of pronouns.

It's up to we students.
It's up to us students.

It was her who knocked the door.
It was she who knocked the door.

We talked to Rudy and him.
We talked to he and Rudy.

It is I who admitted Ms Lucy.
It is me who admitted Ms Lucy.

It is me they are looking for.
It is I they are looking for.

Talk to Stephon and they before making a decision.
Talk to Stephon and them before making a decision.

Can us hikers go with you?
Can we hikers go with you?

Myna and she have quit the team.
Myna and her have quit the team.

You and I are friends.
She and I have married.
he and I are admitted.

They asked him and I to join the staff.
They asked he and me to join the staff.
They asked him and me to join the staff.
They asked he and I to join the staff.

Incorrect

- She called I.
- She invited we.
- We helped they
- She invited he.
- He brought she.

Correct

- She called me.
- She invited us.
- We helped them.
- She invited him.
- He brought her.

SUBJECT – VERB AGREEMENT

There are some expressions in English that may surprise you. You will not easily agree with these. Here are some.

Uncountable + singular

- **Incorrect:** Three packets of red blood cells were transfused.
- **Correct:** Three packets of red blood cells was transfused.

Each + singular

- Incorrect: Each boys are playing.
- Incorrect: Each boy are playing.
  Correct: Each boy is playing.

Every + singular

- Incorrect: Every girls are attending the class.

- Correct: Every girl is attending the class.

Everyone + singular

- Incorrect: Everyone are busy in the ward.
- Correct: Everyone is busy in the ward.
- Incorrect: Everyone except she were working in the ward.
- Correct: Everyone except she was working in the ward.

One of the ...

- Incorrect: One of the medicines are missing.
- Incorrect: One of the medicine is missing.
- Incorrect: One of the medicine are missing.
- Incorrect: One of the medicines is missing.

Can't agree with? Your English is in critical ward. Please get admitted to our Monthly Training Programs to powerup your writing skills and grammar!

WAS / WERE

Look at the three sentences below:

1. During hospitalization, Mr Sam and Peter were diagnosed.
2. During hospitalization, severe pain and limited range of motion was noticed.
3. Three units of blood cells was transfused.

While it is very easy to agree with the first sentence, what is wrong with the second and third sentences?

Banned Expressions

You cannot use judgmental words and expressions. These include "suffer", "patient", "case", "obese",

"overweight", "sadly", "unfortunately," etc.

Incorrect: It would be appreciated if you could discuss hand and food hygiene principles with Mrs Price as she has suffered several bacterial infections.

Correct: It would be appreciated if you could discuss hand and food hygiene principles with Mrs Price as she has sustained several bacterial infections.

OBESE / OVERWEIGHT

The expression "obese" or "obesity" and even "overweight" are judgmental, which means, such expressions are not formal.

Let's check the correct ways to rewrite this word:

- Incorrect: She is obese.
- Incorrect: He is overweight.
- Correct: She has a BMI of 34.

Correct: Her body weight has been above the normal range…

THE "AFOREMENTIONED" / "ABOVEMENTIONED"

You are familiar with the expression, "as she is recuperating after polypectomy…" in the very first paragraph.

However, we have to mention the same procedure name in the second paragraph, too, where we refer to the same as "after which she underwent the "aforementioned" OR "abovementioned" surgery."

Well, since OET says NO to those two words, how are you going to write?

…and she underwent the surgery…"

Why?

"The" is another word for "aforementioned / above mentioned…"

SMOKING AND DRINKING

You should be careful with smoking and drinking, in an OET letter, too!

Incorrect

- She is a smoker.
- She is a drunkard.

Correct

- She drinks in excess.
- Correct: She smokes in excess.

NB: Smoker and Drunkard are judgmental.

"GREATLY" APPRECIATED

Do not use "greatly" or "highly" in the closing sentence.

- Incorrect: It would be greatly appreciated…
- Correct: It would be appreciated…

Stylish Expressions

Don't you feel tired and bored of the same lines you have been writing OET letters with?

Old Style

- "I am writing this letter…
- In the light of the above…
- Please do not hesitate to contact me…

Well, if you are not bored, OET assessors are! They will really appreciate if you could write something differently!

Here are a few lines you can copy!

LETTER CLOSING STYLES

For a patient who is improving

In view of the promising prognosis that Ms Mary has at present, kindly provide her home visits thrice every week.

For a patient whose condition is exacerbating

In view of the deteriorating condition that Ms Walker has at present, kindly provide her home visits thrice every week.

Intensive, deficit, secondary to

Mr Chien is being transferred into your care today for intensive rehabilitative care as he has impaired mobility and selfcare deficit secondary to right knee replacement.

Initiated, “may I bring to your notice...

During hospitalisation, deep breathing and walking exercises were initiated for Mr Woods, which, may I bring to your notice, need to be continued after discharge.

LINES YOU CAN COPY

Mr Patterson has been under our care for the last 14 days for the management of lacerated left arm.

His wound was cleaned, sutured and dressed, and, prophylactic antibiotics were initiated.

DIFFICULTY + V-ING

- Old Style: He has difficulty in chewing.
- Trendy: He has difficulty chewing.
- Trendy Style: She has difficulty sleeping.
- Trendy: She has difficulty concentrating.

OET IS TRICKY!

OET wants to check how sharp and efficient your brains are, so, they will design their exams as tricky as reasonable! Here are some tricky ways OET "fool" you!

Known / not known case

- His gp
- Her gp

Transferring back to the

- Same address
- Family GP
- Community

Irrelevant data (20 – 30%)

- Too many visits
- She visited first with….
- During the subsequent visits, she exhibited similar symptoms….
- Today, when she visited, she showed no improvement in her condition…

Who is patient?

- Mother / Baby? (Breastfeeding)
- Medication / medicines
- Mention the current one

Enclose the others:

Enclosed herewith is a list of medicines that she has to continue for the next 2 to three months

CHRISTOPHER FORT CASES NOTES

CASE NOTES 07 CHRISTOPHER FORT

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

READING TIME: 5 MINUTES |
WRITING TIME: 40 MINUTES

NOTES

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

Patient Details

- Name: Mr Christopher Fort
- Age: 49 years
- Married, lives with wife and 2 children
- Height:173
- Weight: 59
- Temp: 98.6°F
- Pulse: 72 b/m
- Blood pressure:150/100 mm of hg

Admission

- Admission date: 20/2/2020 (with chest pain, radiating to shoulder, difficulty breathing - 2 days along with generalized weakness, nausea, dizziness)
- ECG - ST elevation
- Ckmb+
- Dx - Myocardial infarction

Medical History:

- Peptic ulcer
- Twice clipping done
- Hypertension - 8 years, on tab Nicardia 5 mg once daily
- Diabetic - 9 years, Human mixtrad Bd
- Heavy drinker and smoker (10 years)
- Eats oily foods, sugary creams
- Nil exercise

Medications

- Pan 40 mg BD for one month
- Aspirin 325 mg one month

- Statix 40 mg of one month
- Paraffin 10 mg of one month

Investigations Report:

- RBS:190 mg/dl
- FBS:118mg/dl
- LDL:120mg/dl
- HDL:40mg/dl
- HB: 12

21/2/2020

- Angiogram
- Presence of clots in the left side of the coronary artery.
- Percutaneous transluminal coronary angioplasty done.

Post-operative progress:

- No complications.
- Blood pressure and blood sugar under control.

Recommended by dietitian:

- Avoid oily foods and carbohydrates.
- Increase green leafy veggies, fruits and vegetables, fluid intake.
- He is ready to be discharged after the consultation with consultant.

Discharge plan:

- Schedule follow up with Fbs, FLP, reports on 3/3/2020.
- Medication monitoring
- Quit-line programs
- Blood pressure and blood sugar monitoring
- Dietary management
- Encourage daily Exercise
- Follow up
- Avoid strenuous exercise for two weeks.

Writing Task

Using the given information, write a letter to the district nurse requesting

home visits to ensure medication compliance and dietary restrictions.

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.

CORRECTED LETTER

23 February, 2020

The District Nurse

Dear Nurse,

Re: Mr Christopher Fort, 49 years

Mr Christopher Fort requires home visits to ensure medication compliance and dietary restrictions. He is recuperating after angioplasty and is being discharged today.

Mr Fort was admitted on 20th February, 2020, with chest pain which radiated to the shoulder, breathing difficulty and generalized weakness along with nausea and dizziness. ECG and blood investigations confirmed myocardial infarction. Based on his angiogram results, the next day, which revealed clots, the surgery was performed. His postoperative period has been uneventful during which he has to avoid oily foods, carbohydrates and

to increase the intake of green leafy vegetables, fruits and fluids.

Mr Fort is known to have hypertension and diabetes for which he is on medication. He smokes and drinks heavily for the last 10 years and likes to eat sugar cream and oily foods. With no exercise part of his routine, he follows a sedentary lifestyle.

In view of the present condition, it would be appreciated if you could monitor Mr Fort's medication, blood sugar and blood pressure. Please encourage him to do daily exercise; however, he should avoid strenuous activities for the next two weeks. Kindly advise him regarding dietary management and quit-line programs. Please note that he has a follow up appointment on 03 March with his FBS and FLP reports. His medication and investigation reports are enclosed with this letter.

Please feel free to contact me for further information regarding Mr Fort.

Yours faithfully,

Charge Nurse.

5 SYDNEY LOTEN – RELEVANCE

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: Nursing

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

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

You are a Nurse Practitioner at the Medical Center Brisbane.

Patient Details:

- Name: Sydney Loten
- DOB: August 14, 1946

Address: 5 Peanut Hedge, Carina Heights QLD

- Phone: 07 86734214
- Next of kin: Eby Simmons (adopted son)

Social History:

- Retired Professor; widow, an adopted son 24-year-old student; husband died 2014.
- Lives with her son in a one-storey house, son is often unavailable to care for patient due to school and work.
- Oxygen readily accessible at home via nasal cannula at 2-4L as needed.

Medical History:

- Height: 160 cm Wt. 65 kg
- Occasional alcoholic beverage drinker.
- 1-2 bottles of beer/week (till 2019, Jan; 1 bottle of beer/week (now)
- Smoker, 10-15 sticks/day for 35 years (till 2018); 5 e-cigarettes (since then)
- No previous or surgical procedures
- Diagnosed with COPD in 2010, maintained on Ipratropium bromide inhaler, 1 puff, Budesonide + Formoterol, 2

puffs BID and Prednisone 40 mg (taken as a single daily dose for acute attacks)
- Diabetic since 2007, Metformin 500mg BID, Glipizide 5mg OD
- Hypertensive since 2008, Losartan 40mg OD
- Patient underwent routine colonoscopy, multiple polyps found.

Admission, Diagnosis, Management

- Admitted at Medical Center Brisbane on April 11, 2020.
- Colon polypectomy on April 13, 2020
- Post-op complications at the recovery room, experienced respiratory distress, Arterial Blood Gas revealed.
- Covid19 test negative.
- Metabolic acidosis. Transferred to ICU and moved to regular ward on April 15, 2020
- Hooked to oxygen support at 3-5L NP as needed.

- Patient uncooperative at times and requires encouragement to take medications.
- Difficulty in sitting and cannot walk around the room.

Pain meds given as prn:

- Paracetamol 1g IV
- Endone 2.5 mg PRN for intolerable pain
- On laxative, Senna, OD at bedtime.
- Was on folly catheter.
- Now with adult diaper due to incontinence.
- Stable vital signs at regular ward
- O2 sat at 96-97% at 2-3L.
- "Wean" if able to tolerate 1L.
- **Moderate** post op pain, wound with no exudates

Medical Records

April 17, 2020

- Patient hesitant to ambulate around her room.

- Prefers to walk with assistance.
- Unable to tolerate O2 at 1L. O2 sat at 98% at 2L.
- Anxious during wound dressing.
- Minimal pain at the incision site.
- Encouraged sitting, standing and walking inside her room.
- Poor appetite. Constipation, resolves with laxative.

April 19, 2020

- Patient walks around her room with walker. Can walk along the hospital corridors but requires increase to 3L O2 after walking.
- O2 sat at 98% at rest.
- Less uneasy during dressing change.
- Improved appetite.

April 22, 2020

- Patient can walk with a cane.

- Can tolerate O2 at 1L, O2 sat 98%.
- Minimal pain at incision site.
- Regular bowel movement.
- Still requires adult diapers for incontinence.
- Eager to go home.
- Discharge will be facilitated once O2 availability at home is confirmed.

April 23, 2020

- Patient is ready for discharge. Home medications and instructions given in the presence of her son.
- Need for transition care program explained.
- Continue dressing change at home.
- Advised to monitor O2 consumption.
- Follow up check-up scheduled on April 30. 2020.

WRITING TASK

Given the patient's current situation, you need to write a formal letter to the Nursing Director, Ms Jane Hall, Southern Valley **Community + Transition Care + Program**, 64 Gladstone Road, Highgate Hill Qld 4101. Discuss the need of the patient's continuity of care at home.

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.

CORRECTION

DADS

23rd April, 2020

Ms Jane Hall
Nursing Director
Southern Valley Community
Transition Care

Highgate Hill
64 Goldstone Road, QLD 4101

Dear Ms **Hall**,

Re: Ms Sydney Loten, DOB: 14 August, 1946

PRPDD (known case)

Ms Sydney Loten requires transition care and daily dressing at her home following her discharge today. She is recuperating after colon polypectomy.

Ms Loten was admitted on 11 April, 2020 for routine colonoscopy which **revealed** multiple polyps. She underwent the surgery and, post-operatively, she developed metabolic acidosis and respiratory distress for which she **was** on oxygen therapy. On subsequent days, 98% oxygen saturation at 2 litres was maintained and **she was** encouraged for mobilisation by sitting and standing with assistance. Currently, she is able to walk with the help of a cane. Please note, she is on diapers for urinary incontinence.

A retired professor, Ms Loten lives with son. She has had diabetes, hypertension and chronic obstructive pulmonary disease for the last 10 years for which she **is** on medication. She drinks alcohol and smokes, daily.

It would be appreciated if you could monitor Ms Loten's home medication along with daily dressing care. Of note, oxygen is available at her home. A follow-up visit has been scheduled for the 30th of this month.

Should you require any **more** information regarding Mrs Loten, kindly contact me.

Yours sincerely,
Nurse Practitioner
Medical Centre
Brisbane.

CASE NOTES

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

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

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

NOTES:

You are a Registered Nurse at the Royal Brisbane Hospital where Anthony Nutt is a patient in your care.

- Today's date 29/05/2017
- Patient name Anthony Nutt
- Address Unit 8, 37 Albert Street, Brisbane 4000
- Age 86 years
- DOB 19/07/1936
- Next of Kin Son, Joseph Nutt

Medical history

- Breast Cancer 20 years ago - right total mastectomy
- Did not receive adjuvant radiation, chemotherapy, or hormone therapy or medical follow-up post-operatively.
- Dementia
- Non-smoker
- No known allergies
- Non-drinker

Family History

- Mother died of colon cancer

Social History

- Retired 20 years ago
- Married – wife suffering from newly onset dementia
- One son- Joseph Nutt, 52 years old, unmarried – lives 30 minutes away

Diagnosis

- Recurrent infiltrating ductal carcinoma of the breast.

23/05/2017

- Presented to ER with ulcerated, haemorrhaging right anterior chest mass
- The patient developed a mass on his anterior chest wall -2 years ago
- Mass increased in size, began to ulcerate – bled this morning -- did not seek medical treatment until this morning

Objective

- Temperature - 97.4°F, Pulse- 80, RR – 14, Pulse oximetry of 100% on room air, BP - 162/88.
- A right-sided pedunculated 8 cm × 7 cm mass with a cauliflower-like appearance on chest- ulcerated, erythematous, malodorous, and with scant bleeding
- White blood cell counts 6,500
- Haemoglobin 12.4
- Haematocrit 36.2

- Platelet count 178,000.
- Creatinine of 1.72
- Glucose 106
- A CT chest was performed
- Soft tissue mass in right chest wall measuring 5.2 × 2.75 × 5 cm with postoperative changes of the right axilla.
- Incisional biopsy of right breast mass performed

28/052017

- Pathology returned consistent with Recurrent moderately differentiated duct carcinoma of the breast with ulceration of overlying epithelium - Stage 3
- Pt. not found to be suitable for chemotherapy or curative treatment –
- Oncology evaluation and geriatric evaluations by doctor
- Pt. commenced on hormone therapy with tamoxifen 20 mg daily with one course of palliative radiation.

- Family meeting called- son verbalized concerns over mother's state of health;
- Son unable to take time off work to care for father – says, he won't be able to cope;
- hospice care recommended for pt.
- Consensus decision
- Pt. to be transferred to Queensland Aged Care Centre for hospice care
- Bed available from 29/05/2017 for patient
- Pt.'s wife to be admitted to the same facility due to general deconditioning when bed is available; mother to live with son interim

Discharge plan

- Transfer to Aged Care home
- Son will visit weekly
- Contact community social worker to notify son when bed

available for wife at
Queensland Aged Care Centre

WRITING TASK

Using the information in the case notes, write a referral letter to the Ms. Carrie Andrews, Director of Nursing, Queensland Aged Care Centre, 52 Albert Street, Brisbane 4101, introducing the patient. Using relevant case notes, give his background, medical history, and treatment required.

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.

CASE NOTES - MEDICINE

TIME ALLOWED: READING TIME: 5 MINUTES Task 2 WRITING TIME: 40 MINUTES Read the case notes below and complete the writing task which follows.

Notes:

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

- Name: Mrs Sally Fletcher
- Date of Birth: 3/10/1993
- Marital status: Married, 5 years
- Appointment date: 25/03/2018
- Diagnosis: Endometriosis

Past medical history:

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

Social background:

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

Medical background:

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

Post op care: Keep incisions clean and dry.

Mobility post op:

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

Nursing Management:

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

Medical Progress

- Afebrile. Hct, Hgb, Plts, WBC, BUN, Cr, Na, K, Cl, HCO3, Glu all within normal limits.
- Patient sitting comfortably, alert, oriented × 4 (person, place, time, situation).

Assessment: Good progress overall.

Discharge plan:

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

Writing Task:

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

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

In your answer:

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

The body of your letter should be approximately 200 words.

LETTERS CORRECTED

ENGLISHMELON'S PLATFORM

PPRRRAADDDWK
DADS, PRPDD, DIVING & RISING

Christopher Fort Cases Notes

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

READING TIME: 5 MINUTES |
WRITING TIME: 40 MINUTES

NOTES

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

Patient Details

- Name: Mr Christopher Fort
- Age: 49 years
- Married, lives with wife and 2 children
- Height: 173
- Weight: 59
- Temp: 98.6°F
- Pulse: 72 b/m
- Blood pressure:150/100 mm of hg

Admission

- Admission date: 20/2/2020 (with chest pain, radiating to shoulder, difficulty breathing - 2 days along with generalized weakness, nausea, dizziness)
- ECG - ST elevation
- Ckmb+
- Dx - Myocardial infarction

Medical History:

- Peptic ulcer
- Twice clipping done
- Hypertension - 8 years, on tab Nicardia 5 mg once daily
- Diabetic - 9 years, Human mixtrad Bd
- Heavy drinker and smoker (10 years)
- Eats oily foods, sugary creams
- Nil exercise

Medications

- Pan 40 mg BD for one month
- Aspirin 325 mg one month
- Statix 40 mg of one month

- Paraffin 10 mg of one month

Investigations Report:

- RBS:190 mg/dl
- FBS:118mg/dl
- LDL:120mg/dl
- HDL:40mg/dl
- HB: 12

21/2/2020

- Angiogram + Presence of clots in the left side of the coronary artery.
- Percutaneous transluminal coronary angioplasty done.

Post-operative progress:

- No complications.
- Blood pressure and blood sugar under control.

Recommended by dietitian:

- Avoid oily foods and carbohydrates.

- Increase green leafy veggies, fruits and vegetables, fluid intake.
- He is ready to be discharged after the consultation with consultant.

Discharge plan:

- Schedule follow up with Fbs, FLP, reports on 3/3/2020.
- Medication monitoring
- Quit-line programs
- Blood pressure and blood sugar monitoring
- Dietary management
- Encourage daily Exercise
- Follow up
- Avoid strenuous exercise for two weeks.

Writing Task

Using the given information, write a letter to the district nurse requesting home visits to ensure medication compliance and dietary restrictions.

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.

LETTER

23 February, 2020

The District Nurse

Dear Nurse,

Re: Mr Christopher Fort, 49 years

Mr Christopher Fort requires home visits to ensure medication compliance and dietary restrictions. He is recuperating after angioplasty and is being discharged today.

Mr Fort was admitted on 20th February, 2020, with chest pain which radiated to the shoulder along with breathing difficulty, generalized weakness, nausea and dizziness. ECG and blood investigations confirmed myocardial infarction. Based on his angiogram results which revealed clots, the surgery was performed. His postoperative period has been uneventful during which he has to avoid oily foods, carbohydrates and to increase the

intake of green leafy vegetables, fruits and fluids.

Mr Fort is known to have hypertension and diabetes for which he is on medication. He smokes and drinks heavily for the last 10 years and likes to eat sugar cream and oily foods. With no exercise part of his routine, he follows a sedentary lifestyle.

In view of the present condition, it would be appreciated if you could monitor Mr Fort's medication, blood sugar and blood pressure. Please encourage him to do daily exercise; however, he should avoid strenuous activities for the next two weeks. Kindly advise him regarding dietary management and quit-line programs. It is to be noted that he has a follow up appointment on 03 March with his FBS and FLP reports. His medication and investigation reports are enclosed.

Please feel free to contact me for further information regarding Mr Fort.

Yours faithfully,

Charge Nurse.

Sydney Loten - Relevance

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: Nursing

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

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

You are a Nurse Practitioner at the Medical Center Brisbane.

Patient Details:

- Name: Sydney Loten
- DOB: August 14, 1946

Address: 5 Peanut Hedge, Carina Heights QLD

- Phone: 07 86734214
- Next of kin: Eby Simmons (adopted son)

Social History:

- Retired Professor; widow, an adopted son 24-year-old student; husband died 2014.
- Lives with her son in a one-storey house, son is often unavailable to care for patient due to school and work.
- Oxygen readily accessible at home via nasal cannula at 2-4L as needed.

Medical History:

- Height: 160 cm Wt. 65 kg
- Occasional alcoholic beverage drinker.
- 1-2 bottles of beer/week (till 2019, Jan; 1 bottle of beer/week (now)
- Smoker, 10-15 sticks/day for 35 years (till 2018); 5 e-cigarettes (since then)
- No previous or surgical procedures
- Diagnosed with COPD in 2010, maintained on Ipratropium bromide inhaler, 1 puff, Budesonide + Formoterol, 2

puffs BID and Prednisone 40 mg (taken as a single daily dose for acute attacks)
- Diabetic since 2007, Metformin 500mg BID, Glipizide 5mg OD
- Hypertensive since 2008, Losartan 40mg OD
- Patient underwent routine colonoscopy, multiple polyps found.

Admission, Diagnosis, Management

- Admitted at Medical Center Brisbane on April 11, 2020.
- Colon polypectomy on April 13, 2020
- Post-op complications at the recovery room, experienced respiratory distress, Arterial Blood Gas revealed.
- Covid19 test negative.
- Metabolic acidosis. Transferred to ICU and moved to regular ward on April 15, 2020
- Hooked to oxygen support at 3-5L NP as needed.

- Patient uncooperative at times and requires encouragement to take medications.
- Difficulty in sitting and cannot walk around the room.

Pain meds given as prn:

- Paracetamol 1g IV
- Endone 2.5 mg PRN for intolerable pain
- On laxative, Senna, OD at bedtime.
- Was on folly catheter.
- Now with adult diaper due to incontinence.
- Stable vital signs at regular ward
- O2 sat at 96-97% at 2-3L.
- "Wean" if able to tolerate 1L.
- **Moderate** post op pain, wound with no exudates

Medical Records

April 17, 2020

- Patient hesitant to ambulate around her room.

- Prefers to walk with assistance.
- Unable to tolerate O2 at 1L. O2 sat at 98% at 2L.
- Anxious during wound dressing.
- Minimal pain at the incision site.
- Encouraged sitting, standing and walking inside her room.
- Poor appetite. Constipation, resolves with laxative.

April 19, 2020

- Patient walks around her room with walker. Can walk along the hospital corridors but requires increase to 3L O2 after walking.
- O2 sat at 98% at rest.
- Less uneasy during dressing change.
- Improved appetite.

April 22, 2020

- Patient can walk with a cane.

- Can tolerate O2 at 1L, O2 sat 98%.
- Minimal pain at incision site.
- Regular bowel movement.
- Still requires adult diapers for incontinence.
- Eager to go home.
- Discharge will be facilitated once O2 availability at home is confirmed.

April 23, 2020

- Patient is ready for discharge. Home medications and instructions given in the presence of her son.
- Need for transition care program explained.
- Continue dressing change at home.
- Advised to monitor O2 consumption.
- Follow up check-up scheduled on April 30. 2020.

WRITING TASK

Given the patient's current situation, you need to write a formal letter to the Nursing Director, Ms Jane Hall, Southern Valley **Community + Transition Care + Program**, 64 Gladstone Road, Highgate Hill Qld 4101. Discuss the need of the patient's continuity of care at home.

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.

LETTER

23rd April, 2020

Ms Jane Hall
Nursing Director
Southern Valley Community
Transition Care
Highgate Hill
64 Goldstone Road, QLD 4101

Dear Ms Hall,

Re: Ms Sydney Loten, DOB: 14 August, 1946

Ms Sydney Loten requires transition care and daily dressing at her home following her discharge today. She is recuperating after colon polypectomy.

Ms Loten was admitted on 11 April, 2020 for routine colonoscopy which revealed multiple polyps. She underwent the surgery and, post-operatively, she developed metabolic acidosis and respiratory distress for which she was on oxygen therapy. On subsequent days, 98% oxygen saturation at 2 litres was maintained

and she was encouraged for mobilisation by sitting and standing with assistance. Currently, she is able to walk with the help of a cane. Please note, she is on diapers for urinary incontinence.

A retired professor, Ms Loten lives with son. She has had diabetes, hypertension and chronic obstructive pulmonary disease for the last 10 years for which she is on medication. She drinks alcohol and smokes, daily.

It would be appreciated if you could monitor Ms Loten's home medication along with daily dressing care. Of note, oxygen is available at her home. A follow-up visit has been scheduled for the 30th of this month.

Should you require any more information regarding Mrs Loten, kindly contact me.

Yours sincerely,

Nurse Practitioner.

Somarni Khaze

WRITING SUB-TEST: NURSING
TIME ALLOWED:

READING TIME: 5 MINUTES
PPRRR3AADDD3WK: 5 Min
WRITING TIME: 35 MINUTES

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

Today's Date: 16/07/2021

Patient History

- Somarni Khaze
- DoB 12/05/74
- Works as operating room nurse, Ringwoods Hospital
- Married, 4 children, 3 girls aged 17, 11, 7; boy 12 years.
- Regular periods…
- Past Hx of R breast lump, treated by lumpectomy (5 years ago).
- Dx Benign lesion
- Teetotaller; no regular medication

- Mammogram 2 years ago (no suspicions of malignancy)
- Sister had breast cancer 7 years ago, treated by mastectomy, axillary clearance, chemotherapy.

30/6/2021

Subjective

- Discovered a left breast lump, almond size; not painful, no nipple discharge.

Objective

- Mildly obese (BMI31)
- Pulse 74/M, regular
- BP 120/80
- CVS, RS, ABD are all normal

Local examination:

- Left breast shows 2x2 cm breast lump, hard, non tender with ill-defined margins
- Palpable mobile axillary lymph nodes

- Rt breast normal except for scar from previous surgery.

Assessment

- ? Cancer breast

Management

- Repeat mammogram and order ultrasound
- Patient advised review in 2 weeks' time

13/07/2021

- Pt anxious, worried about result; cannot sleep at night
- BP 150/90 and pulse 88/Min
- U/S shows an 18x 16 mm nodule on left breast with variable echogenicity.
- Mammogram reveals area highly suspicious for malignancy (left breast with multiple nodules at axilla)
- You counsel the patient about the different options of

treatment and you do core biopsy to confirm the diagnosis
- Prescribe diazepam 10 mg nocte to calm the patient down
- Follow up consultation in 3 days for biopsy result and plan of management

16/07/2021

- Biopsy result shows moderately differentiated invasive ductal carcinoma of the left breast.
- Patient is asked to be operated on by breast surgeon Dr Alaa Omar who had operated on her sister before.
- Patient is asked about the possibility of immediate constructive surgery.

Writing Task

You are the Nurse in Charge at Weller Park Medical Centre, 151 Pring St. Weller Park 4121. Write a referral letter to the breast surgeon,

Dr Alaa Omar, 1414 Wickham Tce.,
Spring Hill, 4004.

In your answer:

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

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

LETTER

16 July, 2021

Dr Alaa Omar
Breast Surgeon
1414 Wickham TEC
Spring Hills 4004

Dear Dr Omar,

Re: Mrs Somarni Khaze; DOB: 12 May, 1974

Mrs Somarni Khaze requires an immediate constructive surgery. She has been diagnosed with invasive ductal carcinoma of the left breast.

On 30 June, 2021, Mrs Khaze presented with the complaint of a left breast lump which was the size of an almond. Local examinations revealed 2x2 cm hard lump on the left breast with palpable axillary lymph nodes. She was advised to undergo mammogram, ultrasound and review after two weeks.

On her scheduled visit, Mrs Khaze was quite anxious. She had difficulty

sleeping for which diazepam 10 mg one tablet at night was commenced. Her ultrasound showed an 18x16 mm nodule with variable echogenicity while mammogram revealed highly suspicious malignancy with multiple nodules in the axilla. A detailed counselling session was provided regarding different treatment options following which she underwent core biopsy. She was requested for follow-up after three days of the biopsy report and to discuss plan of treatment.

On today's review, Mrs Khaze' report confirmed moderately differentiated invasive ductal carcinoma. She has requested to be operated by you since her sister was operated and treated at your clinic.

Mrs Khaze lives with family and she used to be a nurse at Ringwoods Hospital. She underwent lumpectomy for the right breast before five years.

It would be appreciated if you could conduct an immediate constructive surgery for her speedy recovery.

Please contact me for further information about Mrs Khaze' health status.

Yours sincerely,

Charge Nurse.

BETSIE ANDERSON

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing
READING TIME: 5 MINUTES | WRITING TIME: 40 MINUTES

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

NOTES

Patient Details

- Betsie Anderson, 89
- Allergy to iodine (flushing, rash)
- Lives in Woodside House nursing home facility;
- Widowed

Medical Background:

- Hypothyroid
- Dementia
- GERD
- Constipation
- ORIF R Hip (2017)

Recent History:

- Pt confused, (oriented to person only)
- Increased somnolence
- New onset urinary incontinence
- Loss of 6 pounds in one week
- Low grade fever

Admission & Discharge

- 16/02/2020
- 19/02/2020

Diagnosis:

- Urinary Tract Infection

Hospital Information:

- Norfolk and Norwich University Hospital

ED record

- Vitals - Temp 38.3C, HR 119, RR 23, O2 Sat 91 on RA
- Labs- WBC 15.2 mg/dl UA + bacteria.
- Urine & Bld Cx pending

- Pt given acetaminophen 650mg po x1 in ED
- Started on IV ciprofloxacin

Nursing Care:

- Daily assessments including LOC, BP
- Assist w/ ADLs
- Frequent toileting with proper hygiene
- Assist with increasing activity
- Starting PT
- Orthostatic BP
- Transition during position changes slowly
- Oriented now, no longer confused
- Pt ready for discharge

Discharge Medications:

- Levothyroxine 200mcg morning
- Protonix 75mg daily
- Colace 100mg morning
- Ciprofloxacin 250mg PO Q12H x14D
- Multivitamin with calcium night

- Aricept 10mg QHS

Discharge Plan:

- FU with GP Dr. Alex Rose in 2 weeks
- Repeat UA and labs in 2 weeks
- Continue daily vitals and assessment
- Observe for signs of dehydration & orthostatic BP

Equipment required:

- Walker, cane, bedside commode

Writing Task

Using the information in the case notes, write a letter to Ms. Stella Howard, head nurse for Woodside Nursing House in Norwich 142 Woodside Rd, Norwich where patient will return after discharge.

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.

LETTER

19 February, 2020

Ms Stella Howard
Head Nurse
Woodside Nursing House
Norwich 142 Woodside Road
Norwich

Dear Ms Howard,

Re: Mrs Betsie Anderson, 89 years

Mrs Betsie Anderson requires continuity of care and management following her discharge today. She is recuperating from urinary tract infection.

Mrs Anderson was admitted on 16 February 2020 with the complaints of confusion and urinary incontinence. On assessment, her temperature was 38.3oC, heart rate, 119 beats per minute, respiratory rate, 23 breaths per minute and oxygen saturation on room air. Her urinalysis was positive for bacteria. A series of investigations revealed

urinary tract infection and her condition was managed with acetaminophen 650 mg orally along with ciprofloxacin intravenously.

It would be appreciated if you could assess blood pressure and level of consciousness daily. She requires assistance in activities of daily living while physiotherapy need to continue. Importantly, please closely monitor any signs of orthostatic blood pressure and dehydration. A follow up visit has been arranged with Dr. Alex Rose in 2 weeks along with repeated urinalysis and labs. Please note, she requires a walker, cane and bedside commode.

Mrs Betsie's current medicines are levothyroxine 200mcg, protonix 75 mg, colace 100mg, ciprofloxacin 250mg, multivitamin with calcium and aricept 10 mg. She is allergic to iodine.

Should you have any queries, please contact me.

Yours sincerely,

Registered Nurse.

https://t.me/englishmelonoet

Derek Shepherd

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

TIME ALLOWED: READING TIME: 5 MINUTES

WRITING TIME: 40 MINUTES

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

NOTES:

Today's Date: 27/12/2017

You are a registered nurse in the Coronary Care Unit, St Vincent's Hospital Melbourne. Derek Shepherd is a patient in your care.

Patient Details

- Name: Derek Shepherd
- DOB: 13 September 1970
- Address: 108 Queen Street Melbourne

- Admitted: 20 December 2017
- Date of discharge: 27/12/2017
- Diagnosis Obstructive Coronary Artery Disease
- Operation - Coronary Artery Bypass Grafts (x 4)

Social History

- Never married
- Lives alone in own home
- Business Development Manager (bank)

Medical History

- Constipation occasionally - takes isabgol for relief
- Smokes 5-6 cigarettes/day
- Alcohol: 2 x 300 ml bottles beer/day
- Ht 185 cm Wt 102 kg (BMI- 29 Overweight)
- Dietary habits: Sausages, deep fried chips, pizzas, pastas,
- Allergic reaction to nuts

20/12/2017

History of presenting complaint:

- Severe chest pain, extreme tightness in chest – felt like someone is standing on his chest,
- Heaviness in both forearms, shortness of breath
- Chest pain started 3-5 months ago, has been increasing in intensity since, got worse on exertion
- Diagnosed with Obstructive Coronary artery disease

Nursing Management and Progress

21/12/2017

- Operation coronary artery bypass grafts (x4)
- Routine postoperative recovery
- Pain/Discomfort managed

23/12/2017

Constipation related to decrease response to urge to defecate

secondary to surgical procedure – no stool for 2 days

- Pt. given isabgol for constipation
- Pain – 5/10
- PT commenced- Rev. by Physio
- Position changes every 4 qh

24/12/2017

- Knowledge deficit (Re-diagnosis, surgical procedure)
- Seemed confused
- Educated regarding event
- PT – continued
- Low fat diet
- No complaints of constipation

26/12/2017

- Pain 2/10
- Pt. walking well – routine visits by PT
- Pt. explained post discharge instructions (resume work after 4 wks.,
- Avoid travelling/strenuous exercises till 6 wk.,

- Follow-up after 6 wks., medications)
- Pt. counselled on changes to lifestyle (cease smoking- referred to Quit line, decrease alcohol, reduce weight, low-fat diet, exercise regime)
- Pt. has knowledge and understanding of diagnosis, procedure, long term rehabilitation – worried about future as evidenced by patient's verbalization "I don't know how I will cope with my job and finance; I might be fired if I don't go to work for a month"
- Refer to Cardiac Rehab.
- S/W for support
- Wound healing well – daily dressing change
- Pt. educated re smoking cessation – referred to Quit line
- Pt. educated re decreasing alcohol
- Low fat diet
- Medications: Aspirin ½ daily, Vicodin q4

Discharge Plan

- Returning Home – avoid strenuous activities, travelling till 6 wks., resume work after 4 wks.
- Follow-up visit after 6 weeks
- Refer to District Nurse – wound management, monitor medications, diet, temp.
- Call Hospital if wound swollen, temp rises above 101-degree F
- Local physiotherapist to continue rehabilitation exercise program- increase physical strength, gradually increase physical activity
- Low-fat diet after discharge
- Pt. Requested more information on simple low-fat recipes that can be prepared at home
- Refer to local Social Worker at Cardiac Rehab. for support to pt. for applying leave from work, financial assistance.

WRITING TASK

Using the information given in the case notes, write a letter to Ms. Christina Yang, Senior Social Worker, Cardiac Rehabilitation Program, Elizabeth Hospital, 43-47 King Street, Melbourne to provide support service to the patient to help him re-adjust to normal life.

- 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.

LETTER (DIETITIAN)

27 December 2017

Dr Addison Burke
Dietitian
Suite 1, 3458, 5th Floor
Church Street, Melbourne

Re: Mr Derek Shepherd, 50 years

Dear Mr Burke,

I am writing to refer Mr Shepherd who requires your expert guidelines regarding diet and how to maintain a healthy weight following his discharge today. He is recuperating after coronary artery bypass graft.

A week ago, Mr Shepherd was admitted with constructive coronary artery disease for which he underwent the surgery on the 21st of this month. Postoperatively, he had constipation which was resolved with tablet isabgol. Currently, he is in stable condition, to maintain which, a low-fat diet has been advised. In addition to these, he underwent

counselling for lifestyle modification which includes weight management and smoking cessation.

In spite of a not-recommended BMI, Mr Burke smokes and drinks in excess. His medical history is significant for intermittent episodes of constipation. In addition to these, he is allergic to peanuts. His diet includes sausages, deep-fried chips, pizzas and pasta.

It would be appreciated if you could send Mr Shepherd dietary guidelines and provide simple low-fat recipes that can be easily prepared at home.

If you have any queries, please feel free to contact me.

Yours sincerely,

Registered Nurse.

Join English Melon OET

Margaret Helen Martin

OCCUPATIONAL ENGLISH TEST
WRITING SUB-TEST: Nursing

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

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

NOTES:

You are a ward nurse in the cardiac unit of Greenville Public Hospital. Your patient, Ms Martin, is due to be discharged tomorrow.

- Patient: Ms Margaret Helen Martin
- Address: 23 Third Avenue, Greenville
- Age: 81 years old (DOB: 23 July 1935)
- Admission date: 15 July 2017

Social/ family background:

- Never married, no children

- Lives in own house in Greenville
- Financially independent
- Three siblings (all unwell) and five nieces/ nephews living in greater Greenville area
- Contact with family intermittent
- No longer drives
- Has “meals on wheels” (meal delivery service for elderly) - Mon-Fri (lunch and dinner) orders meals for weekends
- Diagnosis: Coronary Artery disease (CAD), Angina
- Treatment: Angioplasty (repeat-first 2008)
- Discharge date: 16 July 2017, pending cardiologist’s report.

Medical information:

- Coeliac disease
- Angioplasty 2008
- Anxious about health – tends to focus on health problems
- Coronary artery disease - saprin, clopidogrel (Plavix)
- HTN metoprolol (Betaloc), Ramipril (Tritace)

- Hypercholesterolemia: atorvastatin (Lipitor)
- Overweight (BMI 29.5)
- Sedentary (orders groceries over phone to be delivered, neighbour walks dog)
- Family history of coronary heart disease (mother, 2 of 3 brothers)
- Hearing loss wears hearing aid

Nursing management and progress during hospital stay:

- Routine post-op recovery
- Tolerating light diet and fluids
- Bruising at catheter insertion site, no signs of infection/ bleeding noted post procedure
- Pt anxious about return home, not sure whether she well cope

Discharge Plan:

Dietary

- Low-calorie, high-protein, low-cholesterol, gluten-free diet (supervised by dietician, referred by Dr)

- Frequent small meals or snacks o Drink plenty of fluids Physiotherapy
- Daily light exercise (eg., 15 minute walk, exercise plan monitored by physiotherapist)
- No heavy lifting for 12 weeks

Other

- Monitor wound site for bruising or infection
- Monitor adherence to medication regime
- Arrange regular family visits to monitor progress

Anticipated needs of pt:

- Need home visits from community health/ district nurse- monitor adherence to postoperative medication, exercise, dietary regime
- Regular monitoring by DR., dietician, physiotherapist
- ? Danger of social isolation (infrequent family support)

WRITING TASK

Using the information in the case notes, writing a letter to the Nursing-in- Charge of the district Nursing Service outlining Ms Martin's situation and anticipated needs following her return home tomorrow. Address the letter to Nurse- in-Charge, District Nursing Service, Greenville Community Health Care Centre, 88 Highton Road, Greenville.

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.

LETTER

16 July, 2017

Nurse In Charge
District Nursing Service
Greenville Community Health Care Centre
88 Highton Road
Greenville

Dear Sir/ Madam,

Re: Ms Margaret Helen Martin, 81 years

Ms Margaret Helen Martin requires home visits to provide continued care following her discharge tomorrow. She has been recuperating after repeat angioplasty.

Ms Martin was admitted on 15th July, 2017 with coronary artery disease and underwent the procedure. Postoperatively, she developed bruising and bleeding at the catheter insertion site; however, there were no signs of infection.

Currently, she can tolerate oral fluids and light diets.

Ms Martin's postoperative period was mildly eventful with bruising and bleeding noticed at the catheter insertion site. At present, there are no signs of infection noticed and she has started tolerating light diet and fluids.

Ms Martin lives alone. Her daily meals are provided by meal delivery service and on weekends she orders meals. her BMI is 29.5.

Ms Martin has a history of various medical conditions including Coeliac disease, HTN and hypercholesterolemia.

Ms Martin's dietary pattern has been modified. She has been advised to have frequent small meals or snacks and to drink plenty of fluids. It is very important that she avoid heavy lifting for 12 weeks and regular monitoring by doctor, dietician and physiotherapist. Ms Martin's current medicines are aspirin, Plavix,

Metoprolol, Ramipril, and Atorvastatin which is to be monitored. Regular family visits are be arranged to monitor her progress and to provide support since there may be chances of social isolation. Please note, she wears hearing aid.

It would be appreciated if you could provide ongoing care for her to promote a speedy recovery.

Yours sincerely,

Registered Nurse.

Sandra Peterson

NOTES

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

- Today's Date: 22/03/12
- Hospital - Spirit Hospital - Medical Assessment Unit (MAU)
- Admission Date: 20/03/2012
- Discharge Date: 22/03/2012

Patient Details

- Name: Sandra Peterson
- DOB: 01/01/1921
- Address: 258 Addison St, Applethorpe
- Marital status: widowed – 25 yrs
- Next of kin: daughter – Ann Macarthur ph 0438856277

Diagnosis

URTI (Upper Respiratory Tract Infection) – dehydration, bi- basal crackles heard on chest, SOB

Polypharmacy - on 24 medications at admission including a variety of OTC medication encouraged by her daughter

History of Presenting Illness

13/03/2012 –coughing (yellow sputum)

18/03/2012 - ↓ed mobility, found in a sitting position on the floor in her room, no injuries

19/03/2012 - ↑ed confusion had another fall in the toilet, no injuries

20/03/2012 - BP 190/90, SOB, dizziness, the 3rd fall, an ambulance was called.

Past Medical History

- Moderate dementia
- HTN
- Incontinent of urine – occasionally

Social History

- Lives in 2-bedroom flat with her daughter and son-in-law
- Daughter is overly supportive, overreacting and anxious about her mother's health
- Religion: Orthodox Christianity, attends church weekly with daughter
- Hobbies: listening to classical music, watching movies
- Requires some assistance with bathing, dressing and toileting
- Home Care worker visits 2 x wkly (bathing)

Medical Progress

- X- Ray – normal
- FBC – WCC 9.0, Hb 115g/L
- CT-brain – no acute changes
- Commenced on Augmentin 500 mg x BD, per os
- Now intermittent dry cough
- IV normal saline for 24 hrs

- Medications rationalised by doctor as detailed in discharge plan
- BP 150/70 - after adjustment of anti-hypertensives

Nursing management

- Vital signs: afebrile, haemodynamically stable, saturating 96% room air
- Mobility: short distance – independently ambulant with a seat walker, long distance – wheelchair x 1 assistant
- Hygiene: full assistance required with bathing, some assistance with dressing and grooming
- Psycho/Social: Mild confusion, but co-operative

Discharge Plan

- Community nurse referral
- Continue 500-mg tablet of Augmentin BD x 5 days,

should be taken at the start of a meal
- Metoprolol 25 mg BD
- Candesartan 16 mg mane
- Medications – monitoring and assistance
- Daughter requires education/monitoring due to Hx of polypharmacy
- Ongoing care with personal hygiene required

Writing Task

You are the charge nurse on the MAU where Mrs Sandra Peterson has resided during her hospital stay. Using the information in the case notes, write a letter to the Community Nurse at Spirit Community Health Centre, Cnr Bell & Burn Streets Applethorpe, NSW, 2171. In your letter explain relevant background and medical history and provide information about discharge requirements.

LETTER

22 March, 2012

Address

Dear Nurse,

Re: Ms Sandra Peterson, DOB....

Ms Sandra Peterson requires continued care and management. She is recuperating well from upper respiratory tract infection and is being discharged today.

Ms Peterson **was admitted** to our facility on 20 March, 2012, with the complaints of shortness of breath, dehydration, bi-basal crackles heard from **the** + chest. On examination, her blood **investigations** **were** unremarkable and her blood pressure **was** high even after antihypertensive **was** given. Additionally, she **takes** large number of **medicines** including a variety of **over-the-counter** medication. Ms Peterson **can** walk short distances with the help of a seat-walker

however, she **requires** assistance for long distances using a wheel chair.

It **would** be appreciated if you could provide assistance with Ms Peterson's activities of daily living along with medication. It is important for her to continue Augmentin 500 mg for five days **which** should be taken at the start of a meal **along with** Metformin 25 mg, **and** Candesartan 16 mg in the morning. Please note, her daughter, Ann Macarthur, along with Ms Peterson, **herself requires** education about the side effects of poly-pharmacy.

Should you have any **queries**, please contact me.

Yours faithfully,

Registered Nurse.

Essential Plural Forms

The following are some of the errors you quite often commit.

Singular	Plural
Wife	wives
Calf	Calves
Wolf	Wolves
Half	Halves
Belief	Beliefs
Knife	Knives
Life	Lives
Leaf	Leaves
Mouse	Mice
Man	Men
Woman	Women
Foot	Feet
Tooth	Teeth
Child	Children
Bacterium	Bacteria
Copy	Copies
Baby	Babies
Nappy	Nappies
Carcinoma	Carcinomata
Syllabus	Syllabi

Criterion	Criteria
Appendix	Appendices
Thorax	Thoraces
Arthritis	arthritides
Embryo	embryos
Epididymis	epididymides
Femur	Femora
Genius	Geniuses
Index	Indexes
Sinus	Sinuses
Virus	Viruses
Die	Dice
Ox	Oxen
Child	Children
Person	People
Penny	Pence (in British usage)
Foot	Feet
Tooth	Teeth
Focus	Foci (also focuses)
Radius	Radii (also radiuses)
Fungus	Fungi
Nucleus	Nuclei
Cactus	Cacti
Alumnus	Alumni
Octopus	Octopuses (or octopi)

Analysis	analyses
Crisis	Crises
Thesis	Theses

THAT'S ALL FOR NOW

100 ERRORS DISCUSSED

ENGLISHMELON OET

IRITTY, KANNUR, KERALA
AND THEN, EVERYWHERE!

OET EXPRESS WRITING

100 ERRORS OET WRITING

BIJU JOHN