Writing Phrases for Medical Letter

OPEN ING SALUTATION

Dear Doctor / Registrar / Dr. Smith / Michael,

Re: Patient … (John Smith) , DOB … (1.2.1950) [DOB – Date of birth]

OPENING CLAUSE [Referral/Admission plus Patient data]

Thank you for (urgently) seeing … (the above patient/ Mrs. Polanski), [Referral letter]

a 38 year-old … (worker, profession) **with** … (cholelithiasis)
for further … (management) **and possible** … (operation)

who is currently | in this hospital recovering from … (a stroke)
| **suffering from** … (severe acute asthma)
| bedridden/immobile **with possible** … **following** … **on** … [combination]
(nerve compression) (heavy lifting) (date)

I am writing to refer |my patient **aged** 45 and **married with** 3 children of school age.
I am pleased to refer | this 45yo lady
| Mrs. Smith
| a 45 year-old worker

(This lady of 45years)… was admitted [Admission letter]

to your facility / this hospital / clinic on … (4.5.08)

for further (neurological) **assessment and possible treatment of** … (headaches)
operation … (of a hernia)
management of … (her drug substance abuse)

for a fracture of his … (femur)
for post fracture rehabilitation

I am writing to follow up our conversation earlier today [Advice letter]
about … (your son's management plan)
Further to our earlier conversation … (I am reporting you about …)

REASON FOR REFE RRAL

(Mr. Dubois) … **presented** to me (today) **with signs of** a (possible) … (pulmonary infection)
at my clinic **complaining of** … (left thorax pain)
to emergency

This 5 yo boy **initially presented with** … (tonsillits)
for which he was treated with … (antibiotics)

He is / **has been suffering his first episode of** … (poststrept. nephritis/chest pain)

He was admitted to this hospital on … for a fracture of …
suffering from …
with signs for early renal failure / heart attack

P R O V I S I O N A L D I A G N O S I S (PD)

[NYD - not yet diagnosed]

My provisional diagnosis is … (headaches), possibly … (stress-related)
Today, I diagnosed .. / he is diagnosed with …
The complaints may result from … / caused by …

I believe he has / **may have** … (a urinary tract infection)
I believe that the cause of his complaints is … (an asthma attack)
and is at risk of developing renal failure

Investigation Diagnosis:

The ECG	**indicated possible** … (ischemia)
The liver function tests	**showed** possible … (mild obstruction)
The Xray	**detected** …

P R E S E N T I L L N E S S

Introduction:

1) (He)… **first attended** my clinic **in** … (Nov 2003)
on … / today / 6 weeks ago
for … (a check-up)
complaining of… / **suffering** from …
with symptoms of … (tonsillits)

On his first visit to me on …. he was / has been suffering … (a sore throat)
On … Mr Smith presented (at my clinic) complaining of … **for the previous 10 days**
which was not responding to … (simple analgesia)

2) **His complaints set in** 10 days earlier **and were related to** … (stonrg gardening exercise)

S Y M P T O M S

The pain **occurs** … (on exercise)

He **was/felt** + adjective … (irritable / feverish/ sweaty/ distressed/ nauseated /dehydrated)

suffers from … irritability
complained of …
He **presented with** … an irritable condition
showed… no guarding or rebound on abdominal examination
found it difficult to …
is unable to … see clearly

Apart from this,			
In addition,		**noticed**	*progressively* worsening sight
Furthermore,	he	**experienced**	*a new episode* of pain

Moreover, **reported** *no further* … (fever)
Otherwise,
And there is

At times,
Occasionally,

He (initially) had … (headaches), but has had none since that time until … (now / 3 weeks ago)

She reported no history of … (abdominal tenderness)
This causes her stress
He had a **decreased range of** … (movement on his right hip)

P A S T H I S T O R Y (PH)

[use simple present tense !]

He **has a five year history of** … (osteoarthritis)
She has a history of … hypertension (well controlled by medication)
His (medical) history includes (iron deficiency) **for which he is given** … / treated with …
He also suffers from …

excluding: **She reported** **no history of** dysuria
There has been no history of **being overweight**/ obesity (98kg at 170cm ht)

He has not suffered from … (epilepsy) or other significant illness/injuries before … (accident)

R I S K F A C T O R S / A L L E R G Y

His (cardiovascular) riskfactors **such as** … (hypertension)
include … (hypercholesterol, smoking)
being overweight / obesity
lack of regular exercise / having no regular exercise
a strong family history (**father died of** … aged 48)

Smoking: She has smoked 15 cig. a day for the past … years
He **had cut his smoking to** 10 c. a day [past perfect]

Allergy: **Please note that she is allergic to** … (penicillin)
He **has no known allergies**

C U R R E N T M E D I C A T I O N

Abbreviations: stat (latin: statim) – immediately,
BD – twice, t.d.s./t.i.d. - thrice, q.d.s./q.i.d. - four times
p.c. – after food, nocte – at night, s.l. sublingual, s.c. - subcutaneous

Her current medications include / are …
She also uses … (Mylanta) **for** … (reflux)

(No) effect: The pain has(n't) has not **responded to** simple analgesia
was (not) **relieved by** oral medication, Senna, Zantac

was **persistent**
resistant to Coloxyl, Avapro, Panadol

The was pain **resisted to** … (Aspirin)
His complaint **usually settles with** NSAID and rest

Side-effect: But the medication **caused significant** … (dyspepsia)

T R E A T M E N T

Prescription: He was treated here with … (diuretics)

Combination Treatment !! :

He **was given** … (oxygen) **followed by** … (hospital admission)
in addition to … (adrenalin)
combined with … (life support)
and advised on … (losing weight)

I prescribed … (Respolin) **combined with** … (the Pulmicort)
in addition to

Effect: Initially his response to … (fentanyl) was … (good), but unfortunately his pain **flared up**.
Therefore, **I commenced him on** … (morphine)
I changed him on … (frusemid)
After discussion with Dr. X, I started her on …

After persistently elevated BP readings around x mmHg,
Dosis: he was **commenced/started on** …(nifedipin), this has **recently been increased** to … (20mg)

Operation: An arthroplasty **was performed**.
She **underwent/had** … (an appendicectomy) and recovered well/ will be discharged today.

Recovery: She has been able to … (shower) **with assistance**
Since the operation her wounds have healed and sutures have been removed.
Her **post operative recovery was** **successful**
uncomplicated
uneventful
normal
Subsequently
In the following days, he **recovered by taking** … (Penicillin) for 7 days.
after 7 days **treatment with** … (Penicillin)

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

Her short-term memory **has worsened** while here
Her **general condition has deteriorated**

EXAMINATION

On neurological / physical / cardivascular examination
he scored … (five) **on** a short-term memory test
this lady showed
I found … **no abnormalities**
she was overweight **with normal vital signs** (P80, BP 120/70, T36)

The examination was **unremarkable** / normal
revealed … (elevated liver enzymes, no abnormalities)

(Bilateral fine crepitations) … **were noted on** chest auscultation / examination

Otherwise, examination was normal.

Readings:

The (liver function tests) … **showed (no)** pathological findings
(FBC, MSU, ASOT) significant abnormalities
were consistent with … (hepatic failure)

He had **elevated BP readings** around 150/1000
The blood test was normal and Urea, Creatinine were **slightly elevated**

Technical Investigations:

Tests including …
An Xray/ECG/radiograph **taken here on** … **revealed** … NSA (no signifcant abnormalities)
indicated …

Test for/on … (Mr. Smith) **were done and showed** …
I had test for … (Mrs. Jones) done which showed …
I ordered the following test for … (Michael):

Results:

All tests in summary indicate pathological findings **consistent with** … (hepatitis)
confirm my provisional diagnosis of … (poststreptococcal nephritis)

(The urine analysis) … **showed / confirmed signifcant** … (haematuria)
(Her liver function tests) … **showed possible** … (mild obstruction)
The … (CT Scan) **at that time appeared** … (unremarkable/ normal)

ACTUAL CONSULTATION

[Review, follow-up visit]

On review (Today), … (Mr. Romano) **reports no further episodes of** … (headaches)
presented **persisting** complaints
reviewed me due to … (brown urine) for 4 days.

On review, **investigations showed** … and haematuria of renal origin.

One month later, he returned today with the symptoms above.

PSYCHOLOGICAL + CONCERNS

She was **anxious**
She **showed concerns** that she may have … (cancer), **about which I have reassured her.**
She **worried**

She is most concerned of …
She is a widow and has managed alone until now.

He receives support from … to manage
He needs assistance
He requires

ADVICE

He was **advised to** …(take antibitotics) **and return in** … (2 days)
on … (losing weight)

Mrs. Smith was given advice on … (quitting smoking)

I advised her (that she may need) to **represent to hospital for admission** …

if she gets any worse
or **if she isn't getting better** in 2 days.

To avoid future episodes, he needs … (to carry medical ID at all times stating he is diabetic)

REQUEST / FUTURE MANAGEMENT

Thank you for continuing the care of … (this lady) [discharge letter]

I would appreciate your further assessment and management/treatment
regarding … (his acute worsening condition).
of the possibility of … (cancer)
of the suspected/potential cancer

I would appreciate
I would be grateful
(for) **your opinion regarding** … (his future management)
if you could please **assess this patient**
if you could see … (this lady) **fairly soon for further management**.
if you could **arrange an appointment with** a physiotherapist
an occupational therapist
a social worker

I would be interested if he would be **a suitable candidate for** … (a hip replacement)
I would appreciate if you could **keep me informed about his further management.**

27/08/10

Mr. and Mrs. Murray

4 Temberton Street

Tarra Hill

Brisbane

Comment: Incorrect spelling: Pemberton

Dear Mr. & Mrs. Murray,

I am writing in regard to your 7 years old daughter Kate, who will need extra attention and care as she has fractured her right lower leg.

Comment: Incorrect expression, replace with:
- ..7-year-old daughter

✓*For more details, review Year or Years in the Grammar and Vocabulary Clinic*

She was brought into the hospital by her schoolteacher as both of you were not available when contacted following the incident in the gymnastic class. Her fractured leg has been backslabbed and bandaged along with the supply of crutches on loan. She also has been prescribed with the tablet Panadol 250mg if required.

Comment: Perfect paragraph!

Regarding her fractured right tibia, she must be encouraged to keep her leg elevated to her chest level during the first 48 hours and while resting in order to reduce the swelling. Beside that, her fractured leg should be observed for abnormal sensation such as numbness, tingling or burning or pins and needles as well as swelling in the toes. Please note, if she suffers from any of the symptom, elevate her leg for 20 minutes and if that does not help then ring 0733567853 immediately. In addition, she is scheduled for an appointment for fiberglass cast at 1:30 pm on 3/9/10 at Children's hospital Fracture clinic.

Comment: Use plural form of this word:
- ...any of these symptoms

Comment: Capital required for names of institutions such as hospitals. Compare
1. *I went hospital for a check up (in general so no capital required)*
2. *I went to Spirit Hospital for a check up*
3. *I study at university*
4. *I study at Harvard University*

For more details, review Capitalisation

In the context of her recovery, her fracture will heal fully without any long-term effect which might take at-least 6-10 weeks. However, heavy activities such as running, skateboarding and gymnastics must be avoided for another month after the removal of the cast. Therefore, to improve muscle strength, mobility and gaining balance, involvement of physiotherapist is recommended.

Please contact me if you have any queries regarding your daughter's health.

Yours sincerely,

Ray Peters

Orthopaedic Nurse

Childrens' Hospital Fracture Clinic

Comments and Feedback

Excellent work this time, and you have made a great improvement from the last task. Your grammatical accuracy is much improved and the paragraphs are very clear and well written and the errors are very minor. What I like most is that you personalised your letter very well with personal expressions such as

- your..daughter Kate
- lot's of her/she
- your daughter's health

This has a big impact on the tone and register of your letter.

However, there are still some errors as noted above so keep working hard.

Grade: This letter is A-

Date- 27.06.2010

The General Practitioner
Aboriginal and Torres Strait Islander Community Health Service
55 Annerley road
Woolongabba
4102

Dear Doctor,

Re: Gwen Watego DOB 25.03.1967

I am referring this patient, a 33 year old aboriginal widow who requires further investigations for possible Diabetes mellitus .

Mrs. Watego was admitted to our emergency department for overnight care following a fall outside the shopping mall. She did not loss her consciousness nor hit her head at the time of injury. Her observation was with in the normal limit during hospitalization.

In terms of her medical and social history, she has no history of any allergies and not taking any medication. She had pneumonia 1 year back. Unfortunately her husband passed away 2 years ago. Therefore, her next of kin is her daughter Cath and sons Vincent and Kevin.

During her hospitalization , random blood sugar test was done which showed 11 millimol per liter as she can possibly have diabetes. This patient is a smoker (15 cigarettes per day) and an alcoholic. Therefore, I have discussed the benefits of quitting smoking and have referred her to the Quitline. So, could you please review this patient regarding the above matters.

On examination, her left and right planter surface of the feet has painful callus and ulcer respectively. So, could you please arrange the podiatrist start new sentence here ~~and the dietician for diabetic diet in your facility.'~~ In addition a dietician is required regarding her diet.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

Karuna Gurung

Registered Nurse

Nanango Hospital

Brisbane

Comment: Capital required
•Road

Comment: Capital not required for names of diseases.
For more details, review Capitalisation in the Grammar and Vocabulary Clinic

Comment: Use verb form of this word : lose

Comment: One word: within

Comment: Missing verb
•she has no history of any allergies and is not taking any medication

Comment: Awkward sentence, 2 possible choices are:
•random blood sugar test was done which showed 11 millimol per liter , indicating the possibility of diabetes.
•random blood sugar test was done which showed 11 millimol per liter so she may possibly have diabetes.

Comment: Big error here. Alcoholic means a person who is suffering from alcoholism which means they are a compulsive drinker and addicted to alcohol, which is not the case here. Replace with: moderate to heavy drinker

Comment: This is better expressed as'
•the left and right planter surface of her feet have

Comment: Subject verb agreement is incorrect. Replace with: have *For more details, review Subject-Verb Agreement in the Grammar and Vocabulary Clinic*

Comments and Feedback

Back to C grade with this task as the error count is too high as noted above. Also one problem is you are trying to put too much information in one sentence, see podiatrist/ dietician above.

The big error is regarding your summary of her alcohol use…but better to make that error now rather than in the exam.

Grade: This letter is C+

13 th September

The Director
Community Child Health Service
41 Vulture Street
West End
Brisbane
4101

Dear Sir / Madam ,

Re : Nicole Smith

I am writing to refer Ms Smith an 18 year old single mother , who was admitted to our hospital on 9 th September . She has emergency caesarean section due to fetal distress and her prolong labour .

Ms Smith has post partum hemorrhage , which caused her low hemoglobin and she has on fefol and vitamin C. But her wound was healthy . In addition, her son has problem after his birth ,which has treated with oxygen inhalation for a few minutes .However , he has no signs of jaundice and he is feeding well .

With regard to her social situation, Ms Smith lives in a share flat .She has no contact with the father of her son and her parents .She gets her sole parent benefits.

The mother and her child were discharged today, she requires advice for breast feed ,which she would prefer to change to bottle feeding .Also she need assistance for the care to her baby .Could you arrange a home visit and provide appropriate support to her .Should you have any quires , please do not hesitate to phone me .

Yours sincerely
Jaiwei
Charge nurse
Mater Mothers' Hospital
Brisbane

Comment: Incorrect grammar. You have two choices:
1. I am writing to refer Ms Smith, an 18 year old single mother who was admitted to our hospital
2. I am writing to refer Ms Smith who is an 18 year old single mother. She was admitted to our hospital…..

Comment: Use past tense & article: She had an emergency..

Comment: Use adjective form of this word: prolonged

Comment: Again, past tense is preferred here: had

Comment: Incorrect grammar, use simple present : she is currently on fefol

Comment: The linking words but and in addition are not used correctly which disrupts the flow of information. Refer to the model letter for how to group information regarding the mother and son.

Comment: Incorrect grammar: was treated. Please refer to the attached grammar explanation sheet for advice on passive form

Comment: As this is a negative sentence, you need to connect with or

Comment: Wrong word: breast feeding. It would be useful to say why as well: not confident

Comment: Replace with: and

Comment: Verb subject agreement is incorrect : she needs to…

Comment: Incorrect preposition, replace with: of

Comment: Incorrect preposition, replace with: for

Comment: Incorrect spelling: queries

The OET centre uses the assessment criteria below when assessing referral letters

Overall task fulfilment	Word length is much better this time at 179 words. However the letter is difficult to read due to a lack of purpose on behalf of the writer. Refer to the model letter for an example of how to do demonstrate your understanding of the situation.
Comprehension of stimulus	You have identified some of the key points in this letter. However, as in the previous task you have not grouped the information in a logical manner and identified the connection between some of the facts which you report. For example the fact that she has no contact with the father/ her parents indicates that she will need support. You need to make this point very clear in your letter, and you can not expect the reader to interpret that.
Appropriateness of language	As stated above, comment U5, at times the information is not organized in a clear and logical manner. So you need to spend more time planning and reading the case notes, and organizing your letter. Overall you have not clearly emphasized the important points in this letter. To do this you need to use phrases such as "my main concern is…." To indicate key points.
Control of linguistic features	Quite a few mistakes in this letter, especially with regard to verb tense. This is an extremely important part of referral letters as is strongly affects the meaning of what you say and the time relationships in the case history.
Control of presentation features	Good, just one spelling mistake

10/06/10

The Registered Nurse

Post- Operative Care Resident

Dear Sir/Madam,

RE: Mr. James Hutton

DOB: 25/03/1920

I am referring this patient, a 90 year old retired widowed to your facility for overnight post-operative care as he has undergone right corneal graft.

He is totally blind by his left eye. His right eye was limitedly functioning until his cornea got distorted for which he underwent ~~for~~ a corneal graft under ~~a~~ full local anesthesia. Mr. Hutton's right eye is sedateted and will need an eye patch with the shield to protect from any harm during the night. He is also a hypertensive patient. He is on a range of medications. Please find the attached the medication chart along with the letter.

He is a gold cardholder and his next to kin is his son Mr. William Hutton with whom he is staying but in separate accommodation.

I am concerned that he will need a full assistance with his showering, mobility and dressing until ~~his~~ vision to his right eye comes back. Moreover, he has an appointment with the doctor for the surgery at 11 am tomorrow for which he should be discharged by 10 am. So, could you please kindly take over this patient and do the necessities.

Should you have any queries, please don't hesitate to contact me.

Your's sincerely,

Registered Nurse

Karuna Gurung

Comment: When writing to another health professional, it is better to use their title. Use Sir/Madam when unsure what their profession is (i.e if they are a Director)
- ♣ . Dear Nurse

For more details, review Letter Format in the Grammar and Vocabulary Clinic

Comment: Use noun form: widower
✓*For more details, review Difficult Words in the Grammar and Vocabulary Clinic*

Comment: Incorrect preposition, replace with: in

Comment: Anesthesia is an uncountable noun so no article is required. *For more details, review Countable & Uncountable Nouns in the Grammar and Vocabulary Clinic*

Comment: Incorrect spelling: sedated

Comment: Short sentences like this sound awkward, so better to join them.
- He is also a hypertensive patient and he is on a range of medications for both his medical condition and post-operative requirements. Please find the attached…

Comment: This is not a "concern" but more a fact. 2 possible choices are:
- Regarding his care, he will need
- He will need….

Comment: As above, assistance is an uncountable noun so no article is required.

Comment: You do not need to write his twice

Comment: Incorrect, the "doctor's surgery" means his clinic or office in this case. (tricky vocabulary, I know)
- ..an appointment with his surgeon at….
- .. an appointment with his doctor at….

Comment: Unnecessary and "odd" expression
- Therefore, could you please take over the care of this patient.

Comment: Error
- Yours sincerely

Comments and Feedback

Karuna, there is still a lot of work to do to reach B level, and this letter has exposed many weaknesses. One thing you need to do is learn and follow the "conventions" of formal medical letter writing, especially in the conclusion as noted above. You still have influences of "Indian English" in your writing, so work hard to learn the patterns. Regarding medication, it is fine to write, attached medication chart, but you do need to add a bit more case related information, see above. Apart from that there are a variety of errors so definitely serious review is required this week!

Weaknesses

- Uncountable nouns
- Expression errors
- Vocabulary
- Many small errors

Grade: This letter is mid C

Widow or Widower

- Widow (noun) refers to a woman whose husband has died and who has not remarried.
- Widower (noun) refers to a man whose wife has died and who has not remarried.
- Widowed (adjective) refers either a man or woman whose spouse has died and has not remarried.

Incorrect	Correct
• I am writing to refer Mrs. Saunders, a 58-year-old widowed who admitted with pain, dehydration and nausea. • I am writing to refer Mr. Saunders, a 60-year-old widow who complained of pain in his upper right second molar.	• I am writing to refer Mrs. Saunders, a 58-year-old widow who admitted with pain, dehydration and nausea.(noun) • I am writing to refer this patient a 58-year-old widowed woman who admitted with pain, dehydration and nausea.(adjective) • I am writing to refer Mr. Saunders, a 60-year-old widower who complained of pain in his upper right second molar.(noun)

Sample Doctor Model Letter

14.10.10

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

Dear Doctor:
Re. Amina Ahmed (8years)

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

Initially, accompanied by her parents, she presented to me on 9.10.10 with complaints of fever, runny nose, cough and loss of appetite. She was febrile with a temperature of 39.4 and a pulse rate of 85 beats per minute, but there was no rash or neck stiffness. However, her condition continued to deteriorate over the next two days as the fever could not be controlled by antipyretics. Therefore, blood and urine tests were ordered.

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

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

Yours sincerely,

Dr. Lucy Irving

Kevin Grove Medical Centre
53 Goma Road
Kelvin Grove, Brisbane

Sample: Nurse Model Letter

23 May, 2008

Marcia Devonport
West End Physiotherapy Centre
62 Vulture Street
West End, 4101

Dear Ms Davenport,
Re: Mr. Bob Dawson

I am writing to refer this patient, an 84 year old man, who is under our care with the complaints of a grazed left knee and problems with mobility.

Mr. Dawson has a history of cerebrovascular accident which occurred in 2004. He has had problems with the knee for the last week following an accident when he fell down the stairs.

As per general practitioner's order, we are doing daily home visits and wound dressing and also assisting him with his showers. His wound is healing and is free from infection. He walks slowly with the help of his wife.

Mr. Dawson, who lives with his wife in his own home, is an aged care pensioner. The doctor has advised him to use a walking stick in order to improve his mobility but he is unskilled in using it. It would be greatly appreciated if you could arrange home visits to provide training and assistance to Mr. Dawson

Thank you for agreeing to assist in this matter. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,
Sonya Mathews

Nursing Sister
Blue Nursing Home Care Agency

180 words

Writing Task 1 Doctors

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

16.02.09

Patient History

Miss Cathy Jones - 25 year old single woman
Occupation - receptionist
Family history of deep vein thrombosis
On progesterone-only pill (POP) for contraception
No previous pregnancies

15.02.09
Subjective

Presents to GP surgery at 7 pm, after work
Complains of lower abdominal pain since the evening before, worse in right iliac fossa
Unsure of last menstrual period, has had irregular bleeding since starting
POP 2 months ago, New partner for past 2 months
No bladder or bowel symptoms

Objective

Mild right iliac fossa tenderness, no rebound / guarding

Apyrexial, pulse 88, BP 110/70
Vaginal examination - quite tender in right fornix. No masses

Assessment

Non-specific abdo pain

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

16.02.09

Subjective

Pain has worsened overnight. Now severe constant pain.
Some slight vaginal bleeding overnight also.
Felt faint while waiting in reception.
On questioning, has left shoulder-tip pain also.

Objective

Very tender in the right iliac fossa, with guarding and rebound tenderness
Apyrexial, Pulse 96, BP 110/70
On vaginal examination, has cervical excitation and markedly tender in the right fornix.
Pregnancy test result positive
Urine dipstick clear

Assessment

Suspected ectopic pregnancy

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

Writing Task

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

In your answer:

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

Task 1 Model Letter: Cathy Jones

Gynaecology Registrar
A&E Department
Mater Hospital
South Brisbane

Dear Doctor,

Re: Cathy Jones DOB 1.12.83

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

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

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

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

Please keep me informed of the outcome.

Yours sincerely,

Dr Sally Brown (GP)

Task 2 Case Notes: Brendan Cross

Time allowed: 40 minutes
Read the case notes below and complete the writing task that follows:

Today's Date

21/01/10

Patient History

Brendan, 8 years old boy
Has a sister 6 years, brother 3 years
Mother – housewife
Father – Naval Officer currently on active duty in Indonesia
P.M.H- NAD
Brendan is on 50th percentile for height & weight
Allergy to nuts – hospitalised with anaphylaxis 2 years ago following exposure to peanuts

14/01/10

Subjective

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

Objective

Temperature - 39.8°C
Enlarged tonsils with exudate
Enlarged cervical L.N.
Ab - NL
CVS – NL
RR – NL

Probable Diagnosis

Tonsillitis (bacterial)

Management

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

Review after 5days if no improvement.

19/1/10

Subjective

Mother concerned – sleepless nights, difficulty coping with husband away – mother-in-law coming to help.
Brendan not eating complaining of fever, right knee joint pain, tiredness, lethargy – for 2 days

Objective

Temperature - 39.2°C
Hypertrophied tonsils
Cervical lymph node – NL
Swollen R. Knee Joint
No effusion
Mid systolic murmur, RR - normal

Investigation

ECG, FBC, ASOT ordered

Treatment

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

21/1/10

No change of symptoms
ECG – prolonged P-R interval
ESR – increased
ASOT – Increased

Diagnosis

? Rheumatic fever

Plan

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

Writing Task

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

Centre, Vulture Street, Brisbane 4101.
Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 2 Model Letter: Brendan Cross

21/01/2010

Dr. Joseph Watkins
Greenslopes Medical Clinic
294 Logan Rd
Greenslopes
Brisbane, 4122

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

Dear Dr. Grey,
Re: Brendan Cross

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

He presented with symptoms suggestive of acute bacterial tonsillitis on 14/01/10, when fever and sore throat had occurred over the previous 3 days, associated with lethargy and crying spells. High temperature (39.8), enlarged tonsils with exudate and cervical lymphadenopathy were found. Therefore oral penicillin and paracetamol were prescribed.

Regrettably, he returned on 19/01/10 with worsening symptoms. Fever had persisted with right knee joint pain. Also, he appeared restless, and was finding it difficult to eat and sleep. Examination revealed hypertrophied tonsils and a swollen right knee joint without signs of effusion. There was mid-systolic murmur on heart auscultation. Brufen was prescribed but was not effective. Today, blood tests results reported elevated erythrocyte sedimentation rate and anti-streptolysin O titre. An abnormal electrocardiogram indicated prolonged P-R interval.

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

Yours sincerely,

Dr. Watkins

Word Count 204 words

Task 3 Case Notes: David Taylor

Time allowed: 40 minutes
Read the cases notes below and complete the writing task that follows:

Today's Date
07/11/10

Patient History

Mr David Taylor, 38 years old, married, 3 children
Landscape Gardener
Runs own business.
No personal injury insurance
Active, enjoys sports
Drinks 1-2 beers a day. More on weekends.
Smokes 20-30 cigarettes/day
P.M.H-
Left Inguinal Hernia Operation 2008

12/08/10
Subjective

C/o left knee joint pain and swelling, difficulty in strengthening the leg.
Has history of twisting L/K joint 6 months ago in a game of tennis.
At that time the joint was painful and swollen and responded to pain killers.
Finds injury is inhibiting his ability to work productively.
Worried as needs regular income to support family and home repayments.

Objective

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

Temperature- normal
BP 120/80
Pulse rate -78/min
Investigation - X ray knee joint

Management

Voltarin 50 mg bid for 1/52
Advise to reduce smoking

Review if no improvement.

25/8/10
Subjective

Had experienced intermittent attacks of pain and swelling of the L/K joint
No fever
Unable to complete all aspects of his work and as a result income reduced
Reduced smoking 15/day

Objective

Swelling +
No effusion
Tender on the inner-aspect of the L/K joint
Flexion, extension – normal
Impaired range of power - passive & active

Diagnosis ? Injury of medial cartilage

Investigation – ordered MRI

Management

Voltarin 50mg bid for 1 week

Review after 1 week with investigations

07/11/10
Subjective

Limp still present
Patient anxious as has been unable to maintain full time work.
Desperate to resolve the problem
Weight increase of 5kg

Objective

Pain decreased, swelling – no change
No new complications
MRI report – damaged medial cartilage

Management Plan

Refer to an orthopaedic surgeon, Dr James Brown to remove damaged cartilage in order to prevent future osteoporosis. You have contacted Dr Brown's receptionist and you have

arranged an appointment for Mr Taylor at 8am on 21/11/10

Writing Task

You are the GP, Dr Peter Perfect. Write a referral letter to Orthopaedic Surgeon, Dr. James Brown: 1238 Gympie Road, Chermside, 4352. In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Model Letter 3: Damaged Cartilage

07/11/10

Dr. James Brown
1238 Gympie Rd
Chermside, 4352

Dear Dr. Brown,

Re: David Taylor

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

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

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

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

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

Yours sincerely,

Dr. Peter Perfect
Word Count: 200 words

Writing Task 4 – Karen and William Conway

Time allowed: 40 minutes
Read the cases notes below and complete the writing task that follows:

Today's Date: 15/03/10

Patient History

Mrs Karen Conway has consulted you, her GP, as she and her husband have been trying to conceive for about 18 months without success, and she is becoming concerned that there may be something wrong.
Karen is a 32 year old solicitor.
Her husband, William, is a 33 year old accountant.
Karen: previous pregnancy 10 years ago, terminated. William does not know about this.
William: no previous pregnancies.

15/02/10
Subjective

Karen attends on her own. She reports that neither she or William have any significant medical problems. Neither partner smokes, although she reports that William drinks quite heavily. Also he has to travel regularly with his job.
Married for 3 years, and decided to try for a pregnancy in May 2006, when Karen stopped the pill. Was on Microgynon 30 for the previous 5 years.
Periods are regular
No history of gynaecological problems, or sexually transmitted diseases.

Objective

Karen overweight BMI 28.
Pulse and BP normal.
Abdo exam normal.
As is some time since she last had a smear test, you do a vaginal examination, which is normal, and take a cervical smear.

Assessment

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

Plan

Blood tests for Karen required to confirm that her hormone levels are normal and that she

is ovulating. You explain to Karen that it is necessary for you to see her husband, William also, and ask her to make an appointment for him. Karen anxious that you do not reveal her history of a termination of pregnancy to him.

15/03/10

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

Subjective

Karen's baseline blood tests are normal, except the test for ovulation is borderline. However Karen informs you that she has used a home ovulation-prediction test which did show positive, so it is likely that she is ovulating. Smear test result negative.
As Karen reported, William has no significant medical problems. He says he only drinks 10 units per week, which does not agree with Karen's previous comments that he drinks heavily. He also explains that he works away from home approximately 2 weeks out of 4, so he is not so concerned that Karen has not conceived yet, as he thinks that it is because they haven't been trying long enough. Therefore not keen on being investigated.

Objective

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

Assessment

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

Plan

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

Writing Task

You are her GP, Dr Claire Black. Write the referral letter to Dr John Expert MBBS FRANZCOG, Gynaecologist and IVF Specialist, St Mary's Infertility Centre, Wickham Terrace, Brisbane.
In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 4 Model Letter

15.3.10

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

Dear Dr Expert,

Re: Karen Conway, DOB 1.2.78
William Conway, DOB 2.1.77

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

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

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

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

Yours sincerely,

Dr Claire Black (GP)

Word length: 184 words

Writing Task 5 Alison Martin

Time allowed: 40 minutes
Read the case notes below and complete the writing task that follows:

Today's Date
10/02/10

Patient History

Alison Martin
Female
28 year old, teacher.
Patient in your clinic for 10 years
Has 2 children, 4 years old and 10 months old, both pregnancies and deliveries were normal. Husband, 30 yr old, manager of a travel agency. Living with husband's parents.
Has a F/H of schizophrenia, symptoms controlled by Risperidone
Smoking-nil
Alcohol- nil
Use of recreational drugs – nil

09/01/10

Subjective

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

Objective

Appearance- nearly normal
Mood – not depressed
BP- 120/80
Pulse- 80/min
Ab, CVS, RS, CNS- normal

Management

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

20/01/10

Subjective

Previous symptoms – no change
Has poor concentration and attention to job activities, finding living with husband's parents difficult. Says her mother-in-law thinks she is lazy and is turning her husband against her. Too tired to do much with her children, mother-in-law takes over. Feels anxiety, poor sleep, frequent headaches.

Objective

Mood- mildly depressed
Little eye contact
Speech- normal
Physical examination normal

Tentative diagnosis

Early depression or schizophrenia

Management plan

Relaxation therapy, counselling
Need to talk to the husband at next visit
Prescribed Diazepam 10mg/nocte and paracetamol as required
Review in 2/52

10/02/10
Subjective

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

Objective

Mood – depressed
Little eye contact
Speech – disorganised
Behaviour- bizarre
BP 120/80
Pulse- 80
Ab, CVS, RS, CNS- normal

Probable diagnosis

Schizophrenia and associated disorders

Management plan

Refer to psychiatrist for assessment and further management.

Writing Task

You are the GP, Dr Ivan Henjak. Write a referral letter to Psychiatrist, Dr. Peta Cassimatis: 1414 Logan Rd, Mt Gravatt, 4222. In your letter expand the relevant case notes into complete sentences. Do not use note form. The body of your letter should be approximately 200 words. Use correct letter format.

Task 5 Model Letter: Alison Martin

10/02/10

Dr. Peta Cassimatis
1414 Logan Rd,
Mt Gravatt, 4222

Re: Alison Martin

Dear Doctor,

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

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

She first presented at my clinic on 9 January 2010 complaining of tiredness, a lack of motivation at work and a low grade fever. On review after ten days, she did not show any improvement. She displayed symptoms of paranoia and was suffering from poor sleep, anxiety and frequent headaches. In addition, she was mildly depressed with little eye contact. Relaxation therapy and counselling were started and Diazepam 10 mg at night was prescribed based on my provisional diagnosis of early depression or schizophrenia.

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

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

Yours sincerely,

Dr. Ivan Henjak

Word Count: 204 words

Sample Writing Task 1

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

15.08.09

Patient History
Darren Walker

DOB 05.07.69

Regular patient in your General Practice

09.07. 09
Subjective
Regular check up, Family man, wife, two sons aged 5 and 3
Parents alive - father age 71 diagnosed with prostate cancer 2002.
Mother age 68 hypertension diagnosed 1999.
Smokes 20 cigarettes per day –trying to give up
Works long hours – no regular exercise
Light drinker 2 –3 beers a week

Objective
BP 165/90 P 80 regular
Cardiovascular and respiratory examination normal
Height 173 cm Weight 85kg
Urinalysis normal

Plan
Advise re weight loss, smoking cessation
Review BP in 1 month
Request PSA test before next visit

14.08.09
Subjective
Reduced smoking to 10 per day
Attends gym twice a week, Weight 77 kg
Complains of discomfort urinating

Objective
BP 145/80 P76
DRE hardening and enlargement of prostate

PSA reading 10

Plan
Review BP, smoking reduction in 2 months
Refer to urologist – possible biopsy prostate

Writing Task

Write a referral letter addressed to Dr. David Booker (Urologist), 259 Wickham Tce, Brisbane 4001. Asl to be informed of the outcome.

In your answer:

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

Sample Model Letter 1

15/08/2008

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

Dear Doctor,

Re: Mr. Darren Walker

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

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

When he came for the next visit on 14/08/2009, Mr Walker had reduced smoking from 20 to 10 cigarettes per day and was attending gym twice a week. He had lost 8kg of weight. His blood pressure was improved at 165/90mmhg. However digital rectal examination revealed an enlarged prostate and the PSA reading was 10.

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

Yours sincerely,

Dr.X

Word Length: 205 words

Sample Writing task 2

Read the cases notes below and complete the writing task that follows

Time allowed: 40 minutes

Today's Date

03.07.09

Patient History
Margaret Leon 01 .08. 49

Gender: Female

Regular patient in your General Practice .

14.01.09
Subjective
Wants general check up, single, lives with and takes care of elderly mother.
Father died bowel cancer aged 50.
Had colonoscopy 3 years ago. Clear
Does not smoke or drink

Objective
BP 160/90 PR 70 regular
Ht 152cm
Wt 69 kg
On no medication.
No known allergies.

Assessment
Overweight. Advised on exercise & weight reduction.
Borderline hypertension.
Review in 3 months

25.04.09
Subjective
Feeling better in part due to weight loss

Objective
BP 140/85
PR 70 regular
Ht 152cm
Wt 61 kg

Assessment
Making good progress with weight. Blood pressure within normal range

03.07.09
Subjective
Saw blood in the toilet bowl on two occasions after bowel motions. Depressed and very anxious. Believes she has bowel cancer. Trouble sleeping.

Objective
BP 180/95 P 88 regular
Ht 152cm Wt 50 kg
Cardiovascular and respiratory examination normal.
Rectal examination shows no obvious abnormalities.

Assessment
Need to investigate for bowel cancer
Refer to gastroenterologist for assessment /colonoscopy.
Prescribe 15 gram Alepam 1 tablet before bed.
Advise patient this is temporary measure to ease current anxiety/sleeplessness.
Review after BP appointment with gastroenterologist

Writing Task

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

In your answer:

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

Sample Model Letter 2

03/07/2009

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

Dear Doctor Carlson,

Re: Margaret Leon
DOB 01/08/1949

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

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

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

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

Yours sincerely,

Dr X (GP)

Word Length: 194 words

Sample Writing Task 3

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

Time allowed: 40 minutes

Today's Date

08.08.09

Patient History
Dulcie Wood

DOB 15.07.43

New patient in your General Practice. Moved recently to be near family.

03.07. 09
Subjective
Widowed January 06, three children, wants regular check up, has noticed uncomfortable feeling in her chest several times in the last few weeks like a heart flutter.
Mother died at 52 of acute myocardial infarction, non smoker, rarely drinks alcohol
Current medication: zocor 20mg daily, calcium caltrate 1 daily
No known allegeries

Objective
BP 145/75 P 80 regular
Ht 160cm Wt 61kg
Cardiovascular and respiratory examination normal ECG normal

Plan
Prescribe Noten 50 gm ½ tablet daily in am. Advise to keep record of frequency of fibrillation sensation.
Review in 2 weeks if no increase in frequency.

17.07.09
Subjective
Reports sensations less but woke up twice at night during last 2 weeks

Objective
BP 135/75 P70 regular

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

08.08.09
Subjective
Initial improvement but in last 3 days heart seems to be fluttery several times a day and also at night. Very nervous and upset. Wants a referral to a cardiologist Dr.Vincent Raymond who treated her sister for same condition

Objective
BP 180/90 P70

Action
Contact Dr Raymond's receptionist and you are able to arrange an appointment for Mrs Wood at 8am on 14/08/09

Writing Task

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

In your answer:

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

Sample Model Letter 3

08/08/09
Dr Vincent Raymond
422 Wickham Tce
Brisbane, 4001

Dear Dr Raymond,
Re: Dulcie Wood
DOB: 15/07/43

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

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

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

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

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

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

Yours sincerely,

Dr Z

Word Length: 191 words

Read the cases notes below and complete the writing task which follows

Time allowed: 40 minutes

Today's Date

25.08.09

Patient History
James Warden

DOB 05.07.29

Regular patient in your General Practice

09.07.09
Subjective
Wants regular check up, has noticed small swelling in right groin.
Hypertension diagnosed 5 years ago, non smoker, regularly drinks 2 – 4 glasses of wine nightly and 1 - 2 glasses of scotch at weekend.
Widower living on his own ,likes cooking and says he eats well.
Current medication noten 50 mg daily, ½ aspirin daily, normison 10mg nightly when required, fifty plus multivitamin 1 daily, allergic reaction to penicillin.

Objective
BP 155/85 P 80 regular
Cardiovascular and respiratory examination normal
Urinalysis normal
Slight swelling in right groin consistent with inguinal hernia.

Plan
Advised reduction of alcohol to 2 glasses maximum daily and at least one alcohol free day a week.
Discussed options re hernia. Patient wants to avoid surgery.
Advised to avoid any heavy lifting and review BP and hernia in 3 months

25.08.09
Subjective
Had problem lifting heavy wheelbarrow while gardening. Has a regular dull ache in right groin, noticed swelling has increased.
Has reduced alcohol intake as suggested.

Objective
BP 140/80 P70 regular
Marked increase in swelling in right groin and small swelling in left groin.

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

Writing Task

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

In your answer:

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

Sample Model Letter 4

25/08/2009

Dr. Glynn Howard
Surgical Department,
249 Wickham Tce,
Brisbane 4001

Dear Doctor,

Re: Mr. James Warden
DOB 05/07/29

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

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

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

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

Yours sincerely,

Dr X (GP)

18 August, 2009

Ms. Jenny Chong
Senior Physiotherapist
St Edwards Cardiac Prevention and
Rehabilitation Centre
22 Thompson Street
West End, 4101

Dear Ms. Chong

Re: Alice Denham
DOB: 14/11/1960

Thank you for continuing the physiotherapy treatment of Ms. Denham.

Ms. Denham, a 49 year old primary school teacher, divorced and living with 3 teenage children. She was diagnosed with coronary artery disease who underwent triple bypass surgery on 10/08/2006. She is very anxious about her recovery and would like to resume her full time teaching work.

Ms. Denham has a past medical history of persistent insomnia, hypertension and has been suffering from increased chest tightness and breathlessness over the last 3 months. She is on anginine one tablet sublingually as required and propronolol 40 mg.

On 10 May, 2006 she was admitted with severe chest pain. Her physiotherapy management consists of deep breathing, coughing and exercises to prevent deep vein thrombosis. Later, triflow incentive deep breathing exerciser was introduced.

Ms. Denham has shown signs of improvement by walking independently and able to ascend and descend stairs without breathlessness. She would like to attend rehabilitation centre to maintain motivation and gain confidence.

I would appreciate if you can continue with her treatment. She is going to have a review at outpatient clinic by Dr O'connor at 10 am.

Please do not hesitate to contact me if you require any further information about this patient.

Yours sincerely,

sign
Name
Title

Sample Nurse Model Letter: Nina Sharman

21/03/2012
Dietician
Department of Nutrition and Dietetics
Spirit Hospital
Prayertown
NSW 2176

Dear Dietician,
Re: Ms. Nina Sharman
DOB: 09/02/1951

Thank you for seeing this patient, a 61-year-old single female resident of our Dementia Specific Unit, who had an episode of choking on a piece of food on 20/03/12. She requires an urgent swallowing and nutritional assessment due to a high risk of aspiration and chest infection.

Ms. Sharman's condition has been deteriorating since May, 2011, when she suffered a stroke. Over the last year she has developed advanced dementia and is now confused and disorientated. Apart from this, she is edentulous for both upper and lower teeth and sometimes refuses to wear dentures due to her confusion. Her appetite has increased recently, and she has gained 10kg of weight over the last 5 months. Her current weight is 106kg (BMI of 30). Ms. Sharman also complains of chronic constipation. She has no allergies to medication or food. Her vital signs and blood sugar level were all within normal limits.

In regards to her medical history, Ms Sharman has been living with type 2 diabetes since 2000, which has been managed by a diabetic diet only. She was also diagnosed with ischaemic heart disease in 2005 and has had osteoarthritis for the past 20 years.

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

Yours sincerely,

Registered Nurse
Dementia Specific Unit
Westside Aged Care Facility

The Registrar
Victoria Hospital,
Victoria Rd.,
Melbourne

Date: 22 Feb. 2002

Re: Mrs Fiona Marsden

Dear Dr,

This 30 year-old, mother of 2, housewife, came to my surgery 2 days ago, complaining of mild abdominal pain for a few days. She claimed that her pain was in the lower abdominal area and could be relieved by panadol; however, she denied nausea or vomiting.

Her physical examinations were normal, except a mild tenderness over the right abdominal quadrant with no evidence of hepatosplenomegaly. The possible diagnosis was ovarian cyst enlargement; therefore, FBE, ESR tests and a pelvic ultrasound were requested with a revisit arranged for one week's time.

Mrs Marsden visited my office today as an emergency appointment, complaining that her pain has gradually become worse and severe in intensity since few hours ago. She also reports being weak and fatigued since then.

On examination, she is pale and restless; moreover, there is a severe tenderness with palpable mass in the lower right abdominal quadrant. Based on the evidence, there is a strong possibility that she is suffering from a ruptured ovarian cyst.

Please note that she had a history of tubular ligation two years ago, and a right ovarian cyst (5-6cm) 6 months ago when she was put on 3 months of OCP.

I am referring her to you for admission to your gynaecological ward for further investigation and management regarding her urgent problem.

Thanking you in advance,

Yours sincerely,

Dr X---------- (GP)

UNSWIL Medical Centre

22 King Street
Randwick NSW 2031

24/08/2002

Dr. G Brian
Emergency Department Medical Officer
Alfred Hospital
Commercial Road
Prahan Victoria.

Dear Dr. Brian,

Thank you for seeing Mr. Johnson, a 25 year old man suffering from severe abdominal pain.

He first came to see me at 10am yesterday complaining of crampy central abdominal pain, nausea and several loose bowel movements which he had had in the previous 24 hours. On examination I found that he had generalized central abdominal tenderness. All other investigations were normal. I prescribed analgesics and advised him to increase his fluid intake and to rest.

At 9.00am today, Mr. Johnson presented again as his condition had deteriorated. His pain had increased and had vomited several times overnight. He was also slightly flushed and had tenderness on his right side with mild guarding. Other test results were normal. I suspected viral infection and possibly appendicitis and ordered a blood film. I prescribed Maxolon 10gm four hourly for the vomiting.

Mr. Johnson has come to see me again as his condition has worsened. The pain is now severe, constant and localized to right iliac fossa. He is flushed and restless. The blood film shows a white cell count of 18,000. I suspect that he has acute appendicitis.

I would appreciate if you could urgently assess Mr. Johnson and treat him further.

Yours sincerely

J Harris

Dr J Harris

Dr Michaels
St. Patrick Ave,
Melbourne

Date: 30th June 2004

Re: Mrs Patricia Gordon

Dear Dr Michaels,

I am referring Mrs. Patricia Gordon who first visited my surgery two years ago. She had just married and requested contraception pills; however, she did inform me of her intention to have a family in one to two years time.

On examination at the time, all the test results were unremarkable – breast examination, pap- smear, Rubella test. She was subsequently prescribed Microgynon 30 ED 12x12.

On her next visit last year, she reported that she had stopped her contraceptive pills two months earlier, with the intention of getting pregnant but her menstrual cycle had started again. She was rather disappointed at the time that she did not get pregnant. We discussed temperature and cycle measurements to augment her chances of conception.

She visited my office two weeks ago, tearful and depressed, as nothing seemed to have worked. The temperature chart showed definite and appropriate changes. Her pelvic and general examinations were unremarkable as was her pap-smear test. She was asked to return with her spouse a week later for further investigation.

Last week, Mr. Gordon's examination revealed a healthy young man, and consequently a sperm-count test was arranged.

This morning the couple returned for the result of the test, which showed normal count and viable sperms.

As this couple is keen to start a family soon; I am, therefore, referring this couple to you for further investigation, diagnosis and advice.

Thanking you in advance,

Yours sincerely,

Dr X----------

Doctors – Letter of Referral

Dr F Goldman
171 Victoria Parade
East Melbourne

30/01/2005

Re: Jamie Brown
DOB: 10.5.85

Dear Dr Goldman,

This 5 year-old boy Jamie Brown initially presented with tonsillitis on the 20/12/2005 for which he was treated with Penicillin V 250mg qid for 7 days.

Four weeks later Jamie presented with painless macroscopic haematuria. His only other symptom appeared to be lethargy. Examination was unremarkable: he had tonsillar hypertrophy, his BP – 90/60 and urinalysis confirmed significant haematuria.

On review today, investigations showed a mildly elevated urea and creatinine, a significantly elevated ASCOT titre and haematuria of renal origin.

Patient's blood pressure has increased to 110/90.

I believe Jamie has post-streptococcal nephritis and that he is at risk of developing renal failure. I would appreciate your assessment and management.

Yours sincerely,

Dr X

Mr. Lawrence Mitchell, surgeon.
Suite 12,
Cabrini Medical Centre,
Malvern 3127

2nd Feb 2005

Re: Mr Patrick Freeman D.O.B 20.01.57
16 Garden Ave
Brisbane
QLD
Tel: 0413 111 333

Dear Dr Mitchell,

I am writing to refer Mr Patrick Freeman, a 48-year-old sales manager, to you for further management. He presented at my surgery one month ago complaining of pain in the epigastric area which was accompanied by vomiting and tiredness for the past few months. However, there was no Melena at this point and his pain was relieved by eating a meal.

Duodenal ulcer was a possible diagnosis; therefore, a full set of tests were requested which included X-ray Barium meal.

He returned 3 days later for his results. His pain, nausea and vomiting still persisted. His FBE was normal, but there was a slight increase in ALAT. Also, there was no evidence of ulcer in the X-ray. He was advised to improve his diet and give up both cigarettes and coffee. In addition, Tagamet (200mg tid) was prescribed and he was asked to revisit in 6 weeks time.

He, however, came to my surgery today (3 weeks early), complaining of the epigastric pain and black faeces for one week. On examination, he was pale, agitated and preferred to keep his posture upright. The upper abdominal quadrant was tender; although, his bowel sounds were normal.

Please note that Mr Freeman was hypotensive (B.P 80/50; P 110/min) this morning. He is a 2 pack a day smoker and drinks 5-6 cups of coffee per day.

I believe he is suffering from a bleeding duodenal ulcer which requires immediate attention. I would appreciate if you could examine, assess and treat this patient as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr ----------

Dr Peter Groves
Paediatric gastroenterologist
Royal Children's Hospital

Date: 21st February 2005

Re: Master Ben Schmidt

Dear Dr Groves,

I am writing to refer Master Ben Schmidt, an 8 year old patient of mine, who was first brought to my office by his parents, David and Sue, 12 days ago. On examination, he was feverish (Temp.40.5 °c) with flu and exhibited symptoms relating to Asthma. Otitis media was also diagnosed; therefore, a course of Amoxicillin was prescribed. In addition, Paracetamol tablets as well as Ventolin (2 puff q.i.d) were included.

Ben was brought back to my surgery five days later by his mother on 14th Feb, complaining of his son vomiting. The examination revealed a lowering of his temperature (39.5) but the Asthma was consistent. At this point only Maxilon injection was prescribed.

Yesterday, his mother brought him to my office again this time complaining of bleeding from his bowels which apparently had started 3 days prior. His previous problems had settled, although he was feeling lethargic due to his flu infection. The physical examination revealed no anal fissure. A full set of blood tests were requested at this point to aid with the diagnosis.

Mrs Schmidt was asked to come to my surgery today with Ben. The results show that he is anemic (Hb - 7), and since the problem still persists, I believe this is a serious problem and calls for a colonoscopy and further internal examination to detect the source and cause of hemorrhage.

I would appreciate if you could examine, diagnose and treat this patient as you think appropriate,

Thank you in advance,

Yours sincerely,

Dr X----------

Dr F Goldman
171 Victoria Parade,
East Melbourne

Date: 30 Jan 2005

Re: Jamie Brown

Dear Dr Goldman,

I would like to refer Master Jamie Brown, a five-year-old boy, who was brought by his mother to my surgery six weeks ago. He had sore throat at the time, with a husky voice, feverish and irritable.

On examination, large infected tonsils with exudates were observed as well as tender and enlarged cervical lymph nodes. Accordingly, tonsillitis was diagnosed and a course of penicillin V250 mg (q.i.d) was prescribed for 7 days.

On his return two days ago, his mother reported Jamie to be tired, lethargic and had passed brownish urine 4 days earlier. On examination, he was hypotensive (BP 90/60), had tonsillar hypertrophy, and his urinalysis revealed macroscopic haematuria. With possible diagnosis of UTI or post-streptococcal nephritis, prescribed a number of tests. Plenty of fluid intakes were recommended and a revisit was arranged for two days time.

Jamie was brought to my surgery today by his mother, still asymptomatic. However, elevated blood pressure was observed. His test results showed elevated urea, creatinine and ASCOT. In addition, his urinalysis indicated a macroscopic haematuria, and his mid-stream urine test revealed 4x10 RBC, attributed to renal origin.

I would like to refer Jamie Brown to you with a diagnosis of post streptococcal nephritis with early renal failure. Could you please assess, investigate and treat him as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X----------(GP)

Dr. William Jones
The medical centre
46 Prince Street
AUBURN NSW 2247

Date: 28 January 2006

Re: Mrs. Trudy McHugh
7 Alfred Street
Sydney NSW 2000

Dear Dr Jones,

This 38-year-old woman came to my surgery yesterday, complaining of a sudden onset of left lower abdominal pain for one day. She claimed that it was sharp and constant ~~which~~ and worsened by sitting up, walking or bending. There were no other symptoms; however, she claimed that she had another episode of left abdominal pain one week before.

On examination, there was a great tenderness on the left quadrant of her abdomen, and a vague mass was also palpated in the same region. To exclude pregnancy, β-HCG was requested; in addition, full blood examination and ESR were checked too.

On her visit today, the pain still persisted, but it has become easier. There have not been any bowel motions since two days ago, when she passed a hard stool with bright blood on the outside of it.

Tonight, her pain has worsened - after eating a meal - and she is moderately in distress. There are still no bowel motions or flatus; moreover, her bowel sounds are inaudible. She is febrile (T - 37.4 °C); in addition, there is a left shift in the blood test and her Hb was 9.3.

Please note, she had had an ovarian cystectomy and appendectomy. She was also rushed to hospital at the beginning of this month due to hemorrhage, which was diagnosed as spontaneous abortion.

I am referring her to you with the diagnosis of early bowel obstruction due to diverticulitis or carcinoma, and for further management and treatment including surgery.

Yours sincerely,

Dr X ----------

Dr William Ammerry
!00 Collins St,
Melbourne

22nd Feb 2006

Re: Miss Sally Webster
Aged: 17

Dear Dr Ammery,

This 17 year old student girl first visited my surgery two months ago complaining of chronic constipation. She claimed that she had been trying everything from bran to laxatives to relieve her once every 4-5 days bowel habits, and yet, this condition still persists.

The physical examination was unremarkable (her weight was 54kg). Her request for the strongest laxative was refused; however, increased intake of fluids and vegetable fibers were recommended to improve her condition.

On her next visit six weeks later, her mother accompanied her. The mother was concerned about her daughter's loss of appetite, loss of weight, and the constant arguing at home regarding Sally's eating habits. When spoken to Sally directly, she claimed that she did not know what all the fuss was about, as she was not hungry.

On examination, she was under weight (47kg), pale and thin. Hence, several tests were prescribed, and she was asked to re-visit me at a later date for one to one assessment.

On her re-visit 6 days later, she was distant with little eye contact. She felt her parents were over-reacting, claiming her ideal weight to be 40kg (current weight 47kg). When asked, she denied vomiting and taking laxatives. After all factors considered, I believe Sally is suffering from Anorexia Nervosa.

I would appreciate if you could examine, diagnose and treat this young lady as you think appropriate.

Thank you in advance,

Yours sincerely,

Dr X ----------

Dr Michaels
The Registrar,
St Paul's Hospital,
Victoria Rd,
Melbourne

Date: 20 June 2006

Re: Mrs Julie Hobart

Dear Dr Michaels,

This 33 year-old woman came to my surgery about one week ago, complaining of abnormality in her menstrual cycle. She claimed that her menstrual periods had become sparse and eventually ceased completely. She also claimed to have stopped exercising a year ago because of feeling fatigue and weakness. Meanwhile, she began to gain weight, and noticed the development of facial hair and acne.

On examination, she was mildly obese (W- 73kg, H- 1.57m) with thin extremities. There were fullness of the supraclavicular fat pads and generalised muscular weakness, as she was unable to stand from squatting position without help or difficulty standing from a seated position. In addition to a visible increase of facial hair and acne, there were marked striae on her abdomen and buttocks. While other physical examinations were unremarkable, there was a slight measured hypertension (BP 153/98).

With the possible diagnosis of Cushing's syndrome, early morning cortisol level was requested as well as FBE and Urine analysis. Meanwhile, to control the hypertension, Thiazide diuretics were prescribed.

On her visit today, she reported polyurea and nocturea. Her blood pressure was 144/99, while the result of her laboratory tests showed FBE = 136 and serum glycate = 85%. The morning cortisol level was 21μg/dl.

I am referring this patient to you with the diagnosis of Cushing's syndrome accompanied with Diabetes Mellitus. I would appreciate if you could examine and manage this patient following further tests to confirm my diagnosis.

Yours sincerely,

Dr X----------(GP)

Dr James Collins
256 South Borough Lane
Brisbane
QLD 4290

Date: 21 July 2006

Re: Mrs Heather Lincoln
17 Highcombe Place
Brisbane
QLD

Dear Dr Collins,

Thank you for seeing Mrs Lincoln, an 85-year-old patient of mine who was first brought to my surgery two months ago by her daughter. She was suffering from urinary incontinence and abdominal pain for a week. The daughter claimed that her mother was more confused than usual. In addition, she had refused to eat at the time.

On examination, there was mild suprapubic tenderness by palpation, and the urine test results confirmed UTI; Amoxicillin was, therefore, prescribed for a week. Confusion was reported to have subsided a week later with the elimination of UTI.

A month later, she was brought back to my surgery, because she was found confused, loitering the streets by her neighbours. The daughter was reassured as she was very much distressed and tearful.

On July 4, her daughter reported a further increase in her vague behaviour, unsteady gait and unbalanced emotions. She was also found lying next to her bed, incontinent.

On examination, she had postural hypotension, and exhibited a general confusion. This was assumed to be due to the high dose of Aldomet; consequently, half reduced the dose.

Today, although her gait has improved but she is still confused. Her daughter exclaims that she could no longer cope with her mother's condition and is wondering if a nursing home would be a better option.

Please note, this patient has had a history of hypertension (20 years), type II diabetes (15 years), Dementia (10 years) and recurrent UTI. Her current medications are Aldomet (250mg b.d), Indocit (15mg t.d.s) and Daonit (5mg b.d).

I would appreciate if you could assess this patient and give advice to her daughter for the best possible management.

Yours sincerely,

Dr X----------

Dr Frank Adams
Neurological Ward
South Brisbane Hospital
QLD 4101

26th July 2006

Re: Mrs Phillipa King D.O.B: 18.4.38
Unit 7a, Fremantle place
Brisbane
QLD
Ph: 07 3234 3234

Dear Dr Adams,

I am referring Mrs Phillipa King, a 68-year-old woman, with a diagnosis of CVA to you for further investigation and management. She was found two days ago by a neighbour, lying on her kitchen floor conscious and stating that she had fallen two hours previously but was unable to get up by herself. Consequently, she was admitted to R.B.H yesterday.

Initial consultation with Mrs King revealed a loquacious, distractible lady who felt her main problem was the pain in her left knee which was preventing her from walking. She was also worried about her two cats.

On examination, Mrs King is an obese, large, right handed lady who sat slumped to the right on the chair with her head and eyes also leaned the same way. She showed an UMN facial droop (L) and exhibited dribbling on the same side. Her left arm was poorly positioned under the pillow. She had a left homonymous hemianopic vision as her poor eye only followed across midline left.

Please note that she has been suffering from NIDDM, Osteoarthritis in her left knee and C.O.A.D. She is a 30 pack year smoker and is currently on Ventolin and Naprosyn. Mrs King is a pensioner who lives alone (after losing her husband 3 years ago) with no children, in a housing trust unit in Brisbane. However, a neighbour does visit her twice a week for a chat and a cup of tea.

I would appreciate if you assess and manage this patient from this point on.

Yours Sincerely,

Dr X----------

Dr Jensen
Unit 40, Manor House
Ripley Street
Brisbane
QLD 4880

Date: Sep-11- 2006

Re: Mr Paul Nigels D.O.B: 9-2-72
3 Roach Street
Brisbane QLD
Tel: 0434 333444

Dear Dr Jensen,

This thirty five year-old man has come to this hospital today complaining of headaches, which has been occurring about six weeks of the year. It generally lasts about 1-2 hours each time, especially in the mornings and it worsens by straining, coughing and other stress factors, including psychological ones, which he claims causes some visual blurring. These headaches, however, are partially relieved by panadol.

On examination, there were some observable concentration drifts in speech, slightly blurred right disc as seen by Fundoscopy, and minor cerebellar ataxia. The result of the other neurological and physical examinations was unremarkable and there were no observable features of migraine found.

The possible diagnosis at this point was stress related headaches; in addition, there were some elements in the medical history, which suggested raised ICP. Hence, CT-scan was requested, and he was asked to bring his old films for comparison. A revisit was also arranged for two weeks later.

Please note that he had a major head injury because of a car accident two years ago which put him in coma for eight consecutive days in Prince Henry Hospital. There were several post-traumatic problems including amnesia, blurred vision and limb stiffness (with normal tone). I urge you to check for the list of his present medications with Caulfield Hospital.

Meanwhile, I am referring this patient to you for a second opinion and would be grateful if you could re-examine this patient. I will include the results of all the tests with this letter, and will request the CT-scans to be sent to you directly prior to the patient's visit.

Looking forward to your feed back,

Yours sincerely,

Dr X ----------

Dr Robert Vaughn
34 Volturen St,
Rewanden

Date: 19 Dec. 2006

Re: Mrs Joanne White

Dear Dr Vaughn,

Mrs White, a 36 year-old mother of two, came to my surgery a week ago, reporting a two months history of fatigue, early satiety and left upper quadrant fullness. She had lost 10 pounds of body weight during this time; however, she denied fever, night sweats, nausea, vomiting and other GI problems. Her menses were normal without excessive bleeding.

On examination, her skin was moist and warm. The spleen was palpable 9 cm below the costal margin. Other physical examinations were otherwise unremarkable. Multivitamins were prescribed, but several tests were requested (FBE, ESR, LFT and peripheral blood smear). She was asked to revisit in a week's time.

On her visit today, she is still symptomatic with the results of her tests suggesting a mild leukocytosis (WBC 12K). Other abnormalities could also be seen in other blood cells. I will include the test results with this letter for your careful examination.

Please note that she does not smoke or drink, and has not had any recent exposures or travel. Her paternal grandfather did suffer from adult onset diabetes.

I believe this matter needs further specialist intervention with a possible bone marrow biopsy to help with the correct diagnosis. I would appreciate if you could treat and manage her regarding her problem.

Thanks in advance,

Yours sincerely,

Dr X ----------(GP)

Dr Vaughn
34 Volturen St.
Rewanden

Date: 19th dec 2006

Reg: Mrs Joanne White

Dear Dr Vaughn,

Thank you for visiting Mrs. White, a 36 year-old patient who visited me one week ago. She complained about 2- month fatigue, early satiety, left upper quadrant fullness and 10-pound weight loss. However. she had no history of nausea, vomiting, haematochesia, haematemesis or night sweat.

On examination, her skin was moist and warm. The spleen was palpated 9cm below left costal margin; however, there was no sign of hepatomegaly, lymphadenopathy or thyromegaly. Consequently, a full set of blood tests (FBE, ESR and Peripheral blood smear) as well as biochemical tests including LFT were requested. Furthermore, multivitamins were prescribed and she was asked to come back today.

On her visit today. her problems are still persisting. There was a wide range of results obtained from the laboratory tests. For example. an increase was seen in all kinds of WBCs; however, platelet count and Hb level were normal. In addition, the vitamin B12 level was over 2000 pg/ml, but leukocyte alkaline phosphatase level had decreased.

According to her exhibited symptoms and lab-test results, I believe that her problem is a kind of hematogenous malignancy, which calls for a bone marrow biopsy for a more precise assessment.

I would appreciate if you could provide further management and treatment for this patient from this point on.

Thank you in advance,

Sincerely yours,

Dr. X----------(GP)

Mr Francis Baker
Surgical Registrar,
Victoria Hospital,
Victoria Road,
Melbourne

Date: 14 February 2007

Re: Mr John Webster

Dear Dr Baker,

This 35-year-old mechanic attended my surgery two weeks ago, complaining of six-months of crampy abdominal pain, nausea and severe intermittent diarrhoea. He claimed having seven loose, foul odoured stools per day. He denied any other symptoms; however, the pruritic skin rash developed just before the diarrhoea began.

On examination, the mucous membranes were dry, and there was a diffused abdominal tenderness with no hepatosplenomegaly. Populovesicular lesions were also visible on elbows, knees and buttocks. Other physical examinations were otherwise unremarkable including bowel sounds and sphincter tone. With the possibility of gastroenteritis, diphenoxylate was prescribed and FBE, stool exam and culture were requested.

One week later, his diarrhoea was persisting, which had resulted in a loss of 9kg body weight. Although, WBC, LDH and ALP had increased, a reduction in serum albumin was noted. Prochlorperazine and megestrol were added to his drug requirements, and an abdominal CT-scan was requested. Gluten-intake restriction was also advised based on his skin rash.

Today, he claimed that his diarrhoea had improved, and his skin rash appeared to be healing. Based on the results and observations, I am inclined to celiac sprue as a possible diagnosis.

Please note that he has just stopped smoking tobacco, and drinks only occasionally (mainly beer). He does not have any considerable medical history, though his father died of lymphoma.

I am referring this patient to you for further investigations including colonoscopy and bowel biopsy to confirm my diagnosis.

Yours sincerely,

Dr X----------(GP)

The Registrar
Emergency Department
Royal Melbourne hospital
Flemington Road
Parkville 3052

Dear Doctor,

Re: Mr Derek Romano

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

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

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

Oxygen and one sublingual anginine were given, followed by intravenous morphine (2.5mg). His pain has now settled down, but I consider that he requires admission to the Coronary Care Unit for stabilization. I will telephone later to check on his condition.

Yours sincerely,

Dr X

Mr Dooley
34 Volturen St.,
Rewanden

Dear Mr. Dooley,

re: Mr Bernard smith
24 Derid Street
Farfeth

Thanks for seeing Mr. Smith, a 77 year old retired farmer. He first presented to me in November 1991 with a five year history of right hip pain. At this time he had a two month history of severe pain in the right hip which was not responding to simple analgesia. He found it difficult to bear weight and had a decreased range of movement on his right side.

Otherwise, examination was normal. X-Ray at this time showed moderate degeneration of right hip joint consistent with osteoarthritis.

I commenced him on Indomethacin 50mg t.d.s. Initially his response was good but unfortunately he suffered a further flare up in January 1992. Indomethacin was recommenced at this time but caused significant dyspepsia. I therefore commenced Mylanta and changed him on to Tilcotil 25mg two tablets daily. Unfortunately, his hip pain has continued to worsen and the change in therapy has not helped.

I would appreciate your opinion regarding his future management and would be interested to know if he would be a suitable candidate for a hip replacement.

Thanks for your opinion.

Yours sincerely,

Dr X

Mr. B.Dooly
Orthopaedic surgeon
34 Volturen St.,
Rewanden

Date: 16th Feb 1992

Re: Mr Bernard Smith

Dear Dr Dooly,

Mr Bernard Smith is a 77 year old retired farmer with a 5 year hip trouble. When he visited my surgery 3 months ago, he was limping with a 2 months severe pain in his right hip and knee that did not respond to Panadol.

On examination, he was hypertensive (BP 150/85) and had a decreased internal rotation and flexion of right hip. Osteoarthritis was confirmed with the aid of an X-ray; consequently, he was put on a course of Indomethacin tablets (50mg t.d.s).

He visited my surgery last month complaining of the flare up of his pain. The exacerbation of the pain was due to his cessation of the medication 6 weeks before. On examination the range of his right hip movement had further decreased with inability to bear weight. A new course of endomethacin (50mg t.d.s) was recommenced.

He returned again 6 days later with severe dyspepsia. He was consequently prescribed Mylanta as he showed mild epigastric tenderness, and Indomethacin was replaced with Tilcotil (25mg 2 tablets maine.).

Mr Smith has visited my office today and the examination shows little improvement in his right hip condition. I believe, his osteoarthritis is not responding to the normal treatment with the anti-inflammatory medications and he does require further specialist attention.

I am referring this patient to you for an assessment, advice and the possibility of hip replacement if you consider him a suitable candidate.

Yours sincerely,

Dr X----------