

## WRITING SUB-TEST – TEST BOOKLET

### INSTRUCTIONS TO CANDIDATES

You must write your answer for the Writing sub-test in the **Writing Answer Booklet**.

You must **NOT** remove OET material from the test room.

## Occupational English Test

**WRITING SUB-TEST: MEDICINE**

**TIME ALLOWED: READING TIME: 5 MINUTES**

**WRITING TIME: 40 MINUTES**

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

### **Notes:**

**Assume that today's date is 10 February 2019**

Mrs Priya Sharma is a patient in your general practice who is concerned about her glucose level control.

#### **PATIENT DETAILS:**

**Name:** Mrs Priya Sharma  
**DOB:** 08 May 1958 (Age 60)  
**Address:** 71 Seaside Street, Newtown

#### **Social background:**

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

**Family history:** Many relatives with type 2 diabetes  
Nil else significant

**Medical history:** 1999 – type 2 diabetes  
Nil significant, no operations  
Allergic to penicillin Menopause 12 yrs  
Never smoked, nil alcohol  
No formal exercise

**Current Drugs:** Metformin 500mg 2x /day  
Glipizide 5mg 2x/morning  
No other prescribed, OTC, or recreational

#### **29 Dec 2018**

**Discussion:** Concerned that her glucose levels are not well enough controlled – checks levels often (worried?)  
Attends health centre – feels not taking her concerns seriously Recent blood sugar levels (BSL) 6-18  
Checks BP at home  
Last eye check October 2017 – OK Wt steady, BMI 24  
App good, good diet  
Bowels normal, micturition normal

- O/E:** Full physical exam: NAD  
BP 155/100  
No peripheral neuropathy; pelvic exam not performed  
Pathology requested: FBE, U&Es, creatinine, LFTs, full lipid profile, HbA1c  
Medication added: candesartan (Atacand) tab 4mg 1x/morning  
Review 2 weeks
- 05 Jan 2019** Pathology report received:  
FBE, U&Es, creatinine, LFTs in normal range  
GFR > 60ml/min  
HbA1c 10% (very poor control)  
Lipids: Chol 6.2 (high), Trig 2.4, LDLC 3.7
- 12 Jan 2019** Review of pathology results with Pt Changes in medication recommended  
Metformin regime changed from 500mg x2/day to 750mg 2x/day  
Atorvastatin (Lipitor) 20mg 1x/morning added Glipizide 5mg 2x/morning  
Review 2 weeks
- 30 Jan 2019** Home BP in range Sugars improved  
Pathology requested: fasting lipids, full profile
- 06 Feb 2019** Pathology report received: Chol 3.2, Trig 1.7, LDLC 1.1
- 10 Feb 2019** Pathology report reviewed with Mrs Sharma  
Fasting sugar usually in 16+ (high) range  
Other blood sugars 7-8  
Refer to specialist at Diabetes Unit for further management of sugar levels

### **Writing Task:**

Using the information in the case notes, write a letter of referral to Dr Smith, an endocrinologist at City Hospital, for further management of Mrs Sharma's sugar levels. Address the letter to Dr Lisa Smith, Endocrinologist, City Hospital, Newtown.

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

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

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

Any answers recorded here will not be marked.

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## Occupational English Test

### WRITING SUB-TEST: MEDICINE

### SAMPLE RESPONSE: LETTER OF REFERRAL

Dr Lisa Smith  
Endocrinologist  
City Hospital  
Newtown

10 February 2019

Dear Dr Smith,

Re: Mrs Priya Sharma  
DOB: 08/05/58

Thank you for seeing Mrs Priya Sharma, a type 2 diabetic, for further management of her blood sugar levels.

Mrs Sharma was diagnosed with NIDDM in 1999. She has been monitoring her BP and sugar levels at home since then. She has a strong family history of diabetes and is allergic to penicillin. Her weight is steady (BMI of 24) and an eye examination in October 2017 indicated no issues.

She initially presented on 29/12/18 concerned that her blood sugar levels were no longer well controlled. Her BP that day was 155/100 and her recent sugar levels were ranging between 6 and 18mmol/L. Her medication included metformin 500mg twice a day and glipizide 5mg twice in the morning. I instituted Atacand 4mg once in the morning.

A pathology report received on 05/01/2019 showed HbA1c levels of 10% and GFR greater than 60ml/min. Her cholesterol was high (6.2).

On 12/01/19, I prescribed Lipitor 20mg in the morning. I also increased her metformin regime to 750mg twice daily. Since then, her home-monitored BP has been within range and her cholesterol has fallen to 3.2. Her non-fasting blood sugars are 7-8mmol/L, but her fasting blood sugar levels are usually in the 16+ range, which is high. Therefore, I am referring her to you for your specialist advice.

Yours sincerely,

Doctor