General Instructions

Instructions:

- You have 45 minutes to write this letter.
- During the first 5 minutes, you should not pick the pencil.
- Start writing only when you are told.
- During the Reading Time, try to understand the case notes.

Melons Steps

- Mark (M) PPRRAADDDDDWK.
- Eliminate (E) irrelevant information.
- Launch (L) the letter with DADR.
- Open (O) the letter with PRPDD or PRPTT.
- Narrate (N) the remaining paragraphs using V or W.
- Sign (S) the letter with S/F.

Melons Errors

- Punctuation "Marks".
- Follow "Expansion" Rules.
- Obey "Language" Rules.
- Have an "Order" (DADR, PRPDD, V/W, S/F)
- Do not change "Names".
- Sex (Mr, Ms, Mrs, His, Her).

Details to Fill In:

- CANDIDATE NAME. ROLL NUMBER.
- DATE OF BIRTH. VENUE OF THE TEST. TEST DATE.

Case Notes 1 - Brendon Cross

Occupational English Test – Writing (Nursing)

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

Notes:

The following patient has been under the care of Pediatrician Dr Nancy Rose at the hospital where you are his charge nurse.

Today's Date 14/3/2024

Patient History

- Brendan Cross, Male, DOB: 25/12/2023.
- Has a sister 6 years, brother 3 years.
- Mother – housewife.
- Father – Naval Officer currently on active duty in Indonesia.

P.M.H NAD.

- Allergy to nuts – hospitalised with anaphylaxis 2 years ago following exposure to peanuts.

6/3/2024

- 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 250 mg 6/h, 7 days + Paracetamol as required.
- Review after 5 days if no improvement.

12/3/2024

Subjective

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

Objective

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

Investigation

- ECG, FBC, ASOT ordered

Treatment

- Brufen 100 mg tds.
- Review in 2 days with investigation reports.

14/3/2024

- No change of symptoms.
- ECG – prolonged P-R interval.
- ESR – increased.
- ASOT – Increased.
- Diagnosis. ? Rheumatic fever.

Plan

- Contact Spirit Paediatric Centre.
- Arrange an urgent appointment with Dr Alison Grey, Senior Paediatric Consultant.
- Request further investigation and treatment.

Writing Task

You are a nurse at Green Slopes Medical Clinic, 294 Logan Rd, Green Slopes, Brisbane 4122. Write a referral letter to Dr Alison Grey, Spirit Paediatric Centre, Sixth Street, Brisbane 4101.

In your answer:

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

The body of your letter should be approximately 200 words. Use the correct letter format.

Case Notes 2 - Jake Peterson

Occupational English Test – Writing (Nursing)

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

Notes:

You are a nurse at a boarding school. Jake Peterson is a final year student at your school and has come to you complaining of hair loss and associated depression. He has his final year exams starting shortly.

Patient Details:

- Name: Jake Peterson.
- DOB: 17.03.2006.
- Address: Holy House School, Brenkridge.

Social background:

- Student at boarding school for the past 8 yrs.
- Parents work & live abroad.
- Father (male-pattern baldness-onset in 50s).
- Mother (depression-onset in 40s).
- Non-smoker, 20 units alcohol/week.
- Karate black belt champion; swimmer.

Presenting complaint:

- Alopecia-hair loss from 13 years of age.
- Intermittent cycles (loss and regrowth).
- Aetiology not confirmed (various possibilities. ?Depression)

Treatment Summary

August 2019

- School clinic - presented with hair loss in patches.
- Anxiety.
- Onset: School bullying incident.
- Pt. said 'not a major thing.
- Referral to trichology specialist.

October, 2019

- Trichologist: No aetiology established, possibly exacerbated by stress.
- Prescribed steroid cream (betamethasone dipropionate 0.05% cream 1-2x/day for 3 months)
- Personality changes, aggression, sleep loss.
- Medication discontinued.

2019 – 2022

- No further hair loss; intermittent hair regrowth.

July, 2023

- Return of anxiety and pronounced hair loss.
- General health check ↑6 kg over last 2 months.
- Recommended Dr consultation Re hair loss, anxiety, weight loss.
- Reluctant. Sought natural remedies (homeopathy).
- Efficacy suspected yet keen to try.

December, 2023

- Reports no results + cost implications of homeopathic treatment (kalium carbonicum and silicea) ⟶ Jake distressed, low mood.
- Problems forming/maintaining peer relationships.
- Affecting sports participation.

January, 2024

- Referred to by the school counsellor. Did not attend.

12 March, 2024

- Check-up: + alcohol consumption, min 28 units/wk

2024 March End – April Mid.

- Exam time. Extreme anxiety (arranged separate exam room).

March 23, 2024

- Jake is concerned about transition to university shortly and independent living.
- Says he will need special exam arrangements in the University too.

Plan

- Letter to university medical practice.
- Monitor symptoms and prognosis.
- Advise patients about baldness. Make the patient think it is normal to be bald. No need to cover. Expose him to celebrities who are bald. Eventually, put the thought of wigs out of his mind.
- Alternatively, seek advice from his parents about hair-transplantation.

Writing Task

Using the information given in the case notes, write a letter to Mrs Monica Hendrik, a university practice nurse. In your letter, briefly outline Jake Peterson's history and your concerns. Address your letter to Mrs Hendrik, Senior Nurse Practitioner, University of March Bank Health Centre, Hills Dune Rd, March Bank.

In your answer:

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

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

Case Notes 3 - Fiona

Occupational English Test – Writing (Nursing)

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

Notes:

Assume that today's date is 6 March, 2024. You are Miss Fiona Carwell's School Health Nurse and the patient is attending 6th grade at your school.

Patient Details:

- Name: Fiona Carwell.
- DOB: 06 Dec 2011 (12 y.o.)
- Address: 32 Station Road, Oakville

Social background:

- She's from a migrant family from Spain relocated to Oakville, 1999.
- Father's demise, June 2023, (MVA).
- Family reports grief. Pt reports extreme stress re. worries about the future in the absence of father who was really close with her.
- BMI 29 (recently gained weight due to poor diet control).
- Older brother-mental health problems (2 suicide attempts in last 12 months).

Medical History

08 July, 2023, 0915 hrs

- Feeling very thirsty.
- Passing urine more often than usual, particularly at night.
- Feeling very tired all the time; Weight loss of 6 kg in 2 months.
- Frequent oral thrush. Blurred vision.
- Emergency hospital admission (Oakville General Hospital) following an episode of LOC.

Lab Investigations:

- Random Blood Sugar of 11.9 mmol/L.
- HbA1C high.
- Diagnosis: type 1 DM. Treatment: Novolin N 4 Unit at tarde; Solostar 8 unit at nocte.
- Discharge Date: 15 July, 2023.

Discharge Recommendations:

- Dietician referral.
- Lifestyle management.
- Diabetes Nurse Specialist referral at Oakville General Hospital for follow up care (diet, insulin).
- Review at DNS.

11 August, 2023

- Well maintained Blood Sugar.
- Following healthy lifestyle along with proper nutrition (well-balanced calorie diet). RBS 4.6. Reduced Solostar to 6 unit due to several hypo attacks at night.

18 December, 2023

- Blurred vision. Increased power.
- S/B ophthalmologist.
- Started to wear spectacles.
- Reduced symptoms.
- No headache or Blurred vision (thereafter).

Present Complaint:

6 March, 2024

- Dizziness and light-headedness, sleepy during class.
- Pt reports stress due to grief.
- Pt reports stress induced overeating

Management: RBS 16.8, urine ketones high. Blood ketones 0.9

Plan:

- Referral to Diabetes Nurse Specialist.
- Review of meds.
- Discuss ways to encourage lifestyle changes.
- Plan further management.

Writing Task

Using the information given in the case notes, write a letter of referral to Ms Catherine Flanagan, Diabetes Nurse Specialist, Oakville General Hospital. In your letter, briefly outline Ms Carwell's recent history requesting advice and a review of her medication.

In your answer:

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

Case Notes 4 - Jamie Morgan

Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 04/03/2024

You are a registered nurse in the Coronary Care Unit, St. John's Hospital, London. Jamie Morgan is a patient in your care.

Patient Details

- Name: Jamie Morgan.
- DOB: 22 February 1967.
- Address 9476 Old Dam Road, Barona, London.
- Next of Kin Brother, Justin Morgan 72, Burke St, Old Ormond Street, Queensland, Australia.
- Admitted: 28/02/2024
- Diagnosis: Obstructive Coronary Artery Disease
- First treatment planned: CABG.
- Treatment Provided (due to fear of complications): Percutaneous Coronary Intervention (29/02/2024).

Social History

- Never married.
- Lives alone in own home at Barona, London.
- Computer trainer, Android app developer.

Medical History

- Smoked 30 cigarettes/day until admission.
- Has been compliant to sudden smoking cessation.
- Alcohol: 3 x 300 ml bottles beer / day, till admission date.
- Ht. 177 cm; Wt. 96 kg (stable for the last 15 years).
- Usual diet: Sausages, deep fried chips, burgers, eggs, MacDonald's.
- Allergic reaction to peanuts.

Nursing Management and Progress

01/03/2024

- Routine postoperative recovery but slow.
- Smoking nil, alcohol nil.
- Low fat diet.
- Walking with a little limping.
- Wounds healing.
- Routine visit from Social Worker, Physiotherapist.

03/03/2024

- ? Mild injury to the heart arteries, including tears / rupture.
- No infection, bleeding, or bruising at the catheter site.
- No allergic reaction to dye.
- No kidney damage (from the dye or contrast).
- Blood clots suspected.
- Patient not in critical condition; Can travel.

Current Medicines: Clopidogrel 75 mg BD increased to 300 mg nightly.

Plan

- Returning Home to Barona and then moving to Australia to stay with Mr Justine Morgan on 07/03/2024.
- Appointment made for follow up visit to Dr Sigmund Steve, 02 pm on 11/03/2024 at the doctor's clinic.
- Local physiotherapist to continue rehabilitation exercise program till departure to Australia.

Writing Task

Using the information in the case notes, write a letter to Dr Sigmund Steve, Cardiovascular Surgeon at Caredio, New Ormond Street, Queensland, Australia. In your letter, list out Mr Morgan's recent medical history and discharge plan.

In your answer:

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

Case Notes 5 - Gerald Baker

Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 28 February, 2024

Mr Gerald Baker is a 79-year-old patient on the ward of a hospital in which you are Charge Nurse. He is recuperating after a left total hip replacement (THR) surgery.

Patient Details:

- Admission Date: 25 February, 2024 (City Hospital).
- Surgery: 26 February, 2024
- Discharge Date: 29 February, 2024 (Tomorrow)
- Ongoing high blood pressure.

Social Background:

- Marital Status: Widower (8 years).
- Lives at Greywalls Nursing Home (GNH) (4 years). No children.
- Employed as a radio engineer until retirement aged 65.
- Now aged-pensioner.
- Hobbies: chess, ham radio operator.
- Sister, Dawn Mason (66), visits regularly; v supportive.
- Plays chess with Mr Baker on her visits.
- No signs of dementia observed.

Medical Background:

- 2010 – Osteoarthritis requiring total hip replacement surgery.
- 1991 – Hypertension (ongoing management).
- 1987 – Colle's fracture, ORIF.

Medications

- Aspirin 100 mg mane (recommenced post-operatively).
- Ramipril 5 mg mane.
- Panadeine Forte (co-codamol) 2 qid prn

Nursing Management and Progress:

- Daily dressings surgery incision site.
- Range of motion, stretching and strengthening exercises.
- Occupational therapy.
- Staples to be removed in two wks. (Before 15 March, 2024)
- Also, follow-up FBE and UEC tests at City Hospital Clinic.

Assessment: Good mobility post-operation

- Weight-bearing with use of wheelie-walker; walks length of ward without difficulty.
- Postoperative disorientation re time and place during recovery, possibly relating to anaesthetic – continued observation recommended.
- Dropped Hb post-operatively (to 72) requiring transfusion of 3 units packed red blood cells; Hb stable (112) on discharge – ongoing monitoring required for anaemia.

Discharge Plan: Monitor medications (Panadeine Forte)

- Preserve Skin Integrity.
- Continue the exercise program.

- Equipment required: wheelie-walker, wedge pillow, toilet raiser. Hospital to provide walker and pillow. Hospital social worker organised 2-wk hire of raiser from local medical supplier.

Writing Task:

Using the information in the case notes, write a letter to Ms Samantha Bruin, Senior Nurse at Greywalls Nursing Home, 27 Station Road, Greywalls, who will be responsible for Mr Baker's continued care at the Nursing Home.

In your answer:

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

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

Case Notes 6 - Alvin Thomas

Occupational English Test – Writing (Nursing)

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

Notes:

Imagine that today's date is 19 June, 2024. You have transferred this patient to a neighbouring hospital five minutes ago for emergency assessment and treatment.

Patient Details:

- Name: Alvin Thomas Irvin.
- DOB: 15 July, 2013 (10 years old).
- Address: 789 Elm Street, Adelaide, SA 5000.
- Father: Mr. Thomas Irvin.
- Mother: Mrs. Sona Irvin.

Social Background:

- Healthy, active child.
- Lives with parents and younger sister.
- Incident occurred while playing with friends on an abandoned road near home.

Incident Details:

- 19 June, 2024, approximately 04:00 pm.
- Abandoned road near Elm Street, Adelaide.
- Friends confirmed the snake bite. Snake not identified.
- Presentation: 04:30 pm, 19 June, 2024.
- Bite Site: Right lower leg, lateral aspect.
- Local Symptoms: Pain, swelling, erythema around the bite site.
- Systemic Symptoms: Mild dizziness, nausea

Vital Signs:

- BP: 110/70 mmHg.
- Pulse: 98 bpm.
- Respiratory Rate: 20 breaths/min.
- Temperature: 37.2°C.

Initial Management:

- Limb immobilised and kept at a lower level than the heart.
- No tourniquet applied. Bite site cleaned with antiseptic.
- Compression bandage applied. Paracetamol 250 mg for pain relief.
- IV access established. Normal saline infusion commenced.
- Continuous monitoring of vital signs.
- Observing for signs of systemic envenomation (e.g., coagulopathy, neurotoxic symptoms).
- Blood samples for CBC, coagulation profile, electrolytes, renal function tests.

Plan:

- Transfer to St Philip's Hospital for further evaluation and management.
- Monitor for progression of symptoms.
- Potential administration of antivenom.

Enclosures: Initial assessment and treatment records. Recipient Details:

Writing Task.

Using the information in this case notes, write a letter of referral to Dr Imran Yousuf, Emergency Department, St Philip's Hospital, 456 Health Avenue, Adelaide, SA 5000, for advanced care and management of snakebite + prevent potential complications.

In your answer:

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

The body of your letter should be approximately 200 words.

Case Notes 7 - Noah M Caprio

Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 27 March, 2024

You are Lee Wong, a registered nurse in the Coronary Care Unit, St Andrews Hospital, Brisbane. This patient is in your care.

Patient Details

- Name: Noah M Caprio (Mr).
- DOB 12 January 1959.
- Address: 9476 Old Dam Road, Woodwind Q4390.
- Next of Kin: Brother, Ernie Oriel 72. Bedford St, Jericho, Q4490.
- Admitted 20 March, 2024.
- Diagnosis: Obstructive coronary artery disease.
- Operation Coronary artery bypass grafts (x 4) on 22 March, 2024

LONS (Lifestyle, Occupation, Nutrition, Social) History

- Never married. Lives alone in own home just outside Woodwind.
- Fencing contractor.
- Skips breakfast. Heavy meaty meals for the last three years.
- Smokes 20 cigarettes/day.
- Smoked 40+ cigarettes / day till 2022.
- Chain-smoker till 2020.
- Consumed processed fish in large quantities in the last three months.
- Alcohol: 2 x 300 ml bottles beer / day.
- Usual diet: Sausages, deep fried chips, eggs, MacDonald's;

Medical History

- Ht 170cm; Wt 99kg. Allergic reaction to nuts.
- ? Abdominal Aortic Aneurysm (2022); No follow up. Symptoms ruled out by GP (2024, February)

Nursing Management and Progress

- Routine post-operative recovery slow.
- Advised to cease smoking, reduce alcohol.
- Patient not willing to cease smoking. Says, "it kills."
- Has considerably reduced drinking.
- Commenced a low fat diet recently but failed to cope.
- Walking well. Wounds healing well.
- Routine visit from Social Worker for the last three days.

Discharge Plan

- Going to Jericho on day fifth from discharge to stay with brother.
- Appointment made for follow up visit to local GP Dr. Avril Jensen 2 pm 31 March, 2024.
- Local physiotherapist to continue rehabilitation exercise program for five days.
- Arrange meeting with Mr Steeth Singh, Tobacco Cessation Specialist, at his clinic, Jericho: Phone 666773434.

Writing Task

Write a letter to Mr Steeth Singh, Tobacco cessation Specialist, Gregory Terrace, Jericho. Use the relevant case notes to explain Mr Di Caprio's situation. Include Medical History, Body Mass Index and lifestyle along with a detailed smoking history.

In your answer:

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

The body of your letter should be approximately 200 words.

Case Notes 8 - Michael Chan

Occupational English Test – Writing (Nursing)

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

Notes:

Today's date is 27th May, 2024. You are a nurse working at Sydney Central Hospital and this patient is under your care.

- Name: Mr. Michael Chan.
- Age: 33 years.
- Occupation: Film actor and Producer.
- Patient's Home Address: 456 Elm Street, Sydney, NSW 2000.

12 January, 2023

- Visited his new GP, Dr Sen Hendrik, at Wellness Hospital, Perth with complaints of shortness of breath and poor appetite.
- BP and Sugars normal. ? multiple health issues.
- Commenced multivitamins, advised rest and smoking cessation.

18 January, 2024

- Reviewed with GP.
- The GP observed that the patient did not follow her advice. Mr Chan explained that he honestly did not have trust in the GP's expertise and knowledge. Tensions high between the doctor and patient.

26 April, 2024

- Admitted to Sydney Central Hospital (his new film was being shot there).
- Same complaints. Diagnosed: Hypoxia and Hypothermia.
- Cordarone, 800 mg commenced (for three weeks).
- Corticosteroids. Oxygen therapy for three days.
- Discharged.

27 May, 2024

- Worsening Hypoxia and hypothermia.
- ?Onset of anorexia and insomnia.

Lifestyle Factors:

- Smoker (more than 5 packets per day).
- Drinks socially.
- BMI: 31

Personal Information:

- Last five movies flopped at the box office.
- Experiencing heavy financial losses and liabilities.
- Married to Mary Izabelle, 26 years old.
- Expecting their first baby in a month.

Current Medications:

- Oxygen Therapy: 2 litres per minute via nasal cannula, continuous.
- Multivitamins: Once daily.
- Cordarone, 1200 mg.
- Appetite Stimulant (Megestrol acetate): 400 mg orally once daily.
- Anti-anxiety Medication (Diazepam): 5 mg orally twice daily as needed

Discharge Plan:

- Follow-up Appointment: Schedule a follow-up visit with the primary care physician in one week.
- Referral to pulmonologist for further assessment of hypoxia.
- Referral to nutritionist for diet and weight management.
- Referral to Mental health professional for stress and anxiety management.
- Smoking Cessation Support: Enrol in a smoking cessation program to reduce and eventually quit smoking.
- Alcohol Consumption: Advice to limit social drinking to moderate levels and discuss potential support if needed.
- Educate Mr. Chan about the signs and symptoms of worsening hypoxia and hypothermia, and when to seek immediate medical attention.
- Provide information on healthy lifestyle choices to improve overall well-being and manage stress.
- Monitor for compliance with medication and lifestyle changes.
- Reinforce the importance of follow-up visits and adherence to the discharge plan.

Dietary Recommendations given to the patient:

- Encourage small, frequent, high-calorie meals to address anorexia.
- Include protein-rich and nutrient-dense foods.
- Hydration: Ensure adequate fluid intake to prevent dehydration.

Rest and Recovery (Nursing Management):

- Encouraged adequate rest and stress reduction techniques. Patient is taking a week's break from all activities from tonight.
- Suggested relaxation exercises and mindfulness practices. Patient is compliant.
- Family Support: Discussed with Mr. Chan the importance of family support during this time, particularly with the upcoming birth of his child.

Writing Task

Using the information in the case notes, write a letter to Dr Mona Hendrik, GP, Sydney Hospital for Mr Chan's hypoxia and hypothermia management. Address the letter to Dr Mona Hendrik, 123 Harbour Street, Sydney, NSW 2000.

In your answer:

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

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

Case Notes 9 - Stephanie Cohen

Occupational English Test – Writing (Nursing)

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

Notes:

Imagine that today's date is 30/05/2024. You are a Nurse working in the psychiatric department, now in charge of Ms Cohen.

Patient Details:

- Name: Ms. Stephanie Cohen.
- Age: 45.
- Gender: Female.
- Address: 367 Camel Park, Robinhood, Canberra – AU.
- Contact Number: +61257869944.

Social Details:

- Administrative Assistant.
- Marital Status: Single.
- Lives alone. Limited family support, primarily relies on friends.

Past Medical History:

- Hypertension (well-controlled).
- Asthma (occasional episodes, controlled with inhalers).
- Osteoarthritis (On medication).

Family History:

- History of non-compliance with medications in family (mother and sister)

Present Medical History:

- Depression (on Sertraline 100 mg once daily).
- Chronic joint inflammation (on Ibuprofen 400 mg three times daily).
- Asthma (recently switched from Ventolin to Symbicort inhaler).

Recent Medical History:

- Recent exacerbation of depressive symptoms due to non-compliance with Sertraline.
- Increased joint pain and inflammation due to inconsistent use of Ibuprofen.
- Difficulty managing asthma symptoms due to improper use of new inhaler (Symbicort)

30th May, 2024

- Presented to a psychiatrist to discuss depression.
- Was brought by a colleague.

Objective

- Non-compliance with medications leading to exacerbation of symptoms.
- Depression: Partially managed; symptoms worsening due to non-compliance.
- Chronic joint inflammation: Increased pain and stiffness reported.
- Asthma: Suboptimal control due to difficulty using new inhaler.
- Initial assessment revealed poor medication adherence.
- Provided initial education on medication importance and usage.
- Noted improvement in understanding but compliance remains an issue.

Plan

- Provide thorough education on the correct use of Symbicort, including a demonstration.
- Emphasize on the importance of adhering to prescribed medications (Sertraline and Ibuprofen).
- Address any barriers to compliance.
- Consider necessary dosage adjustments or alternative options for better management.
- Next Scheduled Appointment: 12 June, 2024.

Writing Task

Using the information, write a letter to Ms Benita Carpenter, Community Nurse, 1 Moore St, Canberra ACT 2601, Australia. Phone: +61251249977. Include all relevant information to help Ms Carpenter to provide comprehensive education to the patient at her residence.

In your answer:

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

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

Case Notes 10 - William Mason

Occupational English Test – Writing (Nursing)

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

Notes:

- Today's Date: 24 May, 2024.
- Hospital: Waikiki Private Hospital.

Patient Details:

- Name: William Mason.
- Age: 60.
- Admission Date: 14 May, 2024.
- Discharge Date: 23 May, 2024.
- Diagnosis: Attempted suicide - overdose of Magadol.

Past Medical History

- Bronchitis (multiple episodes).
- Underweight – 65 kg, BMI 18
- Psoriasis.
- Depression related to gambling addiction.
- Began gambling 3 years ago.
- Smoker (30 cigarettes/day).

Social History

- Retired 3 years ago (bank manager).
- Lives with wife, Juliet, and adult son in housing trust in Redfern.
- Wife works at Nest, son unemployed.
- 3 married daughters and 6 grandchildren.
- Regular social drinker.
- Has lost a lot of money including superannuation funds and is in debt.
- Wife and family previously unaware of addiction - very angry but also upset about suicide stress.
- Patient remorseful and ashamed.
- Wants to overcome addiction.
- Used to be a keen lawn bowls player.
- Has lost friends as result of gambling.

Nursing Management and Prognosis:

- Weak and depressed.
- Antidepressants prescribed: Citalopram 40 mg, BP130/95 Diagnosed with Type II diabetes.
- Education (diabetes) regarding diet and oral medication.
- Wheelchair use from 2/2024.
- Psoriasis on Torso and scalp. Diprosone OV cream 2x/day • Ionil T Shampoo.
- Poor appetite, Physically unfit.

Discharge Plan:

- Encouragement to maintain antidepressant medication routines as the SSRI is established.
- Mrs Mason will help with supervision.
- Monthly follow-up appointments with psychologist Dr Leo Brad, Waikiki Private Hospital.
- Social worker appointment to be made for gambling addiction therapy.
- Strong encouragement and assistance to join Gambling Addiction Action Group, Redfern Community Centre.
- Contact with Quitline needs to be encouraged.
- Wheelchair required for another week. Frame advised after this.
- Maintain psoriasis treatment.

- Maintenance of low GI diet for diabetes-involvement (wife) necessary.
- Encouragement in social sporting activities e.g., lawn bowls?

Writing Task

Using the information in the notes, write a letter to the social worker, Ms Kelly Coliath, at the Redfern Community.

In your answer:

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

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

Case Notes 11 - Jane Macintyre

Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date 07 March, 2024

Patient History

- Mrs. Jane Macintyre (DOB 01.03.1985)
- Two children: 5 and 3 years.
- Two miscarriages.

First Pregnancy

- Developed severe pre-eclampsia.
- Delivered via emergency Caesarean Section at 32nd week.
- In intensive care for 3 days, required magnesium sulphate.
- Baby (Sam) weighed 2.1 kg – in Neonatal Intensive Care Unit 2 weeks.
- Did not require ventilation only CPAP (Continuous Positive Airway Pressure)

Second Pregnancy

- BP remained normal.
- Baby (Katie) delivered at full term, weighed 3.4 kg.

Family history of thrombosis.

- Known to be heterozygous for Factor V Leiden.
- Treated with prophylactic low molecular weight heparin in two previous pregnancies.
- No other medical problems.
- Not on any regular medication.
- Negative smear 2021

07 March, 2024

Subjective

- Positive home pregnancy test – fifth pregnancy
- Thinks she is 8 weeks pregnant.
- Last menstrual period 12 January, 2024.
- Painful urination last three days.
- Request referral to the Spirit Mother's Hospital for antenatal care and birth.

Objective

- BP: 120/80; Weight: 60 kg; Height: 165 cm.
- Some dysuria for the past 3 days.
- Urine dipstick: 3+ protein, 2+ nitrites, and 1+ blood.
- Abdomen soft and nontender.
- Fundus not palpable suprapubically.

Assessment

- Needs antenatal referral to an obstetrician in view of her history of severe pre-eclampsia, Caesarean Section, and her age.
- Need to start folic acid.
- Needs to start tinzaparin 3,500 units daily, subcutaneously, in view of thrombosis risk.
- Suspected urinary tract infection based on her symptoms and the urine dipstick result

Plan

- Refer Jane to Dr Anne Childers at the Spirit Mother's Hospital.
- Commence her on folic acid 400 micrograms daily, advise to continue until 12 weeks pregnant.
- Arrange routine antenatal blood tests – results to be sent to the Spirit Mother's Hospital when received.
- Arrange Counselling with Dr Sara Choi, Sage, re antenatal screening for Down's Syndrome in view of her age.
- Jane elects to have a scan for nuchal translucency, which is done between 11 and 13 weeks.
- Provide information on Green slopes Screening Centre.
- Prescribe tinzaparin 3,500 units daily subcutaneously.
- Send a midstream urine specimen to the laboratory.
- Prescribe cephalexin 250 milligrams 6-hourly for five days.

Writing Task

You are Jane's charge nurse at Family Medical Centre, North Brisbane, working closely with Dr Liz Kinder, who has seen Jane today. Write referral letter to Sara Choi, Obstetrician, Sage, 656 Pacific Highway, Chatswood, 2067 (Corner of Pacific Highway & Freeman Road).

In your answer

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

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

Case Notes 12 - Verona Spania

Occupational English Test – Writing (Nursing)

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

Notes:

You are Alexa Sanders, a ward nurse working in the general unit of Lakeshore Hospital, Brisbane. You are preparing a patient admitted in your care today for a haemorrhoidectomy tomorrow (22 May, 2024).

Patient Details

- Patient: Verona Spania.
- DOB: 01/06/1975.
- Residence: 21 Mark Street, Belmont, Brisbane.
- Next of kin: Two sons, working as soldiers in Ukraine (temporary post).
- Admission date: 20 May, 2024.
- Allergies: Sensitive to Penicillin and Aspirin.

Medical History

- Type 2 Diabetes Mellitus, Inflamed bowel syndrome.
- 3 visits with complaints of perianal itching.
- Passing of fresh blood while defecating.
- Diagnosis: Haemorrhoids grade 4.

Presenting Symptoms

- Rectal bleeding with burning pain.
- Prolapse as evidenced during physical examination.
- Slightly tender.

Past Medical History

- 2018 bowel complaints, constipation (? dietary habits).
- 2021 colonoscopy performed; Proctitis, treated with corticosteroids.
- Jan 2022 appendix inflammation, treated with antibiotics.

Previous Advice

- Instructed to soak the area in warm water.
- Advised to maintain a diet with high fibre.
- Tylenol prescribed for pain, lidocaine for itching.
- Proton pump inhibitors for gastritis.

Doctor Consultation

- Pt complaining of constipation and hard stools.
- Pathology ordered.
- Pre-procedure assessment recommended.

Nurse discussion

- Information on management post-surgery given.
- Pre-procedure assessment explained.
- Literature - procedure, pain etc. given.

Social Background

- Lives with husband, an army veteran.
- Stay in an independent house in rural area.

Vitals: Tympanic temp: 37.1˚C, Pulse: 83; BP:135/90; R:17; Wt: 70 kg; Ht: 172 cm

Nursing Management

- Pt administered IV fluids.
- Enema performed.
- FEL Pathological results awaited.
- No sensitivity to codeine.
- Patient signed consent form for haemorrhoidectomy.
- Explained the dosage of anaesthesia + level of sedation understood.
- Patient educated on hospital policy.

Plan

- NPO to start 6 hours prior to surgery.
- Someone from the patient's side should be present at the time of the surgery and thereafter, for driving her home.
- Patient should rest for a week and avoid lifting heavy objects for a month.

Writing Task:

Using the information given in the case notes, write a referral letter to the surgical nurse in the surgical unit of the same hospital, outlining the patient's history and present situation along with Pre-procedure assessment and management.

In your answer:

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

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

Case Notes 13 - Eve Meyers

Occupational English Test – Writing (Nursing)

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

Notes:

You are a school nurse at Columbus the Great's School, Blue Hills, Adelaide. Miss Meyers has been under your care for the last 1 week.

Today's Date: June 6, 2024

- Patient: Miss Eve Meyers.
- 15 years.
- Grade: 9th
- School: Columbus the Great's School, Blue Hills, Adelaide (joined a week ago).
- Previous school: Stellar Convent, Sydney (left to be near her grandparents in Adelaide).

Social

- Father: Richard Palmer.
- Mother: Atlee Palmer.
- Address: 123 Green Valley Road, Blue Hills, Adelaide

Present Concerns:

- Depressive episodes (due to new school environment and parents' separation).
- Unsettled and isolated.
- Significant weight loss (10 kg) recently.
- Poor food habits and avoidance.
- Lack of health consciousness.
- Inattention. "Being lost in class but in a different world" (reported class teacher).
- "Doesn't make friends at all," (Classmates).

Past Medical History:

- Nil significant. Allergies: certain seafood, red meat.
- Mildly anaemic.

Current Medication:

- None.

Diagnosis:

- Adjustment disorder with depressive symptoms.

Treatment Plan:

- Counselling sessions with the school psychiatrist (2 sessions completed; a third tomorrow).
- Nutritional guidance, monitoring.
- Encouragement (social interaction, participation in school activities).
- Inform parents of observed health concerns.
- Request meeting (discuss Eve's health and well-being).
- Plan collaborative support strategies.
- Consider school change?

Writing Task

Using the information in the case notes, write a letter to Eve's parents, (Richard Palmer, Atlee Palmer) to visit the school on any Saturday within 15 days from today to discuss viable solutions in the presence of the school psychiatrist.

In your answer:

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

The body of your letter should be approximately 200 words. Use the correct letter format.

Case Notes 14 - Simpson Reuters

Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 22 May, 2024

You are a community nurse assisting Dr. Peter Smith, GP, covering 3 satellite clinics in a remote mining area of Western Australia. The nearest tertiary hospital to you is 1250 km away in Perth or 2 ½ hours by air evacuation using the Flying Doctor Service. The nearest polyclinic is in Port Hedland with radiology and laboratory facilities but it is a 6-hour drive over dirt roads.

Patient History

- Simpson Reuters.
- DOB: 15/1/69).

LONS (Lifestyle, Occupation, Nutrition, Social)

- Divorced and lives alone.
- Process Technician at a Copper Mine in the remote Pilbara region of Western Australia.
- Works on rotation with 6 weeks on location and 4 weeks off.
- Started his present rotation one week ago.
- Regular overseas holidays.
- Just returned from the Philippines 2 weeks ago after spending a 2-week vacation.
- Enjoys water sports: scuba diving, sailing.
- Smokes 20 cigarettes/ day.
- Drinks 14 units/week.
- Walks half an hour every day.

Medical History

- Hx of typhoid fever, (2015). In hospital for 6 days.
- Not on regular medication.
- No known allergy.

Family History

- Father died of natural causes at 85.
- Mother hypertensive and diabetic aged 76.
- Older sister was treated for cancer (breast) at 40.

20 May, 2024.

Subjective

- Mr Reuters feels unwell, lack of appetite, sense of weakness and lack of energy for 3/7.
- Has reduced smoking to 5 cig/day and not drinking for one week.
- No vomiting but nauseating and passing motion normally.

Objective

- Patient looks tired, not jaundiced.
- Weight 89 kg; Height 193 cm.
- Pulse 84 regular, BP 130 /80, Temp 37.3˚ C.
- CVS, RS are normal.
- Abdominal examination: Lax and mobile with no mass or rebound but tender rt. hypochondrium with no organomegaly.

Assessment and Planning

- Prodromal stage of liver disease or mood swings after changing his drinking and smoking habits.
- Advise low fat, low protein and rich carbohydrate diet.
- Order blood, urine and stool tests.
- Prescribe vitamins B complex tablet one TDS and essentiale forte capsules 2 TDS.
- Review in two days for results.

22 May, 2024

Subjective

- Mr Reuters is getting worse.
- Cannot tolerate foods; only drinks fruit juice and noticed that the urine is getting darker with chills and rigours.

Objective

- Temperature 39˚C; looks jaundiced and dehydrated.
- Abdominal examination shows a palpable, tender liver. No ascites.
- Investigations show normal stool and 2+ urobilinogen in urine tests. Leukocytosis with increased serum bilirubin and deranged liver enzymes (ALT And ALP) in blood tests.

Assessment and Plan

- Start IV fluids and medicate Rocephin one-gram IV BD and Flagyl 500 MG TDS.
- Contacted Flying Doctor Service for urgent US examination or evacuation.
- Result of US shows enlarged liver 20 CM with a 10 x 10 cm cystic lesion in the Rt. Lobe of liver
- Liver abscess diagnosed.
- Arrange a referral to a surgeon in Perth by Flying Doctor Service which will be escorted by you in person.
- Urgent assessment required including ultrasound guided drainage.

Writing Task

Refer patient to the Surgical Registrar via the Emergency Department of Perth General Hospital, 268 Brisbane Rd Cottesloe, Western Australia 6542.

In your answer:

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

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

Case Notes Free - Chuck Hooper

Occupational English Test – Writing (Nursing)

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

Notes:

Imagine that today is 4th August, 2024. Mr Chuck Hooper is recovering after a time of paralysis and you are his nurse assisting him at home from Sphinx Rehabilitation Centre, Sydney.

Patient Details:

- Name: Chuck Hooper.
- Age: 37 years.
- Height: 6 ft; Weight: 82 kg
- Admission: January 25, 2024
- Discharged: Feb 28, 2024

Social

- Wife: Marcy Hooper, 32 years.
- Children: No.
- University football player
- Zonal Sales manager (chemical company)

January 15, 2024

- Car collision (while returning from a pet shop with their new dog – Doberman pinscher, "Duke")
- Subdural hemorrhage (motor section of the brain).
- Complete L paralysis. Speech fully impaired. Double vision.
- In critical list for a month. Company allows 1 year off.
- Duke taken care of by a neighbor.
- Chuck under his GP Dr Ivan Hughes' care.
- Mr. Alva Spence (physiotherapist) joins the team.

February 28, 2024

- Discharged from hospital to continue treatment at home.
- In wheelchair. Initiated Physiotherapy with bath + exercise + wheeled walker.
- Nil progress.

March, 01, 2024

- Emotionally low. (Marcy was found crying).
- Left alone at home. Duke still in the neighbor's kennel.

March 15

- Duke brought home.
- Chuck fell badly (Reports Marcy: "He wanted to be standing up to show Duke that he was alright.")

April 03 - 13

- Deteriorating health.
- Nil progress. Socially and emotionally at the lowest.
- Holding to Duke's belt and trying to talk to the dog.
- His GP Dr Ivan Hughes visits Chuck at home.
- April 09: Progress: 4 steps.
- April 11: Progress: 12 steps but fell badly.
- April 13: Progress: Walked ten metres.

July 30

- Physiotherapy with weights, pulleys and whirlpool baths (Mr Alva Spence).
- Started receiving assistance from Sphinx Rehabilitation Centre (Ms Emma Nova).

August 4

- Chuck walked 200 to the local branch office of his company.
- Worked for 2 hours.
- Is determined to join the company full time from October.

Plan

- Discussed Chuck's progress with his GP at the hospital.
- GP thinks that Duke has been pivotal to Chuck's progress.
- Considers involving animal assisted therapy for further treatment.
- Contact an animal assisted therapist.
- Review after 1 month of AAT.

Writing Task

> You are Ms Emma Noa, Chuck Hooper's nurse at his home. Write a letter to Mr Kevin Sharma, Animal-assisted Therapy (AAT) Centre, Golden Circle, Sydney, requesting his involvement in the care of Chuck with the assistance of Duke. Include the medical and social background of the case.

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.