

Case Notes **01 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.

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 25 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 lymph 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.



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Case Notes **02 Jake Peterson**

Occupational English Test – Writing (Nursing)

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.

Details to Fill In:

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

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

**Notes:**

Imagine today's date is March 23, 2024.

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: 17.03.2009.
- 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 the patient 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



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## Case Notes 03 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

- The 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 essentielle 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 04 Fiona Carwell

### Occupational English Test – Writing (Nursing)

#### 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.

#### Details to Fill In:

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

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 05 Gerald Baker

## Occupational English Test

Time Allowed: Reading Time: 5 Minutes | Writing Time: 40 Minutes

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

### Notes

Today's Date: 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.



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# Case Notes 06 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.



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# Case Notes 07 Noah M Caprio

Occupational English Test – Writing case Notes | 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, Sydney, 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 Sydney one 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, Sydney: Phone 666773434.

## Writing Task

Write a letter to Mr Steeth Singh, Tobacco cessation Specialist, Gregory Terrace, Sydney. 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.



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# Case Notes 08 Marlie Windfield

## Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 21 July, 2024.

You are a school nurse at the boarding school where Marlie Windfield is a 3rd Grade Student. She fell down in the school and is being monitored.

- Patient: Marlie Windfield.
- Age: 8 years.
- Address: Resident scholar at Almond County School, Ottawa North. She has special permission to go home on all Fridays (her home is only 38 miles from school).

Incident Details:

- Date of Incident: 18 July, 2024.
- Location: Basketball court at Almond County School.
- Possible cause: Overstraining and/or exposure to high temperature (37°C)

Symptoms/Condition Post-Fall:

- Dizziness and weakness immediately following the fall.
- Mild headache.
- Fatigue over the past three days.
- Complaints of persistent urination and bloating.

Immediate Care Provided:

- Hydration with oral rehydration solution (ORS).
- Application of ice pack to minor bruises.
- Discussed the incidents with her family physician Dr John Mortimer.

Medications Administered:

- Paracetamol (Tylenol) 250mg: For pain relief and fever management.
- Ibuprofen (Advil) 200mg: For reducing inflammation and managing pain

Social Details:

- Resident scholar, actively participates in school sports and extracurricular activities.
- Known to be cheerful and sociable among peers.
- No stress or anxiety reported (however, close friends reported a sudden change in her behavior).
- Parents (both) running business.
- Residential Address: 3456 Carl Island, Ottawa East – United States.

Academic Performance:

- Marked drop in class test performance over the past three weeks.

Having symptoms suggestive of:

- Heat exhaustion.

- Dehydration.
- Possible urinary tract infection (UTI).
- Potential underlying anemia or other systemic conditions.

Information collected from parents:

- No issues at home. Financially doing better.
- Marie had attended the funeral of her grandmother a month ago. "Was attached to Grannie."

Follow-Up Actions:

- Monitor hydration levels and encourage regular fluid intake.
- Avoid strenuous activities and direct sunlight exposure until fully recovered.
- Schedule a comprehensive medical evaluation to rule out other underlying conditions, including a urine test to check for UTI and blood tests for anemia

Plan:

- Allow Marlie to spend time with family for the next 2 weeks.
- Rest and avoid physical exertion for the next 48 hours.
- Maintain a high fluid intake to ensure proper hydration.
- Administer Paracetamol and Ibuprofen as needed for pain management.
- Follow-up appointment with the family physician for further evaluation, including urine and blood tests (appointment scheduled for 24 July, Monday).

### Writing Task

Using the information in the case notes, write a letter to Marlie's parents highlighting the recent developments. Include all relevant information.

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. However, you needn't include any irrelevant information to reach the word-count; nor do you have to omit any information to avoid.

# Case Notes 09 Michael Chan

## Occupational English Test – Writing case Notes | Nursing

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

### Notes:

Today's date is 27<sup>th</sup> 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 10 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)

30<sup>th</sup> 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 11 Chuck Hooper

## Occupational English Test

### 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.

### 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.

# Case Notes 12 William Mason

## 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.

## Details to Fill In:

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

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 13 Artie Un Lee

## 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.

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

## Notes:

You are the charge nurse of Mr Lee at King Arthur Hospital, 22-28 Albion Street, Surry Hills, Sydney, NSW 2010, Australia.

## Patient Information:

- Name: Mr. Artie Un Lee.
- Age: 55.
- Gender: Male.

## Medical History:

- Bloating, abdominal discomfort, constipation, gas formation, recurrent urinary tract infections (under control with a course of antibiotics Ciprofloxacin 500 mg for a week twice a year).

15/09/2023

- GP visit.
- Bloating, abdominal discomfort, constipation, gas formation.
- Physical examination (abdomen).
- Mild distension, tenderness (lower abdominal area).
- Advised dietary changes (increased fiber intake), prescribed laxatives (e.g., Lactulose 10 g/15 mL) and a probiotic supplement (Lactobacillus rhamnosus GG).

11/01/2024

- Recurrent abdominal discomfort, constipation, gas formation.
- Physical examination similar to the previous visit; no significant changes observed.
- Continued with previous management plan, additional prescription of simethicone (e.g., Gas-X 125 mg) for gas relief.

05/05/2024

- Persistent bloating, abdominal discomfort, gas formation, intermittent constipation.
- Abdominal examination consistent with previous findings; no acute signs.
- Further dietary advice provided, reinforced the importance of fluid intake, and recommended over-the-counter Pancreatin 300 mg (digestive enzymes).

31/05/2024 (today)

- New complaint of pricking pain around a bone on the right rib cage, identified by the patient as fleeting and recurrent.
- Ongoing issues with bloating, gas formation, constipation.
- Mild tenderness in the lower abdomen, no signs of acute distress.
- Patient identified the specific rib on the right side; pain described as fleeting and recurrent.

Assessment:

- Differential diagnosis revealed musculoskeletal pain, possible rib contusion or irritation.
- Consideration of potential referred pain from abdominal or other thoracic organs.
- Need specialist care.

Plan:

- Prescribed Ibuprofen 400 mg for pain management.
- Advised warm compresses to the affected rib area.
- Referral to a gastroenterologist for further investigation.
- Reinforced dietary and fluid intake recommendations, maintained current medication regimen.

### Writing Task

Using the case notes, write a referral letter (Re:) to Dr Gaius Cassius, Gastroenterologist, Queen's Hospital, Surry Hills, Sydney for Mr Lee's further investigations and management involving further imaging tests to rule out any underlying pathology. Monitor for any signs of worsening abdominal symptoms that may require additional investigation.

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. Use the correct letter format.

# Case Notes 14 Anne Hall

Occupational English Test – Writing case Notes | Nursing

Occupational English test – Writing (Nursing)

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

Notes:

You are a nurse in charge of the following patient who has come to consult a GP.

Today's Date: 08 March, 2024

- Patient: Anne Hall (Ms).
- DOB: 19.9.1978.
- Height: 163 cm Weight: 75 kg BMI: 28.2 (08 March, 2024).

Social History:

- Teacher (Secondary – History, English).
- Divorced, 2 children at home (born 2004, 2009).
- Non-smoker (since children born).
- Social Drinker – Mainly spirits.
- Substance Intake: Nil.
- Allergies: Codeine; dust mites; sulphur dioxide.

FHx:

- Mother – hypertension; asthmatic.
- Father – Peptic ulcer.
- Maternal grandmother – Died, heart attack, aged 80.
- Maternal grandfather – Died, asthma attack.
- Paternal grandmother – Unknown.
- Paternal grandfather – Died, old age 94.

PMHx:

- Childhood asthma; chickenpox; measles.
- 1985 tonsillectomy.
- 1992 hepatitis A (whole family infected).
- 1994 sebaceous cyst removed.
- 1997 whiplash injury.
- 2008 depression (separation from husband); SSRI – fluoxetine 11/12.
- 2010 overweight – sought weight reduction.
- 2012 URTI. 2014 dyspepsia.
- 2016 dermatitis; Rx oral & topical corticosteroids.

08 March, 2024

- PC: dysphagia (solids), onset 2/52 ago post viral(?) URTI.
- URTI self-medicated with OTC Chinese herbal product – **contents unknown**.
- No relapse/remittent course. No sensation of lump. No obvious anxiety.
- Concomitant epigastric pain radiating to the back, level T12.
- Weight loss: 1-2kg. Recent increase in coffee consumption.
- Takes aspirin occasionally (2-3 times/month); no other NSAIDs.
- GP's Provisional diagnosis: gastro-oesophageal reflux +/- stricture

**Plan**

Refer **to a** gastroenterologist for opinion and endoscopy if required.

### **Writing Task**

Using the information in the case notes, write a letter of referral for further investigation and definitive diagnosis to the gastroenterologist, Dr Jason Roberts, at Newtown Hospital, 111 High Street, Newtown.

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. Use the correct letter format.



**ENGLISH  
MELON**

# Case Notes 15 Jane Macintyre

Occupational English Test – Writing case Notes | 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 cephalixin 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 the correct letter format.

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

# Case Notes 16 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, Irritable Bowel Syndrome (IBS).
- 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 17 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: 9<sup>th</sup>
- 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.



**ENGLISH  
MELON**

# Case Notes 18 Samantha Red

## Occupational English Test – Writing (Nursing)

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

Notes:

Imagine that today's date is 12 March, 2024 and this patient is visiting a dietician in a hospital where you are the patient's nurse in charge.

Patient Details:

- Name: Ms. Samantha Red.
- Age: 34 years.
- Occupation: Model, Actress.
- Married to George Orwell, entrepreneur.

Chief Complaints:

- Work-Related Stress.
- Reports feelings pressure, anxiety, and fatigue; impact → her overall well-being.
- Body Shape Changes (steroid medication).
- Cortisol Blood Test → High Level.
- Estrogen: 190 pg/m.

Medical History:

- Osteoporosis diagnosed in December, 2023. On vitamins and supplements.
- No allergies.
- Adverse reactions to steroid therapy.
- Elder sister committed suicide five years ago.
- Father has been missing since 2019.

Psychosocial Assessment:

- Poor coping mechanisms and support systems in dealing with work-related stress.
- Poor sleep; mood swings.

Tests

- CBC (Complete Blood Count) to check for any abnormalities. Normal.
- CMP (Comprehensive Metabolic Panel, liver and kidney function). Found glomerular toxicity. Mild kidney injury.
- Endocrine function tests done. Results awaited.

Plan

- Medication Review.
- Collaborate with Ms. Red's primary healthcare provider to reassess the necessity and dosage of steroid medication.
- Consider alternative medications with fewer side effects if appropriate.
- Stress Management: Introduce stress-reduction techniques, such as mindfulness, meditation, or counselling, to help Ms. Red cope with work-related stress.
- Dermatological Interventions: Implement a treatment plan for any dermatological issues identified during the assessment.
- Follow-up: Schedule regular follow-up appointments to monitor Ms. Red's progress and make adjustments to the treatment plan as necessary.

## Writing Task

Write a letter to Ms Red's primary care provider Dr Arthur Rivers to arrange a collaborative treatment plan for her. Encourage maintaining communication with Ms. Red's dermatologist and mental health professional to ensure comprehensive and coordinated care.

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.



ENGLISH  
MELON

# Case Notes 19 Christopher Fort

## Occupational English Test – Writing (Nursing)

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

Notes:

Today's Date: 15/03/2024

Notes:

- Name: Mr Christopher Fort
- Age: 49 years
- Married, lives with wife and 2 children.
- Admission date: 11/3/2024 (with chest pain, radiating to shoulder, difficulty breathing - 2 days along with generalized weakness, nausea, dizziness).
- ECG à ST elevation
- Ckmb+
- Dx - Myocardial infarction.

Medical History:

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

ENGLISH  
MELON

Nursing Management and progress:

- Height:173.
- Weight: 59.
- Temp: 98.6°F.
- Pulse: 72 b/m.
- Blood pressure:150/100 mm of hg.

Medications

- Pan 40 mg BD for one month.
- Aspirin 325 mg one month.
- Statix 40 mg of one month.
- Paraffin 10 mg for one month

Investigations Report:

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

12/3/2024

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

Post-operative progress:

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

Recommended by dietitian:

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

Plan

- Schedule follow up with Fbs, FLP, reports on 20/3/2024.
- Medication monitoring.
- Quit-line programs.
- Blood pressure and blood sugar monitoring.
- Dietary management.
- Encourage daily Exercise.
- Follow up.
- Avoid strenuous exercise for two weeks.

### Writing Task

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

In your answer:

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

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

# Case Notes 20 Jessica Morris

## Occupational English Test – Writing (Nursing)

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

Notes:

Jessica Morris was admitted to the hospital with symptoms of severe abdominal pain and nausea. After a thorough examination, she underwent an emergency appendectomy. She is currently recovering well and you are her charge nurse.

Today's Date: 29 July 2024

Patient Details:

- Name: Mrs. Jessica Morris.
- Age: 42 years.
- Husband: David (45), works as an accountant, very supportive, present during admission.
- Children: Two children (ages 8 and 10), well-cared for by husband during hospitalization.
- Hobbies: Gardening, cooking.
- Lifestyle: No smoking or drinking habits; active lifestyle, enjoys family activities.
- Address: 112 Maple Street, Sydney.
- Admitted: City Hospital, Sydney, 27 July 2024.
- Discharge: 30 July 2024.

Diagnosis

- Acute Appendicitis.
- Severe Abdominal Pain and Nausea.

Medical Background:

- Past Medical History: No significant past medical issues; no known allergies.
- Current Medications: Ceftriaxone 1 g IV once daily for 5 days; Paracetamol 500 mg orally every 6 hours as needed for pain; Antiemetics: Ondansetron 4 mg orally every 8 hours as needed for nausea

Nursing Management and Progress:

- Surgical Procedure: Appendectomy performed on 27 July 2024.
- Wound Care: Dressing on surgical site to be changed daily; site should be kept clean and dry.
- Pain Management: Regular analgesics administered; pain level consistently managed with current medication.
- Observation: Monitoring for signs of infection or complications; no signs of fever or abnormal discharge noted

Assessment:

- Recovery progressing well. No signs of infection / complications.
- Pain Manageable (current analgesics); Patient reports minimal discomfort.
- Mobility: Ambulating (with minimal support); vitals stable, within normal ranges.

Discharge Plan:

- Continue to keep the surgical site clean and dry; monitor for signs of infection such as increased redness or swelling.
- Continue Ceftriaxone and Paracetamol as prescribed; ensure completion of antibiotic course.
- Avoid heavy lifting, strenuous activities, intense physical exertion (at least 2 weeks).
- Follow-Up Appointment in one week to assess recovery and remove stitches if necessary.
- Provide husband with detailed instructions on wound care and medication management.
- Ensure adequate support at home for patient's recovery and assist with childcare if needed.

**Writing Task:**

Using the information in the case notes, write a letter to Zelda Denizen, Community Health Nurse, 15 Walter's Street, Sydney, who will be responsible for Mrs. Morris' continued care at her home.

In your letter:

- 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 21 Henry O'Keefe

## Occupational English Test – Writing (Nursing)

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.

Details to Fill In:

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

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

Today's Date: **20/03/2024.**

You are a nurse with the **Blue Skies Home Nursing Centre**. You visited this patient at home today for the **first time** following a referral from the **Mater Public Hospital**. He was discharged from hospital on 17/03/2024.

- Name: Henry O'Keefe.
- Address: 12 Donaldson Street, Green Slopes, 4121; Phone: (07) 3941 2267
- Date of Birth: 2 February 1941
- Admitted: 12/03/2024.
- Diagnosis: Malignant Melanoma, Left Shoulder.
- Social History → Married aged pensioner. No children. Lives in a housing commission home with wife Dorothy (also an aged pensioner).
- Medical History → Large lesion successfully removed 13/03/2024.
- Discharged **17/03/2024.**

1st Home visit **19/03/2024**

- Nurse in Charge: **Ms Rose Pullen.**
- Time: 10 am.
- Showered patient. Wound dressed – healing satisfactory. No sign of infection. Balance a little shaky. Complaining of increased arthritic pains in hands and legs.
- Taking Glucosamine & Chondroitin Supplement recommended by GP.
- Pain relieved with 3 Panadol 2 times daily.
- Confused about why he had the operation.
- **Dorothy** concerned about future.
- Tells you she will be 83 in October. Says Henry has not been himself since the surgery.
- Keeps forgetting things. She finds it difficult to manage the house and garden.
- Neighbours are helping with shopping.
- Kitchen and bathroom disordered. Trouble finding clean towels. Dishes piled in sink.
- Bed unmade.

Home Visit - **20/03/2024.**

- Henry showered and wound dressed.
- Still a little unbalanced.
- Rests most of the day.
- Does not remember being showered yesterday.
- House still disorganised. Washing piled up in the bathroom.

- Dorothy says she would be lost without help from neighbours who also appear to be cooking meals for the couple.

Concerns:

- Provided there are no complications with the wound healing, your role in providing nursing care ends when sutures are removed after 6 days.
- You consider that Henry and Dorothy need to be assessed for further on-going assistance in managing the house and garden and with shopping and the preparation of cooking.

**Plan**

- Request a home visit by the **Aged Care Assessment Team** as soon as possible to fully assess their needs and to arrange for appropriate further assistance to be provided.
- Removal of sutures at Mater Public Hospital on **25/03/2024**.

**Writing Task**

Using the information in the case notes, write a letter to The Director, Aged Care Assessment Team, Brisbane South Region, 78 Masterson St. Acacia Ridge, Brisbane 4110. Explain why you are writing and what types of assistance may be required.

In your answer:

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

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



ENGLISH  
MELON

# Case Notes 22 Brit Freeman

## Occupational English Test – Writing (Nursing)

### 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.

### Details to Fill In:

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

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

### Notes:

### Patient Details:

Name: Brit Freeman (Mr)

- Date of Birth: 15/08/1970.
- Admitted: 01/06/2024.
- Discharged: 10/06/2024



Imagine today is 14/06/2024. You are in charge of Mr Freeman at Easter Hospital, Adelaide.

### Social History:

- Accountant.
- Married, Children: 2.
- Smoker: 15 cigarettes/day (since age 20).
- Alcohol: Occasional, 2-3 drinks/week.
- Exercise: Sedentary lifestyle, minimal physical activity.

ENGLISH  
MELON

### Nutritional Information:

- Diet: High in processed foods and sugary drinks.
- Current Nutrition Plan: Low-carbohydrate diet, increased fruits, vegetables, and lean protein
- Recommended Changes: Encourage regular meals, reduce sugar intake, increase fiber.
- Body Mass Index (BMI): 175 cm, 95 kg.

### Recommendations given:

- Smoking cessation.
- Reduce alcohol intake.
- Increase physical activity (recommended 30 minutes of moderate exercise 5 times/week).
- Regular follow-up with a dietitian.

### Medical History:

- Hypertension (diagnosed 2010).

- Type 2 Diabetes Mellitus (diagnosed 2015).
- Hypercholesterolemia (diagnosed 2018).
- Obesity (BMI: 31.2).

Medications:

- Metformin 500 mg, twice daily.
- Lisinopril 10 mg, once daily.
- Atorvastatin 20 mg, once daily.
- Aspirin 81 mg, once daily.

01/06/2024

- Chest pain, shortness of breath, fatigue.
- Elevated BP (160/100 mmHg), glucose (fasting: 180 mg/dL), cholesterol (LDL: 160 mg/dL)
- Admitted for further evaluation, start continuous ECG monitoring, adjust medications.

02/06/2024

- Persistent chest pain, mild headache.
- ECG showed ST elevation, Troponin levels elevated.
- Nitroglycerin, morphine (pain management), prepare for angiography.

03/06/2024 (Post-Angiography):

- 70% blockage in left anterior descending artery.
- Percutaneous coronary intervention (PCI) with stent placement.
- Clopidogrel 75 mg daily, continue current regimen

05/06/2024

- Mild chest discomfort, improved breathing.
- Stable vitals, BP: 140/90 mmHg, glucose: 150 mg/dL.
- Monitor progress, educate on medication adherence, lifestyle changes.

07/06/2024

- No new complaints. Findings: Stable vitals, ECG normal, glucose: 140 mg/dL.
- Prepare for discharge, schedule follow-up appointments.

10/06/2024 (Discharge)

- Stable, no chest pain, improved glucose control.
- Discharge Medications: Continue Metformin, Lisinopril, Atorvastatin, Clopidogrel, Aspirin
- Follow-Up: Cardiologist in 1 week, Endocrinologist in 2 weeks, Dietitian in 3 weeks.

14/06/2024 - Follow-Up with Cardiologist:

- No chest pain, mild dizziness occasionally.
- BP: 130/85 mmHg, glucose: 130 mg/dL, LDL: 140 mg/dL.
- Continue current medications, encourage lifestyle modifications, regular follow-ups.

Plan

- Patient has shown compliance with medication but needs continuous motivation for lifestyle changes.

- Smoking cessation program recommended.
- Referral to physiotherapist for a structured exercise program.

### **Writing Task**

Using the case notes, write a letter to Mr Adman Chaudhari, Physiotherapist, 343 Sunrise Apartment, Crescent Villas, Adelaide.

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.



**ENGLISH  
MELON**

# Case Notes 23 Jamie Brown

## Occupational English Test – Writing (Nursing)

### 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.

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

# Case Notes 24 Clare O'Finney

## Occupational English Test – Writing (Nursing)

### 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.

### Details to Fill In:

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

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

### Notes:

Imagine that today is 18 June, 2024 and that Mr O'Finney is your patient who visited City Clinic, Fort City, Sydney – 55, Australia.

### Patient Information:

- Name: Mr. Clare O'Finney.
- DOB: 12 May 1975 (Age: 49).
- Gender: Male.
- Occupation: Businessman.
- Nationality: American.
- Current Location: Visiting Australia



### Clinical Information:

- Date of Visit: 18 June 2024.
- Presenting Condition: Multiple skin conditions (? eczema).



### Symptoms:

- Inflammation and itching on skin.
- Affected areas: inner palms and inner feet.

### Examination, Findings, Treatment.

- Erythematous patches on inner palms and inner feet.
- Excoriations noted.
- Topical corticosteroid cream (Betamethasone 0.1%) applied BID.
- Emollient cream (Cetaphil) applied PRN.
- Lymphocytes: 40.2%; RBC: 5.33 M/cumm; Monocytes: 4.1%; Blood glucose (fasting): 97 mg/dL.
- RAST (Radioallergosorbent test). Results awaited.

### Medical History:

- Similar skin rash two years ago (June 2022) characterized by erythema and itching on the inner palms and inner feet.
- Diagnosed with eczema (2022).

- Treated with topical corticosteroids (Hydrocortisone 1%) and emollient creams (stopped after 1 month).
- Symptoms resolved after two weeks of treatment.
- Chronic Conditions: None.
- Allergies: None
- Current Medications: None

Plan:

- Referral: To dermatologist.
- Provide information on avoiding triggers and proper application of topical treatments.
- Follow-Up: Patient advised to return if symptoms worsen or do not improve in 1 week.
- All test results are attached.

### Writing Task

Using the information in the case notes, write a referral letter to Dr. Athens Cappuccino, 123 Sydney Dermatology Clinic, 456 Harbour Street, Sydney, NSW 2000, for further evaluation and management.

In your answer:

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



ENGLISH  
MELON

# Case Notes 25 Eva Gingerades

## Occupational English Test – Writing (Nursing)

### 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.

### Details to Fill In:

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

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

### Notes:

This patient has been visiting the school's Mental Health Centre and you are her charge nurse at St. Mary's Primary School. She will be moving to Adelaide next month to continue her studies.

Today's Date: 24 July, 2024

### Patient History:

- Name: Eva Gingerades.
- DOB: 15.08.2013.
- Parents: Mr and Mrs Gingerades. 3434 Blithe Street, Charity Circle, Perth.

24 June, 2024

### Subjective:

- Reports difficulty coping with other students.
- Complains of frequent feelings of anxiety and isolation.
- No significant family history of psychiatric issues.
- Non-smoker, does not consume alcohol or caffeine.
- Current Medication: None

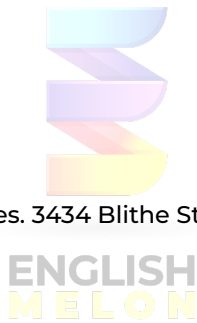
### Objective:

- BP: 110/70; P: 72 regular
- Height: 145 cm; Weight: 40 kg
- Physical examination: Normal
- Mental health screening: Indications of social anxiety and mild depression.

### Plan:

- Referred to school counsellor for weekly sessions.
- Advised to keep a daily journal of her feelings and social interactions.
- Recommended to participate in group activities to improve social skills.
- Review in 4 weeks to assess progress.

14 July, 2024



Subjective:

- Reports slight improvement, but still feels anxious around peers.
- Parents note she has been more withdrawn at home.

Objective:

- BP: 108/68; P: 70 regular
- Assessment: Continue with school counsellor sessions. Initiate referral to a child psychiatrist for further evaluation and potential therapy in Adelaide.

24 July, 2024

Subjective:

- Mixed progress: occasional positive social interactions but persistent anxiety.
- Parents express concern about her transition to a new school in Adelaide.
- Objective: BP: 110/70; P: 72 regular.

Plan:

- Immediate referral to Dr. Sarah Thompson in Adelaide for comprehensive evaluation and therapy.
- Continue weekly counselling sessions with a school counsellor until relocation.
- Engage parents in supportive strategies at home (until relocation), including positive reinforcement and structured routines. Consider continuation in Adelaide.
- Consider need for medication. ? Therapy alone does not yield improvement.
- Coordinate with the new school in Adelaide to implement a support system for her transition, including a peer buddy system and regular check-ins with the school nurse or counsellor.
- Schedule a follow-up appointment in < 1 month of relocation. Purpose: Review adaptation, progress with Dr. Thompson.
- Encourage participation in extracurricular activities. Objectives: Enhance social skills, reduce feelings of isolation.

### Writing Task

Write a letter addressed to Dr. Sarah Thompson, Psychiatrist, 567 North Terrace, Adelaide SA 5000, describing the situation.

In your answer:

- Expand the relevant notes into complete sentences (Do not use note form).
- Eliminate irrelevant details.
- Follow the MELONS Organization (Meeting, Enquiry, Listening, Offering, Neutralization, Summarization).
- Punctuate appropriately with small and capital letters, full stops, and commas.
- Use correct grammar. Insert "the" before body parts/organs.
- Use letter format.

The body of the letter should be approximately 180–200 words. Do not pick up your pen during the 5 minutes of reading time.

# Case Notes 26 Petra Knodel

## Occupational English Test

### 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.

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

### Notes

Imagine today's date is 28th May 2024. Ms Petra Knodel, an Australian National currently in Liverpool (coaching her team of junior football players that is going to play finals in three days).

### Patient Details

- Name: Ms. Petra Knodel.
- Age: 36
- Gender: Female
- Occupation: Coach
- Hospital: St. Clare's Hospital, Liverpool.
- Discharge Date: 27th May 2024.

### Admission Details:

- Admission Date: 20th May 2024
- Complaints: Pain in joints (ankle, back, fingers, hands, muscles, neck, wrist), decreased range of motion, difficulty walking, muscle weakness, joint stiffness, tenderness, swelling, bump on finger.
- No bony outgrowth in fingers or toes, neck stiffness, physical deformity.
- Diagnosis: Rheumatoid arthritis.
- ? Vitamin D deficiency.

### Interim Treatment being provided

- Hydrotherapy (Commenced for a week. Will continue at home).
- Stretching, massage, acupuncture.

### Self-Care Measures (Advised and Explained):

- Physical exercise.
- Weight loss.
- Yoga.
- Heating pad.
- Ice packs
- Cold compress

### Surgical History:

- No Hip replacement, no Knee replacement, no joint replacement.

### Medications:

- Ibuprofen 400 mg, three times daily.
- Prednisone 10 mg, once daily.
- Paracetamol 500 mg, as needed (up to four times daily)
- Tramadol 50 mg, as needed for severe pain (up to three times daily).
- Methotrexate 10 mg, once weekly

#### Past Medical History:

- Diagnosed with rheumatoid arthritis 5 years ago.
- Vitamin D deficiency (treated with supplements)
- History of stress fractures due to high-intensity training.

#### Family History:

- Mother: Osteoarthritis
- Maternal grandmother: Rheumatoid arthritis.

#### Education Provided:

- Importance of adhering to medication regimen to manage arthritis symptoms and prevent flare-ups.
- Techniques for joint protection and energy conservation to minimize stress on affected joints.
- Nutritional advice emphasizing a balanced diet rich in vitamins and minerals to address possible deficiencies.
- Encouraged regular, moderate physical activity tailored to her abilities to maintain joint flexibility and overall fitness.
- Recommended use of heating pads and cold compresses to manage pain and inflammation.
- Advised on weight management strategies to reduce joint stress.

#### Discharge Details:

- Discharge Condition: Stable with manageable pain levels, improved understanding of condition.
- Management.

27/05/2024 02:00 AM

- Ms Knodel's husband called up her GP from home and reported that her condition suddenly worsened at night. Intolerable pain in the joints that made the patient black out twice.
- The GP decides that the patient be transferred under emergency to the nearest hospital.

#### Plan

Transfer to Dr. Fabian at the Emergency Department, Suburban Hospital, Liverpool for further evaluation and management.

#### Writing Task

Using the information the case notes, you need to write a referral letter for Ms Knodel to Dr Sigmund Fabian, Rheumatologist, Suburban Hospital, Bad-waters, Liverpool, UK. for urgent assessment and early healing to make her ready to train her team.

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.



ENGLISH  
MELON

# Case Notes 27 Ms Demi Brooke

## Occupational English Test – Writing (Nursing)

### 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.

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

### Notes:

You are a nurse working at Plena Night Hospital, Belmont, Fitzroy North. The following patient is under your care.

Today's Date: 26 March, 2024

### Patient Details

- Name: Ms Demi Brooke
- Age: 32 years
- Marital Status: Married to George Harrison (National Geographic Photographer).
- Admission Date: 26 March, 2024

### Social Background

- Marine Photographer
- Not admitted to a hospital in the whole life;
- Emotionally not stable (Dx bipolar disorder (at 23) but not taking treatment.
- Smokes occasionally. “When smokes, the room explodes with smoke” (Reports husband).
- Teetotaler (10 years)

04 – 05 pm, 25 March, 2024

- Stung by poisonous box jellyfish while photographing at a fishing area near Run Cliff.
- Fishermen rushed for help. Visible tentacles. Carefully plucked (using tweezers, not very clean).
- Affected skin soaked in extreme hot water (120 to 140 F).
- Mild scalding occurred.

07.00 PM

- Returned home (Patient averse to hospitalization).
- Had hot shower for 30 minutes.
- Hydrocortisone cream applied twice at night.

26 March, 2024, 03.00 AM

- Husband drove her to Plena Night Hospital, Belmont, Fitzroy North.
- HR 140; BP 120/139 RR: 29.
- Pain Management continued.

03.50 AM

- Breathing difficulty.
- Chest and stomach pain, high blood pressure, pricking pain near the heart.
- Discussed the progress with the patient's GP (who suspects a more complex condition called Irukandji syndrome)
- Asked to transfer the patient to Neighbourhood Hospital.
- The patient transferred at 4.15 AM to Neighbourhood Hospital.

### Writing Task

Using the information in the case notes, write a referral letter to Dr Charan Koghar, Emergency Doctor, Neighbourhood Hospital, Belmont Road, Fitzroy North, requesting investigation and management for Ms Brooke.

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.

Letter

Opening

04 – 05 pm, 25 March, 2024

- Stung by poisonous box jellyfish while photographing at a fishing area near Run Cliff.
- Fishermen rushed for help. Visible tentacles. Carefully plucked (using tweezers, not very clean).
- Affected skin soaked in extreme hot water (120 to 140 F).
- Mild scalding occurred.

# Case Notes 28 Thomas Gallagher

## Occupational English Test

### 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.

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

### Notes:

Today's date: 5 Aug 2025

- Patient Name: Mr. Thomas Gallagher
- **DOB: 11 Nov 1984**

### Medical history:

- 2020: Dx → mild depression, managed CBT.
- 2022: Relapse → started sertraline 50 mg OD
- 2023: Lost job → ↑ symptoms, ↓ motivation.
- **15 Jul 2025:** Presented low mood, insomnia, ↓ appetite.
- 18 Jul 2025: PHQ-9 score = 17 → moderate MDD
- 20 Jul 2025: ↑ sertraline → 100 mg OD
- 25 Jul 2025: Referred psychologist → **6 sessions booked.**
- **4 Aug 2025:** Expressed suicidal thoughts (no plan).

### Provisional Dx:

- Moderate major depressive disorder.
- No psychosis or bipolar features.

### Symptoms reported:

- Persistent sadness
- Fatigue
- Difficulty concentrating
- Insomnia
- ↓ appetite
- Feelings worthlessness
- Passive suicidal ideation.

### Observations:

- **Flat affect**
- Tearful during consult
- Poor eye contact
- No self-harm scars
- Oriented, cooperative
- BMI 22.1

### Meds:

- Sertraline 100 mg OD
- Melatonin 3 mg nocte

- PRN paracetamol (headaches)

Allergies:

- **NKDA**

**Investigations:**

- PHQ-9 = 17
- GAD-7 = 11
- Thyroid function → normal
- HbA1c → 5.4%
- Vit D → borderline low (42 nmol/L)

**Social background:**

- Lives alone at 8/22 Barkly St, St Kilda VIC 3182
- Unemployed (laid off 2023)
- No partner, limited social contact
- Parents interstate
- Financial stress → Centrelink support
- No smoking/alcohol
- No pets
- GP primary contact

Psychosocial:

- Feels isolated
- Avoids social situations
- Concerned → future, finances
- Willing engage therapy
- No hx substance abuse



Nutrition:

- Skips meals
- ↓ interest food
- Dietitian referral pending

ENGLISH  
MELON

Discharge plan:

- Refer → Monash Mental Health Outreach
- Weekly psychologist sessions
- Monitor mood + med response
- Dietitian input
- GP review fortnightly
- Crisis plan → after-hours contact

Requests:

- Monitor mood, suicidal ideation.
- Support → therapy engagement.
- Liaise GP → med adjustment.
- Provide social work input.
- Arrange dietitian consult.
- Educate patient → coping strategies.

**Writing Task:**

Using information in case notes, write a letter to Ms. Hannah Boyd, mental health nurse, Monash Health, referring to Mr. Gallagher for community-based psychological support and monitoring.

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.



ENGLISH  
MELON

# Case Notes 29 Jamie Morgan

Occupational English Test – Writing case Notes | Nursing

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.

Details to Fill In:

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

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).

ENGLISH

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 30 Margaret Leon

## Occupational English test – Writing (Nursing)

### 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.

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

### Notes

Today's Date: 13 May, 2024

### Patient History

- Margaret Leon; DOB: 01 .08. 64.
- Gender: Female.
- Regular patient in your General Practice.

1 October, 2023

### 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 exercise & weight reduction.
- Borderline hypertension. Review in 3 months.

08 January, 2024

### Subjective

- Feeling better in part due to weight loss.

### Objective

- BP 140/85; PR 70 regular; Ht 152cm; Wt 61 kg.
- Making good progress with weight. Blood pressure within normal range.

13 May, 2024

- Patient saw blood in the toilet bowl on two occasions after bowel motions.
- Says she is depressed and very anxious.
- Believes she has bowel cancer. Trouble sleeping.

- 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 with GP after appointment with gastroenterologist.

#### Writing Task

Write a letter addressed to Dr. William Carlson, gastroenterologist, 1st Floor, Bellow Chambers, 56 Wickham Terrace, Brisbane, 4001 requesting his opinion and further assessment.

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 correct letter format.

