SET English

Layout & Letter Types

What do we have to do in OET Writing?

Write a professional letter to a healthcare professional to request something.

It should be:
- organised
- logical

As long as you make your decisions on structure and content in line with the purpose, you are unlikely to make big errors.

Layout

<table>
<tr>
<td>
Date

Name
Profession
Address 1
Address 2

Dear …………..,

re: Patient Name & DOB/Age

Paragraph
Paragraph
Paragraph

Yours Sincerely/Faithfully, (depending on knowledge of recipient’s name)

Name
</td>
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There four main letter types in OET Writing:

• Discharge	• Referral
• Transfer / Pre-Procedure	• Update

Technique

It is tempting to think you can develop a technique for every type but our approach at SET is based more on critical thinking and having the right tools for EVERY task. Content is so important! Let's review some letter types below:

Referral

Be very careful! Both of the tasks below are referrals but require different approaches to content for the reader.

PATIENT DETAILS:

Name: James Smith
DOB: **26 Oct 2004**
Next of kin: Mother, Bridget (56 y/o)

Social background:
High school student. Sedentary - no sports, spends many hours at computer.

Family history: Mother: hypothyroidism, rhinitis
Father: deceased (lung cancer 54 y/o)

Medical history: Symptomatic focal epilepsy
Chronic sinus infections
Cystic fibrosis (2006) – poor growth
Healthy diet but overweight (BMI 28.5)
No allergies

Current medications:
Phenytoin 100 mg 3 x daily (anti-seizure)
Panadol Rapid (paracetamol 500 mg)/ 6h
Pulmozyme (dornase alfa), 2.5 mg b.i.d (breaks down sputum)
Creon (Lipase-Protease-Amylase), 4 x caps with food (pancreatic enzymes)

Admission: 02 Feb 2019

Presenting factors:
Severe dyspnoea (SOB), coughing, hypoxia (lack of oxygen), hemoptysis (coughing up blood), fever, headache, facial pain.

Treatment record:

02 Feb 2019 VS: BP: 116/78 mmHg, HR: 82, RR: 18, T: 36.5 C
hydrated; O2 sats = 80%
Erythematous oropharynx (red tongue &throat)
↑ breathing rate (30 breaths/minute)
Sonorous wheeze (indicates lung blockage) & bibasilar crackles (sound at base of lung – indicates mucus/fluid)
Treatment: Ampicillin sulbactam (antibiotic) – Lower respiratory tract infection (LRTI)? bacterial sinusitis?, and supplemental oxygen.

03 Feb 2019 Pt. stable
Chest x-ray: pleural effusion & pneumonia
CT scan: chronic sinusitis (paranasal sinus)
Treatment: azithromycin (500 mg p.o., q.d. (reduce to 250 mg)) (antibiotic), ciprofloxacin (500 mg p.o., 12 hourly) (antibiotic).

17 Feb 2019 Satisfactory clinical recovery
Antibiotics finished
↑ likelihood lung infections & ↑ frequency
Discussion regarding ↓ time in school, ↑ hospital visits: home-schooling?

Discharge plan: Physio – airway clearance technique (q.d./prn)
Dietitian - ↑ exercise, improve/discuss diet
Double lung transplant suitability - explore with surgeon

Writing Task:

Using the information in the case notes, write a letter to Dr Stark for review of Mr James Smith. Address the letter to Dr G Stark, Surgeon, Department of Thoracic Medicine, Smithtown Hospital, Smithtown.

Not for general distribution

Not for general distribution

Notes:

Michael Weir is a patient in your general practice.

Name: Mr Michael Weir (**DOB:** 20 Sep 1970)
Height: 183cm

Background: Smoker
Overweight — long term
Depression — sertraline hydrochloride (Zoloft) since Sep 2012
Married — 3 children (13, 10 & 8yrs)
Real estate agent — reports no time for exercise/relaxation
Active member of local church congregation

Patient History:
29.06.14
Subjective: Here for general check-up. Reports feeling 'run down': tired, stressed, 'sluggish'.
Examination: BP: 96/83, Heart rate (HR): 70bpm
BMI: 27.8 (Wt: 93.1kg)
Chest clear
Skin check — no suspicious lesions found
Tests: CBC, cholesterol/lipids
Plan: R/v in 1wk (discuss test results)

07.07.14
Subjective: Here to receive results of blood tests (cholesterol, CBC)
Still tired, feeling 'down'.
Reports weakness in L leg.
Examination: BP: 90/80, HR: 79 bpm
Chest clear
Sertraline hydrochloride — ongoing
BMI: 28.5 (Wt: 95.5kg)
Test results: Cholesterol: 6.37mmol/L
CBC - low WBC; low RBC, low Hb & Hct; other results in normal range
Assessment: Repeat assessment of hypercholesterolaemia in 3mths.
Monitor general health - tiredness, depressed feelings.
Pt should make lifestyle changes (smoking, diet, exercise, recreation).
Plan: Pt to ↓dietary saturated fat, incorporate regular exercise to ↓weight & cholesterol levels; stop smoking.
R/v in approx 1mth to assess general health, feelings of tiredness & being 'down'.

2

09.08.14
Subjective: Complains of dizziness and reports two recent 'blackouts' (a few minutes each). Feels stressed - busy at work. Mood up and down since last visit. Reports tingling in hands. L leg still feels weak. Breathless, occasional constipation, short of energy. Has been trying to eat better & exercise more - walks (30mins) x2-3/week.
Still smoking.
Examination: BP: 88/70, HR: 76bpm
BMI: 28 (Wt: 93.7kg)
Chest clear
Loss of sensation on L & R hands (sharp/blunt)
Reflexes - diminished L patellar reflex
Tests: Order head & lumbar spinal CT to try to determine cause(s) of leg weakness and associated objective hyporeflexia (?central or spinal — check for spinal cysts/ tumours, etc.).
Assessment: ?multiple sclerosis
Plan: Order CT
Refer to neurologist: a full neurological assessment; ?order MRI

Writing Task:

Using the information given in the case notes, write a letter of referral to Dr M McLaren, Neurologist, Suite 3, 67 The Crescent, Newtown.

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

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

Referrals:

- The recipient does not know the patient.
- Therefore, any of the data could be considered 'vital'
- Patient could be referred for assessment/diagnosis or for intervention - this changes which details are important.
- We have to choose which data - and which level of detail for that data - to include, in order to enable the recipient ***to continue care***.

Discharge

Notes:

Assume that today's date is 11 February 2019.

You are a doctor in the Emergency Department of Newtown Hospital. You have been responsible for the care of Mr John Aloisius, recently admitted with breathing problems.

PATIENT DETAILS:

Name: John Aloisius
Marital status: Single
Residence: 39 Long Street, Bridgeford
DOB: 04 Sep 1985 (33 y.o.)
Next of kin: Brother (age 39)

Social background:
Occupation: archaeologist (recently returned from year-long visit to remote region of Latin America)

Past medical history:
No PMHx
No surgeries
No medication
NSAIDs allergy
Non smoker

Family history: Mother: asthma (since childhood)
Father: dec. 1999 (lung cancer)

01 Feb 2019: Admission to Emergency Department

Presenting problem:
Night sweats & fevers, cough & sputum with some hemoptysis (over several weeks)
VS: BP: 114/72 mmHg, P: 90 beats/minute, T: 38.5°C,
RR: 18 breaths/minute, Oximeter: 92% saturation room air

Physical examination:
Notable for cachexia, chest with scattered rales, no consolidation

Diagnosis: Pulmonary tubercolosis

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Treatment & test results:
Chest x-ray: apical infiltrate

01 Feb 2019 Pt. placed on respiratory isolation
03 Feb 2019: Sputum acid-fast stain & mycobacterial culture positive for tuberculosis
Liver function (AST & ALT): normal
TB medications started: Isoniazid 5 mg/kg PO/IM qDay, Rifampin 10 mg/kg/day PO, Pyrazinamide 15-30 mg/kg
PO, qDay, Ethambutol 2.8g PO twice weekly
HIV serology: negative
Vitamin B-6 50mg PO once daily
11 Feb 2019 Sputum acid-fast stain: negative

Medical progress:
Good
Pt: 'lonely & depressed' (isolation)

Nursing management:
Respiratory isolation (private room) with negative pressure
Normal diet
Follow anti-tuberculosis medication schedule: monitor side-effects
Weekly sputum analysis
Medical staff to wear high-efficiency disposable masks (for bacillus filtration)

Discharge date: 11 Feb 2019

Discharge plan: Continue 4-drug regimen (for 2 months)
Cease pyrazinamide & ethambutol after 2 months
Continue isoniazid + rifampin (daily or intermittent) for 4 mths
Monitor medication compliance: directly observed therapy (DOT) by nurse recommended (→poss. reduction of above regimen to 2 / 3x wk after 2 wks at initial dose)
Monitor for toxicity (CBC, serum creatinine, baseline & periodic liver enzymes)
Baseline & periodic serum uric acid assessments
Periodic visual acuity & red-green color perception (Ishihara test)
Continue vitamin B-6 supplements

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Writing Task:

Using the above information, write a letter of discharge to Dr Hodges, the patient's regular doctor, informing her of the treatment Mr Aloisius has received and advising on further management. Address the letter to Dr Christine Hodges, 2 Hill Forest Road, Newtown.

Discharges:

- The recipient is no longer in an acute state, after some form of treatment.
- The recipient sometimes knows the recipient - it could be a GP. However, sometimes the discharge could be to a rehab centre or a retirement home, in which case the reader might not know the patient.
- Therefore, you have to choose which information is relevant for the reader.
- Generally, the detailed information in discharge letters can be found either in the discharge plan or in case notes relating to the discharge plan. Always remember - choose information in order to enable the recipient ***to continue care***.

Transfer

Notes:

Assume that today's date is 21 May 2019.

You are a doctor in the Emergency Department at Shepton Hospital and are assessing a patient who has been involved in a motorcycle accident.

PATIENT DETAILS:

Name: Richard McKie (Mr)
DOB: 26 May 1998 (32 y.o.)
Residence: 24 Rose Avenue, Shepton (student accommodation - shared room)

Social background:
4th-year medical student (Westland University)
Interests: music (plays the flute), travel abroad, keen motorcyclist (no previous accidents)

Family background:
Mother – COPD, hyperlipidemia
Father – prostate cancer, alcoholic since 48 y.o.
Brother – allergic dermatitis

Past medical history:
R wrist fracture 7 y.o. (fall from bicycle)
Social drinker, mainly beer (approx. 6 units/wk)
Light smoker: 3-5 cigs/day
No allergies
No medications

Hospital Admission 21 May 2019:
Pt →Emergency Department after high-velocity motorcycle accident trauma

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Treatment record:

21 May 2019
Admission VS: BP - 88/60, HR - 110 beats/min, RR - 25 resp/min,
Temp - 36.5°C
Respiratory distress
Cervical collar in situ
Diaphoretic & cyanotic,
Pulse-oximetry 88% (room air)
Glasgow Coma Scale (GCS): 15/15
Thorax examination: R distant breath sounds, hyper-resonance on percussion
R tension pneumothorax →prompt needle decompression
Insertion R chest tube & oxygen →pt. stabilised
Chest X-ray: 5th rib midline facture, no hemothorax
Medications: Oxygen nasal cannula 2L/min
Hydromorphone IV 0.5mg/every 4 hrs
Ampicillin-Sulbactam IV 1g/every 6 hrs
Omeprazole PPI IV 40mg/day
Enoxaparin IV 40mg SC (subcutaneous)/day

Secondary survey:
R periorbital ecchymosis & edema
↓visual acuity, mild enophthalmos
Diplopia (especially upgaze) →?blowout fracture
R hyperalgesia in distribution of infraorbital nerve
Head CT scan: LeFort type II fracture, blowout fracture w. inferior rectus entrapment

Diagnosis:
1. R Blowout fracture
2. LeFort type II fracture
3. R Tension pneumothorax (resolved)

Management:
Monitoring of pt: normal vital signs √
no respiratory distress √
hemodynamically stable √
Chest tube in position, pain controlled
Pt to remain overnight then transfer to Plastic Surgery Dept.

Plan:
Refer →plastic surgeon for management of blowout fracture
w. plastic or maxillofacial surgery

Writing Task:

Using the information in the case notes, write an internal letter of referral to Dr Bellamy, Plastic Surgery Consultant, for review and further management of Mr McKie's blowout fracture. Address the letter to Dr Mary Bellamy, Plastic Surgery Consultant, Shepton Hospital, Shepton.

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Transfers:

- Transfers - a combination of discharge and referral. Patient probably no longer requires acute care for a condition, but needs help with another issue.
- Patient is not known by recipient. Therefore, all information could be relevant. You have to choose which information is relevant for the reader.
- Generally, the recipient only requires current condition and request in detail - other treatment/issues can be summarised . Always remember - choose information in order to enable the recipient ***to continue care***.