1 Planning your letter
2 Groups
3 Letter plan

When we plan, what do you think about?

~~**Letter type**~~

1. **Context:**

    1. Who am I writing to?
    2. What do they already know?
    3. What do they NEED to know to continue care
    4. Why am I writing today?
    5. Is it urgent?

2. **Choosing case notes**
   I should case that he **NEEDs** **[direct]** to *do the job*
   I should also choose case notes that are **APPROPRIATE** **[indirect]**

3. **Paragraphs: OET Sandwich**

SET English

OCCUPATIONAL ENGLISH TEST

WRITING SUB-TEST: MEDICINE

TIME ALLOWED: READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

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

Notes:

Mrs Maria Santini is a patient in your general practice.

Patient details

Name: Mrs Maria Santini (D.O.B.: 01.06.1950)

Residence: 23 High Street
Greenville

Social background:
67-year-old widow, two adult children
Lives alone at home, non-smoker, non-drinker

Patient history:
10.03.2018

Subjective:
Presenting complaint
6wk history progressively ↑ pain R and L knee joints, especially on flexion and extension

4wk history soft lump on back of R knee, restricted joint mobility, mild-moderate persistent pain

↓ Activities of daily living (ADL) – stopped accessing local shops and seeing friends, confined to a two-storey house but recently has experienced difficulty in climbing stairs

↑ Depressive symptoms (+ reclusive, + anti-social, + irritability, + agitation)

History of presenting complaint:

2006	onset of osteoarthritis (OA)
2011	lumbar laminectomy (L5/S1)
2013	bilateral hip replacement (restored almost full function, eliminated pain & discomfort)

Past medical hisory:

2003	hypertension (HT), hyperlipidaemia
2006	OA
2009	paroxysmal atrial fibrillation (AF)

Medications: OA – Glucosamine 1500mg daily
AF – Flecainide 200mg daily, Digoxin 250mcg daily
HT – Trandolapril 2mg daily, Indapamide 1.5mg daily
Hyperlipidaemia – Simvastatin 20mg daily
Allergies – nil

Family history: Mother – acute myocardial infarct, ? died of ischaemic heart disease (IHD)

Objective: T – 36.7°C, P – 80 regular, Ht – 164cm, Wt – 72kg, BP – 130/85
No skin changes, no swelling, no valgus/varus deformity
Concomitant crepitus (crackling sounds when moving joints) in R and L knee joints flexion and extension
Systems review – normal
MRI – degeneration consistent with OA
FBE – normal
LFT – normal
U&E – normal (serum creatinine 145umol/L)

Assessment: Worsening of chronic OA with significant pain, ↓ADL and signs of depression

Diagnosis: Baker's cyst in R knee joint plus worsening OA

Plan: Refer to orthopaedic surgeon for assessment and management of OA
? joint steroid injection
Refer to physiotherapist to improve joint mobility
? Living at Home assessment (? District Nurse)

Writing Task:

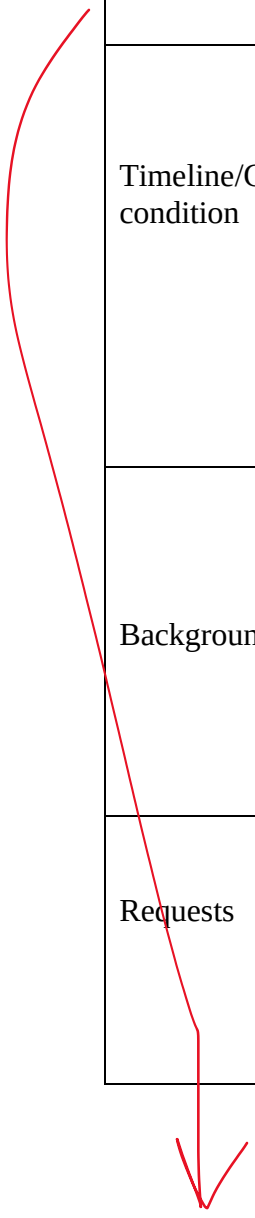
Using the information given in the case notes, write a letter of referral to the orthopaedic surgeon, Dr Bronwyn Clarke. Address the letter to: Dr Bronwyn Clarke, Orthopaedic Surgeon, Orthopaedic Department, Main Hospital, Greenville.

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.

Introduction	• Assessment & management [Purpose]
Timeline/Current condition	• **2006 start of condition here? Here or background?** Today: • 6 wk history of bilateral knee joint pain • 4 wk history: lump of back of the know • Restricted mobility • Mild/moderate persistent pain • MRI: degeneration consistent with OA • **Please note: Glucosamine? Here or background?**
Background	• Widow • Lives alone • Isolated • Confined to 2-storey house • Increase in depressive symptoms • Lumber laminectomy • Bi lateral hip replacement
Requests	• Assessment & management • Potential steroid injection • Note: referral to physio (writer will do this) • Note: consider LAH assessment (writer will do this)



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