OET

Graded Writing Samples

This booklet of graded samples is to assist you to feel more confident about what the assessors are looking for when scoring your writing. The samples were all provided by real candidates, who were completing sample test 5 from the OET website for the first time and without access to the sample answer.

Here are some ways you can use this booklet:

1.

Before you read any further, close the booklet and write the letter for sample test 5 for your profession. Then, as you start reading the different letters and assessor comments, you can try to decide where yours fits using these questions:

- Is your letter stronger or weaker than each letter submitted for your profession?
- Do the strengths and weaknesses mentioned in the assessor comments match your letter?
- Which criteria might you need to improve?

2.

Focus on each assessment criterion in turn. Read the relevant sections that cover this criterion in all the letters for your profession and the assessor comments. Can you understand what has impacted the positive comments?

3.

Read the letter that is at the grade you are aiming for in your test. What has this letter done differently to what you usually write in your letters? Use the assessor comments for this letter as a checklist of things you can try to include in your next letter OR rewrite your letter for this sample test, trying to match all of the things the assessor praised.

4.

Learn from the other OET professions. While you may be less familiar with the healthcare scenarios the other healthcare professionals were writing about, you can still learn from how they covered the Purpose, Genre & Style, Organisation & Layout and Language assessment criteria.

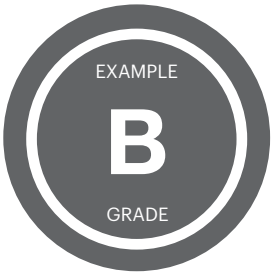
5.

Compare the letters in the booklet, your letter and the sample letter for sample test 5. Notice how all the letters are slightly different and particularly how the best letter in the booklet might be different from the sample letter but still have received a high grade. The assessors are not trying to match your letter to the sample letter. There isn't one perfect way to write a letter that receives a high grade. Instead, a letter will receive a high grade if it meets the assessment criteria at the right bands. (Test-takers securing grade B will have achieved scores of 2 out of 3 for Purpose and 5 out of 7 for the remaining criteria.)

Remember, the assessor comments are for this individual letter. The decisions the candidates made were based on this set of case notes. Success in OET Writing comes from demonstrating good understanding of the case notes you are working with and writing a letter that is personalised to this particular patient and situation. You should not see these letters as templates that can be learned and repeated in your test. While they might contain good examples of language and organisation, OET assessors can tell when candidates are repeating learned templates because the letter is not a good match for the case notes.

Dentistry
Graded Writing Sample

View: Case notes



Dr Deborah Moon
Endodontist
Newton Dentistry Hospital
60 Bay Street
Newtown

15 May 2020

Dear Dr Moon,

Re: Mr Viktor Ivanov DOB: 26/5/1979

I am writing to refer Mr Ivanov, how has reinfection of canal system and periapical abscess of his 26 tooth. Your further management, including endodontic retreatment and placement of a crown are highly appreciated.

Mr Ivanov drinks approximately 3 units of alcohol a week, but does not smoke. He has no known allergies. He has missed 14, 25, 27, 28, 38, 46 and 48 teeth, and has restored 45 and 26 teeth.

At first Mr Ivanov presented on 12 January 2020, complaining of a pain at his left upper quadrant. On examination, his pain was at 26 tooth, which was tender on palpation, and contains a 4mm pocket distally. Therefor, he was advised for root canal therapy, for which he agreed.

During Mr Ivanov's next visits on 22 and 29 January 2020, a rubber ram was placed, and an abscess with three canals were irrigated and dried, and finally gutta-percha and AH26 along with vertical and lateral condensation were performed. His radiograph showed a restored abscess cavity. He was advised for full coverage porcelain. Therefore, an appointment was booked for him. But he has cancelled his next appointments for the porcelain coverage in two occasions.

Today, Mr Ivanov presented complaining of a pain at the same tooth. On examination, a draining buccal sinus was found and his radiograph showed a periapical abscess at his 26 tooth.

Based on the above, I believe Mr Ivanov has a reinfected canal cyst of his 26 tooth. Your further management would be highly appreciated.

Should you require any further information, please do not hesitate to contact me.

Yours sincerely,

Doctor,

Dentistry
Graded Writing Sample

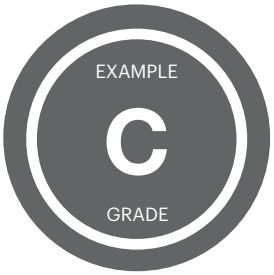
Assessor comments:

This candidate has produced a very well-rounded response with an immediately apparent and clear purpose. The layout is appropriate, and the organisation of each paragraph is written in a logical sequence showing the timeline of dental presentations. Content is appropriate and clear to the reader with all aspects of the patient's dental treatment and request for further treatment included. Conciseness and clarity are marginally affected with the inclusion of the social history and habits of the patient, which is somewhat unnecessary, however this does not distract from the overall clarity of the response. Genre and style are written appropriate to the discipline and reader with technical language used effectively from the dentist to the endodontist, despite the possible confusion in signing the letter as 'doctor'. Language features contain errors, in particular tense and word choices, however this does not interfere with the meaning. The word count of the response is significantly overlength in accordance with task instructions.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Nursing
Graded Writing Sample 1

View: Case notes



The Head Nurse
Ms Jane Gold
Primrose Nursing Home
3 Blackwood Street, Oldtown.

15/05/2021

Dear Ms Gold,

RE: Mr George Gale, DOB: 24/04/1936

I am writing to refer Mr Gale, an 85 year old retiree who was managed at Oldtown hospital for Urinary tract infection. He is due for discharge and he would need temporary home care assistance.

Mr Gale was admitted on the 10th May, 2021 after he fell while brushing his teeth at home. On observation, he appeared confused and disoriented. His vital signs on admission were; temperature 38.1®C, blood pressure 155/80mm of Hg, pulse rate 86b/m and heart rate of 26c/m. He had episode of vomiting, palpitation and dysuria 2 weeks before he fell.

A diagnosis of urinary tract infection was made and he was treated with antibiotics and antipyrexia. He is presently on paracetamol 100mg 4 times daily for osteoarthritis management and Felodipine 5mg daily for blood pressure control.

Mr Gale is a widower and he lives alone on level 2 flat at number 14 Long Street, Oldtown. His son lives abroad but he socialize well with his neighbor.

He would need assistance on assessment for independent living, encouragement to increase daily physical activities to more than 30 minutes. He should be observed for dysuria, vomiting and palpitation.

I would like you to contact me if you need further information.

Yours sincerely,

Charge Nurse

Oldtown Hospital

Nursing
Graded Writing Sample 1

Assessor comments:

This candidate has generally understood the task in terms of correctly addressing the patient's medical condition and has provided an appropriate outline of their history, current situation, and recommendations. However, there were obvious misunderstandings and omissions, for example, 'care home' for 'home care' in the opening paragraph. The content contained the main points with accurate information on the patient's admission condition, treatment, and medication, however the concerns surrounding his continued episodes of confusion (from his UTI) and the links between these and the need for an independent living assessment, were omitted. Genre and style are suitable to the reader and appropriate choice of polite language is evident, with some minor inconsistencies noted. The layout is standard for the task and the organisation is generally clear at a whole text level, although paragraphs could have been more clearly introduced. Language features are generally accurate with minor inaccuracies with subject-verb agreement, word order and articles. Word count is appropriate to task instructions.

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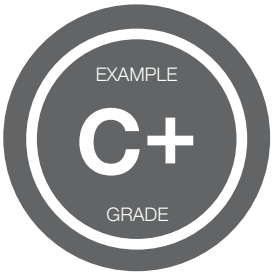
Nursing
Graded Writing Sample 2

View: Case notes



Ms. Jane Gold
Head Nurse
Primrose Nursing Home
3 Blockwood Street, Oldtown

15 May 2021

Dear Nurse,

RE: Mr. George Gale, DOB: 24 April 1936

I am writing to inform you on the status of Mr. George Gale who is recovering from urinary tract infection maybe due to fall and being discharged today into your care. He is presently in need of nursing home care temporarily.

On 10 of May, Mr. Gale presented to us confused and disoriented after falling incident at home due to weak legs while brushing his teeth. He found sprawled on floor for 5 hour by his neighbour that prompted to call for an ambulance. Apart from this, he was febrile with elevated blood pressure, respiratory rate. White blood cells was also elevated. He was then given IV antibiotic amoxicillin 750mg 3 times daily.

Mr. Gale has had osteoarthritis since 2003 and has been hypertensive since 2009, which he takes Felodopine 1 tablet daily and paracetamol 500mg 2 tablets 4 times daily. At home his alone in his own flat with no home help and family nearby.

In view on the above, Mr. Gale is keen to return home however, he needs to be monitored and assessed regularly as he has still episodes of confusion and has decreased mobilization. Please encourage recreation to increase physical activity for Mr. Gale.

I am available whenever you need further information for Mr. Gale.

Yours sincerely,

Dinah Gomez
Nurse
Oldtown Hospital

Nursing
Graded Writing Sample 2

Assessor comments:

This candidate has generally understood the task well and has provided an apparent purpose despite the inaccurate use of tentative language which causes a slight distraction. The response includes overall relevant history, appropriate timeline and accurate medical condition, and concerns and recommendations are mostly addressed. Irrelevant information is included concerning details surrounding the fall, however this does not distract from the key information. The reasons for temporary care in the nursing home are also made reasonably clear, although 'independent living assessment' has been referred to as 'monitored and assessed regularly'. Genre and style are suitable to the reader and appropriate choice of polite language is evident, with some minor inconsistencies, noted. The layout is standard for the task and the organisation is generally appropriate and logical. Language features, however, show inaccuracies and inconsistencies particularly in complex sentence structures. Errors in tenses and preposition choices are particularly evident. Word count is appropriate to task instructions.

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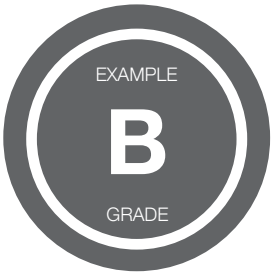
Nursing
Graded Writing Sample 3

View: Case notes



15 MAY 2021

Ms Jane Gold
Head Nurse
Primrose Nursing Home
3 Black Wood Street, Old Town

Dear Ms Gold,

Re: Mr George Gale, aged 85

Thank you for accepting Mr Gale in to your care, who is recuperating from a urinary tract infection. He requires temporary care and management at your service. He is being discharged today.

Mr Gale was brought to the hospital on 10th May 2021 due to a fall at home. He was confused, disoriented and his vital parameters were elevated. The urinalysis indicated high infection which was managed with Amoxicillin 750 mg intravenously. He reported a similar episode two weeks before along with vomiting, palpitation and dysuria.

Currently, Mr Gale has made good progress. However, he is still in a confused stage therefore, requires independent living assessment before transferring back home. Also, he has difficulty in mobilizing, for which he needs at least 30 minutes of daily physical activity.

Mr Gale has osteoarthritis since 2003 and hypertension since 2009, which are controlled with paracetamol 500 mg four times a day and Felodipine 5 mg daily. In addition, he has non-specific colitis, which is being regularly monitored.

M. Gale is a retired retail manager, who lives alone in his own flat. He is a social drinker and smoker.

Please provide him necessary management to achieve the optimum level of self-care before he returns home.

If u have any queries, please do not hesitate to contact me.

Yours sincerely,
Registered nurse.

Nursing
Graded Writing Sample 3

Assessor comments:

This candidate has produced a well-rounded response with the purpose immediately apparent despite failing to mention the fall. Content is appropriate and clear to the reader, with most aspects of key information included and the concerns and recommendations accurately represented. Although, it is noted that the candidate has failed to mention the link between the fall and the UTI diagnosis. The layout is appropriate with clear distinctions between paragraphs. However, the organisation of information could have been better displayed with post -fall care requests summarised at the end of the letter instead of introducing social information. Language features are accurately represented throughout, although paragraphs could have been better introduced with more diversity of language instead of starting with 'Mr Gale...' for the majority. Genre and style are mostly written well despite the slip from formal language to slang, 'If u have any queries...'. Word count is appropriate to task instructions.

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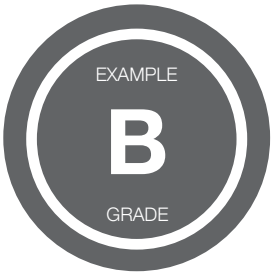
Nursing
Graded Writing Sample 4

View: Case notes



15 May 2021

Ms Jane Gold
Head Nurse
Primrose Nursing Home
3 Blackwood Street, Oldtown.

Re: Mr. George Gale, 85 years old

Dear Ms. Gold,

I am discharging into your care Mr George Gale who was admitted to our hospital on 10 May 2021 after a fall at home. He will temporarily need further care in your nursing home.

Mr Gale has been diagnosed with osteoarthritis in 2003 and hypertension in 2009, for which he takes Paracetamol and Felodopine, respectively. In 2013, he was diagnosed with GORD which he treats with antacid tablets. He was also diagnosed in 2019 with non-specific colitis which is undergoing monitoring and with no required treatment.

On 9 May 2021, Mr Gale had a fall while brushing his teeth, however, an ambulance was called only the following day after neighbors heard calls for help. 2 weeks before the fall, Mr Gale had vomited once, felt palpitations, and had dysuria. Upon admission, he had a high fever, elevated blood pressure and respiratory rate aside from being confused and disoriented. He was diagnosed with UTI which is the probable cause of the fall.

After treatment with antibiotics, he was observed to have neither dizziness nor palpitations, and his vital signs have been noted as normal. He is now ready for discharge. Although he is keen to return to his own home, he is to be discharged to your nursing home as he lives alone without home help.

Due to his significantly lowered mobility, Mr Gale is encouraged to have 30 minutes per day of physical activity. He still presents with episodes of confusion so assessment for independent living is recommended.

Thank you for receiving Mr Gale. If there is any questions or concerns regarding his care, feel free to contact me at Oldtown Hospital.

Sincerely,

Nurse

Nursing
Graded Writing Sample 4

Assessor comments:

Overall, this candidate produces a very well-rounded response, however the word count of the response is significantly overlength in accordance with task instructions. The purpose is immediately apparent with organisation of each paragraph written in a logical sequence. Content is appropriate and clear to the reader, with all relevant aspects of key information included. For example, the response clearly links the patient's condition to the UTI diagnosis, and outlines the patient's history, medications, concerns, recommendations, and post discharge care requirements. Previous medical history is slightly lengthy including somewhat irrelevant information, however this does not distract from the overall clarity of the response. The response is well laid out and polite language is used appropriately. Language features are presented well and linking expressions are used accurately. Only minor grammar slips occur and these do not interfere with meaning.

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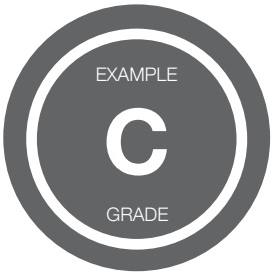
Medicine
Graded Writing Sample 1

View: Case notes

15/5/2021



Re: Ms Bennet Eleanor, 45 years old female.

Dear Dr James Banerjee

Consultant cardiologist

Sanditon City hospital.

I'm writing to you to consult about Ms Bennet Eleanor for helping us to re-review her medication and to find a away to encourage lifestyle changes.

Ms Bennet is a divorced ~~and~~ mother of two children, live a stressful life as lawyer and worries about the quality of father's childcare. Since the last three years she have changed her lifestyle by increasing the alcohol intake and smoking 20 cigarets/day . She is overweight – BMI 29 and almost one exercise per month. It's important to mention that her father died at younger age – 53 due to heat disease.

Before 3 month ago, she had suffered from heart attack after long flight, she underwent emergency defibrillator application and hospitalized at Oakville General Hospital for ballon-expandable stent that been applied via groin. Discharged home with further treatment with captopril 50mg twice/day, atorvastatin 80mg~~/~~daily, and counseling for lifestyle changes.

We also tried to refer her to cardiac rehabilitation sessions but she is not compliance.

At her visit today she is stressful from the side effect of captopril her report's including dizziness, light-headendness, headaches, diarrhea. And she requests captopril discontinuation and reluctant to start new medication.

Please I ask for you'r advice about my patient situation to encourage lifestyle changes, and also please to re-review her medication. Please if you need any further question don't hesitate to contact me

Best regards

GP doctor

Oakville General Hospital

Medicine
Graded Writing Sample 1

Assessor comments:

The candidate generally shows good understanding of the task and provides some sense of purpose initially, although it is then difficult to discover the context of these requests, e.g., medication side-effects. These details are given later in the response, and most of the key details needed to understand the case and continuing care are included and accurate. However, the timeline is somewhat blurred, with 'Before 3 months ago' being the only indication of the time progression of the case; when discharge occurred and the medication was commenced is not clear. The frequency of exercise given is not quite correct, but this is a minor detail. The inclusion of less relevant social details makes the summary slightly long. The professional phrasing used is not always appropriate, with minor inconsistencies noted, e.g., 'I'm writing to you to consult about'. There is a sense of limited familiarity with this aspect because of repetition of basic techniques to request politely. The text is arranged well into logical paragraphs but key details such as the heart attack and side-effects are not highlighted as important. The order of the layout features is non-standard; the reference line (Re:Ms Bennet Eleanor, (45 years old female)* is incorrectly placed before the salutation, which appears to have been absorbed into the address ('Dear Dr James Banerjee, Consultant cardiologist'). Lapses in language accuracy are frequent and cause minor strain. * the patient's name, written title first name surname, and date of birth are the two standard inclusions for this line.

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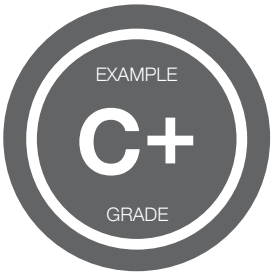
Medicine
Graded Writing Sample 2

View: Case notes



Dr James Banerjee
Consultant Cardiologist
Sanditon City Hospital, Sanditon

Thank you for agreeing to see my patient, Ms Eleanor Bennet. She is a pleasant 45yo commercial lawyer from Oakville. She is divorced with two daughters aged 16 and 18 who are living mainly with their father (custody battle with father contributing to Ms Bennet's stress). Family history includes father who died at 53yo with heart disease and brother with significant mental health problems.

She sustained an MI after a flight on 08-02-2021. She was revived with a defibrillator, and transferred to the ER at OGH. A balloon stent was carried out, she was discharged a week later. Her mother moved in to be her caregiver.

Ms Bennet was discharged on the attached medications and given a referral for cardiac rehab for which she has yet to attend.

Recently, she was seen in my clinic with increased side effects from captopril (dizziness, light-headedness, headaches, diarrhea).
She has increased her alcohol intake and smokes two PPD. She does not have an active lifestyle despite many counselling sessions about this.
I am hopeful you can help find a suitable medication regime and reinforce the benefits and necessities of lifestyle changes.

Sincereley,
Dr Jones

Medicine
Graded Writing Sample 2

Assessor comments:

The candidate begins without an immediate purpose, although it is clear by the final sentence. Insufficient and inaccurate coverage of key case details is noted. For instance, the lifestyle risk factors needed more detail, with no mention of being overweight, or how much alcohol is consumed, and 20 cigarettes/day is given as '20 PPD'. Today's appointment is presented as 'recently' and no date is included at the top of the response either. In addition, as the focus of the case is related to medications, it would be useful to provide the dosage details. Some irrelevance is seen in the opening paragraph, but otherwise it is a clear summary. Polite genre-appropriate language is used, and it is clinical and factual, apart from 'pleasant'. The organisation of information is not always logical, as the paragraphing can be disjointed at times, e.g., the discharge details are separated, as are the lifestyle factors. The lack of a salutation or date also impacts the layout score. A wide range of vocabulary is noted, and highly accurate language structures are used well to present the case.

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Medicine
Graded Writing Sample 3

View: Case notes

15 May 2021

EXAMPLE
B
GRADE

Dr James Banerjee
Consultant Cardiologist
Sanditon City Hospital
Sanditon

Dear Dr Banerjee,

Re: Ms Eleanor Bennet, 45 years old

Thank you for providing care to my patient, 45-year old Ms Bennet, who is having difficulties adhering to treatment post hospitalisation for myocardial infarction.

Ms Bennet was discharged a month ago from Oakville General Hospital after the event on 8 February. She was at the airport at the time of incidence and had just arrived from her flight when she started experiencing shortness of breath, nausea and pain in her jaw. An available defibrillator was applied by a first-aider and she was then rushed to the emergency (Oakville General Hospital). By intervention she had a ballon-expandable stent fixed. Please note that the stent had been inserted via her groin due to small sized arteries in her arm.

She got discharged following a week on admission on medications captopril 50mg twice daily and atorvastatin 80mg daily. Moreover, she was advised on lifestyle changes and had been referred appropriately for cardiac rehabilitation. Currently she is stable, however, complains of experiencing side effects from taking captopril and wishes to discontinue as she is stressed. Even though, drug alternatives were discussed she seems adamant. Also, she has not yet started cardiac rehabilitation.

Since 2019, Ms Bennet has increased her alcohol consumption from 10 to 40 units and smokes a pack a day, thus I am concerned that she is still at risk. She is sedentary and has a BMI of 29. Additionally, there is a family history of heart disease.

I would highly appreciate it if you could assist in reviewing her medications and recommend ways to encourage lifestyle changes as part of her ongoing care.

Yours sincerely,

Doctor.

Medicine
Graded Writing Sample 3

Assessor comments:

This candidate presents purpose but this would have been even clearer had the more specific concerns related to the medication side-effects been presented initially. The key points are generally accurately represented, however the specific side-effects experienced by the patient in today's appointment would have added to the reader's understanding of the case, and there is a misrepresentation in the timeline, as the patient was discharged after a week, the 15th February, not 'a month ago'. The inclusion of some less critical detail relating to the heart attack makes this response notably overlength, despite good judgement in the omission of irrelevant detail in her social history. Appropriate choice of professional and polite language is seen, with some minor inconsistencies noted. The layout is standard for the task. The organisation is generally clear at the whole text level, however a lack of clarity in the third paragraph leads to some confusion. Inaccuracies are noted at times, particularly in tense choices and collocations, but meaning generally remains clear.

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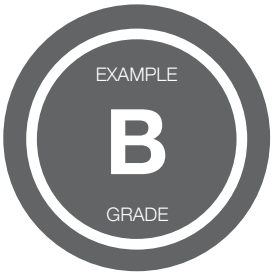
Medicine
Graded Writing Sample 4

View: Case notes



Dr James Banerjee,

Consultant cardiologist,

Sanditon City Hospital, Sanditon

15.05.2021

Dear Dr Banerjee,

Re: Mrs Eleanor Bennet, DOB 16.12.1975

Thank you for seeing Mrs Eleanor Bennet, who had a recent heart attack, for specialist assessment and review of her medication.

Mrs Bennet suffered a heart attack on 8.02.2021, for which she was hospitalized and coronary artery stent was applied. After discharge she was prescribed Captopril 50mg b.d. and Atorvastatin 80mg q.d. and she was referred to cardiac rehabilitation sessions, to which she did not attend.

She visited me today, complaining of headache, light-headedness and intermittent diarrhoea, which she relates to Captopril administration.

Mrs Bennet has multiple cardiovascular risk factors: she smokes 20 cigarettes/day, is overweight and has a low level of physical activity. Also, she has a family history of heart disease. Moreover, she has been under a lot of stress in the last 3 years due to a complicated divorce, and she has increased her alcohol intake to 40 units/week.

Considering those above, I would be grateful for your specialist advice and a re-evaluation of her medication plan. Also, if you could encourage Mrs Bennet for some lifestyle changes, it would be much appreciated.

Should you have any queries, please do not hesitate to contact me.

Sincerely yours,

Doctor

Medicine
Graded Writing Sample 4

Assessor comments:

A clear and immediate purpose establishes the context for the letter and guides the intended reader through the case to the future needs. The response presents all key details accurately, despite not mentioning the date of discharge and commencement on medication, or that the patient had already been advised to improve her lifestyle. In addition, the increased level of stress noted at today's appointment is not included. The candidate has only selected the most relevant details which results in a very clear, concise summary. Professional polite language is appropriate for the intended reader throughout. The text has a layout standard for the task and is organised in a highly logical order, with clear links between and within paragraphs, making it easy to follow. The candidate has excellent control of a wide vocabulary and a range of language structures, with only minor inaccuracies in prepositions and missing articles noted.

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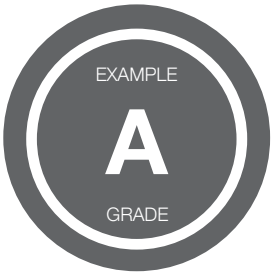
Medicine
Graded Writing Sample 5

View: Case notes



Dr James Banerjee

Consultant cardiologist

Sanditon City Hospital

Sanditon

15/05/2021

Dear Dr Banerjee,

Re: Ms Eleanor Bennet, DOB: 06/12/2021.

Thank you for seeing Ms Bennet, who has recently diagnosed with acute myocardial infarction. She requires a review of her cardiac medications and advice on lifestyle modification.

Ms Bennet is a commercial lawyer, who travels overseas frequently and has been in a stressful family situation. She has recently increased her alcohol consumption, smokes 20 cigarettes a day and rarely exercises. Her BMI is 29. Her family history is significant for heart disease and mental health problems.

On 08/02/2021, she was admitted to the Oakville General hospital due to an acute myocardial infarction after a long-haul flight, for which she underwent urgent balloon-expandable stenting and has been recommended on Captopril 50 mg twice a day and Atorvastatin 80 mg daily. She was also referred for a cardiac rehabilitation clinic which she did not attend and given advice on lifestyle changes. She reports an increase in her stress level despite extra help from her mother.

On 15/05/2021, Ms Bennet presented with symptoms of Captopril-related side effects, including dizziness, headache and diarrhoea, and requests for discontinuation of the medication. She is also reluctant to start new medications.

It would be appreciated if you could review her medication and encourage her lifestyle changes.

Please do not hesitate to contact me if you have any questions.

Yours sincerely,

Doctor

Medicine
Graded Writing Sample 5

Assessor comments:

This candidate presents a clear and immediate purpose, showing good comprehension by giving the context of the recent acute myocardial infarction, as well as both requests for the intended reader. The key details of the case notes are mostly covered well and accurately, with some minor exceptions. For instance, the number of units of alcohol weekly and the date of discharge and commencement on medication are omitted. Excellent selection of case note details allows the reader's focus to remain on the main points in this clear summary. Excellent familiarity with genre is demonstrated, and polite formal language is used well. The text has a layout standard for the task and the information is arranged clearly and logically at a whole-text level. However, the third paragraph is slightly disjointed, where the increased stress detail is added without any clear connection to the previous information. Language is mostly accurate and clear, with only minor lapses with prepositions, tenses, and word choice, e.g., 'has been recommended on Catopril' instead of 'commenced on'.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Occupational Therapy
Graded Writing Sample

View: Case notes

EXAMPLE
C
GRADE

Dr Noah Andrews
Greenhills Medical Centre,
99 Major Street,
Greenhills

15 May 2021

Dear Dr Andrews,

Re: Mr Arthur Jamieson (visited 15/05/2021)

I have done a home assessment with Mr Arthur Jamieson today. The following are the assessment and recommendations.

A discussion had conducted with Mr Arthur Jamieson. He is considering about moving into a aged home care for more care and company. He has difficulty to communicate with ~~unfamiliar~~ unfamiliar people due to dysarthria. He claimed that he is lonely since wife passed and he is bored, he spends most of the time watching television. He does not have ~~a~~ sufficient social support. He has a personal alarm from his son due to increase of falls incident recently. This is caused by ~~inc~~ difficulty in mobilising. He also needs assistance in self care tasks such as grooming and hygiene as well as showering. However, he is showed by his son once per week, his hair is not brushed daily. ~~Although~~ Daughter-in-law does all the laundry and delivers meals ~~only~~ every second day. Supervision or assistance is not provided while eating. He has increased incidents of choking recently and he is also underweight. He has grandchilden but they visit occasionally and do not provide any support.

Mr Arthur Jamieson is glad that he used to eat a lot last time, when he was young. He was a member of social club but he has lost touch with them. He is now ~~having~~ a passionate supporter of his football team.

Occupational Therapy
Graded Writing Sample

View: Case notes

EXAMPLE
C
GRADE

Mr Arthur Jamieson wants to move into an aged care home but strongly opposed by his son. I am planning to have a family meeting with his son and daughter-in-law, mainly to advocate on Mr Arthur Jamieson's behalf and support his choice. I ~~recommend~~ ~~would~~ will recommend them to conduct a mobility assessment to assess the need of a electric wheelchair. Others appropriate adaptive aids will be assessed and recommended as well.

I suggest a review in six weeks and to determine for further intervention needed. Please contact me if you require further information.

Your sincerely,

Occupational Therapist

Occupational Therapy
Graded Writing Sample

Assessor comments:

This candidate presents a clear initial purpose, helping prepare the intended reader for what is to follow, and ends with the expansion of what is to happen next. There is some slight ambiguity of who is to conduct the mobility assessment, and some misrepresentation about what he used to eat, but otherwise the key details are outlined accurately. This is a very overlength response at around 300 words, which has an impact on the score awarded. The social details included are irrelevant to the patient's GP, the other sections of the letter should have been condensed better to fall within the prescribed word limit, and some repetition of detail is unhelpful. The use of appropriately formal and polite language is done well, other than the omitted 's' in 'Your sincerely'. The letter has standard layout and some organisation of information into paragraphs, although they are rather overloaded at times, resulting in momentary confusion for the reader. Language features are generally accurate, and errors do not cause significant strain, or interfere with meaning.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Optometry
Graded Writing Sample

View: Case notes

EXAMPLE
B
GRADE

Dr Sandra Chung

Ophthalmologist

Westbourne Eye and Ear Hospital

555 Mani Street

Central Coat

15 May 2021

Dear Dr Sandra Chung

Re: Ms Teresa Mendora

DOB: 18 Feb 1965

Thank you for seeing Ms Teresa Mendora, a 56-year-old domestic cleaner, who presented to me with recent episodes of transient loss of vision in her left eye. In view of her background history, my provisional diagnosis is retinal transient ischemic attacks (TIAs) with possible source of embolism from left carotid, which needs urgent assessment and confirmation.

Ms Teresa Mendora is known case of hypertension and hyperlipidemia which is under daily dose of 50 mg atenolol and 10 mg simvastatin, respectively. Her complain is recent onset episodic and painless transient vision loss in left eye, lasting for 2-3 hours which happened three-times over last month. However, it resolves each time without intervention and consequent reduction in her vision.

On today's examination, her both eyes' visual acuity, colour vision, and IOP are within normal range. External examination, eye movements, and anterior segment examination of both eyes are normal. However, dilated fundus examination revealed hypertensive retinopathy in both eyes, along with two retinal anterior cholesterol emboli, inferior to macular region on her left eye.

Considering her medical background, evidence of carotid bruit, and her fundus examination my provisional diagnosis is TIAs with possible source of embolism from her left carotid due to narrowing or blockage. It would be grateful if you could see Ms Teresa Mendora for confirmation of diagnosis and urgent assessment for cardio-vascular predisposing risk factor.

Your Sincerely

Optometrist

Optometry
Graded Writing Sample

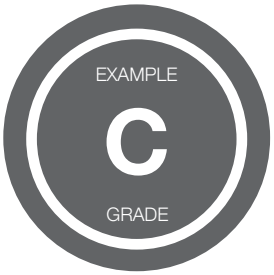
Assessor comments:

This candidate's response is of a high level with all aspects of the letter producing accurate and clear information and awareness of the purpose and audience. Only minor inaccuracies in language features and slight omissions of content (medical and family history incomplete) are evident, however this does not distract from the overall well-rounded response. Conciseness and clarity are slightly affected by the inclusion of the lengthy examination results that were found within normal range, however this does not distract from the overall clarity of the response. Organisation of paragraphs and layout is appropriate, logical and clear and the urgency of requesting further investigation (to confirm the diagnosis and request cardio-vascular assessment) and management is stated at the beginning and end of the response. The final concluding sentence could have been represented with its own paragraph for a smoother ending to the response. Professional and polite language is used appropriately throughout, with clinical and factual writing applicable to genre and reader. The response is notably overlength in accordance with task instructions.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Pharmacy
Graded Writing Sample 1

View: Case notes



Dr. Jo Smythe

150 Station Street Newtown

15 May 2021

Dear Dr. Jo Smythe,

Re: Ms. Sarah King (DOB: 09/06/1979)

I am writing you to discuss medication of Ms. Sarah King: a working lady having 2 daughters, who came to my pharmacy with complaints of sleeping disorder. She has history of SLE for which she was taking indometacin and hydroxychloroquine sulfate since childhood; cyclophosphamide and prednisolone prescribed since 2020. Initially dose of prednisolone was 7.5mg per day which was gradually increased to 35mg per day.

One week ago Ms. Sarah came with complaints of sleep problems, fatigue, stress, headaches and joint pain. She discussed about side effects of steroids she was taking for the treatment. She worried that long term use of steroids may cause serious side effects. I dispensed prednisolone and explained her benefits of steroid treatment and suggested to take rest to avoid prednisolone side effects.

After a day she decided to decrease prednisolone dose from 35mg/day to 5mg/day, on her own. Her plan was to stop taking prednisolone without her GP advice. She started taking sleeping tablets.

She had an appointment with doctor on 13 May 2021; she complaints about increase frustration, fatigue, trouble in sleeping are mood swings.

Today, she requested me to dispense sleeping tablets. I refused to do so and explained her about the side effects of suddenly stopping and started prednisolone. I offered to write you about her medication assessment.

Please feel free to contact me if you have any questions.

Yours Sincerely,

Pharmacist

Pharmacy
Graded Writing Sample 1

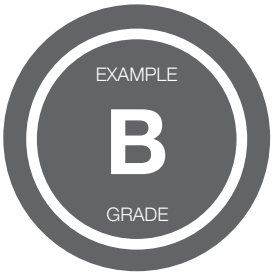
Assessor comments:

This candidate has generally understood the patient's medical situation, however it is not clear that the candidate has understood who the letter is for. The pharmacist is writing to the patient's doctor, but a substantial amount of information in the letter is already known by the doctor, and the doctor is referred to in the third person. Although the content includes the patient's medical request for sleeping tablets and information surrounding the circumstances behind the patient-led reduction in prednisolone, it fails to mention the recommendation to be reviewed by the patient's rheumatologist. Genre and style are generally appropriate, as is the layout. Organisation and paragraphing are not always logical with the patient's medical history stated in the opening paragraph instead of a clear purpose. Language features, particularly vocabulary, are generally accurately presented, however there is an absence of prepositions and articles at times. The word count of the response is notably overlength in accordance with task instructions.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Pharmacy
Graded Writing Sample 2

View: Case notes



15 May 2021

Dr Jo Smythe

Newtown Medical Clinic

150 Station Street

Newtown

Dear Dr Smythe,

Re: Ms Sarah King; D.O.B – 09 June 1979

I am writing out of concern for Ms Sarah King, who requires a referral for comprehensive medication assessment from her rheumatologist and further advice and support from your end.

On 8 May 2021, Ms King visited the pharmacy to refill her script for SLE flare-up due to increased stress. She has been advised on the importance of rest, moderate exercise and to take time off work.

Today, she presented for an over-the-counter sleeping tablet. On discussion, she complained of increased frustration and fatigue, trouble sleeping and exhausted during day, moody and irritable and also, short-tempered with children. In addition, she admits that she is anxious regarding long term steroid use. She was advised to stay on steroid by her doctor, however, she decreased the dose of prednisolone to 5 mg/day without the doctor's awareness and plan to cease prednisolone and start sleeping tablet.

It was explained that sleeping problem may be due to long-term high dose prednisolone and sleeping tablets are not effective in such cases and therefore, sleeping tablets were not dispensed. Apart from this, advised her sudden stoppage or restarting of prednisolone can cause serious side effects.

In view of the above, it would be highly appreciated if you could provide referral to her rheumatologist regarding comprehensive medication assessment.

If you have any queries, please don't hesitate to contact me.

Yours sincerely,

Pharmacist

Pharmacy
Graded Writing Sample 2

Assessor comments:

Overall, this candidate has produced a well-presented response with a clear and accurate purpose. Key information is generally accurately represented with a logical timeline. The pharmacist's concerns regarding the patient-led reduction in prednisolone is well explained along with the patient's concerns and side effects although the candidate does not seem clear that the reader is the patient's doctor. Despite this, genre and style are suitable to the reader and appropriate choice of polite language is evident. Paragraphing and organisation are generally well laid out, although in paragraph 3 there is a slight loss of control which needs a clearer structuring of ideas. A final recommendation is clearly summed up at the end, despite its repetitiveness with the opening paragraph. Language features produce consistent verb errors in simple and complex structures which can cause some confusion, however these inaccuracies in language generally do not interfere with meaning. The word count of the response is notably overlength in accordance with task instructions.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Physiotherapy
Graded Writing Sample 1

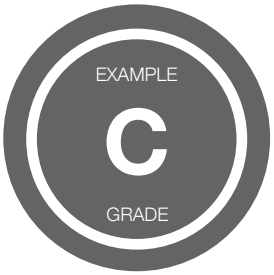
View: Case notes

Dr Sara Rahimian

Stillwater Private Practice

124 Main Street

Still water



15 May 2021

Dear Dr Rahimian,

Re: Mrs Doris Abrams (aged – 35 years)

I am writing to request further investigation for Mrs Abrams, who I suspected diagnosis is Rheumatoid Arthritis.

Today, Mrs Abrams complained of dull pain in her fingers and feet. She has been experiencing more than one hour of morning stiffness as well as sleeping disturbance. However, she could not recall any apparent reasons yet to take any medication. In addition, Mrs Abrams reported unusual fatigue, decreasing appetite and weight loss. On examination, Mrs Abrams's hands and feet presented signs of inflammation (heat and red). Her pain was aggravated by resisted handgrip test. Gait analysis also showed walking difficulty.

Previously visit on 3/1/21, Mrs Abrams believed that her right wrist pain had occurred from a netball game, given that the symptoms were very similar compared to the current one. Due to Mrs Abrams has a strong family history of Rheumatoid Arthritis, I highly recommend seeking advice from you. Further education and management will be conducted afterwards.

It would be appreciated if you could investigate her case to confirm the diagnosis. Should you require any further information, please do not hesitate to contact me.

Yours Sincerely,

Physiotherapist

Physiotherapy
Graded Writing Sample 1

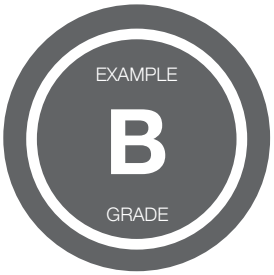
Assessor comments:

This candidate does provide a clear initial purpose of requesting further investigation for suspected RA, but expansion of that, specifically the blood tests and X-rays, is missing in the final paragraph. Much of the case is covered, however the key details missing from the section on future needs as well as the inaccurate inclusion of (embellished) medication and previous wrist sprain and further management details not in the case notes, have an impact on this score. The summary does correctly omit some less important detail. Genre-appropriate language for writing to a health care professional is used well. Layout is standard for the task but connections within paragraphs can be unclear at times. Language is not always accurate, but the errors do not interfere with the intended meaning.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Physiotherapy
Graded Writing Sample 2

View: Case notes



Dr.Sara Rahimian
Stilwater Private Clinic
124 Mainstreet, Stilwater

15 May 2021

Re:Mrs.Doris Abrams,35 years old

Dear Dr.Sara,

I am writing this letter about Mrs.Abram who was suspected to have a diagnosis of RA on fingers and feet and requesting for your further investigation.

Mrs.Abram is working as a fulltime magazine editor and plays netball everyweek.She has a Family history of RA on her maternal uncle and grandfather.Her present complain includes dull aching pain on fingers and feet which is not related to activity and varies in prensetation.Mrs Abram has difficulty sleeping at night secondary to pain and felt tiredness which is unusual to her.she also notice a decrease of appetite associated with 2kg weight loss from 55kg.

Upon examination, the joints of her hands and feet were warm to touch and redness was observed.She felt hand pain upon resisted grip testing.In addition, ambulation with bare feet was compromised by discomfort.

Mrs.Abram is concern about her family history and possible RA risk. It was discussed to have an appointment with a GP and return to physiotherapy for further information and treatment once diagnosed with RA.

It would be appreciated if you could do further investigation on Mrs.Abram regarding her condition.If possible, blood test and X-ray if needed.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Vanessa Manicag
Physiotherapist

Physiotherapy
Graded Writing Sample 2

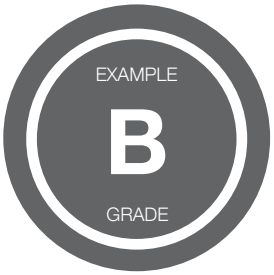
Assessor comments:

This response sets out an immediately clear and well-expanded purpose, with the suspected diagnosis and specific requests for confirming it. The case notes are presented accurately and cover the key details well, allowing the intended reader, the patient's GP, to understand the case to date. Some minor details are omitted, such as the morning stiffness and the suggestion to return to the physio for education should the diagnosis be confirmed. The unnecessary inclusion of some social detail does detract from the clarity and conciseness, as it can be assumed that the GP will already know this, but the past, less relevant wrist sprain history is correctly omitted. The politely formal language used is appropriate throughout the letter, as is the use of abbreviations such as RA, which would be familiar to a GP. The letter has standard layout and is well-organised at a whole-text level. The second paragraph is less well-arranged as it changes topics without skilful signposting. Slips and inconsistencies are noted at times in language features but meaning does remain intact.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Radiography
Graded Writing Sample

View: Case notes



Dr Leah Brown,
Newtown Medical Clinic
200 Main Street
Newtown

15 May 2021

Dear Dr. Brown,

Re: Mr. Max Smith, DOB: 21.06.1966

I am writing regarding our mutual patient, Mr. Smith, referred for a lumbar X-ray for his back pain today. Mr.Smith's examination was not performed due to poor justification, and I would like to explain the reason why we made this decision.

Mr. Smith confirmed he had previous X-rays for the same reason when I asked about his X-ray history before X-raying. Then I checked the records and realized he had done two complete same X-ray procedures ordered by his previous doctor in four months(01/01/2021 and 13/04/2021), but there was no pathology revealed in both times. Based on my investigation, I believe Mr.Smith's current X-ray was unnecessary and advised him to reaccess you to his previous results. However, Mr.Smith was unsure about my suggestion. Therefore, I consulted our radiologist, and he agreed the new request was unjustified.

I informed Mr. Smith his X-ray was canceled to avoid unnecessary radiation, and it will not be helpful to his back pain. Although Mr. Smith was unhappy with this decision, he eventually accepted my advice to revisit you and provide the precious images and reports.

I apologize for the inconvenience. If you require any further information, please do not hesitate to contact me.

Yours sincerely,

Radiographer

Radiography
Graded Writing Sample

Assessor comments:

This candidate has produced a well-represented response with a clear and accurate purpose. Key information is generally represented well with a logical timeline, despite some omissions of relevant content. For example, the candidate mentions the same procedure was requested but didn't highlight the fact that the current requisition did not ask for any additional views from the previous two X-rays. A recommendation to contact the previous doctor and the reasoning for it is clear, with the paragraphing and organisation well laid out. The length of the document is appropriate with the word count in accordance with task instructions. Information is mostly summarised effectively. Appropriate choice of polite language is evident, with some minor inconsistencies noted. Language features produce errors at times in complex structures, with wrong word choices and the absence of words such as subject pronouns and verbs. The repetition of the base word 'X-ray' is also noted in paragraph 2, which causes an uneven flow. These inaccuracies in language generally do not interfere with meaning.

**These comments were provided for this candidate's response to a particular set of case notes. Copying the language used in response to a different set of case notes will not produce the same scores and is strongly discouraged.*

Speech Pathology
Graded Writing Sample 1

View: Case notes

15 May 2021

EXAMPLE
B
GRADE

Mr. Noel O'Hara
Speech Pathologist
14 Red Hill Rise
Mountford

Re: Mr. Henry Macks
DOB: 16 Dec 1970

Dear Speech Pathologist

I am writing to inform you regarding Mr. Henry Macks. He is scheduled to relocate at Mountford and will be under your care. He is diagnosed with secondary progressive multiple sclerosis and shows signs of dysphagia and dysarthria. I am outlining his assessment results and my recommendations for his management plan.

Assessment results showed moderate dysarthria as characterized by deteriorating intelligibility due to fatigue, decreased facial sensation, oral and facial weakness, especially on the left side, and uncoordinated lingual movements. In terms of swallow, he was found to have uncoordinated chewing, decreased lingual motility, and poor bolus formation during the oral phase. During pharyngeal phase, decreased laryngeal excursion was evident. Laryngeal penetration was observed during thin fluids (water). He is suspected to have aspirated, but he was able to cough post-swallow. No signs of aspiration was seen during thickened liquids (orange juice). He is diagnosed with moderate oral and pharyngeal dysphagia.

Given the presentations above, I am recommending diet modification (pureed diet and thickened liquids), postural modification when eating, short intervals between small meals to prevent fatigue, environment modification (encourage quieter environments) to increase speech intelligibility, and techniques to maintain speech intelligibility. Moreover, I am humbly requesting a videofluoroscopic assessment to further investigate the presence of silent aspiration during swallow.

I am writing to provide details of Mr. Macks' assessment results and management recommendations. I hope the details are sufficient for your care. If you have any questions, please do not hesitate to contact me.

Sincerely,

Speech Therapist

Speech Pathology
Graded Writing Sample 1

Assessor comments:

This response has an immediately apparent purpose and is expanded well with recommendations. The case notes are presented accurately and would enable the intended reader to continue care. The summary is overlength, however, and some repetition is noted, especially in the final paragraph. Politely formal and professional language is used well throughout, apart from the overly formal adverb in 'I am humbly requesting'. Information in the text is logically grouped, with an opening purpose, then results of assessments, followed by future recommendations. The results paragraph is slightly too long and splitting it into swallowing detail and oro-motor detail may have aided the reader. Language is used fluently and accurately throughout, despite somewhat stilted or less natural phrasing in the initial two sentences, e.g., I am writing to inform you regarding...'

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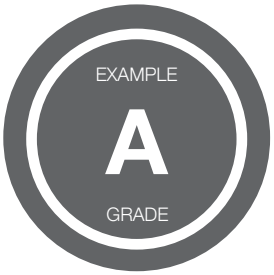
Speech Pathology
Graded Writing Sample 2

View: Case notes



Mr. Noel O' Hara
Speech Pathologist
14 Red Hill Rise
Mountford

15 May 2021

Dear Mr. O'Hara,

RE: Mr. Henry Macks
DOB: 16 Dec 1970

I am writing to refer Henry Macks for a continuation of speech therapy upon relocation to Mountford. He has a diagnosis of moderate oral and pharyngeal dysphagia and moderate dysarthria secondary to progressive multiple sclerosis.

Upon swallowing assessment, his oral mechanism revealed generalized weakness, which was more evident on the left, and decreased facial sensation. His tongue also exhibited slowed and uncoordinated movement. These resulted in decreased speech intelligibility especially when fatigued. Nonetheless he produced clearer speech in quieter environments.

In terms of swallowing, he presented chewing incoordination and decreased bolus formation due to lingual dysmotility in the oral phase. The pharyngeal on the other hand displayed a laryngeal excursion delay which is a sign of penetration. He may also have an aspiration to thin liquids, but not when thickened, due to the presence of coughing post-swallow.

I would greatly appreciate it if an intake of smooth, pureed diet and thickened fluids could be commenced. These should be taken with an adequate posture and with small frequent meals to address fatigue. I would also recommend a videofluoroscopic swallow assessment to rule out the possibility of silent aspiration. Lastly, compensatory strategies could be provided to maintain intelligible speech despite fatigue.

Yours sincerely,

Speech Pathologist

Speech Pathology
Graded Writing Sample 2

Assessor comments:

The candidate presents an immediately clear purpose which is then expanded in the final paragraph's recommendations for further treatment. The most important details of the case are outlined accurately, other than the initial incorrect 'swallowing assessment' which should have been an oro-motor exam. One detail that would have added to the clinical picture is when the MS was diagnosed, but nonetheless, it is a very clear and concise summary of complex and detailed case notes. Appropriately formal and polite professional phrases for a colleague are used throughout, and the lack of a polite closing phrase does not overly detract from the high level of reader-awareness. Organisation and layout are entirely appropriate, ensuring that the text is easy to follow. A wide vocabulary is demonstrated, as is a wide range of accurate language features.

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