



Introduction to the Writing Sub-Test

Monday 5th October 2026



Objective

- Gain a deeper understanding of the writing sub-test.
- What will the question and case notes look like?
- Which techniques are required (writing criteria)?
- Questions?



Reading Sub-Test: Key Info

- Includes one writing task.
- 45 minutes total
 - 5 minutes reading
 - 40 minutes writing

NOTE: You are not given protected time to proofread your work.

- You are required to write a letter (e.g. a referral).
- You will be given: background context, profession specific case notes, an task instructions.

Additional Writing Sub-test Information

- The body of the letter should be approximately **180-200 words long**. (This is an important part of achieving a good score in the writing sub-test.)
- The letter should be in a **formal style** and the notes you are given will highlight **who** you will be writing to.
- Key skills required include: retrieving specific, key information whilst filtering out any information that may not be beneficial for the recipient in context. The information then needs to be summarised effectively to make it clear for the reader.
- No additional information based on your own knowledge should be included. The focus must be on the case notes provided. This is a writing test and you won't be tested on your medical knowledge.

Writing Sub-test: Case Notes Example

Occupational English Test

WRITING SUB-TEST: NURSING
TIME ALLOWED: READING TIME: 5 MINUTES
WRITING TIME: 40 MINUTES

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

Notes:

Assume that today's date is 10 February 2019

Mr Lionel Ramamurthy, a 63-year-old, is a patient in the medical ward of which you are Charge Nurse.

Hospital: Newtown Public Hospital, 41 Main Street, Newtown

Writing Task:

Using the information given in the case notes, write a discharge letter to Ms Georgine Ponsford, Resident Community Nurse at the Community Retirement Home, 103 Light Street, Newtown. This letter will accompany Mr Ramamurthy back to the retirement home upon his discharge tomorrow.

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.

Make sure to read the introduction and task instructions carefully. This will tell you what type of letter you need to write and who you are writing to.

This will help you to identify the information you need from the case notes, in order to write the letter.

The format instructions are very important. Any information provided will need to be expanded into full sentences.

Writing Sub-test: Case Notes

PATIENT DETAILS:

Name: Lionel Ramamurthy (Mr)
Marital status: Widowed – spouse dec. 6 mths
Residence: Community Retirement Home, Newtown
Next of kin: Jake, engineer (37, married, 3 children <10)
Sean, teacher (30, married, working overseas, 1 infant)

Admission date: 04 Feb 2019

Discharge date: 11 Feb 2019

Diagnosis: Pneumonia

Past medical history:

Osteoarthritis (mainly fingers) – Voltaren (diclofenac)
Eyesight ↓ due to cataracts removed 16 mths ago – needs check-up

Social background:

Retired school teacher (history, maths). Financially independent. Lonely since wife died.
Weight loss approx. 4 kg in 6 months – associated with poor diet.

Medical history: 2007: Type 2 diabetes diagnosed (controlled by diet)

04 Mar 2018 Chronic obstructive pulmonary disease (COPD) diagnosed

Medical background:

Admitted with pneumonia – acute shortness of breath (SOB), inspiratory and expiratory wheezing, persistent cough (→ chest & abdominal pain), fever, rigors, sleeplessness, generalised ache. On admission – mobilising with pick-up frame, assist with ADLs

(e.g., showering, dressing, etc.), very weak, ambulating only short distances with increasing shortness of breath on exertion (SOBOE).

Medical progress:

Afebrile.
Inflammatory markers back to normal.
Slow but independent walk & shower/toilet.
Dry cough, some chest & abdom. pain.
Weight gain (1.5kg) post r/v by dietitian.

Nursing management:

Encourage oral fluids, proper nutrition.

Ambulant as per physio r/v.

Encourage chest physio (deep breathing & coughing exercises).

Sitting preferred to lying down to ensure postural drainage.

Assessment:

Good progress overall

Discharge plan:

Paracetamol if necessary for chest/abdom. pain.

Keep warm.

Good nutrition – ↑ fluids, eggs, fruit, veg (needs help monitoring diet).

Case notes will have **clear headings**.

However, they will include information that is not necessary to include in the letter, so being able to decide which information is required for the person you are writing to, is an important skill in the writing sub-test.

The Letter: What needs to be included?

Ms Georgine Ponsford
Resident Community Nurse
Community Retirement Home
103 Light Street
Newtown

Address of the recipient should be in the top left corner of the page.

10 February 2019

The letter should then include the correct date. You will need to look for the reference to the date in the case notes, to ensure you use the correct one.

Dear Ms Ponsford,
Re: Lionel Ramamurthy, aged 63

Mr Lionel Ramamurthy was admitted on 4 February 2019 having contracted pneumonia. He is now ready for discharge back into your care tomorrow.

On admission, he was experiencing fevers and rigors. He suffered dyspnoea, wheezing and sleeplessness. He had chest and abdominal pain due to prolonged persistent coughing.

After a week in hospital, he has stabilised and his breathing problems are now resolved. However, he still experiences some chest and abdominal pain, with a dry cough. His nursing management in hospital initially consisted of a walking frame and assistance with showering and dressing. Mr Ramamurthy is now more independent. He is also able to walk about slowly without assistance, and shower and use the toilet independently.

Make sure to address the correct person, then include the name and date of birth of the patient your letter is regarding.

Paracetamol may be administered as needed if chest and abdominal pain persists and Mr Ramamurthy should be kept warm. Please encourage oral fluids, and ensure that he sits up, rather than lies down, whenever possible to ensure postural drainage. He should ambulate regularly, and continue with deep breathing and coughing exercises.

Body of the letter should include only the relevant information for the function of the letter (e.g. referral, discharge etc).

Mr Ramamurthy was very weak on admission to hospital, but has gained weight with dietitian input. He will need ongoing monitoring of his diet.
If you have any queries, please contact me.

Complete the letter Yours Sincerely, (Name of job description, e.g. 'Charge Nurse')

Yours sincerely,

Writing sub-test: Assessment criteria and level descriptors

Band	Purpose	Band	Content	Conciseness & Clarity	Genre & Style	Organisation & Layout	Language
3	Purpose of document is immediately apparent and sufficiently expanded as required	7	Content is appropriate to intended reader and addresses what is needed to continue care (key information is included; no important details missing); content from case notes is accurately represented	Length of document is appropriate to case and reader (no irrelevant information included); information is summarised effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader (discipline and knowledge); technical language, abbreviations and polite language are used appropriately for document and recipient	Organisation and paragraphing are appropriate, logical and clear; key information is highlighted and sub-sections are well organised; document is well laid out	Language features (spelling/punctuation/vocabulary/grammar/sentence structure) are accurate and do not interfere with meaning
		6	Performance shares features of bands 5 and 7				
2	Purpose of document is apparent but not sufficiently highlighted or expanded	5	Content is appropriate to intended reader and mostly addresses what is needed to continue care; content from case notes is generally accurately represented	Length of document is mostly appropriate to case and reader, information is mostly summarized effectively and presented clearly	Writing is clinical/factual and appropriate to genre and reader with occasional, minor inappropriacies; technical language, abbreviations and polite language are used appropriately with minor inconsistencies	Organisation and paragraphing are generally appropriate, logical and clear; occasional lapses of organisation in sub-sections and/or highlighting of key information; layout is generally good	Minor slips in language generally do not interfere with meaning
		4	Performance shares features of bands 3 and 5				
1	Purpose of document is not immediately apparent and may show very limited expansion	3	Content is mostly appropriate to intended reader; some key information (about case or to continue care) may be missing; there may be some inaccuracies in content	Inclusion of some irrelevant information distracts from overall clarity of document; attempt to summarise only partially successful	Writing is at times inappropriate to the document or target reader; over-reliance on technical language and abbreviations may distract reader	Organisation and paragraphing are not always logical, creating strain for the reader; key information may not be highlighted; layout is mostly appropriate with some lapses	Inaccuracies in language, in particular in complex structures, cause minor strain for the reader but do not interfere with meaning
		2	Performance shares features of bands 1 and 3				
0	Purpose of document is partially obscured/unclear and/or misunderstood	1	Content does not provide intended reader sufficient information about the case and what is needed to continue care; key information is missing or inaccurate	Clarity of document is obscured by the inclusion of many unnecessary details; attempt to summarise not successful	The writing shows inadequate understanding of the genre and target reader; mis- or over-use of technical language and abbreviations cause strain for the reader	Organisation not logical, putting strain on the reader; or heavy reliance on case note structure; key information is not well highlighted and the layout may not be appropriate	Inaccuracies in language cause considerable strain for the reader and may interfere with meaning
		0	Performance below Band 1				

Writing sub-test: Assessment criteria and level descriptors

Criterion	Description
Purpose Helps the reader get a quick and precise sense of what is asked of them	Due to time constraints, health professionals want to understand the purpose behind a written handover document (e.g. referral letter) very quickly and efficiently. This criterion therefore examines how clearly the writing communicates the purpose of the document to the reader. The purpose for writing should be introduced early in the document and then clearly expanded on later (often near the end of the document). The purpose should be easily and immediately identifiable to the reader, so there is no need to search for it.
Content - Considers necessary information (audience awareness: what does the reader need to know?) - Considers accuracy of information	The content criterion examines a number of aspects of the content: - All key information is included - Information is accurately represented - Audience awareness is key here. The writing needs to be appropriate to the reader (and their knowledge of the case) and what they need to know to continue care.
Conciseness & Clarity - Considers irrelevant information (audience awareness: what doesn't the reader need to know?) - Considers how effectively the case is summarised (audience awareness: no time is wasted)	Health professionals value concise and clear communication. This criterion, therefore also considers: - whether unnecessary information from the notes is included and how distracting this may be to the reader, i.e. Does this affect clarity? Is there any information that could be left out? - how well the information (the case) is summarised and how clearly this summary is presented to the reader.
Genre & Style Considers the appropriateness of features such as register and tone to the document's purpose and audience	Referral letters and similar written handover documents need to show awareness of genre by being written in a clinical/factual manner (e.g. not including personal feelings and judgements) and awareness of the target reader through using professional register and tone. The use of abbreviations should not be overdone thereby assuming common prior knowledge. If written to a medical colleague in a similar discipline, then judicious use of abbreviations and technical terms would be entirely appropriate, but if the medical colleague was in a totally different discipline, or a letter was from a specialist to a GP, more explanation and less shorthand would be desirable. If the target readership includes the patient, the information must be worded appropriately, e.g. minimising medical jargon.
Organisation & Layout Considers organisational features of the document	Health professionals value documents that are clearly structured so it is easy for them to efficiently retrieve relevant information. This criterion examines how well the document is organised and laid out. It examines whether the paragraphing is appropriate, whether sub-sections within the document are logically organised and whether key information is clearly highlighted to the reader so that it is not easily missed. The criterion also considers whether the layout of the document is appropriate.
Language Considers aspects of language proficiency such as vocabulary, grammar, spelling, punctuation	Health professionals are concerned with linguistic features only to the extent that they facilitate or obstruct retrieval of information. This criterion examines whether the language is accurate, used appropriately and whether it interferes with reading comprehension or speed.

Medical Terms and Abbreviations

- Medical terms and abbreviations may be included in the case notes you receive as part of the writing sub-test.
- It is important that you revise these any understand what they mean and how to expand them (when required), in your writing.

WBC white blood count	y.o. years old	? possible/maybe/ suspected/tentative	↑ increased/raised
↓ decreased/reduced/ lowered	→ caused/ led to/ resulted in	← caused by/ resulted from	+ / ++ present/ increased presence
- absent			

Any Questions?

