OET writing samples: doctors, with answers

3 original practice cases with case notes and a model letter. Allow 5 minutes to read and 40 minutes to write, then compare. A model shows one good way to answer. It is not an official OET sample or a marking guide, and all patients are fictional.

Sample 1: Urgent referral letter

Urgent referral to a gastroenterologist: iron-deficiency anaemia and rectal bleeding

Assume that today's date is 21 October 2026. Using the information in the case notes, write a letter of referral to Dr Anna Lindqvist, a gastroenterologist at Riverside Endoscopy Centre, requesting urgent assessment and colonoscopy. Address the letter to Dr Anna Lindqvist, Gastroenterologist, Riverside Endoscopy Centre, 140 Harbour Road, Northbridge. 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.

Patient details

- Name: Mr Kevin Doherty
- DOB: 14/03/1965 (61 yrs)
- Address: 22 Fernhill Road, Ashgrove
- Occupation: retired bank manager (retired 2024)

Social background

- Married (Linda), 2 adult children living overseas
- Ex-smoker (quit 1998); alcohol approx. 10 standard drinks/wk
- Usually plays golf 2x/wk — stopped last month, 'too tired'
- Booked trip to Europe Dec 2026 — keen to 'get everything sorted' before then

Medical history

- Hypertension (2015) — perindopril 5 mg mane
- Osteoarthritis both knees — ibuprofen 400 mg PRN (approx. 3x/wk, 2 yrs)
- Appendicectomy age 12
- Seasonal hay fever — loratadine PRN
- Allergies: penicillin (rash)
- Family Hx: father — colorectal cancer, diagnosed aged 68
- No previous colonoscopy; did not return national bowel screening kit (2023)

08/10/26 — presenting complaint

- 3/12 fatigue, ↓ exercise tolerance, SOB climbing stairs
- Unintentional wt loss 6 kg in 4/12 (88 → 82 kg)
- 6/52 change in bowel habit: looser stools 2–3x/day; occasional dark red blood mixed with stool
- No abdominal pain, nausea or vomiting; appetite normal
- Sleeping poorly — attributes to neighbour's renovations

Examination

- Pale conjunctivae; HR 92 reg; BP 128/76; BMI 26
- Abdo soft, non-tender, no masses, no hepatomegaly
- PR: no palpable mass; dark red blood on glove

Investigations (results 14/10/26)

- FBC: Hb 98 g/L (ref 130–180), MCV 72 fL; ferritin 6 µg/L
- iFOBT: positive
- U&E, LFTs normal; coeliac serology negative
- Lipids: total cholesterol 5.4 mmol/L

Management

- Ibuprofen ceased — regular paracetamol 1 g up to QID for knees

- Commenced oral iron (ferrous sulfate 325 mg, 105 mg elemental iron) daily
- Pt anxious about possibility of cancer
- Pt's friend's wife recently diagnosed with bowel cancer; pt watched TV documentary on bowel cancer
- Pt asked whether golf club membership can be paused on medical grounds — letter provided

Plan

- Urgent referral to gastroenterologist for colonoscopy ± gastroscopy
- Repeat FBC and ferritin in 4/52
- GP review 2/52, or earlier if bleeding increases or symptomatic

Model letter: sample 1

21 October 2026

Dr Anna Lindqvist
Gastroenterologist
Riverside Endoscopy Centre
140 Harbour Road
Northbridge

Dear Dr Lindqvist,

Re: Mr Kevin Doherty, DOB 14/03/1965

I am writing to request urgent assessment and colonoscopy for Mr Doherty, a 61-year-old man with iron-deficiency anaemia and rectal bleeding.

He presented on 8 October with a three-month history of fatigue and breathlessness on stairs and an unintentional 6 kg weight loss over four months. For six weeks he has had looser stools two to three times daily, with occasional dark red blood mixed with the stool. His father was diagnosed with colorectal cancer at 68, and Mr Doherty has never had a colonoscopy.

On examination, he had pale conjunctivae and a heart rate of 92. His abdomen was soft without masses, and rectal examination revealed dark red blood but no palpable mass. Investigations showed haemoglobin 98 g/L, MCV 72 fL and ferritin 6 µg/L, with a positive iFOBT. Coeliac serology and renal and liver function were normal.

He has hypertension treated with perindopril and is allergic to penicillin. I have ceased his ibuprofen and commenced oral iron and regular paracetamol. He is anxious about the possibility of cancer. I will repeat his blood count and ferritin in four weeks.

Thank you for seeing him urgently.

Yours sincerely,
General Practitioner

Why this letter works

Kept: Urgency is in the first line. The symptoms, family history and results that justify it follow in the order a gastroenterologist would look for them.

Left out: Golf, hay fever, the appendicectomy, cholesterol, the neighbour's renovations and the television documentary do not affect the decision to scope.

Sample 2: Urgent referral letter

Urgent referral to a rheumatologist: suspected rheumatoid arthritis

Assume that today's date is 21 October 2026. Using the information in the case notes, write a letter of referral to Dr Raj Menon, a rheumatologist, requesting urgent assessment and treatment. Address the letter to Dr Raj Menon, Rheumatologist, Westside Specialist Suites, Level 3, 210 Victoria Street, Westside. 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.

Patient details

- Name: Mrs Rania Haddad
- DOB: 17/08/1982 (44 yrs)
- Occupation: dental hygienist

Social background

- Married; one son aged 6
- Smokes approx. 5 cigarettes/day; alcohol 2–3 standard drinks/wk
- Attends gym 3x/wk — stopped 1 month ago
- Planning to try for a second pregnancy within the next year
- Pt upset that a locum GP in August told her the pain was 'just overuse'

Medical history

- Tonsillectomy age 9
- Seasonal allergic rhinitis
- No previous joint problems
- Medications: progestogen-only contraceptive pill
- Allergies: nil known
- Family Hx: maternal aunt — rheumatoid arthritis; mother — hypothyroidism

Presenting complaint (14/10/26)

- 11/52 pain and swelling both hands and wrists, symmetrical; now also both feet (balls of feet)
- Morning stiffness approx. 90 min
- Difficulty gripping dental instruments; 1 wk off work
- Fatigue; no rash, mouth ulcers, dry eyes or recent infection
- Read online about turmeric for joint pain — taking turmeric/curcumin capsules (500 mg daily, OTC) for 3/52

Examination

- Synovitis: bilateral MCP 2–3, PIP 2–3 and wrists; tender MTP joints bilaterally; positive MTP squeeze test
- No nodules, no rash; other systems NAD
- BMI 23; BP 122/78

Investigations (results 19/10/26)

- RF 85 IU/mL (positive); anti-CCP >300 U/mL (strongly positive)
- CRP 24 mg/L; ESR 42 mm/hr
- FBC, LFTs, U&E normal; hepatitis B and C serology negative; CXR normal
- X-ray hands and feet: periarticular osteopenia, no erosions

Management

- Naproxen 500 mg BD with esomeprazole 20 mg daily — partial relief
- Advised smoking cessation (smoking linked to worse RA); quit support offered
- Corticosteroids not started — to await specialist review

Plan

- Urgent referral to rheumatology for assessment and DMARD initiation
- GP review 2/52

Model letter: sample 2

21 October 2026

Dr Raj Menon
Rheumatologist
Westside Specialist Suites
Level 3, 210 Victoria Street
Westside

Dear Dr Menon,

Re: Mrs Rania Haddad, DOB 17/08/1982

I am writing to request urgent assessment and DMARD initiation for Mrs Haddad, a 44-year-old dental hygienist with suspected rheumatoid arthritis.

She presented on 14 October with an 11-week history of symmetrical pain and swelling in her hands and wrists, now also affecting the balls of both feet, with approximately 90 minutes of morning stiffness. Difficulty gripping instruments has caused one week off work. A maternal aunt has rheumatoid arthritis.

Examination revealed bilateral synovitis of the second and third MCP and PIP joints and wrists, with tender MTP joints and a positive squeeze test. Rheumatoid factor was 85 IU/mL, anti-CCP above 300 U/mL, CRP 24 mg/L and ESR 42 mm/hr. X-rays showed periarticular osteopenia without erosions. Blood count, renal and liver function, hepatitis B and C serology and chest X-ray were normal.

She is taking naproxen 500 mg twice daily with esomeprazole, with partial relief. I have not started corticosteroids, pending your review. Relevant to your treatment choice, she plans a second pregnancy within the next year and smokes approximately five cigarettes daily. She also takes turmeric capsules and has no known allergies.

Yours sincerely,
General Practitioner

Why this letter works

Kept: The pregnancy plan is kept and explained because it affects which DMARD the rheumatologist can choose.

Left out: The locum's comment, the gym, the tonsillectomy, hay fever and her mother's thyroid disease do not change what the specialist does next.

Sample 3: Referral letter

Chronic kidney disease with persistent proteinuria: referral

Original independent practice. All patient findings and arrangements are fictional case facts, not general clinical recommendations. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. Assume that today is 3 November 2026. Mr Shammas has attended your general practice to discuss his latest results. You are Mr Riad Shammas's general practitioner. Using the case notes, write a referral letter to Dr Heba Makhlouf, Consultant Nephrologist, Renal Outpatient Clinic, 26 Clinic Road, SW1A 2AA, requesting investigation of his chronic kidney disease and persistent proteinuria, with advice on further management. In your answer: expand the relevant notes into complete sentences; do not use note form; use letter format. The body of the letter should be approximately 180–200 words.

Patient details

- Name: Mr Riad Shammas
- DOB: 18/02/1970 (56 yrs)
- GP review: 03/11/26; renal abnormalities first identified April 2026

Social background

- Office administrator; works regular daytime hours
- Lives with partner; independent with daily activities
- Enjoys photography; recently bought a camera
- Complained waiting-room chairs were uncomfortable and staff seemed unhelpful

Medical history

- Childhood tonsillectomy; no ongoing complications
- No diagnosed diabetes or hypertension; no previous renal diagnosis; no stones or recurrent urinary infections
- No known family history of renal disease
- No regular medication; no known drug allergies
- Denies NSAIDs, herbal remedies or bodybuilding supplements

Serial investigations

- 06/04/26: eGFR 58 mL/min/1.73 m²
- 06/07/26: eGFR 54 mL/min/1.73 m²
- 26/10/26: eGFR 51 mL/min/1.73 m²
- 06/07/26: urine ACR 78 mg/mmol
- 26/10/26: repeat early-morning urine ACR 86 mg/mmol
- Both urine samples: clinically well; no recent strenuous exercise
- Urine microscopy: no haematuria; cultures negative on both occasions
- Ultrasound 29/10: normal-sized kidneys; no hydronephrosis or cysts; bladder unremarkable, no significant post-void residual
- HbA1c 26/10: 36 mmol/mol
- Potassium 4.5 mmol/L; serum albumin 39 g/L on 26/10

Current assessment

- Reports foamy urine for 3/12
- No oedema, dyspnoea, dysuria or visible haematuria
- Today: BP 128/78 mmHg; no peripheral oedema
- No rash, joint symptoms or recent intercurrent illness
- Assessment: CKD with unexplained persistent albuminuria; possible glomerular disease

Plan

- Refer nephrology: establish cause; advise further investigations and renal protective treatment
- Serial laboratory results and ultrasound report enclosed
- GP to continue renal function/BP monitoring pending specialist review

Model letter: sample 3

3 November 2026

Dr Heba Makhlouf
Consultant Nephrologist
Renal Outpatient Clinic
26 Clinic Road
SW1A 2AA

Dear Dr Makhlouf,

Re: Mr Riad Shammas, DOB 18/02/1970

I am writing to refer Mr Shammas, a 56-year-old office administrator with chronic kidney disease and unexplained persistent albuminuria, to establish the cause and for advice on further investigations and renal protective treatment.

His eGFR has fallen from 58 in April to 54 in July and 51 mL/min/1.73 m² on 26 October. His urine ACR was 78 mg/mmol in July and 86 mg/mmol on an early-morning sample in October. Microscopy showed no haematuria, and cultures were negative.

He reports three months of foamy urine but has no oedema, dyspnoea, dysuria, visible haematuria, rash, joint symptoms or recent illness. Today his blood pressure was 128/78 mmHg. Ultrasound on 29 October showed normal-sized kidneys without hydronephrosis or cysts and no significant post-void residual. HbA1c was 36 mmol/mol, potassium 4.5 mmol/L and albumin 39 g/L.

He has no known diabetes, hypertension, family history of renal disease or drug allergies. He takes no regular medication and denies using NSAIDs, herbal remedies or bodybuilding supplements.

Serial results and the ultrasound report are enclosed. I will continue monitoring his renal function and blood pressure pending your review.

Yours sincerely,
General Practitioner

Why this letter works

Kept: The trend matters more than any single result, so the three eGFR values and two ACR values appear together.

Left out: Photography, the waiting-room chairs and the childhood tonsillectomy give a nephrologist nothing to act on.