OET writing samples: nurses, 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: Discharge letter

Discharge to the community nursing service: new insulin and diabetic foot ulcer

Assume that today's date is 21 October 2026. Mr Bates is being discharged home this afternoon. You are a registered nurse on the medical ward at Lakeside Hospital. Using the information in the case notes, write a letter to Ms Jane Ellis, Nurse Unit Manager of the Community Nursing Service, requesting continued care for Mr Bates at home. Address the letter to Ms Jane Ellis, Nurse Unit Manager, Northside Community Nursing Service, 17 Station Road, Northside. 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 Harold Bates
- DOB: 04/02/1952 (74 yrs)
- Address: 9 Wattle Court, Northside
- Admitted: 13/10/26; discharge: 21/10/26

Social background

- Lives with wife (78), who has mild memory problems — unable to assist with insulin or dressings
- Retired postman; enjoys lawn bowls
- Son lives 30 min away, visits weekly
- Single-level home, 2 steps at front door
- Wife told staff that pt 'never listens to doctors and eats whatever he likes'

Medical history

- Type 2 diabetes (15 yrs); HbA1c 10.2% on admission
- Diabetic retinopathy — reduced vision; cannot read insulin pen dose window or small print
- Peripheral neuropathy both feet
- Hypertension — perindopril 5 mg daily
- Hypercholesterolaemia — atorvastatin 40 mg nocte
- L total knee replacement 2018
- Allergies: nil known

Admission

- Infected neuropathic ulcer R foot (under 1st metatarsal head) with cellulitis
- Foot X-ray: no evidence of osteomyelitis; wound swab: Staphylococcus aureus (methicillin-sensitive)
- IV cefazolin 5 days → oral cefalexin 500 mg QID until 28/10/26
- Cellulitis resolved; afebrile since 16/10

Diabetes management

- Insulin glargine commenced 15/10 — current dose 14 units at 08:00 daily
- Gliclazide ceased; metformin 1 g BD continued
- BGLs 6–11 mmol/L over last 48 hrs; target 6–10 mmol/L before meals
- Pt and wife educated about hypoglycaemia; uses meter with large display; hypo treatment at home
- Prefers to have breakfast at 07:30 after reading the newspaper

Wound

- Ulcer 1.5 × 1.0 cm, depth 0.3 cm; granulating; minimal exudate; surrounding skin intact
- Dressing: clean with sodium chloride 0.9%, non-adherent foam dressing — change daily
- Must wear offloading shoe when walking

- Physiotherapy: mobilising independently with offloading shoe
- Complained about noise from patient in next bed

Discharge plan

- Community nursing daily from 22/10: administer/supervise insulin, check BGL, wound care; if BGL < 4 mmol/L treat per hypoglycaemia protocol, recheck in 15 min and notify GP; report BGL > 15 mmol/L or signs of infection to GP
- GP review 28/10 — insulin titration
- High-risk foot clinic (podiatry) 29/10
- Diabetes educator 04/11

Model letter: sample 1

21 October 2026

Ms Jane Ellis
Nurse Unit Manager
Northside Community Nursing Service
17 Station Road
Northside

Dear Ms Ellis,

Re: Mr Harold Bates, DOB 04/02/1952

I am writing to request daily community nursing from 22 October for Mr Bates, a 74-year-old man being discharged today after treatment for an infected right foot ulcer with cellulitis.

Mr Bates has type 2 diabetes with retinopathy and peripheral neuropathy. As he cannot read his insulin pen and his wife is unable to assist, please administer or supervise his insulin glargine, 14 units at 08:00 daily, and check his blood glucose, aiming for 6–10 mmol/L before meals. Readings below 4 mmol/L should be treated according to the hypoglycaemia protocol, rechecked after 15 minutes and reported to his GP. Please also report readings above 15 mmol/L.

The ulcer under his first metatarsal head measures 1.5 × 1.0 × 0.3 cm and is granulating. Please clean it with 0.9% sodium chloride and apply a non-adherent foam dressing daily, reporting any signs of infection to his GP. He continues cefalexin 500 mg four times daily until 28 October and must wear his offloading shoe when walking.

He will see his GP on 28 October, the high-risk foot clinic on 29 October and the diabetes educator on 4 November.

Yours sincerely,
Registered Nurse
Medical Ward, Lakeside Hospital

Why this letter works

Kept: The reader must act from tomorrow, so the request comes first, followed by exactly what the nurse has to do and when to call the GP.

Left out: His bowls, the newspaper, the noisy patient in the next bed, the knee replacement and the wife's comment about doctors change nothing for the community nurse.

Sample 2: Advice letter to a carer

Advice to a carer: managing newly diagnosed heart failure at home

Assume that today's date is 21 October 2026. You are the heart failure nurse at Riverbend Heart Clinic. Mr Russo has agreed that you may write to his daughter, who is his main carer. Using the information in the case notes, write a letter to Ms Teresa Russo advising her on how to help her father manage his condition at home. Address the letter to Ms Teresa Russo, 31 Olive Grove, Riverbend. 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 Vincent Russo
- DOB: 12/12/1946 (79 yrs)
- Retired builder

Social background

- Lives with daughter (Teresa, 52), who is his main carer; she works part-time (3 days/wk)
- Mr Russo has consented to information being shared with his daughter
- Daughter describes father as 'stubborn and difficult'
- Daughter going through a divorce — 'very stressed'
- Has a dog; enjoys walking it to the local park

Medical history

- Heart failure with reduced ejection fraction — diagnosed 10/26 (echocardiogram: ejection fraction 35%)
- Hypertension (since 2005)
- Gout — takes ibuprofen (bought over the counter) during flare-ups
- Inguinal hernia repair 1998
- Brother died of a heart attack aged 70
- Allergies: nil known

Clinic review 20/10/26

- Presented to GP with breathlessness and swollen ankles; referred to cardiology
- Now breathless climbing one flight of stairs; sleeping on 2 pillows
- Mild ankle swelling; weight today 84.2 kg (was 87.5 kg 2 wks ago)
- BP 112/68; HR 76
- ECG: sinus rhythm

Medications (cardiologist)

- Furosemide (fluid tablet) 40 mg each morning
- Perindopril 2.5 mg daily; bisoprolol 1.25 mg daily (dose to be increased slowly at clinic visits)
- Avoid ibuprofen and other anti-inflammatories — GP to advise alternative gout treatment
- May feel dizzy when standing — stand up slowly
- Cardiologist plans to add spironolactone and dapagliflozin at later visits if kidney function and potassium allow
- Baseline bloods 20/10: creatinine 98 µmol/L, eGFR 64, Na 139 mmol/L, K 4.4 mmol/L
- Repeat blood test in 1 wk at local pathology collection centre (form given)

Self-care advice

- Weigh every morning after using toilet, before breakfast, same scales, similar clothing; record in diary
- Contact clinic if weight increases by > 2 kg in 2 days, or breathlessness/ankle swelling worsens, or needs more pillows to sleep
- Individual fluid allowance prescribed: 1.5 L/day, including drinks and liquid foods (tea, soup, ice cream); review at next clinic
- Reduce salt — no added salt; avoid processed foods
- Take furosemide in the morning to avoid passing urine at night; plan outings accordingly

- Call ambulance for chest pain, severe breathlessness at rest or fainting
- Gentle daily walking encouraged
- Influenza vaccine given 20/10

Plan

- Heart failure clinic review 03/11/26 — bring weight diary
- Clinic phone: 5550 1234 (Mon–Fri 8:30 am–4:30 pm); after hours — GP after-hours service

Model letter: sample 2

21 October 2026

Ms Teresa Russo
31 Olive Grove
Riverbend

Dear Ms Russo,

Re: Mr Vincent Russo, DOB 12/12/1946

I am writing, with your father's consent, to advise you how to help him manage his newly diagnosed heart failure at home.

Each morning, please encourage him to weigh himself after using the toilet and before breakfast, using the same scales and similar clothing, and to record the result in a diary. Please telephone our clinic on 5550 1234 if his weight increases by more than 2 kg in two days, if his breathlessness or ankle swelling worsens, or if he needs more pillows to sleep. Outside clinic hours, contact the GP after-hours service. Call an ambulance if he has chest pain, severe breathlessness at rest or faints.

He should have no more than 1.5 litres of fluid daily, including tea, soup and ice cream, and should avoid added salt and processed foods. His fluid tablet is best taken in the morning. He may feel dizzy, so he should stand up slowly. He must also avoid ibuprofen; his GP will advise on gout treatment. Gentle daily walking is encouraged.

He needs a blood test in one week. Please bring his weight diary to the clinic on 3 November.

Yours sincerely,
Heart Failure Nurse
Riverbend Heart Clinic

Why this letter works

Kept: The reader is a carer, not a clinician, so the letter uses plain words such as fluid tablet and tells her exactly when to call and whom.

Left out: Her divorce, her comment that he is stubborn, kidney results, the ejection fraction and medicines planned for later visits do not help her at home.

Sample 3: Referral letter

Referral to a community mental health nurse after an intentional overdose

Assume that today's date is 22 October 2026. Ms Gledhill is being discharged home this afternoon. You are a registered nurse on the medical ward of the local hospital. Using the information in the case notes, write a letter to Ms Eleanor Holroyd, Community Mental Health Nurse, referring Ms Gledhill for follow-up in the community. Address the letter to Ms Eleanor Holroyd, Community Mental Health Nurse, Community Mental Health Service, 14 Park Street. 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: Ms Caroline Gledhill
- DOB: 14/03/2004 (22 yrs)
- Address: Flat 4, 61 Mill Street (shared flat)
- Admitted: 19/10/26; discharge: 22/10/26

Social background

- Final-year law student; exams in 5/52; part-time café job, hours recently ↓ → money worries
- Shares flat with 2 flatmates (both students)
- Relationship with boyfriend (2 yrs) ended 3/52 ago
- Mother lives 1 hr away; will stay with pt at flat for 1/52 after discharge
- Close to older sister, who phones daily
- Parents divorced 10 yrs ago; father remarried, minimal contact
- Plays netball weekly; owns a cat
- Mother told staff ex-boyfriend 'was always a waste of space'

Medical history

- Low mood, poor sleep, ↓ appetite approx 4/12; not previously treated; no GP contact
- Self-harm (cutting) age 15–16, saw school counsellor at the time; nil since
- Alcohol: binge drinking most weekends (approx 8–10 standard drinks/night); nil illicit drugs
- Tonsillectomy age 8
- Allergies: nil known

Admission

- Intentional OD: approx 30 × paracetamol 500 mg tabs, taken alone at flat after phone argument with ex-partner; alcohol taken same evening
- Texted friend 2 hrs later → ambulance called; presented approx 4 hrs post-ingestion
- IV acetylcysteine full course completed; LFTs and INR normal on completion; medically fit for discharge
- Complained about hospital food and being woken for overnight obs

Psychiatric assessment (20/10/26)

- Dx: moderate depressive episode; OD described as impulsive; pt regrets OD — 'I just wanted everything to stop'
- Denies current suicidal intent or plan; ongoing intermittent passive thoughts ('better if I wasn't here')
- Protective factors: close to sister and mother, wants to finish degree, responsibility for cat
- Sertraline 50 mg mane commenced 21/10; monitor for ↑ agitation / suicidal thoughts early in treatment (age < 25)

Safety plan

- Written safety plan completed with pt: warning signs (isolating, not sleeping, drinking alone), coping strategies, contacts (sister, mother), crisis line & ED
- Means restriction: no paracetamol/other OTC medicines kept at flat; mother to hold & give sertraline; 1/52 supply only dispensed
- Pt agreed to avoid alcohol; effect of alcohol on mood discussed
- Consent given for referral & for information sharing with mother

Plan

- Community MH nurse: home visit within 48 hrs of discharge (by 24/10); ongoing support, risk review, monitor mood & response to sertraline
- GP review 1/52 (29/10) — sertraline review & repeat prescription
- Referred to university counselling service; pt considering request for exam deferral

Model letter: sample 3

22 October 2026

Ms Eleanor Holroyd
Community Mental Health Nurse
Community Mental Health Service
14 Park Street

Dear Ms Holroyd,

Re: Ms Caroline Gledhill, DOB 14/03/2004

I am referring Ms Gledhill, a 22-year-old law student being discharged today after an intentional paracetamol overdose, for a home visit by 24 October, ongoing support and risk review.

She was admitted on 19 October after taking approximately 30 paracetamol 500 mg tablets with alcohol following an argument with her ex-partner. She completed intravenous acetylcysteine, and her liver function and INR were normal. Psychiatric assessment diagnosed a moderate depressive episode. She regrets the overdose and denies current suicidal intent or plan, although she has intermittent passive thoughts. She self-harmed at 15–16 and binge drinks most weekends.

Sertraline 50 mg each morning was commenced on 21 October. As she is under 25, please monitor for increased agitation or suicidal thoughts, as well as her mood and response to treatment.

A written safety plan has been completed, and she has agreed to avoid alcohol. Her mother will stay for one week and will hold and give her sertraline, and no over-the-counter medicines will be kept at the flat. She has consented to this referral and to information sharing with her mother. Her GP will review her on 29 October.

Yours sincerely,
Registered Nurse
Medical Ward

Why this letter works

Kept: Risk comes before background: what happened, what she says now, what the nurse must monitor and what is already in place at home.

Left out: The tonsillectomy, netball, the cat, hospital food and the mother's opinion of the ex-boyfriend add nothing to the risk review.