OET writing samples: speech pathology, with answers

2 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: Transfer of care letter

Transfer of care: developmental language disorder, family relocating

Assume that today's date is 20 November 2026. Toby's final session at your service is on 4 December 2026. You are a paediatric speech pathologist at a community health service in Melbourne. Using the information in the case notes, write a letter to Ms Rebecca Alavi, Senior Paediatric Speech Pathologist, asking her to continue therapy for Toby after his family moves to Brisbane. Address the letter to Ms Rebecca Alavi, Senior Paediatric Speech Pathologist, Children's Community Health Service, 40 Wharf Street, Brisbane QLD 4000. 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: Toby Javadi
- DOB: 18/09/2021 (5 yrs 2 mths)
- New address from 12/12/26: 27 Riverside Parade, Brisbane QLD

Social background

- Lives with parents and older sister (8 yrs)
- Sister: no speech or language concerns
- Family relocating to Brisbane 12/12/26 (father's job transfer)
- Due to start Prep late 01/27
- Attends kindergarten 3 days/wk; teacher reports plays well but difficulty following group instructions
- Loves dinosaurs and trains → useful for engagement in sessions
- Mother reports paternal grandmother thinks Toby is 'just lazy'
- Mother unhappy with kindergarten — says teacher 'doesn't bother' with Toby

Developmental and medical history

- Term birth, uncomplicated
- First words 20 mths; 2-word combinations approx. 3 yrs
- Audiology 04/26: hearing normal bilaterally
- Recurrent ear infections age 2 — resolved; no grommets
- Mild eczema — moisturiser BD
- Paediatrician review 05/26: motor and social development age-appropriate; no other diagnoses

Initial assessment (05/26)

- Referred by GP 04/26 following kindergarten concerns
- CELF-P3: core language score well below average; receptive and expressive language both affected, expressive > receptive
- Diagnosis: developmental language disorder (DLD)
- Speech sounds age-appropriate; intelligible to unfamiliar listeners
- Language sample: short sentences (3–4 words); omits 'is' and verb endings (-ing, -ed); pronoun errors (e.g. 'him go')
- Limited vocabulary; frequent use of 'thing' for unknown words

Therapy and progress

- Weekly 45-min individual sessions since 05/26 (approx. 24 sessions); mother attends all
- Goals: (1) 'is' + verb-ing (2) regular past tense -ed (3) he/she pronouns (4) vocabulary — describing objects by category and function
- Approaches: recasting, focused stimulation, visual sentence frames; word mapping for vocabulary

• Progress: 'is' + verb-ing approx. 80% in structured play; he/she consistent in structured tasks, emerging in conversation; past tense -ed approx. 40%
• Vocabulary: now names categories (animals, food) and describes function; uses 'thing' ↓
• Mother does home practice 10 min daily with picture books; confident using recasting
• Missed 3 sessions 08/26 — family holiday
• Therapy room air conditioning broken 10/26 — Toby distracted in 2 sessions

Plan

• Continue: past tense -ed; pronouns in conversation; introduce following multi-step instructions and narrative skills before school starts
• Formal reassessment due 05/27
• Recommend liaison with new school re classroom supports (e.g. visual instructions)
• Mother consents to sharing of reports; assessment and progress reports enclosed with referral; last session here 04/12/26

Model letter: sample 1

20 November 2026

Ms Rebecca Alavi
Senior Paediatric Speech Pathologist
Children's Community Health Service
40 Wharf Street
Brisbane QLD 4000

Dear Ms Alavi,

Re: Toby Javadi, DOB 18/09/2021

I am writing to ask you to continue speech pathology therapy for Toby, aged 5 years 2 months, who has developmental language disorder and moves to 27 Riverside Parade, Brisbane on 12 December 2026. His last session with me is on 4 December 2026.

Toby was assessed in May 2026. His CELF-P3 core language score was well below average, with receptive and expressive language both affected, expressive more than receptive. His speech sounds are age-appropriate. Since May he has attended weekly 45-minute sessions with his mother, using recasting, focused stimulation, visual sentence frames and word mapping. He now uses 'is' plus verb-ing about 80% of the time in structured play, and he uses he and she consistently in structured tasks but is only emerging in conversation. Regular past tense -ed is at about 40%. He now names categories and uses 'thing' less.

Please continue work on past tense -ed and pronouns in conversation, and introduce following multi-step instructions and narrative skills before he starts Prep in late January 2027. Formal reassessment is due in May 2027. I recommend liaison with his new school about classroom supports such as visual instructions. His mother consents to sharing reports, which are enclosed.

Yours sincerely,
Paediatric Speech Pathologist
Community Health Service, Melbourne

Why this letter works

Kept: The request to continue therapy and the move dates come first, then the diagnosis, progress and next goals that let the new therapist resume without reassessing from the start.

Left out: His sister, the grandmother's comment, the mother's view of the kindergarten, eczema, birth history, the missed holiday sessions and the broken air conditioning do not shape the handover.

Sample 2: Results and request letter

Silent aspiration on swallow study: update on fluid and medication changes

Assume that today's date is 22 October 2026. Mrs Farquhar's videofluoroscopic swallow study was completed two days ago. You are a speech pathologist in the outpatient speech pathology department of the local hospital. Using the information in the case notes, write a letter to Mrs Farquhar's GP, Dr Rahul Fordyce, updating him on the results of her swallow study and your recommendations, and asking him to review her medications. Address the letter to Dr Rahul Fordyce, General Practitioner, Family Medical Practice, 22 Main 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: Mrs Isla Farquhar
- DOB: 03/05/1947 (79 yrs)
- Address: Unit 4, 15 High Street
- Referred by GP (Dr Rahul Fordyce) 2/12 ago: ? swallowing problem — recurrent chest infections

Social background

- Lives with daughter (52), who prepares meals and manages medications
- Retired primary school teacher; plays bridge weekly
- Son lives overseas; daughter says her brother 'never helps with anything'
- Daughter works part-time from home

Medical history

- Recurrent chest infections: 3 episodes in last 6/12, each treated with oral antibiotics by GP
- R CVA 2022 — mild residual L arm weakness
- Type 2 diabetes — metformin 1 g BD (large tablet)
- Hypertension — perindopril daily
- Osteoporosis — calcium carbonate/colecalciferol tablet daily (large tablet)
- Low potassium — slow-release potassium chloride tablet BD (large; must not be crushed)
- Bilateral cataract surgery 2015
- Allergies: nil known

Speech pathology assessment

- Clinical swallow assessment 06/10/26: no cough on thin fluids; mildly wet voice after drinks
- Full upper and lower dentures — fit well
- Daughter reports: pt takes tablets one at a time with several mouthfuls of water; large tablets 'feel stuck'; sometimes found left in mouth
- Videofluoroscopic swallow study (VFSS) 20/10/26
- VFSS: silent aspiration of thin fluids (no cough response); delayed swallow initiation
- VFSS: no aspiration with mildly thick fluids (IDDSI Level 2); soft & bite-sized solids (IDDSI Level 6, current diet) cleared well — no change needed
- VFSS: barium test tablet held in throat; cleared only after several swallows
- Pt complained about long wait in radiology waiting room

Treatment/Progress

- All fluids → mildly thick (IDDSI Level 2); thickener supplied; daughter trained in preparation
- Sit fully upright for all food, fluids and medications and for at least 30 min after
- Single small sips from a cup; no straws
- Oral hygiene incl. dentures twice daily to ↓ risk of aspiration pneumonia
- Pt initially reluctant — dislikes taste/texture of thickened drinks; agreed to trial
- Risk of ↓ fluid intake on thickened fluids → dehydration

Plan

• URGENT GP medication review with pharmacist (metformin, calcium/vitamin D, potassium chloride SR) — consider smaller or alternative forms; SR potassium must not be crushed

• 22/10/26: phoned GP practice & community pharmacist → same-day medication-specific administration plan needed before further doses of large tablets; daughter informed. Any new form/vehicle must suit assessed swallow (thin liquid medicines not automatically safe)

• GP to monitor chest and hydration; daughter to keep daily fluid intake chart

• Daughter advised: fever, ↑ breathlessness or productive cough → see GP promptly

• SP home review 4/52 — check acceptance of thickened fluids; repeat VFSS PRN

Model letter: sample 2

22 October 2026

Dr Rahul Fordyce
General Practitioner
Family Medical Practice
22 Main Street

Dear Dr Fordyce,

Re: Mrs Isla Farquhar, DOB 03/05/1947

I am writing to update you on the results of Mrs Farquhar's videofluoroscopic swallow study on 20 October 2026 and to ask you to review her medications urgently with a pharmacist.

The study showed silent aspiration of thin fluids, with delayed swallow initiation. There was no aspiration with mildly thick fluids, and her current soft, bite-sized diet needs no change. A barium test tablet was held in her throat and cleared only after several swallows. All fluids should now be mildly thick (IDDSI Level 2), and her daughter has been trained to prepare them. She should sit fully upright for food, fluids and medications and for at least 30 minutes afterwards, take single small sips without straws, and clean her mouth and dentures twice daily.

Please review metformin, the calcium and vitamin D tablet and the slow-release potassium chloride, which must not be crushed, and consider smaller or alternative forms. Any new form must suit her swallow. I phoned your practice and her community pharmacist today, because a medication-specific plan is needed before further doses of large tablets. Please also monitor her chest and hydration. I will review her at home in four weeks.

Yours sincerely,
Speech Pathologist
Outpatient Speech Pathology Department

Why this letter works

Kept: The urgent medication request is in the first sentence, and the swallow findings follow because they explain why the large tablets are a problem.

Left out: Her bridge, her son, the stroke, cataract surgery, the long radiology wait, and her dislike of thickened drinks are not needed for the medication review.