Parkinson's disease with swallowing concerns: advice

Original independent practice. All patient details, appointments and individual care-plan decisions are fictional. Assume that today's date is 3 November 2026, following yesterday's swallowing assessment. You are Mr Roel Bruce's general practitioner. Write to his wife and agreed carer, Ms Amanda Leonardi, 22 Station Road, AB10 1AA. Explain his documented swallowing plan, when to seek help and the arranged specialist reviews. Address her suggestion of moving his Parkinson's medicines to mealtimes, reinforcing use of his verified current prescription chart. A list of individual medicines is not required. Use plain language. 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.

Choose one box per line: I = Include / C = Compress / O = Omit. Answers and reasons are on the webpage (scan QR).

	I	C	O
Patient details			
1. Name: Mr Roel Bruce	☐	☐	☐
2. DOB: 08/06/1952 (74 yrs)	☐	☐	☐
3. Home: 22 Station Road, AB10 1AA	☐	☐	☐
4. Wife/carer: Ms Amanda Leonardi; lives with pt	☐	☐	☐
5. Consent recorded: share swallowing advice with wife	☐	☐	☐
Medical and social background			
6. Parkinson's disease diagnosed 2018; specialist follow-up ongoing	☐	☐	☐
7. Current Parkinson's prescription chart checked against labelled packs with wife; copy at home; doses/times unchanged	☐	☐	☐
8. Cognitively alert; feeds himself; wife prepares meals	☐	☐	☐
9. Independent indoors; needs help with buttons	☐	☐	☐
10. Remote inguinal hernia repair; uncomplicated	☐	☐	☐
Earlier reviews			
11. 12/10/26: wife reports coughing when gulping drinks	☐	☐	☐
12. Weight stable; no recent chest infection	☐	☐	☐
13. Urgent speech and language therapy referral made	☐	☐	☐
14. 28/10: smaller sips helped; occasional coughing persists	☐	☐	☐
15. No food sticking or painful swallowing reported	☐	☐	☐
Swallowing assessment and individual plan			
16. 02/11: therapist's home swallowing assessment; wife present	☐	☐	☐
17. Usual food and unthickened drinks retained after assessment	☐	☐	☐
Swallowing assessment and individual plan			
18. No coughing observed with single sips during assessment	☐	☐	☐
19. Individual plan: fully awake/upright; wife nearby; small mouthfuls/single sips, slowly; finish each before next	☐	☐	☐
20. Wife demonstrated prompts correctly; pt wishes to continue self-feeding	☐	☐	☐
21. Follow current prescription chart doses/times; no moving doses to meals/stopping/crushing; medicine-swallowing difficulty → urgent same-day practice advice before next dose due; NHS 111 if unavailable	☐	☐	☐
22. No difficulty swallowing usual tablets reported at assessment	☐	☐	☐
23. Recurrent coughing/wet voice → stop meal; urgent practice/NHS 111 advice	☐	☐	☐
24. Choking, unable to breathe/speak/cough effectively → 999; follow operator	☐	☐	☐
Home support and follow-up			
25. Wife asks about moving Parkinson's doses to mealtimes to simplify new routine; no changes made; requests written advice	☐	☐	☐
26. Wife unhappy with previous appointment's waiting time	☐	☐	☐
27. Neighbour's unrelated marital dispute discussed during visit	☐	☐	☐
28. Therapist home reassessment booked 10/11	☐	☐	☐
29. Parkinson's specialist review 17/11; bring swallowing symptom record	☐	☐	☐
30. 03/11: GP letter requested to explain agreed home plan	☐	☐	☐