Suspected myasthenia gravis: referral

Original independent practice. Allow 45 minutes: 5 minutes for reading and 40 minutes for writing. Assume that today's date is 6 November 2026. You are Ms Hagan's general practitioner. Using the case notes, write a referral letter to Dr Annie Deeley, Neuromuscular Specialist, Outpatient Neurology Service, 24 Clinic Road, NSW 2000, Australia. Request assessment and advice regarding possible myasthenia gravis, communicating the fluctuating symptoms, examination findings and pertinent negatives without presenting the diagnosis as confirmed. 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: Ms Kori Hagan	☐	☐	☐
2. DOB: 14/03/1992 (34 yrs)	☐	☐	☐
3. GP review: 06/11/2026; first neurology referral	☐	☐	☐
Social background			
4. School administrator; afternoon computer work increasingly difficult	☐	☐	☐
5. Lives with partner; independent in daily activities	☐	☐	☐
6. Stopped driving voluntarily because of intermittent double vision	☐	☐	☐
7. Enjoys baking; entered local cake competition	☐	☐	☐
8. Reports sister's marriage difficulties; requests confidentiality	☐	☐	☐
Medical history			
9. No previous neurological diagnosis or thyroid disease	☐	☐	☐
10. Symptoms began gradually 6/52 ago: intermittent R ptosis + binocular diplopia	☐	☐	☐
11. Worse with prolonged activity/late afternoon; ↓ after rest; often absent on waking	☐	☐	☐
12. Past appendicectomy, aged 15; uncomplicated recovery	☐	☐	☐
13. Regular medicines: nil; no known drug allergies	☐	☐	☐
Current assessment			
14. Arms tire washing hair; improves after resting	☐	☐	☐
15. No persistent limb weakness, falls or neck weakness	☐	☐	☐
16. No dysphagia, choking, speech change or breathlessness	☐	☐	☐
17. No headache, eye pain, sensory disturbance or sphincter symptoms	☐	☐	☐
Current assessment			
18. No recent infection; no weight loss	☐	☐	☐
19. Afternoon examination today: alert; comfortable at rest	☐	☐	☐
20. Speech clear; no respiratory distress observed	☐	☐	☐
21. Sustained upgaze → increased R ptosis; improves after rest	☐	☐	☐
22. Pupils equal/reactive; reflexes and sensation normal	☐	☐	☐
23. Limb power initially full; repeated shoulder abduction increasingly difficult	☐	☐	☐
Investigations and treatment			
24. FBC, electrolytes, TSH (04/11): reported normal by laboratory	☐	☐	☐
25. No antibody testing, neurophysiology or imaging performed	☐	☐	☐
26. No condition-specific treatment started	☐	☐	☐
Plan			
27. Patient concerned symptoms will affect employment	☐	☐	☐
28. Refer for assessment of possible myasthenia gravis; diagnosis unconfirmed; request investigation/management advice	☐	☐	☐
29. Complained receptionist was unfriendly during booking	☐	☐	☐
30. Earlier advice recorded: new swallowing/breathing problems → urgent medical assessment; severe difficulties → ambulance. GP addendum 06/11/2026: earlier escalation advice superseded; patient re-contacted and advised new swallowing difficulty → urgent medical assessment; any breathing difficulty or severe swallowing difficulty → call 000 immediately for ambulance; do not wait for breathing symptoms to become severe or for specialist appointment	☐	☐	☐