The Purpose Statement: Purpose statement reflecting correct context

(Exercise based on "Steven Boyce" found in Module 9 of the Intensive Online writing Course)

Introduction

While you do NOT HAVE to use the words "transfer", "discharge", "referral" in your purpose statement, the opening of your letter should always reflect

1. Patient issue (relevant diagnosis for the specific reader)
2. Your reason for writing the letter (call-to-action for the reader)
3. Level of urgency OR frequency with which the reader should act (as relevant)

Demonstration

Let us look at ways the below ORIGINAL SAMPLE could be improved

ORIGINAL SAMPLE	**"Thank you for seeing Mr Boyce who is being referred to further assessment of persistent cough and currently suffering from allergic pneumonitis and weight loss."**
COMMENTS	There are 3 issues to note which give us the **PURPOSE / REASON** for writing this letter: 1. The patient has allergic pneumonitis 2. It requires ongoing treatment, not just one visit or prescription 3. This patient is **MOVING HOUSE** and so going to another GP clinic that will be **TAKING OVER HIS CARE COMPLETELY** Additionally, **GRAMMAR** needs to be corrected so meaning is clear. (Clarity is one of the examiners' criteria).

How could we improve the Original Sample above?

Ex. 1	Thank you for seeing Mr Boyce who is being referred **TO your clinic FOR ongoing assessment** and **management** of his allergic pneumonitis, **as** he is moving back to his parents. **Content:** "Ongoing" tells the reader that the patient should be seen more than just once. "Management" is used because the patient already has a confirmed diagnosis. Continued care of this is what he needs. **Grammar:** • refer TO some place or someone BUT refer FOR something

Ex. 2	Thank you for **accepting** Mr Boyce who was diagnosed with allergic pneumonitis, confirmed by laboratory tests. As he wants to move back to his parents **in Richmond**, he is being transferred to your clinic for further monitoring **OR for ongoing monitoring and management**. **Content:** Using the word "accept" gives the same message as "transfer" **Grammar:** Good
Ex. 3	I am writing **in advance** about **THE transfer OF** Mr Boyce, 28 years old, who **HAS BEEN** recently diagnosed with allergic pneumonitis. He needs further follow up and monitoring by your community clinic **since he must relocate** to Richmond where he is to live with his parents. **Content:** Diagnosis and reason for letter given in full, including indicating that the reader now has full responsibility for patient follow up **Grammar:** Good
Ex. 4 (TEACHER SAMPLE)	Thank you for **accepting care of** Mr Boyce who requires **ongoing** assessment and management of allergic pneumonitis and review of his recent secondary weight loss. He is moving to your community to reside with family. **Content:** A very concise purpose statement. "Accepting care" indicates that the reader is now responsible for future follow up. It means the same as "I am transferring". Also, we mention why the action is needed. **Grammar:** Good

EXERCISE: Below are 3 case notes. Write the PURPOSE STATEMENT ONLY for each.

- GAlverez
- RMatthews
- PMorris

WRITING SUB-TEST: **NURSING**
TIME ALLOWED: **READING TIME:** **5 MINUTES**
WRITING TIME: **40 MINUTES**

NURSING: You are the nurse in the outpatient clinic of the local hospital, following up a discharge. Read the case notes and complete the relevant task that follows.

NOTES:

Patient: Gertie Alvarez **Age:** 68 years old

Address: 62 Pickering Farm Estate

Social history: Owns cattle farm with husband >30 years
Smokes 5-10 cigarettes / day x 35 years
Alcohol – rarely

Medical Background: Hypertension
Peripheral venous disease

Medication: Indapamide 2.5 mg o.d., Verapamil SR 240mg o.d.; Atorvastatin (Lipitor) 40 mg o.d.

24 Sep 2019: **Seen in Emergency Department, referred from private GP**

- Fatigue, headache, pounding in ears x 2 weeks. No fainting, dyspnea or chest pain
- BP 153/104; ECG – NAD; other systems – normal

Diagnosis: Uncontrolled hypertension

28 Sep 2019: **In-patient discharge summary**
1) Uncontrolled hypertension 2) High cholesterol -↑total 242mg/dl (normal < 200mg/dl) ; ↑LD160mg/dl (normal <100mg/dl) 3) small R ankle ulcer noted

Medications: Indapamide 1.25 mg o.d., Verapamil SR 180mg o.d.; Atorvastatin (Lipitor) 20 mg o.d.

Instructions: 1) continue medications 2) advised low sodium, low fat diet
3) to stop smoking 4) monitor ankle wound & keep clean
5) 1-month appointment to Out-Patient clinic

29 Oct 2019: **Outpatient clinic**
Ankle wound persists. Otherwise feels well; still smoking; no rest from farm work

Examination: BP 148/88 R ankle – swollen +, 1.0 cm shallow wound, surrounding skin discoloration
Right leg Doppler U/S done → venous insufficiency

Assessment: venous stasis ulcer

Plan:
1) ↑Verapamil to 240mg o.d.; other meds as before
2) Wound – antibiotic gauze dressing
3) Pressure stockings – put on soon after rising in morning
3) To stop smoking completely

29 Nov 2019: Smoking & diet unchanged; not using pressure stockings (uncomfortable to wear while farming); puts antibiotic ointment on ankle wound occasionally; ✓taking meds

Examination: BP 144/82 CVS/RS/Abd – normal
R ankle- swollen ++, superficial 4 cm wound, exudate, mild foul odour. Surrounding skin rash dry, flaky.

Assessment: Chronic venous stasis ulcer

Plan: 1) Counselled on importance of pressure stockings, low sodium diet, and stopping smoking
2) Continue meds
3) Repeat out-patient appointment in one month
3) Refer to Wound Care Practice for cleaning, dressings and reinforcement of counselling

WRITING TASK- NURSING

Using the information in the case notes, write a referral letter to the Wound Care Practice, requesting assistance with management. Address your letter to the Practice Duty Nurse.

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**

CASE NOTES F – TIA & Fall Risk

WRITING SUB-TEST: **MEDICINE**
TIME ALLOWED: **READING TIME:** **5 MINUTES**
WRITING TIME: **40 MINUTES**

You are the Head Ward Nurse on a medical ward**.** Below are case notes of your patient. Read the notes and complete the task that follows.

NOTES:

Patient: Roger Matthews **Date of birth:** 82 years old

Address: Mandeville Assisted Living Community

Medical Hx: Transient ischemic attack (TIA) 1 year ago – followed up by neurologist & GP
No diabetes or hypertension

Routine medications: Aspirin 100 mg o.d.

Social Hx: Widowed 4 years ago. Enjoys daily country walks. Non-smoker. Moderate drinker. Son lives in another state.

Family history: Nil significant

28 June, 2018 **A&E Department**

Complaints: Fell 45 minutes ago while out walking. Loss of consciousness– patient cannot remember (confused). Pain in head and left arm.

Examination: mm – pink, dryish BP 151/98 Other vitals normal ECG normal

CVS / RS / Abdomen – normal
CNS - moderately confused but obeys instructions without assistance. Glasgow coma scale 4-4-6. Pupils equal and reactive. Reflexes normal R=L

Minor scratches to upper R arm bruised, tender but normal function

Lab tests: Full blood count – normal; blood alcohol – 0; Blood glucose – normal;
PT/PTT – normal INR 1.9 LDL 198mg/dL
Na & BUN– mildly elevated; ECG - normal
CT scan head – no abnormality

Diagnosis: 1) ?Transient ischemic attack (TIA) 2) mild concussion 3) mild dehydration

Management: 1) Admit to ward
2) IV fluids for rehydration
3) Plavix 300 mg and Aspirin 325 mg p.o stat

CASE NOTES F – TIA & Fall Risk

29 June, 2018

Subjective: Slept well. Still does not recall falling. Knows his address, date of birth and roommate's name.

Objective: Alert; responses appropriate GCS 4-4-6. BP 142/82; PR 78/min; Temp 37.3C.

Roommate brought clothing and toiletries; provided details: Mr. Matthews had a fall in his room a month ago. Roommate found him and helped him to his feet. Mr. Matthews told roommate that just before the fall, his right had started shaking and he became dizzy. Felt normal again within half hour → refused medical attention. Roommate not confident Mr. Matthews always takes his aspirin.

Diagnosis: Recurrent TIA

Management: 1) Discontinue IV
2) MRI → no abnormality seen
3) Plavix 75 mg AND Aspirin ER 162.5 mg p.o. once daily

1 July, 2018

Observations: Patient slept well; anxious to go home. Now recalls feeling weak and dizzy before his fall.

Discussed diagnosis and increased risk and dangers of fall in future. Patient consents to son and assisted living facility admin being informed.

Management: 1) Discharge
2) ASA extended release 162.5 p.o. once daily
2) Update patient's son, GP and neurologist
3) Letter to assisted living facility about increased fall risk
4) Schedule for angiography

WRITING TASK

Using the information in the case notes, write a summary letter to the Head Nurse at Mandeville Assisted Living Community outlining Mr. Matthews most recent issues.

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**

WRITING SUB-TEST: **NURSING / MEDICINE**
TIME ALLOWED: **READING TIME:** **5 MINUTES**
WRITING TIME: **40 MINUTES**

MEDICINE: You are the general physician at a university clinic.
NURSING: You are the Nurse Practitioner at a university clinic.
Read the case notes then complete the task that follows.

NOTES:

University Clinic registration: Sept 2017

Patient: Penny Morris **Age:** 19 years old

Height: 168 cm **Weight:** 59kg **BMI:** 20.9 (normal 18.5–24.9)

Past medical history: Infant – umbilical hernia surgery

Social: Parents divorced 2 years ago; mother lives in another state; father in military overseas. Has a boyfriend locally.
Lives in Student Residence; hobby tennis – has played since high school. Works part time (office supply store).
Smokes occasionally.

Family history: Parents – nil known. No siblings.

Medication: None

Clinic visits:

1 Dec 2017: Headaches – global, worst when studying. Relieved by sleep. No photophobia, aura or vomiting.
Paracetamol. Advised 7-8 hours sleep nightly & eye exam.

8 May 2018: Tenderness outer R elbow since last tennis game (5 days ago). Tingling in thumb & first finger.
Ibuprofen 600mg tds after meals. Rest joint; ice packs x tds.
Patient requests sick note x 2 weeks for part-time job - needs a break after breaking up with boyfriend recently

2 Oct 2018: Discomfort in throat when swallowing. No pain on swallowing, reflux or coughing. Thinks some foods might cause it (vegetables, meat)
Examination: ears, nose, throat, chest, abdomen – normal.
Management: Reassured.

15 Nov 2018 Constipated. Appetite↓. Eats mainly cheese pizza and pasta (most "comfortable foods" to eat).
Examination: Wt. 56 kg (BMI 19.8) All systems – normal.
Management: Fiber laxative. Advised ↑ fluids & fibre (fruits, vegetables).

21 Mar 2019 "Quite tired". Studies stressful. Quit job. Diet still poor: breakfast - coffee and slice of toast; dinner – pizza or pasta; nothing between. Does not eat most meats, fruits, vegetables or nuts.
Examination: pale mucous membranes. No jaundice. Wt. 53 kg (BMI 18.8) Chest, abdomen – normal.
Management: CBC, BUN, Liver function tests
Patient refused dietitian consultation
Multivitamin. Diet advice repeated
Review in 2 weeks with test results

4 April 2019 Missing morning classes – too tired. No menstruation since last December (not sexually active). Food issues continue - not going out with friends, feels under pressure to eat like them; does not usually like the food. Denies concern about being thin and body image. No thoughts of self-harm.

Examination: Clothing too big. Wt 52 kg (BMI 18.4) All systems - normal.

Lab results: WCC – normal. RBG, electrolytes & blood clotting – all normal.
Hb -9.5 ↓; Cholesterol↓; BUN ↓; serum protein ↓

Diagnosis: Malnutrition, eating disorder, depression

Management: Counselled & persuaded to see dietitian
Does not wish mother involved
Continue multivitamins
Request psychologist earliest assessment and management plan

WRITING TASK – NURSING/MEDICINE

Using the information given, write a referral letter to the psychologist, asking for further assessment and management of this patient. Address your letter to Mr. Bradley Hinds, Mental Health Practice, University Boulevard.

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**

PURPOSE STATEMENT PRACTICE – InSync 5.10.2022

Examples of purpose statement that fulfill the 3 criteria of

1. Patient issue (relevant diagnosis for the specific reader)
2. Your reason for writing the letter (call-to-action for the reader)
3. Level of urgency OR frequency with which the reader should act (as relevant)

A. GAlvarez

- I am writing to refer Mrs. **Alvarez who** was diagnosed with peripheral venous disease and who has developed a chronic venous stasis ulcer on her right ankle. She requires your further assistance and ongoing management following her discharge on 28. September. Mrs. Alvarez has hypertension which contributes to her issues.

- Thank you for accepting Mrs. Alvarez into your care**, who** developed a chronic venous stasis ulcer on her right ankle, into your care. She needs your professional assistance and further management after her discharge on 28. September.
  Mrs. Alvarez, who suffers from hypertension, first presented…..

- *Alternative:* Thank you for accepting into your care, Mrs. Alvarez who has developed a chronic venous ulcer….

B. RMatthews

- I am writing to update you on the details regarding Mr. **Matthews who** was newly diagnosed with mild concussion and dehydration. He needs your ongoing **monitoring** following HIS discharge as he is at risk for further falls.

- I am writing to refer Mr. Matthews back into your care. He was newly diagnosed with mild concussion and dehydration following a fall while out walking. In his **ongoing care**, please consider that he is at risk for further falls.

C. PMorris

- I am writing to refer Ms. Penny Morris, a 19-year-old female, who was diagnosed with depression, associated with eating disorder and malnutrition. She requires your expert assessment and appropriate management as soon as possible / at your earliest appointment.

PURPOSE STATEMENT PRACTICE – InSync 5.10.2022

GRAMMAR:

Defining and non-defining (relative) clauses

Relative clauses start with *who, which, that, whose… and can either define the subject OR simply give extra information.*

Defining clause: I am a teacher **who works online**.

Non-defining clause: The teacher, **who works often from home**, often teaches in classrooms and lecture halls, as well.

- A relative clause should not be so long that the reader loses track of what the main subject was.
- The relative pronoun should not be so far from the subject, or with so many interrupting subjects in the first part of the main clause, that the reader is at risk of not being clear on what "who, which, what" refer to.

These two elements go beyond correct grammar to good "readability" and style.