

DEPARTMENT OF HEALTH & FAMILY WELFARE
 GOVERNMENT OF WEST BENGAL
 OPD Patient Card

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Name : Sex : Ref. From : Age : Yrs. Months Days		Visit No. : 1 Department : Doctor / Unit Name (DOW) : Room No. :	
Day : Reg. No. : Reg. Date : Card No. : Time :		Visit Date : Visit No. : 2 Department : Doctor/Unit : Visit Date : Tm. : Entry No. :	
Day : Reg. No. : Reg. Date : Card No. : Time :		Visit Date : Visit No. : 3 Department : Doctor/Unit : Visit Date : Tm. : Entry No. :	
Day : Reg. No. : Reg. Date : Card No. : Time :		Visit Date : Visit No. : 4 Department : Doctor/Unit : Visit Date : Tm. : Entry No. :	

<p>ADVICE</p> <p>Ref</p> <p>10</p> <p>10</p> <p>10</p> <p>Diabetic clinic</p> <p>Eye OPD</p> <p>Neurology OPD</p>	<p>Clinical Notes</p> <p>8102 NAT 67</p> <p>W/pt 40 yrs w/ Hb: 7.9</p> <p>Cx 2 4.8</p> <p>Nervous</p> <p>↑ Lipidic</p> <p>Bf x 170</p> <p>B/L BR</p>
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