

COLLEGE OF MEDICINE & SAGORE DUTTA HOSPITAL

Government of West Bengal

Kamarhati, Kolkata - 700 058

( X-RAY / ULTRA SOUND )

OUTDOOR / INDOOR REQUISITION FORM

Patient's Name..... *Shila Sankar* Registration No. .... *107735*  
Age..... *45y* ..... Male / Female..... *F* ..... Religion-Hindu / Muslim / Christian  
Address.....  
Physician / Surgeon.....  
Ward / O.P.D. .... *ER* ..... Bed No. .... Paying Bed No. ....  
Description of disease.....  
Type of X-Ray / Investigation..... *CT Scan of Brain*

Report :

Signature of attending  
*[Signature]*  
Medical Officer

Signature  
Radiology / E.C.G. Deptt.  
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