

College & Hospital (Paschim Medinipur)

U.S.G. REQUISITION FORM

69466



Patients' Name *Chabi Doley* Age *75* Sex *M* M/F.....

Under Doctor *U.A* Ward / O.P.D. *MMB*.....

Paying / Non-Paying / Bed No. .... Clinical Diagnosis .....

Particulars Parts to be Examined *CXR P.A view*.....

Date : *22/08/18*

*[Signature]*  
Adviser

Signature of the Radiologist  
MMC & H (Paschim Medinipur)

REPORT

ght:  
e: 22/08/20

Amount  
100.00

SHRABONI

Total Amount : Only  
RECP 11:37

Amount : 100.00  
Adj/Disc Amt : 100.00  
PAID. AMOUNT : 0.00  
DUE AMOUNT : 0.00

FOR MIDNAPORE DIAGNOSTICS PVT LTD

Signature of the Patient

Grievance Redressal Ph. No. : (03222) 222471, Mob. : 9476220002