

118081

JMM

Hospital

Kaly

Health District

Nadiv

District

Voucher for Free Services from PPP Diagnostic Lab

Patient Name: Mrs. Ahomed Age: 30 Sex: M

Address: Chowdhan Jogaddal

Register Id: 2326 Date: 20/8/18

Received the services and I have not paid any amount for the service.

Mrs. Ahomed

Signature of the Patient

Superintendent

Hospital

Health District, District

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M.  
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31001

nday

08/2018

083028

083028

Visit No. : 4-  
TM.

San-  
Kalyan

2541

8 232695267

used  
of lot of

20/8/18

c/o LBP for 1 1/2 months  
not relieved  
on medication

- MRI LS spine.

Adv.

[Signature]



# J. N. M. HOSPITAL, KALYANI

ELECTRO THERAPUTIC DEPARTMENT (X-RAY)

Name..... MIRAJ AHMAD ..... Age..... 30 ..... Sex..... M. .....

Address..... R 83026 .....

Physician/Surgeon..... IT ..... Ward.....

No. of Bed Cabin..... Paying / Non-Paying.....

Brief history of case Lower back pain.

Clinical Diagnosis MRI L-S spine.

Particular Point to be investigated.  
Instruction

Date- 20/8/18

Miraj Sahran  
Signature  
College of Medicine &  
J. N. M. Hospital Kalyani  
Nadia

## REPORT

2541

8147g

933695267

Adv.

- MRI L.S. spine.

20/8/18

c/o LBP for 1 1/2 month  
not relieved  
in medication

SD/UT  
nday  
932734  
5-2018  
083026  
01:16PM

Visit No. : 4  
TM.

DEPARTMENT OF HEALTH & FAMILY WELFARE  
**GOVERNMENT OF WEST BENGAL**  
**OPD Patient Card**  
**COLLEGE OF MEDICINE & JNM HOSPITAL**  
**WEST BENGAL UNIVERSITY OF HEALTH SCIENCES**  
**KALYANI, NADIA, PIN - 741 235**

MALE MEDICINE 182

MIRAJ AHMAD

[JNMM/RG1800093734]

User Name : DR. J. P. ...  
 Date : Monday

Name :	Age :	Yrs.	Months	Days	Regd. No. :	Day :
Sex :	Ref. From :	MALE MEDICINE Dr. KRISHANU BANIK			13-0	13-05-2018
Visit No. : 1	Department :				Reg. No. :	
Doctor/Unit Name (DOW) :	Room No. :				Card No. :	
Visit Date :			Visit Date :			Time :
Department :			Department :			
Doctor/Unit :			Doctor/Unit :			
Entry No. :			Entry No. :			

Visit No. : 2 Visit Date : Department : Doctor/Unit : Entry No. :	Visit No. : 3 Visit Date : Department : Doctor/Unit : Entry No. :	Visit No. : 4 Visit Date : Department : Doctor/Unit : Entry No. :
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Clinical Notes	ADVICE
<p><i>Ref</i></p> <p><b>LBP</b></p> <p><i>LBP for 1 1/2 months</i></p> <p><i>Referred to RT leg</i></p> <p><i>20/8/18</i></p> <p><i>c/o LBP for 1 1/2 months</i></p> <p><i>not relieved</i></p> <p><i>in medication</i></p>	<p><b>Ref to Dr. No. 000</b></p> <p>T. Pam (500/650) Acq- 1 box x 3 DPC                  T. I buprofen (200/400)- x 5d.                  T. Fm (20/40) Rab 20 Antacid                  T. Pan (40/D) omez (20)- 1 box x 00 AC                  T. Coamony elcv (625/375)- x 10d.                  T. Vit BC-                  T. cifron (500/250)-</p> <p><i>Diclofenac gel for locally used</i></p> <p><i>X-Ray L-S spine AP, S lat ob</i></p> <p><i>Adv.</i></p> <p><b>- MRI LS spine.</b></p>