

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

166552



Report / Treatment is required of

Name..... *Dr. Dipak Mishra* Age..... *51 yr* Sex..... *M*

Address.....

Physician / Surgeon..... Ward..... *GER* No. of Bed / Cabin

Paying / Non Paying

Brief history of case

Clinical Diagnosis

MRI cervical spine

Particulars point to be Investigated

MRI left shoulder

Instruction

Date..... *6/11/13*

Premal Mallick
Signature.....
061113

REPORT

- Notes :
- (1) This form should, except in urgent cases, be signed by the Visiting Staff.
 - (2) A note should, in all fracture cases, be made as to whether the splints may be removed.
 - (3) The time at which a Bismuch meal has been given should be noted.
 - (4) In the M. C. H. this form should be sent to the X-Ray Department at 8-30 a.m. for appointment of time.