

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

RG 18 00 688 085

Report / Treatment is required of

Name..... Sallehan Bibi ..... Age..... 54 ..... Sex..... F .....

Address.....

Physician / Surgeon..... I ..... Ward..... FMWc ..... No. of Bed / Cabin..... N42

Paying / Non Paying ..... F3 .....

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated MRI Brain

Instruction

Date..... 2/10/18 .....

R.G. Kar Medical College & Hospital  
Female Medicine Ward  
6th Floor  
Signature..... I .....

### 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.