Plate No. ....

Register No. ....

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department R418076102

Report / Treatment is required of

Name .... Madhuri Gain .... Age ..... 55 ..... Sex ..... F .....

Address ....

Physician / Surgeon ..... III - S ..... Ward ..... FSW ..... No. of Bed / Cabin ..... 14 .....

Paying / Non Paying ....

Brief history of case

Clinical Diagnosis

A case of ? choledocholithiasis c̄ chronic calculous cholecystitis (according to previous report).

Particulars point to be Investigated MRCP

Instruction

Date ..... 2/10/18 ..... Signature .....[signature].....

REPORT

Notes : (1) This form should, except in urgent cases, by 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.