

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name *Riddhi Das* Age *10 months* Sex *M*

Address .....

Physician / Surgeon *IV* Ward *MWB* No. of Bed / Cabin *5*

Paying / Non Paying .....

Brief history of case *Fever + Convulsion*

Clinical Diagnosis

Particulars point to be Investigated *MRI Brain*

Instruction  
Date *2/10/18*

Signature 

### REPORT

*Ph - 8017706397*  
*Ph - Barasat.*

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.