

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

Report / Treatment is required of

Name *Zulfikar Mondal* Age *51* Sex *M*

Address

Physician / Surgeon *I* Ward *MMW-6* No. of Bed / Cabin *14*

Paying / Non Paying

Brief history of case

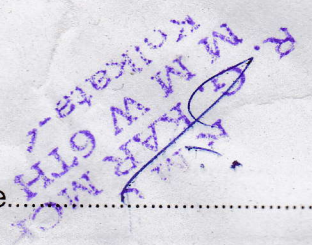
Clinical Diagnosis

Particulars point to be Investigated *MRI Brain*

Instruction

Date *28/11/18*

Signature



REPORT

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- 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