Plate No. .....

Register No. .....

1800 8539 44

MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

port / Treatment is required of

Name..... Kakali Pramanick

Address..... Age..... 30 ..... Sex..... f .....

Physician / Surgeon.....

Paying / Non Paying ..... Ward..... EBORE ..... No. of Bed / Cabin .....

Brief history of case

Clinical Diagnosis L/# .....

Particulars point to be Investigated

Instruction MRI of LS-spine

Date..... 8/12 .....

Signature..... Pramanick Mandal .....

REPORT

Name of the referring ...

Designation of the referring doctor : _____

Mobile No. of Patient/Patient party : 8159972684.

Imaging required : MRI L/S spine.

Subhankar Pal.

Full Signature of Rogi Sahayak

Received the service & I have not paid any amount for the service
Signature / LTI of the patient

Countersignature of on duty DNS

For any grievance contact Grievance Redressal Cell - 033-25557005, 8902023240,6291584407