

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name..... Saurik Das ..... Age..... 12 ..... Sex..... M .....

Address.....

Physician / Surgeon..... Dr. (MCWG) Paul ..... Ward..... MCWG ..... No. of Bed / Cabin..... 40 .....

Paying / Non Paying .....

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated MRI brain

Instruction

Date..... 4/12/18 .....

Signature.....  .....

### 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