

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

RG18094525

Report / Treatment is required of

Name..... Supriya Aich ..... Age..... 38y ..... Sex..... F

Address..... - .....

Physician / Surgeon..... T. A. Med ..... Ward..... FM 06 ..... No. of Bed / Cabin..... (3)

Paying / Non Paying .....

Brief history of case

Lower backache.

Clinical Diagnosis

Particulars point to be Investigated

MRI L5 spine ± MRI (RT) hip  
± contrast.

Instruction

Date..... 10/12/18 .....

R.M.O.  
Female Medicine Ward  
R.G. Kar Medical College & Hospital  
Signature..... [Signature]  
Anita Kumar

### REPORT

M → 22  
CR → 06

[Signature]

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.