

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

R61800811808

Report / Treatment is required of

Name..... 6/0 SERINA KHATUN Age..... 19 day Sex..... Male

Address.....

Physician / Surgeon..... paed Ward..... SNCL No. of Bed / Cabin..... 011

Paying / Non Paying

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated MRI Brain (non contrast)

Instruction

Date..... 10/12/18

Signature..... [Signature]

REPORT

This form should, except in urgent cases, be signed by the Visiting Staff.
Note should, in all fracture cases, be made as to whether the splints may be removed.
Time at which a Bismuch meal has been given should be noted.
The M. C. H. this form should be sent to the X-Ray Department at 8-30 a.m. for analysis.