

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

2418078910

Report / Treatment is required of

Name..... Sabita Mali ..... Age..... 35yr ..... Sex..... F .....

Address.....

Physician / Surgeon..... Neuromedici ..... Ward..... Neuromed ..... No. of Bed / Cabin F9 .....

Paying / Non Paying .....

farede

Ur - 27mg/dl  
Cr - 0.5mg/dl.

Brief history of case


Clinical Diagnosis

Particulars point to be Investigated

MRI Brain (P+E) + MR venogram

Instruction

Date..... 6/10 .....

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