

Register No. *2618W707868*

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

Report / Treatment is required of

Name *Atul Majumdar* Age *53yr* Sex *M*

Address

Physician / Surgeon *Unit-I* Ward *MMWJ* No. of Bed / Cabin *X4*

Paying / Non Paying

Brief history of case

Clinical Diagnosis *MRI Brain (P+C)*

Particulars point to be Investigated

Instruction

Date *8/20/18*

Signature *[Signature]*

REPORT

*9474 268436
P.S. Gopalmagn*

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- 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.