

# R. G. KAR MEDICAL COLLEGE & HOSPITAL OPD

## Electro Therapeutic Department

RUKMPA18005727  
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Report / Treatment is required of

Name..... Shibaji Bose ..... Age..... 24 yr ..... Sex..... M .....

Address.....

Physician / Surgeon..... Ward..... No. of Bed / Cabin .....

Paying / Non Paying.....

Brief history of case Back pain (cervical and lumbar region)

Clinical Diagnosis MRI spine (cervical and lumbar) and Sacrum.

Particulars point to be Investigated Whole spine

Instruction

Date..... Signature..... [Signature]

### REPORT

[Signature]  
RMOICER  
R.G.K.M.C.H.

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.