

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

Report / Treatment is required of

Name..... Dilip Karmakar Age..... 47y Sex..... M

Address.....

Physician / Surgeon..... Unit V (Med) Ward..... MMWS No. of Bed / Cabin..... 215

Paying / Non Paying

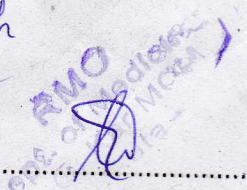
Brief history of case Paraparesis

Clinical Diagnosis

Particulars point to be Investigated Thoracolumbar spine MRI with whole vertebral screening

Instruction

Date..... 20/10/18

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.