

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

Report / Treatment is required of

Name..... Sova Chowdhury Age..... 84y Sex..... F

Address.....

Physician / Surgeon..... V-V-Med Ward..... FMW6 No. of Bed / Cabin..... X10

Paying / Non Paying

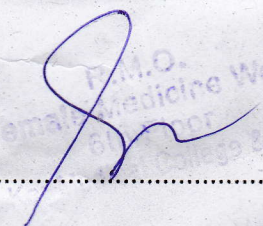
Brief history of case 2 CVA

Clinical Diagnosis MRI Brain

Particulars point to be Investigated

Instruction

Date..... 24/10/18

Signature..... 

REPORT

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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.