

Plate No. ....

Register No. ....

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name..... MANJU ADHIKARY Age..... 55 yrs Sex..... Female  
Address.....  
Physician / Surgeon..... VE (M.B.D.) Ward..... PMWB No. of Bed / Cabin..... 42

Paying / Non Paying .....

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated

Instruction

Date.....

*Paraforestis ↓ Evaluation*  
*MRI-DL spine - Screening of*  
*Cervical spine. (Plain).*

### REPORT

Signature.....  
*[Signature]*  
*Md. Anisul Hasan*  
*PT. W-VE (M.B.D.)*

R.M.O.  
Female Medicine Ward  
6th Floor  
R.G. Kar Medical College & Hospital

- (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 Bismuth 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.