

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name..... Tushar Ray ..... Age 45 yrs ..... Sex M

Address.....

Physician / Surgeon..... J.D. (S) ..... Ward..... 200 ..... No. of Bed / Cabin.....

Paying / Non Paying .....

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated

Instruction

Date..... 10/10/18 .....

MCP

10/10/18

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

**REPORT**