

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

RG-1800791132

Report / Treatment is required of

Name..... Najrul Haque Age..... ⁵⁸~~58~~ y Sex..... m

Address.....

Physician / Surgeon..... A Med Ward..... mmw 6 No. of Bed / Cabin..... (8)

Paying / Non Paying

Brief history of case

MRI brain

Clinical Diagnosis

Particulars point to be Investigated

Instruction

Date..... 21/11

Signature..... [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.