

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

RA180072603

Report / Treatment is required of

Name..... Asare Bisi Age..... 54 Sex..... M

Address.....

Physician / Surgeon..... I C. Med Ward..... PMW-6 No. of Bed / Cabin..... X8

Paying / Non Paying

Brief history of case

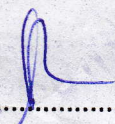
Clinical Diagnosis

MRI brain.

Particulars point to be Investigated

Instruction

Date..... 15/10/18

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.