

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name..... MONOJ DAS ..... Age..... 50 Y ..... Sex..... M .....

Address..... ..

Physician / Surgeon..... U-R(M) ..... Ward..... MMWS ..... No. of Bed / Cabin..... 13 .....

Paying / Non Paying .....

Brief history of case MRI (P+C) & MRS of BRAIN

Clinical Diagnosis Ur - 28

Particulars point to be Investigated Cr - 0.8

Instruction

Date..... 29/10/18 .....

Signature.....  
*Visiting Physician*  
*Dept. of Medicine*  
*MMW 5th*  
*R.G. Kar M.C.H., Kol-4*

### REPORT

- 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.