Form No. 815

Plate No. .....

Register No. .....

R. G. KAR MEDICAL COLLEGE & HOSPITAL

Electro Therapeutic Department

RG 1800681700

Report / Treatment is required of

Name.....Fatema Bibi.....Age.....50yr.....Sex.....F.....

Address.....

Physician / Surgeon.....medicine (S).....Ward.....Emw-5.....No. of Bed / Cabin .....

Paying / Non Paying .....

Brief history of case

Clinical Diagnosis

Particulars point to be Investigated MRI of brain

Instruction

Date.....29/9.....

Signature.....

REPORT

Notes : (1) This form should, except in urgent cases, by 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.