

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

RG1800779281

Report / Treatment is required of

Name..... DIP MUKHERJEE ..... Age..... 28y ..... Sex..... Male .....

Address.....

Physician / Surgeon..... U - IC - Chest ..... Ward..... Male Chest ..... No. of Bed / Cabin..... (30) .....

Paying / Non Paying..... Non-paying .....

Brief history of case..... LOB + Cough .....

Clinical Diagnosis..... Miliary TB .....

Particulars point to be Investigated

~~Chest X-ray (P-A view)~~  
MRI Brain (Plain + Contrast)

Instruction

Date..... 12/11/18 .....

Signature..... ONKAR PRAJAP  
R.M.O.  
Chest Medicine  
RATH  
R. G. K. 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 Bismuth meal has been given should be noted.
  - (4) In the M. C. H. this form should be sent to the X-Ray Department at 9.30 a.m. for appointment of