

# R. G. KAR MEDICAL COLLEGE & HOSPITAL

## Electro Therapeutic Department

Report / Treatment is required of

Name *Shiba Das* Age *45* Sex *M*

Address .....

Physician / Surgeon *V-II(0)* Ward *Teu(M)* No. of Bed / Cabin *26*

Paying / Non Paying .....

Brief history of case *AC Joint disruption.*

Clinical Diagnosis

Particulars point to be Investigated *MRI of B/L shoulder joint*

Instruction

Date *1/12/18*

Signature *Satyaki Chakraverty*

### REPORT

*RMO  
TCU 04 Fr  
R.G. Kar M.C.H.*

- 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 appo