



STATE OF KARNATAKA

DEPARTMENT OF HEALTH AND FAMILY WELFARE
KARNATAKA GOVT. MEDICAL COLLEGE, BANGALORE

Page No. _____
Date _____

Subject: _____
Topic: _____
Date: _____

1. Name of the patient: _____
2. Age: _____
3. Sex: _____
4. Address: _____
5. Date of admission: _____
6. Date of discharge: _____
7. Date of death: _____
8. Date of autopsy: _____
9. Date of necropsy: _____
10. Date of examination: _____

Sl. No.	Particulars	Remarks	Signature
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Signature of the Doctor: _____
Date: _____

Signature of the Nurse: _____
Date: _____