

No. 815

Plate No.
Register No. 145794

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Sabita Paul Age 53y Sex F

Address _____

Physician / Surgeon Dr. Dutta Ward ccv No. of bed/cabin 10

Paying / Non-Paying _____

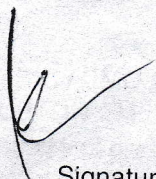
Brief history of case _____

Clinical Diagnosis C.T. Brain

Particular point to be investigated _____

Instructions _____

Date 8/7/18

Signature 

Report _____

Weight: _____
Date: 03/07/20
DIT

Amount
600.00

600.00
0.00
0.00
600.00

HEART RESEARCH CENTRE

- Note:—
- (1) This form should expect 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 have been given should be noted.
 - (4) In the M. C. H. this form should be send to the X-Ray Department at 8-30 a.m. for appointment to time.