

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

987

Name Smita Boddh Age 13y Sex F

Address _____

Physician / Surgeon _____ Ward _____ No. of bed/cabin _____

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

C - T. scan of Brain

Particular point to be investigated

Instructions

Date

3/7

[Signature]

Signature

Report

Weight:
Date: 03/07/2018

Amount
600.00

600.00
0.00
0.00
600.00

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.