Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

0382

Report / Treatment is required of

Name Puja Gupta Age 22 Sex F

Address

Physician / Surgeon Ward No.of bed/cabin

Paying / Non-Paying

Brief history of case C.T. Scan Brain

Clinical Diagnosis

Particular point to be investigated

Instructions

Date 5/7 Signature

Report

Weight:
Date: 03/07/2018
T

Amount
600.00

600.00
0.00
0.00
600.00

RCH 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.