gal Form No. 815

Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH

159

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name _____ Age 52 Sex M

Address _____

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

Paying / Non-Paying

Brief history of case

Clinical Diagnosis C.E.C.T Thoras

Particular point to be investigated

Instructions

Date

Signature

Report

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.

Weight:
Date: 03/07/201
EDIT

Amount
870.00
800.00
1,670.00
0.00
0.00
1,670.00

EARCH CENTRE