

No. 815

Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Reshmi Rhatra Age 24 Sex F

Address _____

Physician / Surgeon [Signature] Ward _____ No. of bed/cabin _____

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

1) A.T. Low C/S
2) A.T. Low h.d. Spine

Particular point to be investigated

Instructions

Date

[Signature]

Signature

Report

Weight:

Date: 03/07/201

DIT

Amount
1,740.00

1,740.00
0.00
0.00
1,740.00

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.