

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Weight:
Date: 04/07/2018

Name Alonda Col Bose Age 90 Sex M

CREDIT	
at	Amount
	600.00

Address _____

Physician / Surgeon S Debnath Ward MMW No. of bed/cabin 269

Paying / Non-Paying

Brief history of case

Clinical Diagnosis CT-Bron

Particular point to be investigated

600.00
0.00
0.00
600.00

Instructions

Date 04/07/18

Signature Sh

RESEARCH CENTRE

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.