DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Rayveer Shaw Age 1 Sex M

Address

Physician / Surgeon Ward No. of bed/cabin

Paying / Non-Paying

Brief history of case

Clinical Diagnosis CT Scan Brain

Particular point to be investigated

Instructions

Date 4/7 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.

ght:
e: 04/07/2018

Amount
600.00

600.00
0.00
0.00
600.00
CENTRE