Plate No.
Register No.

# DISTRICT HOSPITAL HOWRAH

289

## ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Nabab khan Age 07 month Sex M

Address

Physician / Surgeon Ward No.of bed/cabin

Paying / Non-Paying

Brief history of case

Clinical Diagnosis C.T. Scan of Brain

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.

eight:
ate: 04/07/2018
T

| Amount |
|---|
| 600.00 |
| 600.00 |
| 0.00 |
| 0.00 |
| 600.00 |

ARCH CENTRE