

West Bengal Form No. 815

Plate No.  
Register No.

# DISTRICT HOSPITAL HOWRAH

## ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Srijan Sakhmal Age 8 Sex M

Address \_\_\_\_\_

Physician / Surgeon  Dr. S.K. C Ward \_\_\_\_\_ No. of bed/cabin \_\_\_\_\_

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

*CT Scan  
Brain*

Particular point to be investigated

Instructions

Date

*[Signature]*  
Signature

Report