

West Bengal Form No. 815.

Plate No.
Register No.

no PD

DISTRICT HOSPITAL HOWRAH
ELECTRO-THERAPEUTIC DEPARTMENT

013

Report / Treatment is required of

Name *md Dasim* Age *76ys* Sex *male*

Address _____

Physician / Surgeon _____ Ward _____ No. of bed/cabin _____

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

c. T. scan whole A+D -

/

Particular point to be investigated

Instructions

Date

31/7.

[Signature]

Signature

Report