

910

# DISTRICT HOSPITAL HOWRAH

## ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name A Singh Age 20 Sex M

Address \_\_\_\_\_

Physician / Surgeon \_\_\_\_\_ Ward \_\_\_\_\_ No. of bed/cabin \_\_\_\_\_

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

CT Scan DL  
Spine

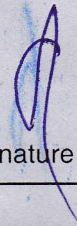
Particular point to be investigated

Instructions

Date

1/8

Signature



Report