

West Bengal Form No. 815

Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH
ELECTRO-THERAPEUTIC DEPARTMENT

565

Report / Treatment is required of

Name A. Bejan Age 200 Sex A

Address _____

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

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

CT Scan of Brain

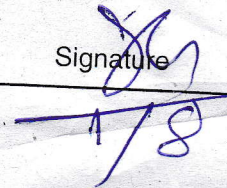
Particular point to be investigated

Instructions

Date

Report

Signature


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