

West Bengal Form No. 815

Plate No.
Register No. 437

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Ridika Shawr Age 1 Sex F

Address _____

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

Paying / Non-Paying
Brief history of case
Clinical Diagnosis

CT Scan Brain

Particular point to be investigated

Instructions

Date 8/8

Signature [Signature]

Report