

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

615

Report / Treatment is required of

Name A. Jaisan Age 20 Sex F

Address _____

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

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

At scan of Brain

Particular point to be investigated

Instructions

Date

Signature

Report

[Signature]
12/8/8