

# DISTRICT HOSPITAL HOWRAH

## ELECTRO-THERAPEUTIC DEPARTMENT

884

Report / Treatment is required of

Name S. Mukherjee Age 13 Sex P

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

Signature

Report

Sb  
13/8/19