

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name Sajid Ahmed Age 20 Sex M

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 17/8

Signature [Signature]

Report