

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

149695

Report / Treatment is required of

Name Bulko Sardan Age 60 Sex F

Address _____

Physician / Surgeon Dr S. Pal Ward Rayu No. of bed/cabin X91

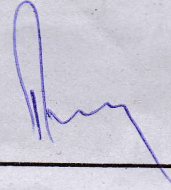
Paying / Non-Paying

Brief history of case

Clinical Diagnosis
Ⓡ side hemiparesis CT scan brain

Particular point to be investigated

Instructions
Date 1/27/18

Signature 

Report

Weight:
Date: 01/07/2018
DIT

Amount
600.00

600.00
0.00
0.00
600.00

RESEARCH CENTRE

- Note:—
- (1) This form should expect in urgent cases be signed by the visiting staff.
 - (2) A note should in all fracture cases be made as to whether the splints may be removed.
 - (3) The time at which a Bismuth meal have been given should be noted.
 - (4) In the M. C. H. this form should be send to the X-Ray Department at 8-30 a.m. for appointment to time.