315

Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name ______ Age ______ Sex ______

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 Signature

Report

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.

Weight:
Date: 02/07/20
EDIT

	Amount
	600.00
	600.00
	0.00
	0.00
	600.00

EARCH CENTRE