No. 815

Register No.

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

538

Report / Treatment is required of

Name Rubina Age 27Y Sex F

Address

Physician / Surgeon Ward No. of bed/cabin

Paying / Non-Paying

Brief history of case C.T. scan of Brain

Clinical Diagnosis

Particular point to be investigated

Instructions

Date 3/7. 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 rem
(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

Weight:
Date: 03/07/2018
DIT

Amount
600.00

600.00
0.00
0.00
600.00

SEARCH CENTRE