

West Bengal Form No. 815

Plate No.
Register No.

DISTRICT HOSPITAL HOWRAH
ELECTRO-THERAPEUTIC DEPARTMENT

374

Report / Treatment is required of

Name S. Khatun Age 8 Sex F

Address _____

Physician / Surgeon _____ Ward _____ No. of bed/cabin _____

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

CT Scan of

Particular point to be investigated

Brain

Instructions

Date 6/8

Signature [Signature]

Report