

DISTRICT HOSPITAL HOWRAH

ELECTRO-THERAPEUTIC DEPARTMENT

Report / Treatment is required of

Name P. Singh Age 28 Sex M

Address _____

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

Paying / Non-Paying

Brief history of case

Clinical Diagnosis

H.R. CT Therapy

Particular point to be investigated

Instructions

Date

[Signature]
Signature

Report