

LETTER OF APPROVAL / RECOMMENDATION

To,

The Coordinator,
MediWheel (M/s. Arcofemi Healthcare Pvt. Ltd.)

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS	EMPLOYEE DETAILS
NAME	MS. PRAJAPATI FALGUNI BABUBHAI
EC NO.	168839
DESIGNATION	CUSTOMER SERVICE ASSOCIATE
PLACE OF WORK	GHADKAN
BIRTHDATE	07-07-1990
PROPOSED DATE OF HEALTH CHECKUP	23-11-2024
BOOKING REFERENCE NO.	24D168839100118596E

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from **24-10-2024** till **31-03-2025** The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a **cashless facility** as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

Chief General Manager
HRM & Marketing Department
Bank of Baroda

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact MediWheel (M/s. Arcofemi Healthcare Pvt. Ltd.))

प. पत्र संख्या/
I Card No.
10790

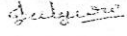



देना बैंक
DENA BANK

(A Government of India Enterprise)



नाम / Name : FALGUNI. B. PRAJAPATI
DOB / जन्म तिथि : 07/07/1990
पिता का नाम /
Father's Name : BABUBHAI. S. GURJAR
पी. आर. ए. एन. /
PRANEMPY/ P.F NO : 0011212
रक्त समूह / BG : B+ve
जारी करने की तिथि / Date Of Issue : 22/12/2017

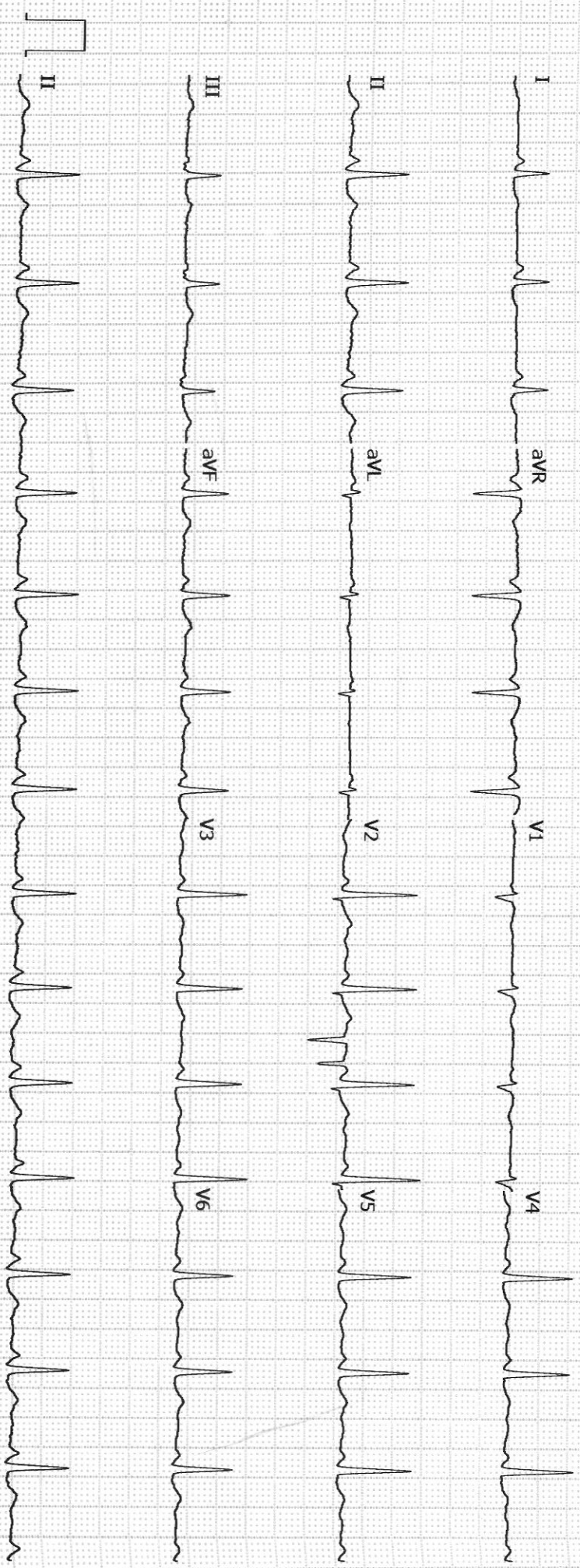

कर्मचारी के हस्ताक्षर
Signature of Staff


जारीकर्ता प्राधिकारी के हस्ताक्षर
Signature of Issuing Authority

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 68 ms
QT / QTcbaz : 334 / 406 ms
PR : 102 ms
P : 98 ms
RR / pp : 670 / 674 ms
P / QRS / T : 41 / 62 / 74 degrees

Sinus rhythm with short PR
Otherwise normal ECG



COLOUR DOPPLER ECHOCARDIOGRAPH REPORT

Patient's Name : Palguni Age : _____ Sex : _____
 Ref. by Doctor : _____ IP/OP No. : _____ Date : _____

MITRAL VALVE : 1
 AORTIC VALVE : 1
 TRICUSPID VALVE : 2
 PULMONARY VALVE :
 AORTA : 29
 LEFT ATRIUM : 29
 LV Dd/ Ds : 37/22 EF 60%
 IVS / LVPW / D : 10/8
 IVS : 1 cm to ch
 IAS :
 RA :
 RV : 12
 PA :
 PERICARDIUM : n

VEL	PEAK	MEAN
M/S	Gradient mm Hg	Gradient mm Hg
MITRAL	0.9/0.7	
AORTIC	1.0	
PULMONARY	0.7	
COLOUR DOPPLER	no MR/AR/TR	

RSVP :
 CONCLUSION : 2) W size / S ystole for

COLOUR DOPPLER ECHOCARDIOGRAPH REPORT

Aashka Hospitals Ltd.
Between Sargasan and Reliance Cross Roads
Sargasan, Gandhinagar - 382421. Gujarat, India
Phone: 079-29750750, +91-7575006000 / 9000
Emergency No.: +91-7575007707 / 9879752777
www.aashkahospitals.in
CIN: L85110GJ2012PLC072647



PATIENT NAME: FALGUNI B PRAJAPATI

GENDER/AGE: Female / 34 Years

DATE: 23/11/24

DOCTOR:

OPDNO: OSP35456

X-RAY CHEST PA

Both lung fields show increased broncho-vascular markings.
No evidence of collapse, consolidation, mediastinal lymph adenopathy, soft tissue infiltration or pleural effusion is seen.
Both hilar shadows and C.P. angles are normal.
Heart shadow appears normal in size. Aorta appears normal.
Bony thorax and both domes of diaphragm appear normal.
Left cervical rib is seen.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

REPORT REPORT REPORT REPORT REPORT

PATIENT NAME: FALGUNI B PRAJAPATI

GENDER/AGE: Female / 34 Years

DATE: 23/11/24

DOCTOR:

OPDNO: OSP35456

SONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: Liver appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen. No evidence of dilated IHBR is seen. Intrahepatic portal radicles appear normal. No evidence of solid or cystic mass lesion is seen.

GALL BLADDER: Gall bladder is physiologically distended and show tiny GB polyp of about 4.2 mm. No evidence of calculus or changes of cholecystitis are seen. No evidence of pericholecystic fluid collection is seen. CBD appears normal.

PANCREAS: Pancreas appears normal in size and shows normal parenchymal echoes. No evidence of pancreatitis or pancreatic mass lesion is seen.

SPLEEN: Spleen appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen.

KIDNEYS: Both kidneys are normal in size, shape and position. Both renal contours are smooth. Cortical and central echoes appear normal. Bilateral cortical thickness appears normal. No evidence of renal calculus, hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 10.2 x 4.3 cms in size.

Left kidney measures about 9.9 x 4.4 cms in size.

No evidence of suprarenal mass lesion is seen on either side.

Aorta, IVC and para aortic region appears normal.

No evidence of ascites is seen.

BLADDER: Bladder is normally distended and appears normal. No evidence of bladder calculus, diverticulum or mass lesion is seen. Prevoid bladder volume measures about 320 cc.

UTERUS: Uterus is anteverted and appears normal in size, shape and position. Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 4.7 mm. No evidence of uterine mass lesion is seen.

Bilateral adnexa appears normal.

COMMENT: Tiny GB polyp.

Normal sonographic appearance of liver, pancreas, spleen, kidneys, para aortic region, bladder and uterus.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST



LABORATORY REPORT



Name : FALGUNI B PRAJAPATI	Sex/Age : Female/ 34 Years	Case ID : 41102200485
Ref.By : HOSPITAL	Dis. At :	Pt. ID : 5090009
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Nov-2024 09:00	Sample Type :	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time :	Acc. Remarks : Normal	Ref Id2 : O24256899

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Haemogram (CBC)			
Haemoglobin	15.4	G%	12.0 - 15.0
RBC (Electrical Impedance)	5.27	millions/cu mm	3.80 - 4.80
PCV(Calc)	46.69	%	36.00 - 46.00
Lipid Profile			
Cholesterol	238.77	mg/dL	110 - 200
Triglyceride	172.04	mg/dL	<150
Chol/HDL	5.00		0 - 4.1
LDL Cholesterol	156.56	mg/dL	0.00 - 100.00
Liver Function Test			
Proteins (Total)	9.40	gm/dL	6.40 - 8.30
Albumin	5.84	gm/dL	3.5 - 5.2

Abnormal Result(s) Summary End

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : **FALGUNI B PRAJAPATI** Sex/Age : **Female/ 34 Years** Case ID : **41102200485**
 Ref.By : HOSPITAL Dis. At : Pt. ID : 5090009
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 09:51	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin	H 15.4	G%	12.0 - 15.0
RBC (Electrical Impedance)	H 5.27	millions/cumm	3.80 - 4.80
PCV(Calc)	H 46.69	%	36.00 - 46.00
MCV (RBC histogram)	88.6	fL	83 - 101
MCH (Calc)	29.2	pg	27.00 - 32.00
MCHC (Calc)	33.0	gm/dL	31.50 - 34.50
RDW (RBC histogram)	11.90	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

		UNIT	EXPECTED VALUES	[Abs]	EXPECTED VALUES
Total WBC Count	8270	/μL	4000.00 - 10000.00		
Neutrophil	[%] 57.0	%	40.00 - 70.00	4714	/μL 2000.00 - 7000.00
Lymphocyte	36.0	%	20.00 - 40.00	2977	/μL 1000.00 - 3000.00
Eosinophil	2.0	%	1.00 - 6.00	165	/μL 20.00 - 500.00
Monocytes	5.0	%	2.00 - 10.00	414	/μL 200.00 - 1000.00
Basophil	0.0	%	0.00 - 2.00	0	/μL 0.00 - 100.00

PLATELET COUNT (Optical)

Platelet Count	359000	/μL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	1.58		0.78 - 3.53

SMEAR STUDY

RBC Morphology : Normocytic Normochromic RBCs.
 WBC Morphology : Total WBC count within normal limits.
 Platelet : Platelets are adequate in number.
 Parasite : Malarial Parasite not seen on smear.

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah

M.D. (Pathologist)

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Laboratory : "KEDAR" Opposite Krupa Petrol Pump, Near Parimal Garden,
 Ahmedabad - 380006 ☎ 079-40408181 / 61618181
 contact@neubergsupratech.com

Regd. Office : Plot No. 7, Industrial Estate, Rajiv Gandhi Salai, Perungudi,
 Chennai - 600096, Tamil Nadu, India. | CIN - U85300TN2017PTC114099
 www.neubergsupratech.com



LABORATORY REPORT



Name : FALGUNI B PRAJAPATI	Sex/Age : Female/ 34 Years	Case ID : 41102200485
Ref.By : HOSPITAL	Dis. At :	Pt. ID : 5090009
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 10:36	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR <i>Westergren Method</i>	03	mm after 1hr	3 - 20	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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M.D. (Pathologist)

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Ref.By : HOSPITAL	Dis. At :	Pt. ID : 5090009
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 09:32	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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HAEMATOLOGY INVESTIGATIONS

BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology) (Both Forward and Reverse Group)

ABO Type	B
Rh Type	POSITIVE

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : **FALGUNI B PRAJAPATI** Sex/Age : **Female/ 34 Years** Case ID : **41102200485**
 Ref.By : HOSPITAL Dis. At : Pt. ID : 5090009
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Nov-2024 09:00 Sample Type : Plasma Fluoride F, Plasma Fluoride PP, Serum Mobile No :
 Sample Date and Time : 23-Nov-2024 09:00 Sample Coll. By : Ref Id1 : OSP35456
 Report Date and Time : 23-Nov-2024 10:36 Acc. Remarks : Normal Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Plasma Glucose - F <i>Photometric, Hexokinase</i>	94.9	mg/dL	70.0 - 100	
Plasma Glucose - PP <i>Photometric, Hexokinase</i>	113.9	mg/dL	70.0 - 140.0	
BUN (Blood Urea Nitrogen) <i>GLDH</i>	8.0	mg/dL	7.00 - 18.70	
Uric Acid <i>Uricase</i>	5.34	mg/dL	2.6 - 6.2	
Creatinine	0.66	mg/dL	0.50 - 1.50	

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh , A-Abnormal)

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LABORATORY REPORT



Name : FALGUNI B PRAJAPATI	Sex/Age : Female/ 34 Years	Case ID : 41102200485
Ref.By : HOSPITAL	Dis. At :	Pt. ID : 5090009
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 12:00	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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Glycated Haemoglobin Estimation

HbA1C <i>Immunoturbidimetric</i>	5.60	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) <i>Calculated</i>	114.02	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

- HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemc control.
- Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.
- Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.
- Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.
- In such circumstances glycemc control can be monitored using plasma glucose levels or serum Fructosamine.
- The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh , A-Abnormal)

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M.D. (Pathologist)

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LABORATORY REPORT



Name : **FALGUNI B PRAJAPATI** Sex/Age : **Female/ 34 Years** Case ID : **41102200485**
 Ref.By : **HOSPITAL** Dis. At : Pt. ID : **5090009**
 Bill. Loc. : **Aashka hospital** Pt. Loc :

Reg Date and Time : 23-Nov-2024 09:00 Sample Type : Serum Mobile No :
 Sample Date and Time : 23-Nov-2024 09:00 Sample Coll. By : Ref Id1 : **OSP35456**
 Report Date and Time : 23-Nov-2024 10:36 Acc. Remarks : Normal Ref Id2 : **O24256899**

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol <i>CHOD-POD</i>	H	238.77	mg/dL	110 - 200
HDL Cholesterol <i>Accelerator Selective Detergent</i>		47.8	mg/dL	40 - 60
Triglyceride <i>Glycerol Phosphate Oxidase</i>	H	172.04	mg/dL	<150
VLDL <i>Calculated</i>		34.41	mg/dL	10 - 40
Chol/HDL <i>Calculated</i>	H	5.00		0 - 4.1
LDL Cholesterol <i>Calculated</i>	H	156.56	mg/dL	0.00 - 100.00

NEW ATP III GUIDELINES (MAY 2001). MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal <100	Desirable <200	Low <40	Normal <150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240		High 200-499
High 160-189			

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment
- For LDL Cholesterol level Please consider direct LDL value
- Risk assesment from HDL and Trglycende has been revised. Also LDL goals have changed.
- Detail test interpreation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : **FALGUNI B PRAJAPATI** Sex/Age : **Female/ 34 Years** Case ID : **41102200485**
 Ref.By : **HOSPITAL** Dis. At : Pt. ID : **5090009**
 Bill. Loc. : **Aashka hospital** Pt. Loc :

Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Serum	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 10:52	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T. <i>NADH (Without P-5-P)</i>	30.42	U/L	0 - 55	
S.G.O.T. <i>NADH (Without P-5-P)</i>	22.82	U/L	5.0 - 34.0	
Alkaline Phosphatase <i>Para-Nitrophenyl Phosphate</i>	145.00	U/L	40.00 - 150.00	
Gamma Glutamyl Transferase <i>L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate</i>	37.33	U/L	0 - 38	
Proteins (Total) <i>Colorimetric, Biuret</i>	H 9.40	gm/dL	6.40 - 8.30	
Albumin <i>Colorimetric-Bromo-Cresol Green</i>	H 5.84	gm/dL	3.5 - 5.2	
Globulin <i>Calculated</i>	3.56	gm/dL	2 - 4.1	
A/G Ratio <i>Calculated</i>	1.64		1.0 - 2.1	
Bilirubin Total <i>Photometry</i>	0.67	mg/dL	0.3 - 1.2	
Bilirubin Conjugated <i>Diazotization reaction</i>	0.21	mg/dL	0 - 0.50	
Bilirubin Unconjugated <i>Calculated</i>	0.46	mg/dL	0 - 0.8	

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh ,A-Abnormal)

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M.D. (Pathologist)

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Name : FALGUNI B PRAJAPATI	Sex/Age : Female/ 34 Years	Case ID : 41102200485
Ref.By : HOSPITAL	Dis. At :	Pt. ID : 5090009
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Nov-2024 09:00	Sample Type : Serum	Mobile No :
Sample Date and Time : 23-Nov-2024 09:00	Sample Coll. By :	Ref Id1 : OSP35456
Report Date and Time : 23-Nov-2024 10:07	Acc. Remarks : Normal	Ref Id2 : O24256899

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Thyroid Function Test				
Triiodothyronine (T3)	131.86	ng/dL	70 - 204	
Thyroxine (T4) CMIA	9.94	ng/dL	4.87 - 11.72	
TSH CMIA	1.41	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTN and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipient hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a suppressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone. Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy

First trimester
Second trimester
Third trimester

Reference range (microIU/ml)

0.24 - 2.00
0.43-2.2
0.8-2.5

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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DR. KHUSHBOO PATEL
MS (OBS & GYN)
REG. NO. G-31287

UHID:		Date: 23/11/24	Time: 11:25 AM
Patient Name: Falguni Prayapati		Age: 34 yr	Mobile No:
Complaint and duration: Health checkup Unmarried			
History: 3-4 @ 9m @ 28-30 days Cus Menstrual irregular			
Menstrual history:	Flow	Duration of Bleeding	Presence of pain
Cycles			
LMP: 18/11/24			
H/O Associated illnesses:			
HTN:		DM:	
Thyroid disorder:	NAD	Others:	
Family History:			
Medication history: On Homeopathy sinusitis RA			
Obstetric History :		Last child:	
No of deliveries : Unmarried			
Allergy History: NAD			
Nutritional Screening: Well-Nourished / Malnourished / Obese			
General Examination:			
CVS	BP:	Oedema of ft	
RS	Wt: 49 kg	Tongue	
Breast examination:			

Prescription

P/

A

L/E

P/S- cervix

P/V

Provisional Diagnosis:

Investigation: USG Pelvis (sk)

Plan of care:

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration
		T. Ovables 170		oral	100	30w

Follow-up:

Consultant's Sign: DR. Khan

Aashka Hospitals Ltd.
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www.aashkahospitals.in
CIN: L85110GJ2012PLC072647



DR. TAPAS RAVAL
MBBS . D.O
(FELLOW IN PHACO & MEDICAL
RATINA)
REG.NO.G-21350

UHID:	Date:	Time:
Patient Name: <i>Palguni...</i>		Age / Sex: <i>34 / F</i> Height: <i>153 - cm</i> Weight: <i>48.7 - kg</i>
History: <i>C/O</i> <i>Ruzy chur no</i>		
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination: <i>D.V. < G16</i> <i>G16</i> <i>M.V. < G16</i> <i>G16</i> <i>colour with neck</i>		
Diagnosis:		

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Eye examination:

	RIGHT			LEFT		
	S	C	A	S	C	A
D						
N						

Other Advice:

Follow-up:

Consultant's Sign:

