MALVIN DIAGNOSTICS
Legacy of Trust

MC-5569

Patient Name : MR. VIJAY KUMAR	**Registration Time :** Nov 18, 2024, 09:51 a.m.
Age / Gender : 46 years / Male	**Receiving Time :** Nov 18, 2024, 10:59 a.m.
MR No. / IPD No. : /	**Reporting Time :** Nov 18, 2024, 03:00 p.m.
Patient Type / Bed No. : I /	241118046
Referred By : ARCOFEMI HEALTH CARE PVT.LIMITED (MEDIWHEEL)	**Panel :** Dr Arcofemi Health Care PVT.limited (MediWheel)
	Client Code : ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)

HAEMATOLOGY

Complete Haemogram - Hb RBC count and indices, TLC, DLC, PLATELET, ESR.

Test Description	Value(s)	Unit(s)	Reference Range
Hemoglobin (Hb) Method : Whole Blood, SLS-haemoglobin	13.3	g/dL	13.0 - 17.0
Erythrocyte (RBC) Count Method : Whole Blood, DC detection	4.62	x 10^6/uL	4.5 - 5.5
HCT Method : Whole Blood, RBC pulse height detection	**41.5**	%	42 - 52
Mean Cell Volume (MCV) Method : Whole Blood, Electrical Impedence	89.8	fL	78 - 100
Mean Cell Haemoglobin (MCH) Method : Whole Blood, Calculated	28.8	pg	27 - 31
Mean Corpuscular Hb Concn. (MCHC) Method : Whole Blood, Calculated	32.0	g/dL	32.0 - 35.0
Red Cell Distribution Width (RDW) CV Method : Whole Blood, Calculated	13.4	%	11.5 - 14.0
Total Leucocytes (WBC) Count Method : Whole Blood, Flow cytometry	5.9	x 10^3 /uL	4 - 10
DLC (Differential Leucocytes Count)			
Neutrophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	60.1	%	40 - 80
Lymphocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	31.8	%	20 - 40
Monocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	5.4	%	2 - 10
Eosinophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	2.4	%	1 - 6
Basophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	0.3	%	0 - 2
Absolute Neutrophil Count Method : Whole Blood, Calculated	3.55	x 10^3/uL	2.0 - 7.0
Absolute Lymphocyte Count Method : Whole Blood, Calculated	1.88	x 10^3/uL	1 - 3

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Panel : Dr Arcofemi Health Care PVT.limited (MediWheel)
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Test Description	Value(s)	Unit(s)	Reference Range
Absolute Monocyte Count Method : Whole Blood, Calculated	0.32	x 10^3u/L	0.2-1.0
Absolute Eosinophil Count Method : Whole Blood, Calculated	0.14	x 10^3/uL	0.02 - 0.5
Absolute Basophils Count Method : Whole Blood, Calculated	**0.02**	x 10^3/uL	0.02 - 0.1
Platelet Count Method : Whole Blood, DC Detection	209	x 10^3/uL	150 - 450
ESR - Erythrocyte Sedimentation Rate Method : Whole blood , Modified Westergren Method	14	mm/hr	<10

Interpretation:

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Tests done on Automated Six Part Cell Counter.

END OF REPORT

Dr.Arti Tripathi
MD Pathology
Chief Consultant, Pathology
DMC No: 43012

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Age / Gender : 46 years / Male	**Receiving Time :** Nov 18, 2024, 10:59 a.m.
MR No. / IPD No. : /	**Reporting Time :** Nov 18, 2024, 03:01 p.m.
Patient Type / Bed No. : I /	241118046
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Test Description	Value(s)	Unit(s)	Reference Range
IMMUNOLOGY			
T3, T4, TSH (Thyroid Profile Total),Serum			
(Triiodothyronine) T3-Total	0.85	ng/mL	0.80 - 2.00
Method : ECLIA			
(Thyroxine) T4-Total	7.9	ug/dL	5.10 - 14.10
Method : ECLIA			
TSH-Ultrasensitive	2.21	uIU/mL	0.27-4.20
Method : ECLIA			

Interpretation

The Biological reference interval provided is for Adults.

For age specific reference interval, please refer to the table given below.

TSH	T3/FT3	T4/FT4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hypothyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non Thyroidal illness/Secondary Hyperthyroidism

TSH (mU/mL)			
Childern	New Born	0.7	15.2
	6 days - 3 Months	0.72	11
	4 -12 Months	0.73	8.35
	1-6 Years	0.7	5.97
	7-11 Years	0.6	4.84
	12-20 years	051	4.3
Adults		0.27	4.20

TSH levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentration are observed during the afternoon. diurnal variation in TSH levels is approx 50%+/-, hence time of the day can influence the measured serum concentration.

END OF REPORT

Patient Name : MR. VIJAY KUMAR

Age / **Gender :** 46 years / Male

MR No. / **IPD No. :** /

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241118046

Panel : Dr Arcofemi Health Care PVT.limited (MediWheel)

Client Code : ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)

Test Description	Value(s)	Unit(s)	Reference Range

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Test Description	Value(s)	Unit(s)	Reference Range

HAEMATOLOGY

Blood Group (ABO)

Blood Group Method : Forward and Reverse by Slide method	"O"		
RH Factor	Positive		

Methodology

This is done by forward and reverse grouping by slide agglutination method.

Interpretation

Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required.Confirmation of the New-born's blood group is indicatedwhen the A and B antigen expression and the isoagglutinins are fully developed (2–4 years).

END OF REPORT

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BIOCHEMISTRY

LFT (Liver Function Test,Serum)

Test Description	Value(s)	Unit(s)	Reference Range
Total Protein	7.8	g/dL	6.4-8.3
Method : Biuret Method			
Albumin	4.3	g/dL	3.5 - 5.2
Method : Bromocresol Green			
Globulin	3.50	g/dL	1.8 - 3.6
Method : Calculated			
A/G Ratio	1.23	ratio	1.2 - 2.2
Method : Calculated			
SGOT	23	U/L	0 to 40
Method : IFCC without Pyridoxal Phosphate			
SGPT	32	U/L	0 to 41
Method : IFCC without Pyridoxal Phosphate			
Alkaline Phosphatase-ALP	78	U/L	40-129
Method : PNP AMP Kinetic			
GGT-Gamma Glutamyl Transferase	29	U/L	0 to 60
Method : IFCC			
Bilirubin Total	0.40	mg/dL	0.0-1.20
Method : Colorimetric Diazo Method			
Bilirubin - Direct	0.10	mg/dL	Adults and Children: < 0.30
Method : Colorimetric Diazo Method			
Bilirubin - Indirect	0.30	mg/dL	0.1 - 1.0
Method : Calculated			

Interpretation :

SGOT/ SGPT: Increased in Acute viral hepatitis, Biliary tract obstruction (cholangitis, choledocholithiasis), Alcoholic hepatitis and Cirrhosis, liver abscess, metastatic or primary liver cancer; non-alcoholic steatohepatitis; right heart failure. Decreased in Pyridoxine (vit B6) deficiency.

Alkaline Phosphatase: Increased in Obstructive hepatobiliary disease, Bone disease (physiologic bone growth, Paget disease, Osteomalacia, Osteogenic sarcoma, Bone metastases), Hyperparathyroidism, Rickets, Pregnancy (third trimester). Decreased in Hypophosphatasia.

GGT: Increased in Liver disease Acute viral or toxic hepatitis, Chronic or subacute hepatitis, Alcoholic hepatitis, Cirrhosis, Biliary tract obstruction.

Protein: Moderate-to-marked hyperproteinemia maybe due to multiple myeloma and other malignant paraproteinemias, Hypoproteinemia may be due to decreased production or increased protein loss.

Albumin: Increased in Dehydration, Shock, Hemoconcentration. Decreased in hepatic synthesis(Chronic liver disease, malnutrition, malabsorption, malignancy), Increased losses (Nephrotic syndrome, Burns, Trauma, Hemorrhage with fluid replacement, acute or chronic glomerulonephritis), Hemodilution (pregnancy, CHF) and Drugs (estrogens).

Bilirubin: A substance produced during the normal breakdown of red blood cells.Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

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Test Description	Value(s)	Unit(s)	Reference Range

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BIOCHEMISTRY

Lipid Profile,Serum

Test Description	Value(s)	Unit(s)	Reference Range
Cholesterol-Total **Method : Enzymatic Colorimetric,CHOD-POD**	194	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.
Triglycerides **Method : Enzymatic Colorimetric ,GOD-POD**	127	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
Cholesterol-HDL Direct **Method : CHOD-POD (Homogenous Enzymatic)**	**38**	mg/dL	No Risk - >55 mg/dL Moderate risk - 35-55 mg/dL High risk - < 35 mg/dL
LDL Cholesterol **Method : Calculated**	**130.60**	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
Non - HDL Cholesterol, Serum **Method : Calculated**	156	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL
VLDL Cholesterol **Method : Serum, Calculated**	25.40	mg/dL	0 - 30
CHOL/HDL RATIO **Method : Calculated**	**5.11**	Ratio	3.5 - 5.0
LDL/HDL RATIO **Method : Calculated**	**3.44**	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
HDL/LDL RATIO **Method : Calculated**	**0.29**	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

Note: 10-12 hours fasting sample is required.

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Test Description	Value(s)	Unit(s)	Reference Range

END OF REPORT

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MALVIN DIAGNOSTICS
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MC-5569

Patient Name : MR. VIJAY KUMAR	**Registration Time :** Nov 18, 2024, 09:51 a.m.
Age / **Gender :** 46 years / Male	**Receiving Time :** Nov 18, 2024, 10:59 a.m.
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Test Description	Value(s)	Unit(s)	Reference Range
BIOCHEMISTRY			
KFT (Renal Function Test,Serum)			
Urea	29.1	mg/dL	16.6-48.5
Method : kinetic (urease-GLDH)			
BUN	13.60	mg/dL	6-20
Method : Calculated			
Creatinine	1.00	mg/dL	0.70-1.30
Method : Kinetic Colorimetric (Jaffe Method)			
Uric Acid	5.1	mg/dL	3.4-7.0
Method : Enzymatic Colorimetric: Uricase-POD			

Interpretation :

Urea:- Increased in renal diseases,urinary obstructions, shock, congestive heart failure .Decreased in liver failure and pregnancy.

Creatinine :- Elevated in renal dysfunction, reduced renal blood flow shock, dehydration, Congestive heart failure, Diabetes Acromegaly. Decreased levels are found in Muscular Dystrophy.

Uric acid:- Increased in Gout, Arthiritis, impaired renal functions and starvation.Decreased in Wilson's disease, Fanconis Syndrome and Yellow Atrophy of Liver.

Sodium:-Increased in Excessive dietary salt ,Diuretic therapy,Adrenal insufficiency,Salt-wasting nephropathy and Vomiting.Decreased levels are seen in Hyperaldsteronism ,Hyponatremia,Prerenal Azotemia,Renal Failure and Glomerulonephritis.

Potassium:- Low levels is common in vomiting, diarrhea, alcoholism, and folic acid deficiency. Increase level are seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid potassium infusion.

Chloride:- Increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis, diabetes insipidus, adrenocortical hyperfuction. Decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis.

END OF REPORT

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MALVIN DIAGNOSTICS
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MC-5569

Patient Name : MR. VIJAY KUMAR	**Registration Time :** Nov 18, 2024, 09:51 a.m.
Age / Gender : 46 years / Male	**Receiving Time :** Nov 18, 2024, 10:59 a.m.
MR No. / IPD No. : /	**Reporting Time :** Nov 18, 2024, 03:00 p.m.
Patient Type / Bed No. : I /	241118046F
Referred By : ARCOFEMI HEALTH CARE PVT.LIMITED (MEDIWHEEL)	**Panel :** Dr Arcofemi Health Care PVT.limited (MediWheel)
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Test Description	Value(s)	Unit(s)	Reference Range
BIOCHEMISTRY			
Glucose (Fasting)			
Glucose Fasting	**143**	mg/dL	Normal: 72-106 Impaired Tolerance: 100-125 Diabetes mellitus: >= 126 (on more than one occassion) (American diabetes association guidelines 2018)
Method : Plasma,Enzymatic Hexokinase			

Interpretation

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

END OF REPORT

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MR No. / IPD No. : /		**Reporting Time :** Nov 18, 2024, 03:31 p.m.
Patient Type / Bed No. : I /		241118046
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Test Description	Value(s)	Unit(s)	Reference Range
IMMUNOLOGY			
PSA Total (Prostate Specific Antigen),Serum			
Prostate-specific antigen (Total)	0.018	ng/mL	0.0-2.0

Method : ECLIA

INTERPRETAION

- Prostate-specific antigen (PSA) is a glycoprotein produced by the prostate gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels.
- If total prostate-specific antigen (PSA) concentration is < 2.0 ng/mL, the probability of prostate cancer in asymptomatic men is low. When total PSA concentration is > 10.0 ng/mL, the probability of cancer is high and further testing is recommended.

Note :-

- Normal results do not eliminate the possibility of prostate cancer.
- The test specimens should be obtained before the patients undergoing prostate manipulation procedures like biopsy/transuretheral resection.

END OF REPORT

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CLINICAL PATHOLOGY

Urine (RE/ME)

Test Description	Value(s)	Unit(s)	Reference Range
Physical Examination :			
Volume Method : Visual Observation	40		mL
Colour Method : Visual Observation	Pale Yellow		Pale Yellow
Transparency (Appearance) Method : Visual Observation	**Hazy**		Clear
Deposit Method : Visual Observation	Absent		Absent
Reaction (pH) Method : Double Indicator method	6.0		4.5 - 8.0
Specific Gravity Method : Ionic Concentration	1.025		1.010 - 1.030
Chemical Examination (Dipstick Method) Urine			
Urine Protein Method : Protein Ionisation/ Manual	Absent		Absent
Urine Glucose (sugar) Method : Oxidase Reaction/ Manual	Absent		Absent
Blood (Urine) Method : Peroxidase Reaction	Absent		Absent
Microscopic Examination Urine			
Pus Cells (WBCs) Method : Microscopy	2 - 3	/hpf	0 - 5
Epithelial Cells Method : Microscopy	2 - 3	/hpf	0 - 4
Red blood Cells Method : Microscopy	Absent	/hpf	Absent
Crystals Method : Microscopy	Absent		Absent
Cast Method : Microscopy	**Granular cast** **Present**		Absent
Yeast Cells Method : Microscopy	Absent		Absent
Amorphous Material Method : Microscopy	Absent		Absent

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Test Description	Value(s)	Unit(s)	Reference Range
Bacteria	Absent		Absent
Method : Microscopy			
Others	Absent		

Remarks:-

Epithelial cells	Urolithiasis bladder carcinoma or hydronephrosis ,ureteric stents or bladdercatheters for prolonged periods of time.
Granular casts	Low intratubular pH,high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration,acute congestive heart failure, renal diseases.
Calcium Oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of VitaminC, the use of vascodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit(A verrhoa carambola)or its juice
Uric acid	Artharitis
Bacteria	Urinary infection when present in significant numbers and with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

END OF REPORT

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Atrial Rate

Ventricular Rate

Rhythm

Axis

P. Wave

P.R. Interval

QRS Duration

Q.T. Duration

Q.T. Interval

Conclusion

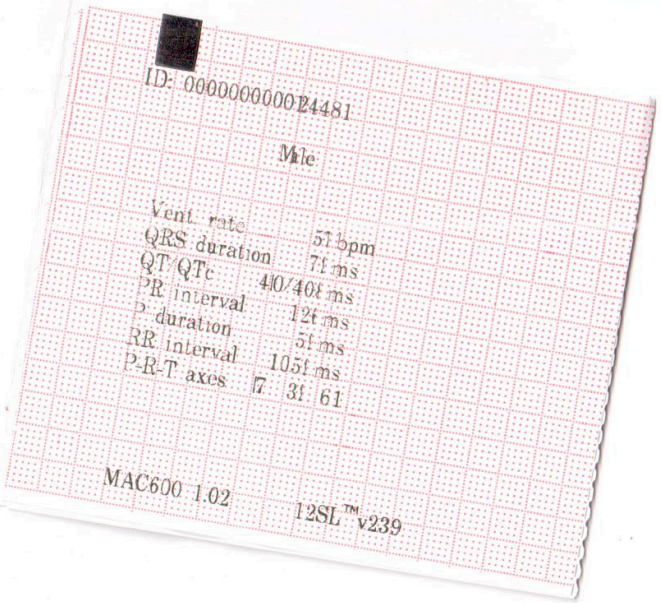
ST Segment

T. Wave

-Others

Signature

Doctor I/C



Echocardiography Report

Name: **Mr. Vijay Kumar**
Age/Sex: 46yrs/M
Date 18.11.2024
MR No: 124481
View ---fair

Summary of 2D echo-

- No chamber enlargement/hypertrophy seen.
- No RWMA
- LVEF- 60%.
- Grade II diastolic dysfunction (E/E'=7).
- Good RV function.
- No MR.
- Trace TR.
- No thrombus detected.
- No pericardial effusion seen
- IVC shows normal inspiratory collapse.

Observations

Dimensions

- LVID d = 39 (35-55mm)
- LV IVS= 10 (6-11mm)
- Pwd = 09 (6-11mm)
- Ao = 20 (20-37mm)
- LA = 25 (21-37mm)

Mr Vijay Kumar
Date: November 18, 2024

Age: 46 Y/ Sex: M
MR No:- 124481

ULTRASOUND WHOLE ABDOMEN

Excessive bowel gases noted in abdomen.

Liver is enlarged in size measuring 16.2 cm with diffuse increase in echogenicity s/o Moderate hepatomegaly with grade-II fatty infiltration-----Advice:- Fibro scan correlation. No focal lesion seen in the liver.
Intrahepatic bile ducts and portal radicals are normal in caliber.
Portal vein is normal in caliber

Gall bladder does not show any evidence of cholecystitis or cholelithiasis.

- CBD- proximal visualized part: - is not dilated.
- CBD- Mid and distal segment is obscured due to technical limitation.
- Central IHBR:- normal in caliber

Both kidneys are of normal size, shape and echopattern. No calculus, growth or hydronephrotic changes seen in either kidney. The parenchymal thickness is normal & cortico-medullary differentiation is well maintained.

Spleen is normal in size and echotexture.
Pancreas does not show any pathology.

Urinary bladder is distended and shows no mural or intraluminal pathology.
Prostate is normal in size and shape. No focal lesion is seen.
No free fluid or pelvic collection seen.

Please correlate clinically.

DR. GLOSSY B SABHARWAL, MD
CONSULTANT RADIOLOGIST
This report is only a professional opinion and it is not valid for medico-legal purposes.

JEEWAN MALA HOSPITAL

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Mark of Excellence

Name: Mr. Vijay Kumar   Age: 46yr   Sex: M

Ref by ....   Date: 18/11/24

M.R. No. .... H/O Drug Allergy - Yes / No ....

Deptt. of Medicine

Dr. Vineet Sabharwal
M.B.B.S., M.D. (MED)
Senior Physician
DMC No.: 3860

Dr. Rakesh Sharma
M.B.B.S., M.D. (MED)
Senior Consultant Physician
DMC No.: 5671

Dr. Vishal Garg
M.B.B.S., MD (Internal Medicine)
Senior Consultant Physician
Post Graduate in Diabetes (Boston, USA)
Thyroid Specialist (ATS, USA)
DMC No.: 50003

Dr. Pankaj Kumar
M.B.B.S. (Hons.) DTCD
Consultant Physician,
Pulmonologist & Intensivist
DMC No.: 18751

Dr. Glossy Sabharwal
MBBS, MD Radio-Diagnosis
Clinical and Interventional Radiologist
Maternal-Fetal Medicine Specialist
Fetal Medicine Foundation Certified (UK)
Fellow - Breast Interventional Imaging (Paris)
Ex - Jt. Secretary IRIA (Delhi)
Harvard University Certified
Yale School of Medicine Certified
Certified Reproductive Health Specialis
Distinction Holder MD Radiology
ECFMG Certified (USA)
Young Investigator Scholar (AOCR - Japan)
Member
ISUOG (USA)
IRIA (India)
SFM (UK)
IFUMB (India)
RSNA (USA)
e-mail: docglossy@gmail.com
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Mob.: 9811020477, DMC No. 58599

Dr. Laxmi Kant Tomar
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DM (Neurology)
DMC NO- DMC/R/5022

Dr. Jatin Anand
M.D. (Psychiatry)
DMC No.: 61376

Dr. Mudit Gupta
MBBS
DNB (General Medicine)
DM (Nephrology)
DMC No.: 34678

Dr. Avinash Bansal
MBBS, MD (Medicine)
DM (Cardiology) SGPIMS
DMC- 33007

Dr. Sandeep Bhagat
MBBS
MD (General Medicine)
DNB (Gastro)
DMC No.: 16977

Dr. Sandeep Garg
MBBS
MD (Pulmonary Medicine)
DMC No.: 52901

Dr. Nikhil Sharma
MBBS, DDV
Consultant Dermatology & Cosmetology
DMC No.: 27578

BP - 120/80 mmHg
PR - 85 /min
SpO_2 - 98 %
Temp - 97.6°F

~~xxxxx~~ -

based on primary investigations
patient is vitally stable

DR. SYED NAZMUS SAQUIB
CASUALTY MEDICAL OFFICER
DMC - DMC/R/27484
JEEWAN MALA HOSPITAL
NEW DELHI - 110005

Treatment Adv for..........days - Next Followup Visit on..........

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Mark of Excellence

Name: MR Vijay Kumar Age: 46y Sex: M

Deptt. .... Ref by .... Date: 18/11/24

M.R. No. .... H/O Drug Allergy-Y/N ....

Deptt. of General & Laparoscopic Surgery

Dr. Vinay Sabharwal
M.B.B.S., M.S., FICA
Hon. Surgeon to Fmr. President of India
Sir Ganga Ram Hospital
Sr. Member : Assciaciation of Surgeons of India
Indian Association of Gastro. Endo Surgeons
Indian Hernia Society
Association of Min. Access Surgeons of India
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DMC No. 4687

Dr. Malvika Sabharwal
MBBS, DGO, F.I.C.O.G., Dipl. Endo. Surgery (USA)
Awarded Padmashri by the President of India
Chief Dept. of Gynae, Laparoscopic, Endoscopy Surgery
President, Delhi Gynae Endoscopy Society (2018)
Founder Chairperson: Indian Ass. of Gynae. Endoscopists
International Society of Gynae. Laparoscopists
American Association Gynae. Laparoscopy
Federation of obst. & Gynae. Societies of India
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E-mail: drmalvika@jmh.in
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DMC No. 4686

Deptt. of E.N.T.

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Senior Consultant
D.M.C. No.: 12647

Dr. Rajeev Nangia
M.B.B.S., M.S. (E.N.T.)
Senior Endoscopic Surgeon
DMC No. 4681

Deptt. of Ophthalmology

Dr. Ashwani Seth
M.B.B.S., M.S.
Senior Consultant Eye Surgeon
D.M.C. No.: 13702

Dr. S.C. Pahwa
M.B.B.S., M.S. (Ophth)
Eye Surgeon
D.M.C. No.: 8424

Deptt. of Dentistry

Dr. Varun Aggarwal
B.D.S., M.D.S., CAIC, M.I.D.A.
Consultant Implantologist
& Unit Head

Dr. Neha Gupta
B.D.S., PGCHM, F.I.C.D., M.I.D.A.
Senior Consultant
Deptt. of Dentistry

+0.75 D[illegible]
129

LE +0.50
-1.50/160°

VA < 6/9, 6/12
Near < N6, N10

IOP [illegible] 40
[illegible]

Ant Segment - R/E - NAD

L/E Corneal opacity
c Iris ruptures
Lenticular opacity

Fundus B/E - NAD

Colour vision - Normal
on Ishihara chart

Blood:
Adv TSH
T3
T4.

Rx
- Andre Eye drops
Plus
s [illegible]

DR. S.C PAHWA
M.B.B.S., M.S (Ophth)
EYE Specialist
DMC No. - 8424
Jeewan Mala Hospital
New Delhi-110005

18/11/24

Treatment Adv for............days Next followup Visit on............

JEEWAN MALA HOSPITAL

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Mark of Excellence

Name Mr. Vijay kr. Age 46 Sex M.

Deptt. Dental Health checkup Ref by Date 17/11/24

M.R. No. H/O Drug Allergy-Y/N

Deptt. of General & Laparoscopic Surgery

Dr. Vinay Sabharwal
M.B.B.S., M.S., FICA
Hon. Surgeon to Fmr. President of India
Sir Ganga Ram Hospital
Sr. Member : Assciaciation of Surgeons of India
Indian Association of Gastro. Endo Surgeons
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Consultant Implantologist
& Unit Head

Dr. Neha Gupta
B.D.S., PGCHM, F.I.C.D., M.I.D.A.
Senior Consultant
Deptt. of Dentistry

O/E:- Stain ++
Cal ++.

Adv. OP.

Rx. Scaling Tooth paste

DR. NEHA GUPTA
B.D.S., P.G.C.H.M.
Consultant Dental Surgeon

Treatment Adv for.....days Next followup Visit on.....

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