



NABH



No.1

<b>PATIENT NAME :</b>	<b>Mrs. T LAYYA BABY</b>	<b>DATE :</b>	<b>08/03/25</b>
<b>AGE :</b>	<b>37 years</b>	<b>GENDER: FEMALE</b>	<b>PATIENT ID :</b>
<b>REF BY :</b>	<b>CMO</b>	<b>OP/IP :</b>	<b>HEALTH CHECK</b>

**2D- ECHOCARDIOGRAPHY**  
**M - MODE AND DOPPLER MEASUREMENTS**


(c.m)	(c.m)	(cm/sec)		
AO : 2.8 (2.5-3.7)	LVIDD : 4.0 (3.5-5.5)	MV EV : 105	AV : 85.9	MR : NORMAL
LA : 3.5 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 110		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 1.1 (0.6-1.1)	PV : 84.4		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : -----	AV : -----	TR : TRIVIAL TR. PASP-27mmHg
TAPSE: 2.0 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

**DESCRIPTIVE FINDINGS**

Left Ventricle	: CONCENTRIC LVH
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis:	NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

**IMPRESSION :**

NORMAL CHAMBER DIMENSIONS  
 NORMAL LV SYSTOLIC FUNCTION EF : 60%  
 NORMAL LV DIASTOLIC FUNCTION  
 NO PULMONARY ARTERY HYPERTENSION  
 NO REGIONAL WALL MOTION ABNORMALITIES  
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

  
**DR. RAHUL PATIL**  
 CONSULTANT CARDIOLOGIST



NABH



No.1

**DEPARTMENT OF RADIODIAGNOSIS**

<b>Name</b>	T Layaa Baby	<b>Date</b>	08/03/25
<b>Age</b>	37 years	<b>Hospital ID</b>	UHJA24012965
<b>Sex</b>	Female	<b>Ref.</b>	Health check

**ULTRASOUND ABDOMEN AND PELVIS**

**FINDINGS:**

**Liver** is normal in size and *shows mildly increased echopattern*. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

**Gall bladder** is normal without evidence of calculi, wall thickening or pericholecystic fluid.

**Pancreas** - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

**Spleen** is normal in size, shape, contour and echopattern. No evidence of mass or focal lesions. *Small splenunculus is seen, measuring 1.0 cms near the hilum.*

**Right Kidney** is normal in size (10.4 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

**Left Kidney** is normal in size (10.2 x 4.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

**Retroperitoneum**- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

**Urinary Bladder** is over distended, normal in contour and wall thickness. No evidence of calculi.

**Uterus** is anteverted and normal in size, measures 9.0 x 5.0 x 3.9 cms. Myometrial echoes are normal. Endometrium measures 9.4 mm. Menstrual cup is seen insitu.

**Right ovary** is normal in size and echopattern, measures 3.8 cc.

**Left ovary** is normal in size and echopattern, measures 2.4 cc.

**Both adnexa:** Normal. No mass is seen.

There is no ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

**IMPRESSION:**

- **Mild fatty infiltration of liver (Grade I).**
- **No other definite sonological abnormality detected.**



**Dr. Elluru Santosh Kumar**  
Consultant Radiologist



NABH



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**UNITED  
HOSPITAL**

*Care Par Excellence*  
Jayanagar, Bangalore

### DEPARTMENT OF RADIODIAGNOSIS

<b>Name</b>	T Layaa Baby	<b>Date</b>	08/03/25
<b>Age</b>	37 years	<b>Hospital ID</b>	UHJA24012965
<b>Sex</b>	Female	<b>Ref.</b>	Health check

### RADIOGRAPH OF THE CHEST (PA – VIEW)

#### FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

#### IMPRESSION:

- **No radiographic abnormality.**

**Dr. Elluru Santosh Kumar**  
Consultant Radiologist

Name: Mrs. tlayaa baby  
 Birth date: / /  
 Sex: F  
 Weight: kg  
 Height: mmHg  
 Heart rate: bpm  
 IR int: 154 ms  
 RS dur: 92 ms  
 IT/QTc(E) int: 414/ 429 ms  
 I/QRS/T axis: 65/ 31/ 34 °  
 IV5/SV1 amp: 2.44/ 1.06 mV  
 IV5+SV1 amp: 3.50 mV

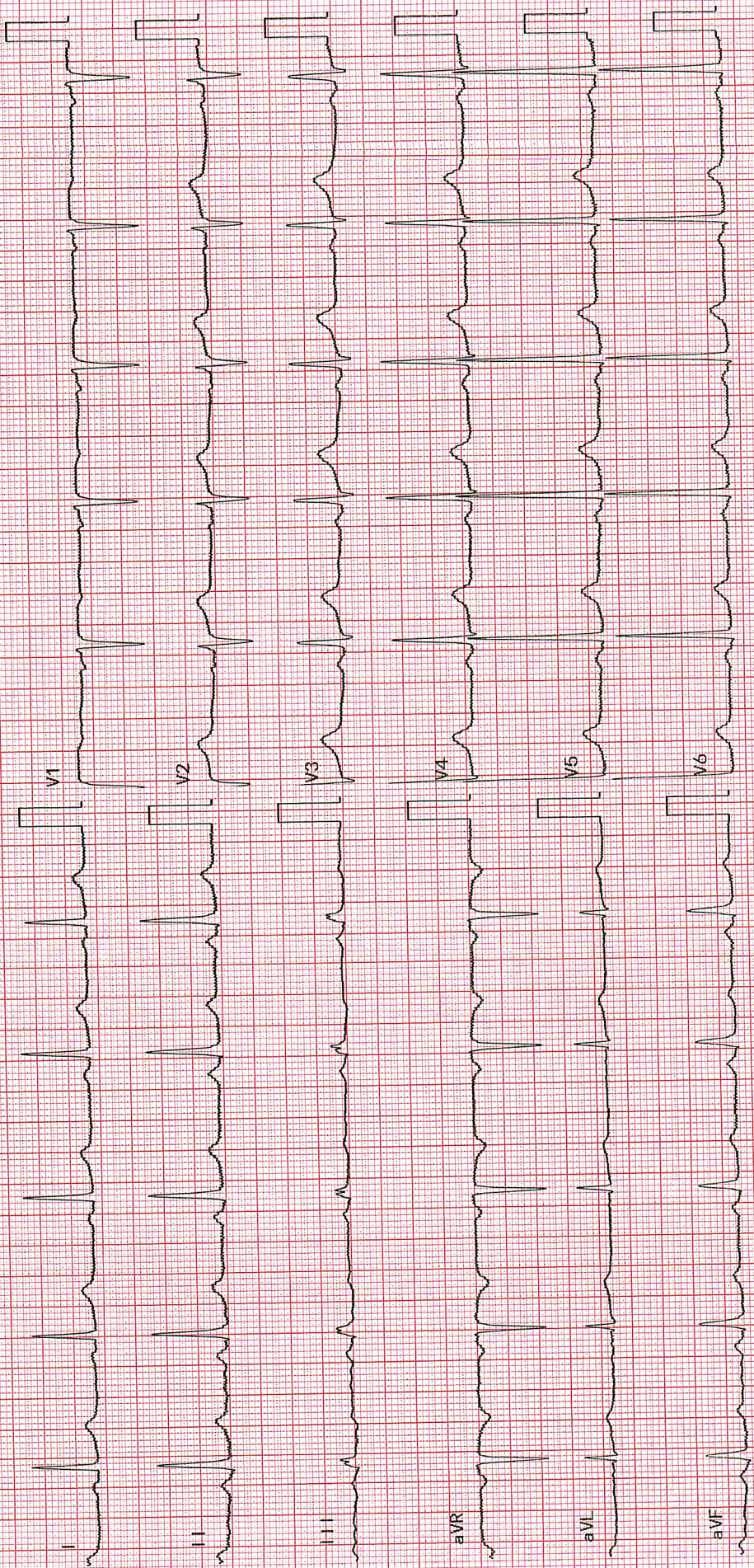
Unconfirmed Report

Reviewed by:

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s

10 mm/mV





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### Out Patient Record

Patient Name : Mrs.T LAYAA BABY

UHID : UHJA24012965

Age / Sex : 37 Years / Female

OP NO/Reg Dt : 08-03-2025 08:43 AM

Spouse / Father Name : .

Department :

Address : . , Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Ashmitha Padma MBBS, MD  
(GENERAL MEDICINE), PGDCC,FEM  
KMC No. : 02M1087

#### Complaints / Findings / Observations :

HT: 162 cm

WT: 76.5 kg

Bp: 127/90  
mmHg

#### Investigations:

SpO<sub>2</sub>: 99 %

HR: 75 bpm

#### Treatment / Care of Plan / Provisional Diagnosis :

#### Follow Up Advice :

Signature of the Doctor

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. T LAYAA BABY	Order No : 1000119891
UHID : UHJ A24012965	Registered On : 08/03/2025 08:43:55 AM
Age/Sex : 37/Years Female	Collected On : 08/03/2025 09:21:14 AM
Ward / Bed No :	Reported On : 08/03/2025 12:54:11 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240018263
Station : At Hospital	Mobile No : 9066596246
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<b><u>BIOCHEMISTRY</u></b>			
<b>FASTING GLUCOSE</b> (Method: Hexokinase)	109	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
<b>POST PRANDIAL GLUCOSE</b> (Method: Hexokinase)	116	mg/dL	70-140
<b>GLYCOSYLATED HAEMOGLOBIN (HBA1C)</b>			Sample: Whole blood (EDTA)
<b>HBA1C</b> (Method: HPLC)	5.5	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
<b>Estimated Average Glucose (eAG)</b> (Method: Calculated)	111	mg/dL	
<b>THYROID PROFILE (TOTAL T3, TOTAL T4 &amp; TSH)</b>			Sample: Serum
<b>TOTAL T3</b> (Method:CLIA)	1.09	ng/mL	0.87-1.78
<b>TOTAL T4</b> (Method:CLIA)	10.43	ng/dL	5.1-14.1
<b>THYROID STIMULATING HORMONE (TSH)</b> (Method:CLIA: Ultra-sensitive)	1.47	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
<b>LIPID PROFILE</b>			Sample: Serum
<b>TOTAL CHOLESTEROL</b> (Method:CHOD-POD)	266	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
<b>TRIGLYCERIDES</b> (Method:Enzymatic GPO-POD)	70	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
<b>HDL CHOLESTEROL</b> (Method:ENZYMATIC METHOD)	55.9	mg/dL	< 40 - Low ≥ 60 - High

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<b>LDL CHOLESTEROL</b> (Method: Calculated)	196.10	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
<b>VLDL CHOLESTEROL</b> (Method: Calculated)	14.00	mg/dL	< 30
<b>TOTAL CHOLESTEROL : HDL RATIO</b> (Method: Calculated)	4.76		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
<b>LDL/HDL CHOLESTEROL RATIO</b> (Method: Calculated)	3.51		< 2.5 Optimal
<b>NON HDL CHOLESTEROL</b> (Method: Calculated)	210.10	mg/dL	< 130
<b>URIC ACID</b> (Method:Uricase - POD(Enzymatic))	6.0	mg/dL	2.6-6.0
<b>BLOOD UREA NITROGEN(BUN)</b> (Method:Urease GLDH - Kinetic)	8	mg/dL	7.93-20.07
<b>CREATININE</b> (Method:Modified Jaffe, Kinetic)	0.65	mg/dL	0.6-1.1
<b>LIVER FUNCTION TEST</b>			
<b>TOTAL BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.78	mg/dL	0.3-1.2
<b>DIRECT BILIRUBIN</b> (Method:Dichlorophenyl Diazotization)	0.14	mg/dL	0.0-0.2
<b>INDIRECT BILIRUBIN</b> (Method: Calculated)	0.64	mg/dL	0.2-1.0
<b>TOTAL PROTEIN</b> (Method:BIURET)	8.0	g/dL	6.6-8.3
<b>ALBUMIN</b> (Method:BCG)	4.26	g/dL	3.5-5.2
<b>GLOBULIN</b> (Method: Calculated)	3.74	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.14		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	16	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	64	U/L	46-122
GGT (Method:IFCC)	16	U/L	< 38



**Dr. Varsha Shree R**  
M.D(Pathology)  
CONSULTANT PATHOLOGIST  
KMC No : 103567



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**HAEMATOLOGY**
**COMPLETE BLOOD COUNT(CBC)**

Sample: Whole blood (EDTA)

<b>HAEMOGLOBIN</b> (Method:Photometric Measurement: Oxyhemoglobin method)	12.39	g/dL	12-16
<b>PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT)</b> (Method: Calculated)	37.4	%	37-47
<b>TOTAL WBC COUNT (TLC)</b> (Method:Coulter Principle)	7500	Cells/Cum	4000-11000
<b>DIFFERENTIAL COUNT</b>			
<b>NEUTROPHILS</b> (Method:Optical/Impedance)	65.24	%	40-75
<b>LYMPHOCYTES</b> (Method:Optical/Impedance)	26.52	%	20-45
<b>EOSINOPHILS</b> (Method:Optical/Impedance)	2.01	%	0-6
<b>MONOCYTES</b> (Method:Optical/Impedance)	5.75	%	2-10
<b>BASOPHILS</b> (Method:Optical/Impedance)	0.48	%	0-2
<b>RED BLOOD CORPUSCLES(RBC)</b> (Method:Coulter Principle)	4.41	million/cum	4.0-5.2
<b>MCV</b> (Method:Derived from RBC Histogram)	84.7	fL	78-100
<b>MCH</b> (Method: Calculated)	28.1	pg	27-31
<b>MCHC</b> (Method: Calculated)	33.1	g/dL	31-37
<b>RDW - CV</b> (Method: Calculated)	14.0	%	11.5-14.5
<b>PLATELET COUNT</b> (Method:Electrical Impedance)	4.25	Lakhs/Cum	1.5-4.5


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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.88	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.0	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	4890	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	150	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1990	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	430	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	40	Cells/Cum	20-100
<b>ERYTHROCYTE SEDIMENTATION RATE(ESR)</b> (Method:Modified Westergren Method)	75	mm/hour	1-20
<b>BLOOD GROUPING &amp; RH TYPING</b>			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Method)	A		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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<u>CLINICAL PATHOLOGY</u>			
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.005		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN	Absent		Absent
<small>(Method:Protein Error of pH Indicator)</small>			
GLUCOSE	Absent		Absent
<small>(Method:GOD-POD)</small>			
KETONE BODIES	Absent		Absent
<small>(Method:Nitroprusside method/ Rothera's test)</small>			
BILIRUBIN	Negative		Negative
<small>(Method:DIAZO/FOUCHET'S TEST )</small>			
BILE SALT	Absent		Absent
<small>(Method:Hay's sulfur test)</small>			
NITRITE	Negative		Negative
<small>(Method:Griess method)</small>			
UROBILINOGEN	Normal		
<small>(Method:Azo coupling method)</small>			
LEUKOCYTE ESTERASE	Negative		Negative
<small>(Method:Leukocyte Esterase activity)</small>			
BLOOD	Negative		Negative
<small>(Method:Peroxidase Reaction)</small>			
MICROSCOPIC EXAMINATION			

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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
<b>URINE SUGAR, FASTING</b> (Method:GOD-POD)	Absent		
<b>URINE SUGAR (POST PRANDIAL)</b>	Absent		

Verified By  
G Mahesh kumar

---End of Report---



**Dr. Varsha Shree R**  
M.D(Pathology)  
CONSULTANT PATHOLOGIST  
KMC No : 103567