ETERNAL HOSPITAL MEDICAL TESTING LABORATORY

Patient Name	Mrs. KIRAN MEENA	**Lab No**	4059434
UHID	40022528	**Collection Date**	26/10/2024 10:50AM
Age/Gender	30 Yrs/Female	**Receiving Date**	26/10/2024 10:54AM
IP/OP Location	O-OPD	**Report Date**	26/10/2024 6:23PM
Referred By	Dr. EHS CONSULTANT	**Report Status**	Final
Mobile No.	9950555133		

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range
BLOOD GLUCOSE (FASTING)			Sample: Fl. Plasma
BLOOD GLUCOSE (FASTING)	105.0	mg/dl	71 - 109

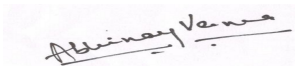
Method: Hexokinase assay.
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

BLOOD GLUCOSE (PP)			Sample: PLASMA
BLOOD GLUCOSE (PP)	91.4	mg/dl	Non – Diabetic: - < 140 mg/dl Pre – Diabetic: - 140-199 mg/dl Diabetic: - >=200 mg/dl

Method: Hexokinase assay.
Interpretation:-Diagnosis and monitoring of treatment in diabetes mellitus and evaluation of carbohydrate metabolism in various diseases.

THYROID T3 T4 TSH			Sample: Serum
T3	1.360	ng/mL	0.970 - 1.690
T4	7.76	ug/dl	5.53 - 11.00
TSH	3.39	µIU/mL	0.27 - 4.20

RESULT ENTERED BY : SUNIL EHS



Dr. ABHINAY VERMA

MBBS|MD|INCHARGE PATHOLOGY

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BIOCHEMISTRY

T3:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T3 is utilized in thediagnosis of T3-hyperthyroidism the detection of early stages ofhyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

T4:- Method: ElectroChemiLuminescence ImmunoAssay - ECLIA

Interpretation:-The determination of T4 assay employs acompetitive test principle with an antibody specifically directed against T4.

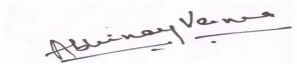
TSH - THYROID STIMULATING HORMONE :- ElectroChemiLuminescenceImmunoAssay - ECLIA

Interpretation:-The determination of TSH serves as theinitial test in thyroid diagnostics. Even very slight changes in theconcentrations of the free thyroid hormones bring about much greater oppositechanges in the TSH levels.

LFT (LIVER FUNCTION TEST) Sample: Serum

BILIRUBIN TOTAL	1.14	mg/dl	0.00 - 1.20
BILIRUBIN INDIRECT	0.79	mg/dl	0.20 - 1.00
BILIRUBIN DIRECT	**0.35 H**	mg/dl	0.00 - 0.30
SGOT	20.4	U/L	0.0 - 32.0
SGPT	16.6	U/L	0.0 - 33.0
TOTAL PROTEIN	7.6	g/dl	6.6 - 8.7
ALBUMIN	4.6	g/dl	3.5 - 5.2
GLOBULIN	3.0		1.8 - 3.6
ALKALINE PHOSPHATASE	54	U/L	35 - 104
A/G RATIO	1.5	Ratio	1.5 - 2.5
GGTP	8.0	U/L	0.0 - 40.0

RESULT ENTERED BY : SUNIL EHS



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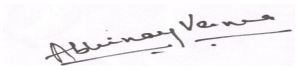
BIOCHEMISTRY

BILIRUBIN TOTAL :- Method: DPD assay. Interpretation:-Total Bilirubin measurements are used in the diagnosis and treatment of various liver diseases, and of haemolytic and metabolic disorders in adults and newborns. Both obstruction damage to hepatocellular structive.
BILIRUBIN DIRECT :- Method: Diazo method Interpretation:-Determinations of direct bilirubin measure mainly conjugated, water soluble bilirubin.
SGOT – AST :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGOT(AST) measurements are used in the diagnosis and treatment of certain types of liver and heart disease.
SGPT - ALT :- Method: IFCC without pyridoxal phosphate activation. Interpretation:-SGPT(ALT) Ratio Is Used For Differential Diagnosis In Liver Diseases.
TOTAL PROTEINS :- Method: Biuret colorimetric assay. Interpretation:-Total protein measurements are used in the diagnosis and treatment of a variety of liver and kidney diseases and bone marrow as well as metabolic and nutritional disorder.
ALBUMIN :- Method: Colorimetric (BCP) assay. Interpretation:-For Diagnosis and monitoring of liver diseases, e.g. liver cirrhosis, nutritional status.
ALKALINE PHOSPHATASE :- Method: Colorimetric assay according to IFCC. Interpretation:-Elevated serum ALT is found in hepatitis, cirrhosis, obstructive jaundice, carcinoma of the liver, and chronic alcohol abuse. ALT is only slightly elevated in patients who have an uncomplicated myocardial infarction. **GGTP-GAMMA GLUTAMYL TRANSPEPTIDASE** :- Method: Enzymetic colorimetric assay. Interpretation:-y-glutamyltransferase is used in the diagnosis and monitoring of hepatobiliary disease. Enzymatic activity of GGT is often the only parameter with increased values when testing for such diseases and is one of the most sensitive indicator known.

LIPID PROFILE

TOTAL CHOLESTEROL	138.5		<200 mg/dl :- Desirable 200-240 mg/dl :- Borderline >240 mg/dl :- High
HDL CHOLESTEROL	54.0		High Risk :-<40 mg/dl (Male), <40 mg/dl (Female) Low Risk :->=60 mg/dl (Male), >=60 mg/dl (Female)
LDL CHOLESTEROL	79.7		Optimal :- <100 mg/dl Near or Above Optimal :- 100-129 mg/dl Borderline :- 130-159 mg/dl High :- 160-189 mg/dl Very High :- >190 mg/dl
CHOLESTERO VLDL	17	mg/dl	10 - 50
TRIGLYCERIDES	86.9		Normal :- <150 mg/dl Border Line:- 150 - 199 mg/dl High :- 200 - 499 mg/dl Very high :- > 500 mg/dl
CHOLESTEROL/HDL RATIO	3	%	

RESULT ENTERED BY : SUNIL EHS



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BIOCHEMISTRY

CHOLESTEROL TOTAL :- Method: CHOD-PAP enzymatic colorimetric assay. **Interpretation:-**The determination of the individual total cholesterol (TC) level is used for screening purposes while for a better risk assessment it is necessary to measure additionally lipid & lipoprotein metabolic disorders. **HDL CHOLESTEROL :-** Method:-Homogenous enzymetic colorimetric method. **Interpretation:-**HDL-cholesterol has a protective against coronary heart disease, while reduced HDL-cholesterol concentrations, particularly in conjunction with elevated triglycerides, increase the cardiovascular disease. **LDL CHOLESTEROL :-** Method: Homogenous enzymatic colorimetric assay. **Interpretation:-**LDL play a key role in causing and influencing the progression of atherosclerosis and in particular coronary sclerosis. The LDL are derived form VLDL rich in TG by the action of various lipolytic enzymes and are synthesized in the liver. **CHOLESTEROL VLDL :-** Method: VLDL Calculative
TRIGLYCERIDES :- Method: GPO-PAP enzymatic colorimetric assay. **Interpretation:-**High triglycerde levels also occur in various diseases of liver, kidneys and pancreas. DM, nephrosis, liver obstruction. **CHOLESTEROL/HDL RATIO :-** Method: Cholesterol/HDL Ratio Calculative

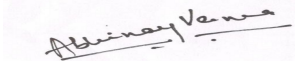
Sample: Serum

UREA	20.90	mg/dl	16.60 - 48.50
BUN	10	mg/dl	6 - 20
CREATININE	0.54	mg/dl	0.50 - 0.90
SODIUM	141	mmol/L	136 - 145
POTASSIUM	4.94	mmol/L	3.50 - 5.50
CHLORIDE	105.7	mmol/L	98 - 107
URIC ACID	3.5	mg/dl	2.4 - 5.7
CALCIUM	9.80	mg/dl	8.60 - 10.00

CREATININE – SERUM :- Method:-Jaffe method, Interpretation:-To differentiate acute and chronic kidneydisease.
URIC ACID :- Method: Enzymatic colorimetric assay. Interpretation:- Elevated blood concentrations of uricacid are renal diseases with decreased excretion of waste products, starvation,drug abuse and increased alcohol consume.
SODIUM:- Method: ISE electrode. Interpretation:-Decrease: Prolonged vomiting or diarrhea,diminished reabsorption in the kidney and excessive fluid retention. Increase: excessive fluid loss, high salt intake andkidney reabsorption.
POTASSIUM :- Method: ISE electrode. Intrpretation:-Low level: Intake excessive loss formbodydue to diarrhea, vomiting renal failure, High level: Dehydration, shock severe burns, DKA, renalfailure.
CHLORIDE – SERUM :- Method: ISE electrode. Interpretation:-Decrease: reduced dietary intake,prolonged vomiting and reduced renal reabsorption as well as forms of acidosisand alkalosis.
Increase: dehydration, kidney failure, some form ofacidosis, high dietary or parenteral chloride intake, and salicylate poisoning.
UREA:- Method: Urease/GLDH kinetic assay. Interpretation:-Elevations in blood urea nitrogenconcentration are seen in inadequate renal perfusion, shock, diminished bloodvolume, chronic nephritis, nephrosclerosis, tubular necrosis, glomerularnephritis and UTI.
CALCIUM TOTAL :- Method: O-Cresolphthaleine complexone. Interpretation:-Increase in serum PTH or vit-D are usuallyassociated with hypercalcemia. Increased serum calcium levels may also beobserved in multiple myeloma and other neoplastic diseases. Hypocalcemia may
beobserved in hypoparathyroidism, nephrosis, and pancreatitis.

Sample: WHOLE BLOOD EDTA

RESULT ENTERED BY : SUNIL EHS



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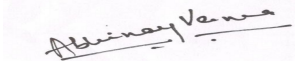
BIOCHEMISTRY

HBA1C	4.9	%	< 5.7% Nondiabetic 5.7-6.4% Pre-diabetic > 6.4% Indicate Diabetes Known Diabetic Patients < 7 % Excellent Control 7 - 8 % Good Control > 8 % Poor Control

Method : – Turbidimetric inhibition immunoassay (TINIA), **Interpretation:-**Monitoring long term glycemic control, testing every 3 to 4 months is generally sufficient. The approximate relationship between HbA1C and mean blood glucose values during the preceding 2 to 3 months.

RESULT ENTERED BY : SUNIL EHS



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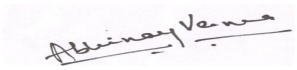
BLOOD BANK INVESTIGATION

Test Name	Result	Unit	Biological Ref. Range
BLOOD GROUPING	"AB" Rh Positive		

Note :
1. Both forward and reverse grouping performed.
2. Test conducted on EDTA whole blood.

RESULT ENTERED BY : SUNIL EHS



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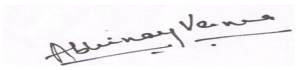
HEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range
			Sample: WHOLE BLOOD EDTA
HAEMOGLOBIN	12.5	g/dl	12.0 - 15.0
PACKED CELL VOLUME(PCV)	37.8	%	36.0 - 46.0
MCV	**100.5 H**	fl	82 - 92
MCH	**33.2 H**	pg	27 - 32
MCHC	33.1	g/dl	32 - 36
RBC COUNT	**3.76 L**	millions/cu.mm	3.80 - 4.80
TLC (TOTAL WBC COUNT)	5.63	10^3/ uL	4 - 10
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHILS	59.6	%	40 - 80
LYMPHOCYTE	32.3	%	20 - 40
EOSINOPHILS	2.3	%	1 - 6
BASOPHIL	**0.5 L**	%	1 - 2
MONOCYTES	5.3	%	2 - 10
PLATELET COUNT	3.80	lakh/cumm	1.500 - 4.500

HAEMOGLOBIN :- Method:-SLS Hemoglobin Methodology by Cell Counter. Interpretation:-Low-Anemia, High-Polycythemia.
MCV :- Method:- Calculation by sysmex.
MCH :- Method:- Calculation by sysmex.
MCHC :- Method:- Calculation bysysmex.
RBC COUNT :- Method:-Hydrodynamic focusing. Interpretation:-Low-Anemia, High-Polycythemia.
TLC (TOTAL WBC COUNT) :- Method:-Optical Detector block based on Flowcytometry. Interpretation:-High-Leucocytosis, Low-Leucopenia.
NEUTROPHILS :- Method: Optical detector block based on Flowcytometry
LYMPHOCYTS :- Method: Optical detector block based on Flowcytometry
EOSINOPHILS :- Method: Optical detector block based on Flowcytometry
MONOCYTES :- Method: Optical detector block based on Flowcytometry
BASOPHIL :- Method: Optical detector block based on Flowcytometry
PLATELET COUNT :- Method:-Hydrodynamic focusing method. Interpretation:-Low-Thrombocytopenia, High-Thrombocytosis.
HCT: Method:- Pulse Height Detection. Interpretation:-Low-Anemia, High-Polycythemia.
NOTE: CH- CRITICAL HIGH, CL: CRITICAL LOW, L: LOW, H: HIGH

ESR (ERYTHROCYTE SEDIMENTATION RATE)	**55 H**	mm/1st hr	0 - 15

RESULT ENTERED BY : SUNIL EHS



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Method:-Modified Westergrens.
Interpretation:-Increased in infections, sepsis, and malignancy.

End Of Report

RESULT ENTERED BY : SUNIL EHS

DEPARTMENT OF RADIO DIAGNOSIS

UHID / IP NO	40022528 (43046)	**RISNo./Status :**	4059434/
Patient Name :	Mrs. KIRAN MEENA	**Age/Gender :**	30 Y/F
Referred By :	Dr. EHS CONSULTANT	**Ward/Bed No :**	OPD
Bill Date/No :	26/10/2024 10:35AM/ OPSCR24-25/25213	**Scan Date :**	
Report Date :	26/10/2024 12:01PM	**Company Name:**	Mediwheel - Arcofemi Health Care Ltd.

ULTRASOUND STUDY OF WHOLE ABDOMEN

Liver: Normal in size & echotexture**.** No obvious significant focal parenchymal mass lesion noted. Intrahepatic biliary radicals are not dilated. Portal vein is normal.

Gall Bladder: Lumen is clear. Wall thickness is normal. CBD is normal.

Pancreas: Normal in size & echotexture.

Spleen: Normal in size & echotexture. No focal lesion seen.

Right Kidney: Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted**.**

Left Kidney: Normal in shape, size & location. Echotexture is normal. Corticomedullary differentiation is maintained. No evidence of significant hydronephrosis or obstructive calculus noted.

Urinary Bladder: Normal in size, shape & volume. No obvious calculus or mass lesion is seen. Wall thickness is normal.

Uterus: Normal in size, shape & anteverted in position. Endometrial thickness is normal. Endometrial cavity is empty. No mass lesion is seen. Cervix is normal.

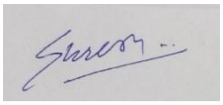
Both ovaries: Bilateral ovaries are normal in size, shape & volume.

Others: No significant free fluid is seen in pelvic peritoneal cavity.

IMPRESSION: USG findings are suggestive of

- **No significant sonographic abnormality noted.**

Correlate clinically & with other related investigations.



DR. SURESH KUMAR SAINI
RADIOLOGIST
MBBS, MD.
Reg. No. 22597, 36208.

DEPARTMENT OF CARDIOLOGY

UHID / IP NO	40022528 (43046)	**RISNo./Status :**	4059434/
Patient Name :	Mrs. KIRAN MEENA	**Age/Gender :**	30 Y/F
Referred By :	Dr. EHS CONSULTANT	**Ward/Bed No :**	OPD
Bill Date/No :	26/10/2024 10:35AM/ OPSCR24-25/25213	**Scan Date :**	
Report Date :	26/10/2024 11:45AM	**Company Name:**	Final

REFERRAL REASON: HEALTH CHECKUP

2D ECHOCARDIOGRAPHY WITH COLOR DOPPLER

M MODE DIMENSIONS: -

		Normal			Normal
IVSD	**9.9**	**6-12mm**	**LVIDS**	**27.6**	**20-40mm**
LVIDD	**44.9**	**32-57mm**	**LVPWS**	**15.9**	**mm**
LVPWD	**9.9**	**6-12mm**	**AO**	**24.0**	**19-37mm**
IVSS	**15.9**	**mm**	**LA**	**30.8**	**19-40mm**
LVEF	**60-62**	**>55%**	**RA**	**-**	**mm**

DOPPLER MEASUREMENTS & CALCULATIONS:

STRUCTURE	MORPHOLOGY	VELOCITY (m/s)				GRADIENT (mmHg)	REGURGITATION
MITRAL VALVE	NORMAL	E	0.76	e'	-	-	NIL
		A	0.53	E/e'	-		
TRICUSPID VALVE	NORMAL	E		0.52		-	NIL
		A		0.68			
AORTIC VALVE	NORMAL	1.40				-	NIL
PULMONARY VALVE	NORMAL	0.96				-	NIL

COMMENTS & CONCLUSION: -

- ALL CARDIAC CHAMBERS ARE NORMAL
- NO RWMA, LVEF 60-62%
- NORMAL LV SYSTOLIC FUNCTION
- NORMAL LV DIASTOLIC FUNCTION
- ALL CARDIAC VALVES ARE NORMAL
- NO EVIDENCE OF CLOT/VEGETATION/PE
- INTACT IVS/IAS

IMPRESSION: - NORMAL BI VENTRICULAR FUNCTIONS

DR SUPRIY JAIN
MBBS, M.D., D.M. (CARDIOLOGY)
DIRECTOR & INCHARGE CARDIOLOGY

DR MEGHRAJ MEENA
MBBS, SONOLOGIST FICC, CONSULTANT PREV. CARDIOLOGY & INCHARGE CCU

DR ROOPAM SHARMA
MBBS, PGDCC, FIAE CONSULTANT & INCHARGE EMERGENCY, PREV. CARDIOLOGY(NIC) & WELLNESS CENTER