

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. SUMITA KARMAKAR	Order No	: 1000120079
UHID	: UHJ A24013016	Registered On	: 09/03/2025 08:31:37 AM
Age/Sex	: 41/Years Female	Collected On	: 09/03/2025 08:59:24 AM
Ward / Bed No	:	Reported On	: 09/03/2025 01:13:51 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJ A240018336
Station	: At Hospital	Mobile No	: 9733091695
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	91	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	94	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	105	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.23	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	8.74	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	3.85	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)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	180	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	112	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	55.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	101.90	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	22.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.23		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	1.83		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	124.30	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.8	mg/dL	2.6-6.0
LIVER FUNCTION TEST			
Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.69	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.52	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.5	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.28	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.22	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.33		2:1
SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	22	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	103	U/L	46-122
GGT (Method:IFCC)	14	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	28.7	mg/dL	17-43
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.63	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	20.63		12~20 : 1

Sample: Serum



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)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.29	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	34.6	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	6020	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	63.16	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	26.86	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.25	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.47	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.26	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	3.99	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	86.7	fL	78-100
MCH (Method: Calculated)	28.3	pg	27-31
MCHC (Method: Calculated)	32.6	g/dL	31-37
RDW - CV (Method: Calculated)	14.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.79	Lakhs/Cum	1.5-4.5


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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	11.55	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.2	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3800	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	260	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1620	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	330	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	32	mm/hour	1-20
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Method)	B		
Rh Factor (Method:Agglutination Method)	Negative		

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	6.0		5.0-8.0
SPECIFIC GRAVITY	1.020		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			


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

Verified By
Sridhar Kandukuri

---End of Report---



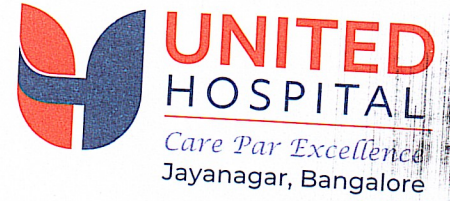
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CONSULTANT PATHOLOGIST
KMC No : 103567



NABH



No.1



PATIENT NAME:	Mrs. SUMITA KARMAKAR	DATE:	09/03/25
AGE :	41 Years	Sex: FEMALE	UHID :
REF BY :	CMO	OP/IP :	24013016
			HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 3.6 (3.5-5.5)	MV EV : 112	AV : 75.2	MR : NORMAL
LA : 3.4 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 118		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 75.7		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ---	AV : ---	TR : TRIVIAL TR. PASP-26mmHg
TAPSE: 2.1 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.0 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
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

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

(Signature)
DR. RAHEL PATIL
 CONSULTANT CARDIOLOGIST



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Sumita Karmakar	Date	09/03/25
Age	41 years	Hospital ID	UHJA24013016
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral prominent broncho vascular markings are seen in lung fields.

Bilateral lung fields are grossly normal.


Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **Bilateral prominent broncho vascular markings in lung fields.**
- **No radiographic abnormality.**


Dr. Varun
Consultant Radiologist



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No.1

DEPARTMENT OF RADIO DIAGNOSIS

Name	Sumita Karmakar	Date	09/03/25
Age	41 years	Hospital ID	UHJA24013016
Sex	Female	Ref.	Health check


BILATERAL SONOMAMMOGRAPHY

FINDINGS:

Skin and subcutaneous fat of bilateral breasts appear normal.
Heterogeneous background echotexture is seen in both breasts.
No focal solid / cystic lesions seen.
Ducts appear normal.
No significant lymphnodes noted in bilateral axilla.

IMPRESSION:

- No significant abnormality detected in this study.


Dr. Varun
Consultant Radiologist



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No.1

DEPARTMENT OF RADIO DIAGNOSIS

Name	Sumita Karmakar	Date	09/03/25
Age	41 years	Hospital ID	UHJA24013016
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in 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.

Right Kidney is normal in size (10.1 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (9.2 x 5.2 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 normal in contour and wall thickness. No evidence of calculi.

Uterus is anteverted and normal in size, measures 8.9 x 3.6 x 4.8 cms. Endometrium measures 5 mm. **There is a posterior wall small fibroid measuring 7 mm.**

Right ovary is normal in size and echopattern.


Left ovary is normal in size and echopattern.

Both adnexa: Normal. No mass is seen.

There is no ascites.

IMPRESSION:

- Small uterine fibroid.
- No other definite sonological abnormality detected.


Dr. Varun
 Consultant Radiologist



NABH



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mrs.SUMITA KARMAKAR	UHID	: UHJA24013016
Age / Sex	: 41 Years / Female	OP NO/Reg Dt	: 09-03-2025 08:31 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 - 154 cm
 WT - 58.2 kg
 SpO₂ - 99 %
 PR - 53 bpm
 BP - 104/63 mmHg

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

Name: ~~Schiller~~ *Schiller*
 Birth date: / mmHg
 Weight: kg
 Height: cm
 Heart rate: bpm
 R int: 130 ms
 RS dur: 74 ms
 P/QTc(E) int: 400/396 ms
 I/QRs/T axis: 22/ 70/ 43 °
 V5/SV1 amp: 0.92/ 0.71 mV
 V5+SV1 amp: 1.63 mV

10 mm/mV 25 mm/s Filter: H50 D 35 Hz 10 mm/mV
 Unconfirmed Report
 Reviewed by:

