MC-6135

Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE
COMPLETE PATHOLOGICAL SOLUTION

213193

Name	: Mr. KUNAL PAWAR	**Collected On**	: 9/11/2024 11:39 am
Lab ID.	: 213193	**Received On**	: 9/11/2024 11:49 am
Age/Sex	: 21Years / Male	**Reported On**	: 10/11/2024 3:25 pm
Ref By	: JINKUSHAL CARDIAC CARE & SUPER SPECIALITY HOS	**Report Status**	: FINAL

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	148.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	**33.7**	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	84.8	mg/dL	Desirable level : <161 mg/dl. High :>= 161 - 199 mg/dl. Borderline High :200 - 499 mg/dl. Very high :>499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	17	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	97	mg/dL	Optimal:<100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high :>= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.88		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.39		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

---------- END OF REPORT ----------

Checked By
Pathologist

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist
Regd.No.: 3401/09/2007

24 HOURS 7
Main Center :- 2-3, 'Silver Plaza' E.S.I.S. Hospital Road, Opp. Suryadarshan Tower, Thane (W)-400 604. ☎ +91 91363 56284
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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	17.0	gm/dl	13 - 18
HEMATOCRIT (PCV)	50.9	%	42 - 52
RBC COUNT	4.83	x10^6/uL	4.70 - 6.50
MCV	**105**	fl	80 - 96
MCH	**35.2**	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.9	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	7310	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	71	%	40 - 80
LYMPHOCYTES	21	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	257000	/ cumm	150 to 410
MPV	10	fl	6.5 - 11.5
PDW	16.6	%	9.0 - 17.0
PCT	0.260	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

---------- END OF REPORT ----------

Checked By
SHAISTA Q

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
CHEMICAL EXAMINATION			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.020		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	3-5	/ HPF	0 - 5
EPITHELIAL	1-2	/ HPF	0 - 5
CASTS	Absent		
CRYSTALS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		

Result relates to sample tested, Kindly correlate with clinical findings.

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPECIMEN	Serum		
T3	113.0	ng/dl	84.63 - 201.8
T4	8.90	µg/dl	5.13 - 14.06
TSH	1.70	µIU/ml	0.35 - 4.94

DONE ON FULLY AUTOMATED ANALYSER MAGLUMI SNIBE X3

T3 (Triiodo Thyronine)

AGE	RANGE
1-30 days	100-740
1-11 months	105-245
1-5 years	105-269
6-10 years	94-241
11-15 years	82-213
15-20 years	80-210

T4 (Thyroxine)

AGE	RANGES
1-14 Days	11.8-22.6
1-2 weeks	9.9-16.6
1-4 months	7.2-14.4
4-12months	7.8-16.5
1-5 years	7.3-15.0
5-10 years	6.4-13.3
11-15 years	5.6-11.7

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

---------- END OF REPORT ----------

Checked By
SHAISTA Q

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* BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CREATININE, SERUM			
*** SERUM CREATININE**	0.89	mg/dL	0.7 - 1.3
METHOD	Enzymatic Colourimetric Method		

Creatinine is critically important in assessing renal function. In blood, it is a marker of glomerular filtration rate.As the kidneys become impaired for any reason, the creatinine level in the blood will rise due to poor clearance of creatinine by the kidneys. Abnormally high levels of creatinine thus warn of possible malfunction or failure of the kidneys.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	05	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	76.8	mg/dL	70 - 110
BLOOD GLUCOSE PP	83.7	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION
- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : >=126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)
- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : >=200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS
- Fasting plasma glucose >=126 mg/dl
- Classical symptoms +Random plasma glucose >=200 mg/dl
- Plasma glucose >=200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin > 6.5%

***Any positive criteria should be tested on subsequent day with same or other criteria.

GLYCOCELATED HEMOGLOBIN (HBA1C)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.1	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	99.7	mg/dL	NON - DIABETIC : <=5.6 PRE - DIABETIC : 5.7 - 6.4 DIABETIC : >6.5
METHOD	Particle Enhanced Immunoturbidimetry		

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
BLOOD UREA NITROGEN, SERUM			
*** BLOOD UREA NITROGEN**	9.71	mg/dL	7 - 18
TOTAL PROTEIN			
S. TOTAL PROTIEN	6.85	g/dl	6.4 - 8.3
S. ALBUMIN	4.30	g/dl	3.2 - 5.0
S. GLOBULIN	2.55	g/dl	1.9 - 3.5
A/G RATIO	1.69		0 - 2
Method: Biuret			
*** SERUM URIC ACID**	5.8	mg/dL	2.6 - 7.2
Method: Uricase -POD			
GAMMA GT	20.2	U/L	13 - 109
BILIRUBIN (TOTAL,DIRECT,INDIRECT)			
TOTAL BILLIRUBIN	0.78	mg/dL	0.1 - 1.2
BILLIRUBIN (DIRECT)	**0.41**	mg/dL	0.0 - 0.4
BILLIRUBIN (INDIRECT)	0.37	mg/dL	0.0 - 1.1
Method(Diazo)			
*S.ALKALINE PHOSPHATASE	87.0	U/L	53 - 128
Method: PNP AMP KINETIC			

Result relates to sample tested, Kindly correlate with clinical findings.

---------- END OF REPORT ----------

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ID: 170

kunal pawar

Male 21Years

Req. No. :

HR	:	74	bpm
P	:	88	ms
PR	:	138	ms
QRS	:	83	ms
QT/QTcBz	:	352/391	ms
P/QRS/T	:	72/97/70	°
RV5/SV1	:	1.284/0.384	mV

Diagnosis Information:

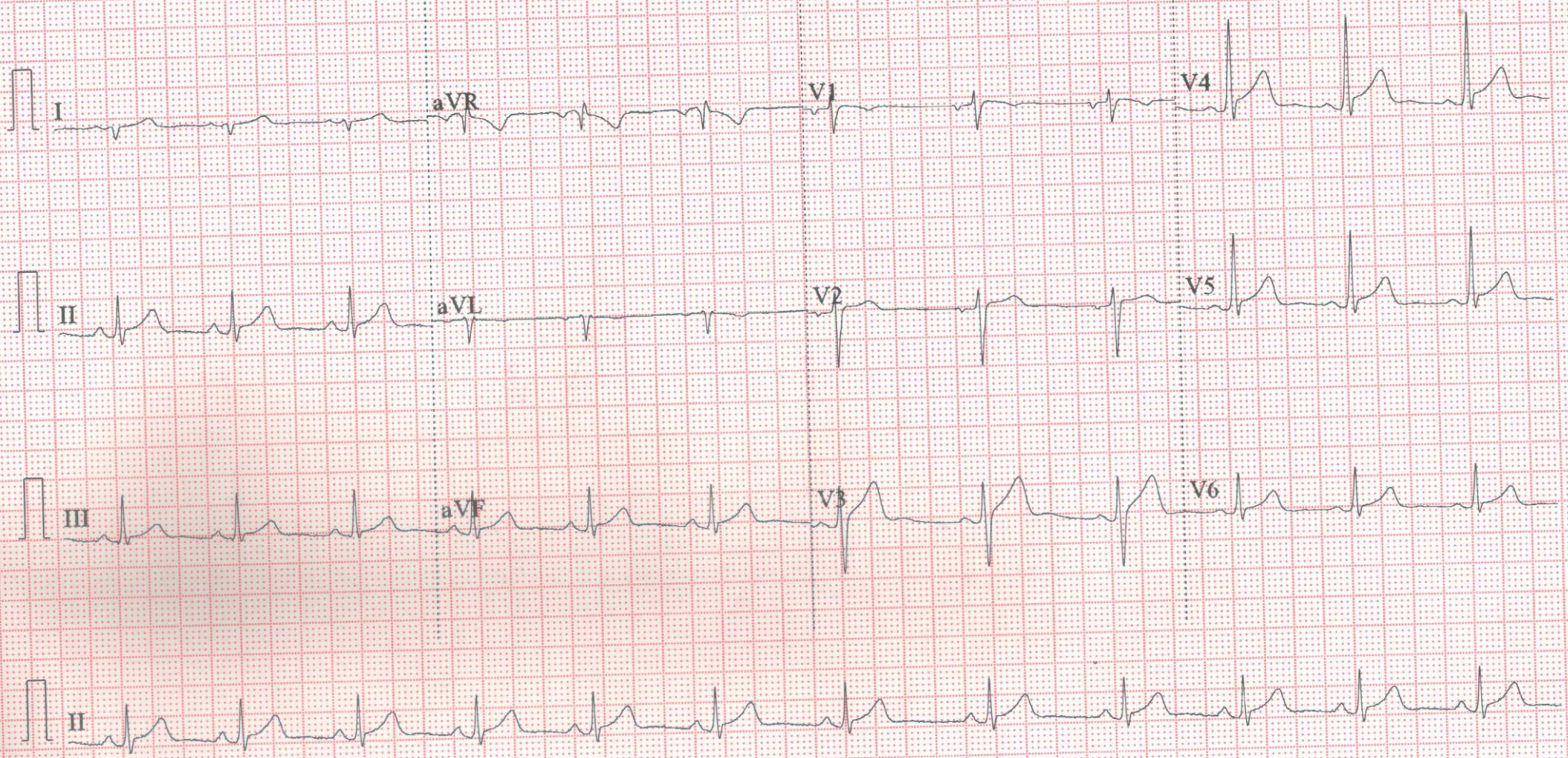
Sinus Arrhythmia

Larged PtfV1

Slight ST Elevation(V4,V5)

Right Axis Deviation

Report Confirmed by:



[redacted] 0.5-25Hz 50 25mm/s 10mm/mV 4*2.5s+1r SE-1200Express V2.22 SEMIP V1.92

JINKUSHAL
CARDIAC CARE
AND SUPER SPECIALITY HOSPITAL

CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination of,

Mr./Ms./Mrs. Mr. Kunal Pawar on (DD / MM / YYYY) .

After reviewing the medical history and upon clinical examination, it has been found that he/she is:

Fitness Status	Mark (✓) Below, where applicable
• **Medically Fit**	✓
• **Fit with restriction/recommendations** Though following restriction have been revealed, in my opinion, these are not impediments to the prospective job 1. ..... 2. ..... 3. ..... However the employee should follow the advice/medication that has been communicated to him/her. Review after _____ days is recommended.	He is fit to Resume his work.
• **Currently Unfit** Review after _____ days is recommended.	
• **Unfit**	

Signature

Dr. Mayur Jain
Medical Officer
Jinkushal Cardiac Care and Super specialty Hospital
Second floor, Rosa Vista, Opp. Suraj Water Park,
Kavesar, Ghodbunder Road, Thane(W) – 400607.

DR. MAYUR JAIN
DM CARDIOLOGY
2007/04/0818

This certificate is not meant for medico-legal purposes.

SEFRA DIGITAL X-RAY

JINKUSHAL HOSPITAL, Rosa Vista, Opp. Suraj Water Park, Waghbill, G.B. Road, Thane (W)
Mob.: 7678031047 / 9833520607 | Time : 9 am. to 9 pm. | SUNDAY ON CALL)

PORTABLE X-RAY AVAILABLE

PATIENT NAME : MR. KUNAL PAWAR	**AGE / SEX 21 YRS / M**
REF BY DR: JINKUSHAL HOSPITAL	**DATE : 09/11/2024**

X-ray Chest PA

Bilateral lung fields appear clear. No obvious pleural/parenchymal lesion noted.

Bilateral hila are normal.

Both costo-phrenic and cardio-phrenic angles appear clear.

Cardiac silhouette is within normal limits.

Both domes of diaphragm appear normal.

Bony thoracic cage & soft tissues appear normal.

Impression: No significant abnormality detected.

Suggest Clinical correlation and further evaluation.

Thanks for referral

Dr. Devendra Patil
MD Radiology

Disclaimer: report is done by teleradiology after the images acquired by PACS (picture archiving and communication system) and this report is not meant for medicolegal purpose Investigations have their limitations. Solitary pathological/Radiological and other investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. Please interpret accordingly. Patient's identification in online reporting is not established, so in no way patient identification is possible for medico-legal cases.

MEDICAL EXAMINATION REPORT

Name Mr./~~Mrs./~~ ~~Miss~~	Kunal Pawar	
Sex	Male/ ~~Female~~ Male	
Age (yrs.) 22	UHID :	
Date	09 / 11 / 20	Bill No. :
Marital Status	Married/ No. of Children / Unmarried/ Widow :	
Present Complaints	No Any Complaints.	
Past Medical : **History** Surgical :	No ~~Any~~ Medical Surgery.	
Personal History	Diet : Veg ☐ / Mixed ☑ : Addiction : Smoking ☐ / Tobacco Chewing ☐ / Alcohol ☐/ Any Other	
Family History Father = Mother = Siblings =	HT / DM / IHD / Stroke / Any Other Mother = HT / DM / IHD / Stroke / Any Other Siblings = HT / DM / IHD / Stroke / Any Other	
History of Allergies	Drug Allergy Any Other Not known.	
History of Medication	For HT / DM / IHD / Hypothyroidism Any Other No Any History.	
On Examination (O/E)	G. E. : N.A.D. R. S. : AEBE clear C. V. S. : S1S2 (+) C.N.S. : Conscious & Oriented P/A : Soft / Non tendir. Any Other Positive Findings :	

Height 170 cms	**Weight** 58. **Kgs**	
BMI		
Pulse (per min.) 82/min.	**Blood Pressure (mm of Hg)**	120/80 **mm of Hg**
	Gynaecology	
Examined by	Dr.	
Complaint & Duration		
Other symptoms (Mict, bowels etc)		
Menstrual History	Menarche _____ Cycle _____ Loss _____ Pain _____ I.M.B. _____ P.C.B. _____ L.M.P. _____ Vaginal Discharge _____ Cx. Smear _____ Contraception _____	
Obstetric History		
Examination :		
Breast		
Abdomen		
P.S.		
P.V.		
Gynaecology Impression & Recommendation		
Recommendation	No Any Fresh Complaints. Trace Reports.	
Physician Impression	No Any Other Complaints. Or History.	
Examined by :	- Overweight = To Reduce Weight - Underweight = To Increase Weight	

No. 16 Parwati