



MEDICAL CERTIFICATE

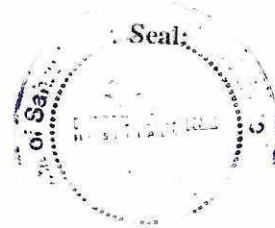
I, Dr. Rizwan malik do hereby certify that I have carefully examined  
Sri./Smt. Rewati Raut (Whose signature is given below), son / daughter  
of ..... is physically  unfit to join school / organization / undergo  
professional education.

Signature of Candidate / Guardian: Rewati Raut

Signature of Doctor: R.M. Registration No: **Dr. Rizwan Malik**  
**MBBS, MD (Medicine)**  
**Consultant Physician**  
**and Diabetologist**  
**MMC Reg. No. : 2011/05/1654**

Place: Pune

Date: 30.05.2024



**Place Label Here**  
 Pt. Name : \_\_\_\_\_  
 UMR : \_\_\_\_\_  
 Age : \_\_\_\_\_ Sex : \_\_\_\_\_  
 IP : \_\_\_\_\_  
 If label not available, write Pt. Name, IP No., Sex,  
 Date, Name of Treating Physician

**OPD Nursing Assessment - Adult**

Name: Rewati Raut Date of Birth : \_\_\_\_\_ Age/Sex: 23/F UMR No.: 23406

**Assessment :**

Height: 152 cms Weight: 75 kg. BMI: \_\_\_\_\_ Respiration: 20/min Pulse H/R : 102/min  
 BP: 116 mmHG Temperature : \_\_\_\_\_ °F/°C SpO2 98 % BSL \_\_\_\_\_  
 Chief Complaints : 64

**Tick Appropriate :**

Interpreter Needed

Yes  No

Nutritional Status: Weight Loss/Gain in Last 3 Months

Yes  No

If Weight Loss / Gain-Dietary Referral

Yes  No

Psychological Assessment Agitated Anxious

Yes  No  Normal

(If Agitated, Inform Physician)

Irritable

Any Allergies Known Including Drugs : No

Past History: Any Surgeries Explain : No

Any Other illness: Explain : No

Pain Score: Numerical Scales (1-10) \_\_\_\_\_ Location \_\_\_\_\_ Characteristics \_\_\_\_\_

Need to be seen immediately by the Doctor \_\_\_\_\_  Yes  No

Fall risk: Age 65Yrs. \_\_\_\_\_ Tremors \_\_\_\_\_ High Grade Fever \_\_\_\_\_ H/O Fall in last 3 months \_\_\_\_\_

Cardiac Medicines \_\_\_\_\_ Seizure Medications \_\_\_\_\_ Fall Prevention Education Done \_\_\_\_\_

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
<u>Shweta</u>	<u>024523</u>	<u>SK</u>	<u>28/5/24</u>

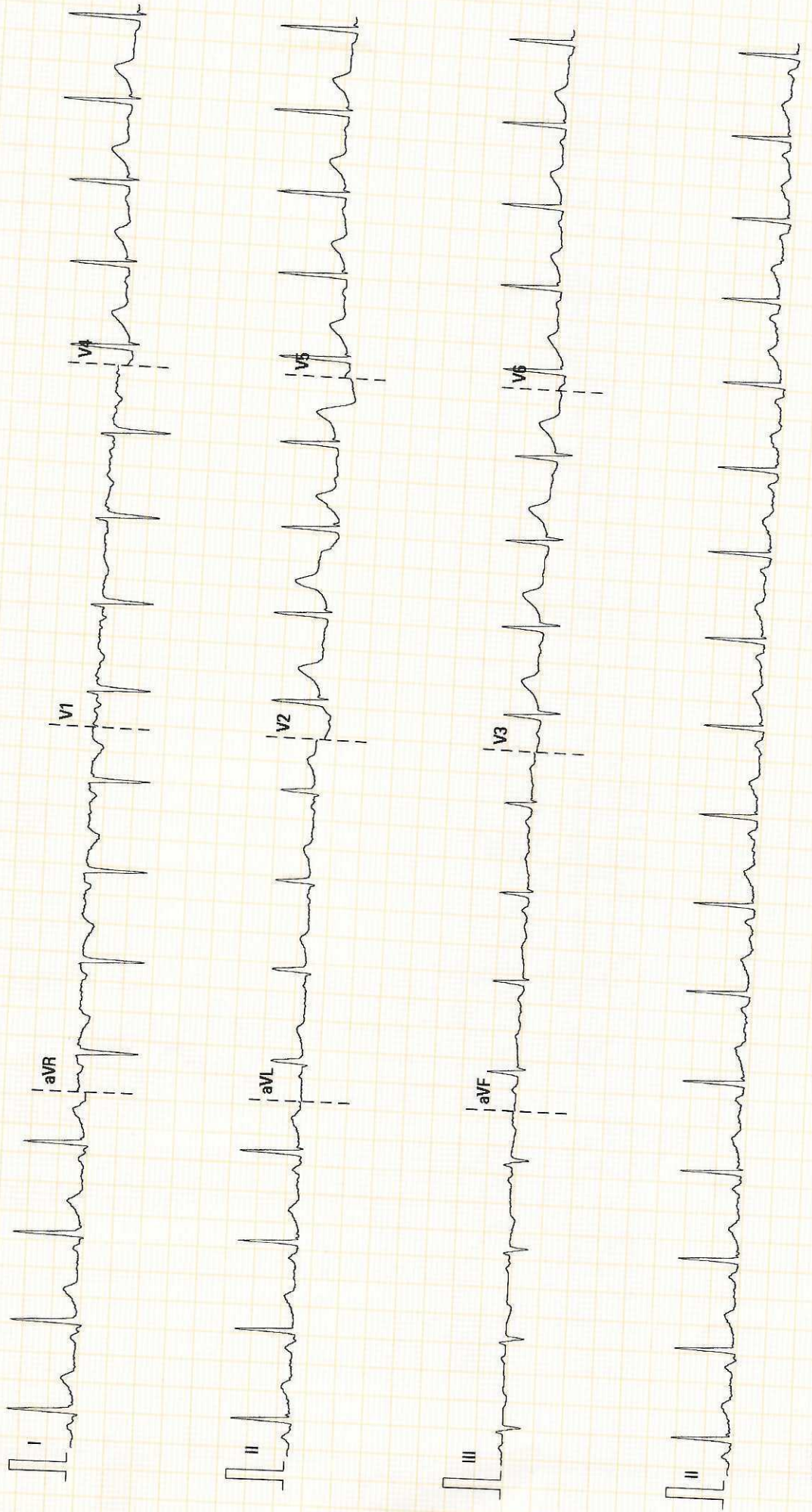
28-05-2024 12:26:38 PM

Name: rewati raui  
Age: 23 Years  
Gender: Female

Vent. Rate 99 bpm  
PR Interval 122 ms  
QRS Duration 80 ms  
QT/QTc Interval 340/408 ms  
P/QRS/T Axes 53/23/22 deg  
QTc:Hodges

Sinus rhythm  
Normal ECG

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz BDR 35 Hz

MEDICOVER KLE PUNE

02.10.00/V28.4.1 SN:FN-26035806



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Miss. REWATI SANA RAUT	<b>Age /Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC23499/PUU23406	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 28-May-24 01:33 pm	<b>Report Date</b> : 28-May-24 04:37 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
<b>CUE (COMPLETE URINE EXAMINATION)</b>			
<b><u>GENERAL EXAMINATION</u></b>			
VOLUME	Urine	10	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		SLIGHTLY TURBID	CLEAR
SPECIFIC GRAVITY		1.025	1.010 - 1.030
PH		6.0	4.5 - 8.0
<b><u>CHEMICAL EXAMINATION</u></b>			
PROTEIN	Urine	TRACE	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		TRACE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
<b><u>MICROSCOPIC EXAMINATION</u></b>			
PUS CELLS	Urine	8-10	0 - 5 /hpf
RBC		0-1	0 - 2 /hpf
EPITHELIAL CELLS		10-12	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

\*\*\* End Of Report \*\*\*

System Name : m



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Miss. REWATI SANA RAUT	<b>Age / Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC23499/PUU23406	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 28-May-24 11:42 am	<b>Report Date</b> : 28-May-24 04:48 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>COMPLETE BLOOD COUNT</b>				
<b>COMPLETE BLOOD COUNT</b>				
HAEMOGLOBIN	EDTA Blood	9.8	11.7 - 15.5 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		8,370	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		288000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.50	3.9 - 5.0 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		29.5	36 - 46 %	Analogical integration
MCV		65.6	82 - 95 fl	Calculated
MCH		21.7	27 - 32 pg	Calculated
MCHC		33.1	32 - 36 g/dL	Calculated
RDW(cv)		13.8	11.5 - 14.0 %	Calculated
MPV		10.9	6 - 9.5 fl	Calculated
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	EDTA Blood	60.4	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		30.7	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		0.8	00 - 06 %	DHSS/Microscopy
MONOCYTES		7.3	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.8	00 - 01 %	DHSS/Microscopy
<b>PERIPHERAL SMEAR EXAMINATION</b>				
RBC morphology	EDTA Blood	Microcytic+ , hypochromic+ ,Anisopoikilocytosis+, Pencil cells+		
WBC morphology		No Atypical cells seen		
PLATELETS		Adequate on smear		
NOTE		Adv: Serum Iron studies and serum ferritin level.		
<b>BLOOD GROUPING AND RH</b>				
BLOOD GROUP	Blood	" B "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		11	0 - 20 mm/1st hour	WESTERGREN`S METHOD

\*\*\* End Of Report \*\*\*

System Name : m



**DEPARTMENT OF LABORATORY**

**Patient Name** : Miss. REWATI SANA RAUT  
**Age / Gender** : 23 Y(s)/Female  
**Bill No/ UMR No** : PUBC23499/PUU23406  
**Referred By** : Dr. GENERAL MEDICINE CONSUL  
**Received Dt** : 28-May-24 12:10 pm  
**Report Date** : 28-May-24 05:00 pm

Parameters                      Specimen    Result                      Biological Reference In Method

System Name : m



**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Miss. REWATI SANA RAUT	<b>Age / Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : PUBC23499/PUU23406	<b>Referred By</b> : Dr. GENERAL MEDICINE CONSUL
<b>Received Dt</b> : 28-May-24 12:11 pm	<b>Report Date</b> : 28-May-24 03:28 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>SERUM CREATININE</b>		0.54	0.6 - 1.2 mg/dL	Jaffe
SGPT (ALT)		39.0	<= 33 U/L	Enzymatic
<b>SERUM BILIRUBIN TOTAL</b>		0.32	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
DIRECT BILIRUBIN		0.17	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.15	<= 1.0 mg/dL	
<b>FBS (FASTING BLOOD SUGAR)</b>				
<b>FASTING BLOOD GLUCOSE</b>		101.8	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
NOTE			Kindly correlate clinically. Repeat test with strict 10-12 hours fasting fresh sample, if indicated.	
<b>BUN(BLOOD UREA NITROGEN)</b>				
BUN (Blood Urea Nitrogen.)		7.1	7.0 - 21.0 mg/dL	Calculatead
<b>PPBS (POST PRANDIAL BLOOD SUGAR)</b>				
PPBS (POST PRANDIAL BLOOD SUGAR )		109.6	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase

\*\*\* End Of Report \*\*\*

Lab Incharge

**Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB**  
CONSULTANT PATHOLOGIST

Test results related only to the item tested.  
No part of the report can be reproduced without written permission of the laboratory.

System Name : m



<b>Patient ID:</b>	PUU23406	<b>Patient Name:</b>	REWATI RAUT
<b>Age:</b>	23 Years	<b>Sex:</b>	F
<b>Accession Number:</b>	PUBC23499-PK	<b>Modality:</b>	DX
<b>Referring Physician:</b>	HC	<b>Study:</b>	CHEST
<b>Study Date:</b>	28-May-2024		

### X RAY CHEST PA VIEW

**FINDINGS :** Chest PA view with no comparison study shows.

The visualized lung fields are clear.

No obvious consolidation is seen.

There is no pleural effusion or pneumothorax seen.

No pneumoperitoneum is seen.

The cardiac silhouette appears within normal limits.

The diaphragmatic shadow and mediastinal structures are within normal limits.

Visualized osseous structures demonstrate no obvious abnormality.

### IMPRESSION :

**No radiographically evident acute cardiopulmonary process in the present study.**

**Dr. Sunita Shewale (MBBS, DMRE)  
Consulting Radiologist**

**Dr. Sunita Shewale**  
Consulting Radiologist  
MBBS, DMRE

Date: 28-May-2024 13:42:37