CARDIOLOGY

UHID / IP NO	210810 (15200)	RISNo/Study :	58517
Patient Name :	Mr. MANJU M	Age/Gender :	42 Y/M
Referred By :	Dr. SRIDHAR SRINIVASAN G	Ward/Bed No :	OPD
Bill Date/No :	25/03/2023 8:37AM/ OPCR/23/7553	Scan Date :	
Report Date :	25/03/2023 12:05PM	Company Name:	Final

M- MODE MEASUREMENTS

AO	2.43	cm	RVIDD	1.20	cm
LA	3.50	cm	IVSD	1.03	cm
AO/LA RATIO	0.75	cm	LVIDD	4.54	cm
AV CUP	1.46	cm	LVPWD	0.99	cm
EPSS	0.9	cm	IVSS	1.53	cm
DE	1.83	cm	LVIDS	2.86	cm
EF SLOPE	0.7	cm	LVPWS	1.33	cm
SV	57.41		EDV	94.22	ml
CO			ESV	31.34	ml
HR			EF	67.73	%
LVMI			FS	37.90	%
OTHERS			LV MASS	178.32	grams

DESCRIPTIVE FINDINGS: Technically Adequate Study. Normal Sinus rhythm during Study.

LEFT VENTRICLE	Normal in size
LEFT ATRIUM	Normal in size
RIGHT VENTRICLE	Normal in size
RIGHT ATRIUM	Normal in size
WALL MOTION ANALYSIS	No RWMA
TRICUSPID VALVE	Normal
MITRAL VALVE	Normal
PULMONIC VALVE	Normal
AORTIC VALVE	Normal
IAS & IVS	Intact
AORTA & PA	Normal In Size
SYSTEMIC & PULMONARY VENIS	Normally Draining
PERICARDIUM	Normal
OTHERS	No Intra Cardiac Thrombus, Tumour or Vegetation

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CARDIOLOGY

UHID / IP NO	210810 (15200)	**RISNo./Status :**	58517/
Patient Name :	Mr. MANJU M	**Age/Gender :**	42 Y/M
Referred By :	Dr. SRIDHAR SRINIVASAN G	**Ward/Bed No :**	OPD
Bill Date/No :	25/03/2023 8:37AM/ OPCR/23/7553	**Scan Date :**	
Report Date :	25/03/2023 12:05PM	**Company Name:**	Final

DOPPLER STUDY

VALVES	VELOCITY	GRADIENT	REGURGITATION	OTHERS
P V	0.71m/s		NO PR	
MV	E: 0.70 m/s A: 0.59 m/s		NO MR	
AV	1.33 m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		NO TR	
OTHERS				

SUMMARY FINDINGS:

NORMAL CARDIAC CHAMBERS & VOLUMES

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-67 %)

NO CLOT / EFFUSION / VEGETATION/PAH

Dr. PRANEETHS
CONSULTANT
CARDIOLOGIST

Mr. Deva Sagayam C

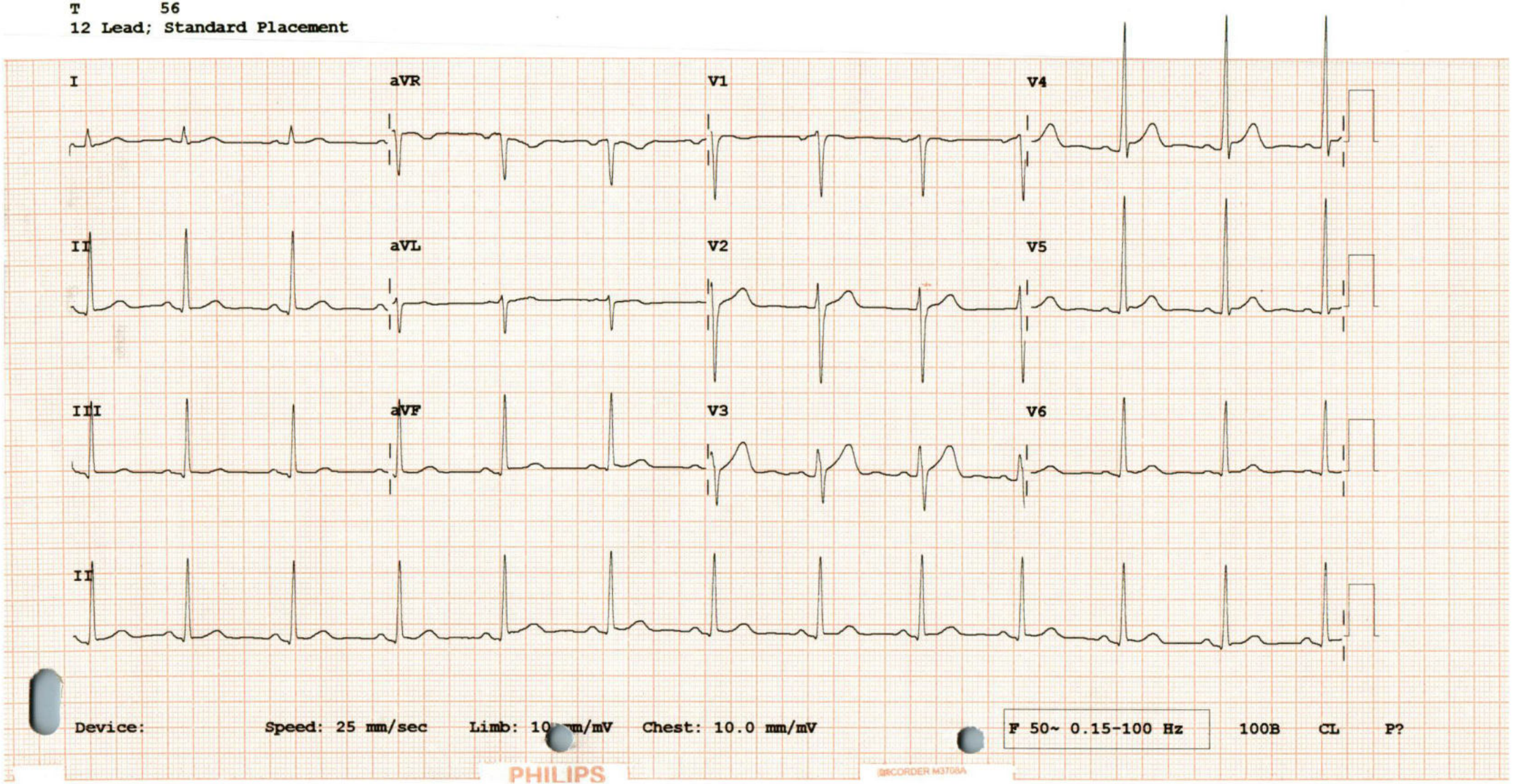
.MANOO M 42/M 25/03/2023 10:00:51 AM

Male

Rate 74

PR 158
QRSD 89
QT 364
QTc 404

--AXIS--
P 76
QRS 80
T 56
12 Lead; Standard Placement



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OPHTHALMOLOGY ASSESSMENT FORM

NABH
Safe – I
for Hospital Infection Control

Patient Name : Mr Manjunath. **Age /Sex :** 42/M. **UHID No.:** 210810. **Date :** 25/3/23.

Chief Complaints :

Routine check up
Nil visual complaints.
No need blue.

Others : Cold, Fever, Nausea, Vomiting, Giddiness.

Past History : Eye Treatment (Y / N) Eye Operation (Y / N)

General Health : DM ☐ HTN ☐ Heart Disease ☐ Br. Asthma ☐ Allergies ☐ Any Others ☐

VISION

	Right Eye	Left Eye
PL :		
Distant PH :		
GL :		
Near PL :		
GL :		

Colour vision: Normal.

AMSLER GRID :

AR Reading:

Dry	SPH	CYL	AXIS
RE	~~-0.00~~	-1.50	80
LE			

Wet	SPH	CYL	AXIS
RE	+0.25	-2.50	90
LE			

Acceptance :

IPD : 63

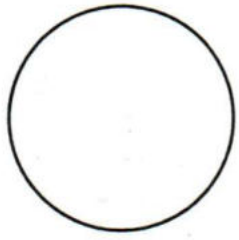
RIGHT EYE				LEFT EYE			
SPH	CYL	AXIS	VA	SPH	CYL	AXIS	VA
+0.25	-1.50	80	6/6	+0.25	-2.00	90	6/6.
+1.25	-1.50	80	N6/6	+1.25	-2.00	90	N6/6

Ocular Examination : Extra Ocular Movements :-

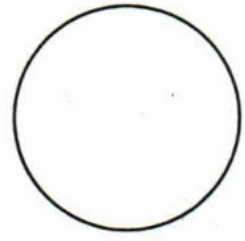
	RIGHT EYE	LEFT EYE
Anterior Segment		Lids :
		LAC. Apparatus
		Conj
		Cornea :
		AC depth :
		Iris
		Pupil
		Lens
Posterior Segment		Media
		DISC
		Macula
		Blood Vessels
		BGF

Fundus:

Right Eye



Left Eye



IOP : < 12 / 13 mm Hg.

Provisional Diagnosis: Myopic astigmatism & presbyopia

Medicine & Advice:

Annual eye check up

25/1/25

Date & Time

Arvat

Dr. Name & Signature

LABORATORY

Patient Name	Mr. MANJU M	**Lab No**	58517
UHID	210810	**Sample Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 9:33AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 1:38PM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	

HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD GROUP	"A"			
RH TYPE	POSITIVE			
			Sample: Blood	
HAEMOGLOBIN	17.3	gm/dl	14.00 - 18.00	
TOTAL COUNT	7250	cells/cumm	4500.00 - 11000.00	
DLC				
NEUTROPHILS	58	%	35.00 - 66.00	
LYMPHOCYTES	34	%	24.00 - 44.00	
MONOCYTES	05	%	4.00 - 10.00	
EOSINOPHILS	03	%	1.00 - 6.00	
BASOPHILS	00	%	0.00 - 1.00	
R.B.C COUNT	5.82	mill/cumm	4.50 - 5.90	
PACKED CELL VOLUME (PCV)	50.0	%	40.00 - 50.00	
PLATELET COUNT	1.53	lakh/cumm	1.50 - 4.50	
M.C.V	85.9	fL	80.00 - 100.00	
M.C.H	29.8	pg	26.00 - 34.00	
M.C.H.C	34.7	%	32.00 - 36.00	
ESR (ERYTHROCYTE SEDIMENTATION RATE)	**13 H**	mm/hr	0.00 - 10.00	

--End Of Report--

Verified By
Shashi Kumar G

BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

LABORATORY

Patient Name	Mr. MANJU M	**Lab No**	58517
UHID	210810	**Sample Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 9:33AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 2:52PM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
			Sample: Serum	
BLOOD UREA NITROGEN	11.8	mg/dl	Upto 14 years : 5 - 18 mg/dl Male (above 14 years): 8 - 24 mg/dl Female (above 14 years): 6 - 21 mg/dl Pregnant women : 5 - 12 mg/dl	
SERUM CREATININE	0.73	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	94.2	mg/dl	74.00 - 100.00	
GLYCOSYLATED HAEMOGLOBIN (HbA1c)				
HbA1c (GLYCOSYLATED Hb)	**6.4 H**	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	136.98	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	**214 H**	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	98.9	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	**33.9 L**	mg/dl	35.00 - 55.00	
LDL CHOLESTEROL - DIRECT	**134.7 H**	mg/dl	0.00 - 130.00	
TC/HDL	6.31			
LDL/HDL	3.97			
			Sample: Serum	
LIVER FUNCTION TEST (LFT)				

< 5.7 normal
5.7 – 6.4 Prediabetic
> 6.4 – Diabetic.

Ravi Shankar K
Bio Chemist

Verified By
Shashi Kumar G

LABORATORY

Patient Name	Mr. MANJU M	**Lab No**	58517
UHID	210810	**Sample Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 9:33AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 2:52PM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	

TOTAL BILIRUBIN	0.44	mg/dl	Adult - 0.2 - 1.3 mg/ dL **Special condition:** Premature - <2.0 mg/ dL Full term - <2.0 mg/ dL 0-1 day - Premature- 1.0 - 8.0 mg/ dL 0-1 day - Full term - 2.0 - 6.0 mg/ dL 1 - 2 days Premature - 6.0 - 12.0 mg/ dL 1 - 2 days Full term - 6.0 - 10.0 mg/ dL 3 - 5 days Premature - 10.0 - 14.0 mg/ dL 3 - 5 days Full term - 4.0 - 8.0 mg/ dL
DIRECT BILIRUBIN	0.20	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.24	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	20.5	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	26.7	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	92	IU/L	53.00 - 128.00
TOTAL PROTEIN	6.78	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.52	g/dl	3.50 - 5.20
SERUM GLOBULIN	**2.26 L**	g/dl	2.30 - 3.50
A/G RATIO	**2.00 H**	%	1.00 - 1.50
POST PRANDIAL BLOOD GLUCOSE	108	mg/dl	70.00 - 140.00
URIC ACID	4.7	mg/dl	4.50 - 8.10

--End Of Report--

Verified By

Shashi Kumar G
Bio Chemist

Ravi Shankar K

LABORATORY

Patient Name	Mr. MANJU M	**Lab No**	58517
UHID	210810	**Sample Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 11:05AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 3:02PM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
UIRNE GLUCOSE FASTING				
URINE SUGAR	NIL		NEGATIVE	
			Sample: Urine	
PHYSICAL CHARACTERS				
COLOUR	Pale Yellow			
APPEARANCE	Clear		Clear	
SPECIFIC GRAVITY	1.020			
PH	6.0			
CHEMICAL CONSTITUENTS				
ALBUMIN	Nil			
SUGAR	Nil			
BILE SALTS	Absent			
BILE PIGMENTS	Absent			
KETONE BODIES	NEGATIVE			
BLOOD	Absent			
MICROSCOPY				
PUS CELLS	1-2 /HPF			
R.B.C	Nil			
EPITHELIAL CELLS	0-1 / HPF			
CASTS	Nil			
CRYSTALS	Absent			
BACTERIA	Absent			
URINE GLUCOSE-POST PRANDIAL				
URINE SUGAR	NIL		NEGATIVE	

--End Of Report--

Verified By Shashi Kumar G

BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

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DEPARTMENT OF RADIOLOGY & IMAGING

Patient Name	Mr. MANJU M	**RIS No**	58517
UHID	210810	**Order Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 11:41AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 11:46AM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	25601

USG

LIVER: Liver is 14.3 cm in size, both lobes of liver are normal in size with homogeneous echotexture. No evidence of any focal lesion / intrahepatic billiary dilatation noted. CBD and Portal vein normal in size and echotexture.

GALL BLADDER: Well distended, gall bladder wall thickness is normal. Contents are clear. No evidence of gall stones / cholecystitis.

PANCREAS: Only head is visualised and appears normal. Rest of the pancreas obscured by bowel gas.

SPLEEN: Normal in size measuring 10.9 cms with normal echotexture.

KIDNEYS: Both Kidneys are normal in size, shape, contour & position. Cortico medullary differentiation is well maintained. No evidence of any hydronephrosis / hydroureter.

Right Kidney measures : 11.1 x 4.1 cms. Parenchymal thickness 1.6 cms.

Left Kidney measures : 11.4 x 5.5 cms. Parenchymal thickness 1.8 cms.

URINARY BLADDER: Well distended with clear contents. Wall thickness is normal.

PROSTATE: Normal in size and echotexture. Vol: 17.1 cc. No focal lesion seen.

No obvious free fluid in the peritoneal cavity.

IMPRESSION: NO SONOLOGICAL ABNORMALITY DETECTED.

***** Note: All abnormalities cannot be detected by Ultrasound scan due to technical limitation, obesity and other factors. Scan findings to be correlated with old reports or other investigations.***

--End Of Report--

Verified By
Ms Hemalatha K R

Dr. B SWAROOP
MBBS MD(Radiology)
CONSULTANT RADIOLOGIST

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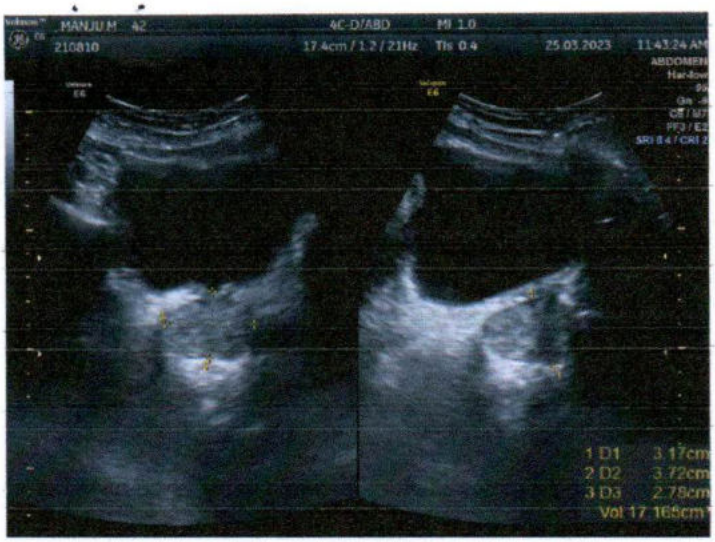

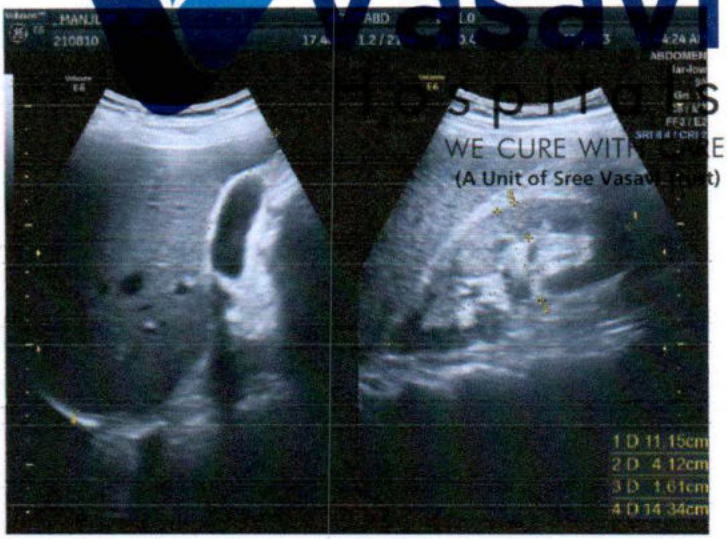

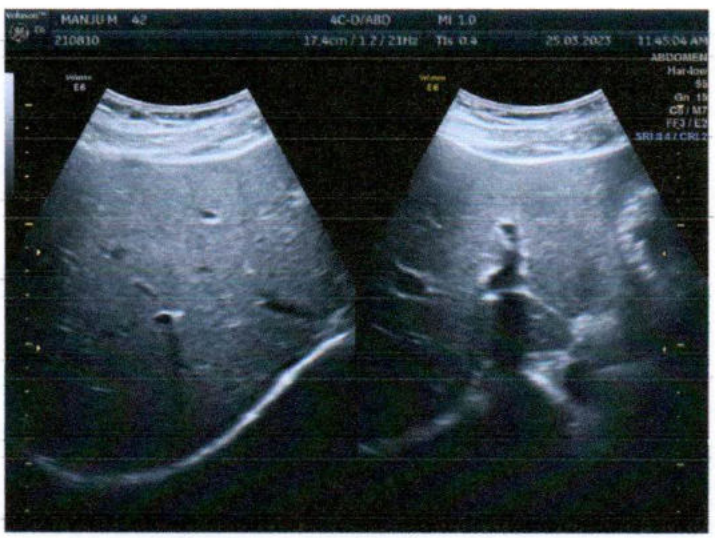

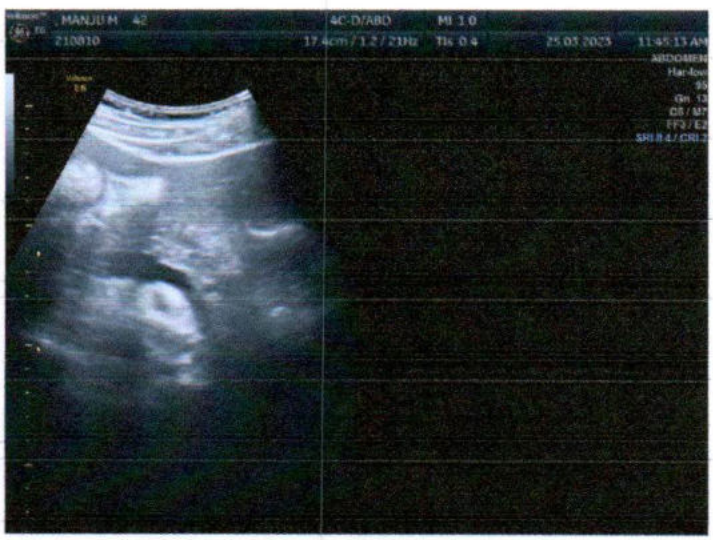

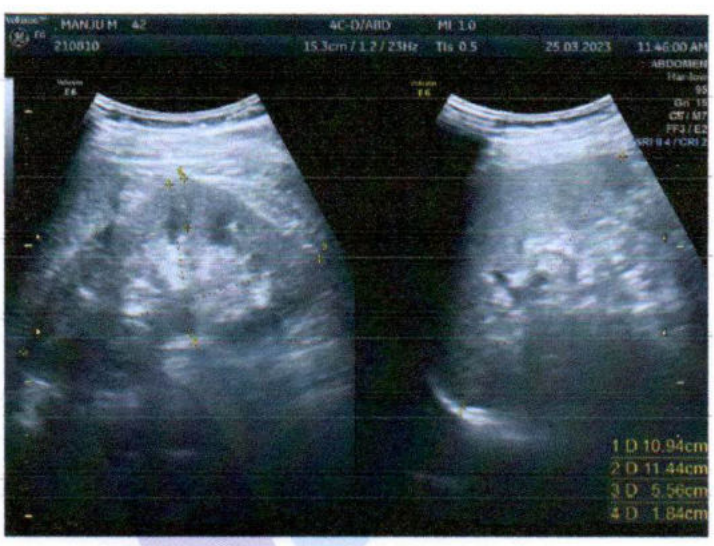

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DEPARTMENT OF RADIOLOGY & IMAGING

Patient Name	Mr. MANJU M	**RIS No**	58517
UHID	210810	**Order Date**	25/03/2023 8:37AM
Age/Gender	42 Yrs/Male	**Receiving Date**	25/03/2023 11:05AM
Bed No/Ward	OPD	**Report Date**	25/03/2023 11:42AM
Referred By	Dr. SRIDHAR SRINIVASAN G	**Report Status**	Final
Bill No.	OPCR/23/7553	**Manual No.**	46868

X-RAY

CHEST PA VIEW (X RAY) 1

FINDINGS:

The lungs on the either side show equal translucency.

Cardiac size and ventricular configuration are normal.

Both hilar region appear normal.

Both C P angles appear clear.

Both domes of diaphragm appear normal.

Bony cage and soft tissue appear normal.

IMPRESSION: ESSENTIALLY NORMAL STUDY.

--End Of Report--

Verified By
Ms Hemalatha K R

Dr. B SWAROOP
MBBS MD(Radiology)
CONSULTANT RADIOLOGIST

Printed on 25/03/2023 11:41

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OPD Prescription

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Reg. No 210810 **Issue Date** 25/3/23
Name Manju **Age/Sex** 42y/m
Doctor Dr. Sridhar. S **Department**
Patient Mob. **Category**

BP: 130/80 **Height:** 173 **Weight:** 75.6 **Pain:** **Pulse:** 95 b/m **Tempature:** (N) **SpO2:** 97%

Allergies: [ ] YES [ ] NO Details: Nil mm Hg cm BMI: 25.3 COVID 19 Positive: [ ] YES [ ] NO

Previous Drug Reactions: [ ] YES [ ] NO Details:

History and complaints: c/o Pain in the small joints of both hands. since 3-4 months.
O/E
CVS - S1S2 heard
RS - BL NVBS

Past History:

Examination:

Investigations:

Provisional/Final Diagnosis:

Advice
(1) Diabetic diet
(2) Cap uprise D3 (60k) once a week ↑ 8 weeks.
(3) Tab. Lanzol ER 60 - (SOS).

Drug orders:

Advice: (Lifestyle / Rehab / Diet)

Nutritional Screening: [ ] Poor [ ] Moderate [ ] Well → RA factor, CRP.

Fall Risk: [ ] No Risk [ ] Low [ ] high

Follow up: Date: _____ Time: _____ with CCP

Name & Signature of the Consultant with Stamp:

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Appointment: 080 71 500 500 | Emergency: 080 71 500 555