



MC-2176

Lab No. : SIL/11-02-2023/SR7284062
Patient Name : KUMARI AKANKSHA PRABHA
Age : 37 Y 8 M 2 D
Gender : F

Lab Add. : Sevoke Road, Siliguri 734001
Ref Dr. : Dr. MEDICAL OFFICER
Collection Date: 11/Feb/2023 12:52PM
Report Date : 11/Feb/2023 02:37PM



Test Name	Result	Unit	Bio Ref. Interval	Method
*POTASSIUM, BLOOD , GEL SERUM				
POTASSIUM,BLOOD	4.30	mEq/L	3.1-5.5 mEq/L	ISE INDIRECT
*CHLORIDE, BLOOD , .				
CHLORIDE,BLOOD	100.00	mEq/L	98 - 107 mEq/L	ISE INDIRECT
CREATININE, BLOOD , GEL SERUM	0.55	mg/dl	0.55 - 1.02 mg/dl	ALKALINE PICRATE
GLUCOSE, FASTING , BLOOD, NAF PLASMA				
GLUCOSE,FASTING	94	mg/dl	70 - 100 mg/dL	Hexokinase Method
CALCIUM, BLOOD				
CALCIUM,BLOOD	8.69	mg/L	8.6-10.0 mg/dl	OCPC
TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .				
TOTAL PROTEIN	7.46	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN	4.1	g/dl	3.4-5.0 g/dl	BCP
GLOBULIN	3.40	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.19		1.0 - 2.5	Calculated
*GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD				
GLYCATED HEMOGLOBIN (HBA1C)	5.7	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	39.0	mmol/mol		HPLC

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:

Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
 Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
 Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad-VARIANT TURBO 2.0, Bio-Rad D 10**Method : HPLC Cation Exchange****HbA1C : DUAL REPORTING OF UNITS Ref 2,3,4**

Suraksha Diagnostic Pvt. Ltd. has commenced reporting HbA1c in dual units. This is in keeping with current International recommendations to allow a transition phase from current reporting units (%) to the eventual (IFCC) units (mmol/mol). It is anticipated that only IFCC units will be used after 2 years of dual reporting. Please note that the method of analysis has not changed. Although the two results look numerically different, they are clinically equivalent. In defining HbA1C, the unit mmol /mol was determined to be the most accurate description of what is being measured. This will make the measurement more precise and allow for better comparisons of HbA1c results from different laboratories and hospitals throughout the world.

Standardization & traceability Ref 2,3,4

HbA1c is standardized & traceable to IFCC methods HPLC-CE & HPLC-MS. This new unit (mmol/mol) is used as part of this standardization. This change in HbA1c calibration is to conform to national & international best practice. The initiative will mean that HbA1c is measured specifically & reproducibly. It also enables the use of international reference ranges & harmonization of medical decision or target values.

Recommendations for glycemic targets Ref 1

- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
- Ø The timing and frequency of SMBG should be tailored based on patients individual treatment, needs, and goals.
- Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
- Ø If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.
- Ø For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.
- Ø Some patients may benefit from HbA1c goals that are more or less stringent.



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Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B₁₂/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.

Reference: Glycated hemoglobin monitoring BMJ 2006; 333:586-8

References:

1. Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.
2. Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.
3. Geistanger A, Arends S, Berding C, Hoshino T, Jeppsson J-O, Little R, Siebelder C and Weykamp C, on behalf of the IFCC Working Group on Standardization of HbA1c: Statistical Methods for Monitoring the Relationship between the IFCC Reference Measurement Procedure for Hemoglobin A1c. Clin Chem 2008; 54(8): 1379-8.
4. International Expert Committee Report, drawn from the International Diabetes Federation (IDF), the European Association for the Study of Diabetes (EASD), American Diabetes Association (ADA), International Federation of Clinical Chemistry and Laboratory Medicine, International Society for Pediatric & Adolescent Diabetes. International Congress - IFCC, WorldLab, EuroMedLab- Berlin, 2011.

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LIPID PROFILE , GEL SERUM

CHOLESTEROL-TOTAL	241.34	mg/dl	Desirable: < 200 mg/dL Borderline high: 200-239 High: > 240 mg/dL	CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE
TRIGLYCERIDES	184.92	mg/dl	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	ENZYMATIC, END POINT
HDL CHOLESTEROL	40.64	mg/dl	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	DIRECT MEASURE-PEG
LDL CHOLESTEROL DIRECT	168.0	mg/dl	OPTIMAL : <100 mg/dL, Near optimal/ above optimal : 100-129 mg/dL, Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	DIRECT MEASURE
VLDL	33	mg/dl	< 40 mg/dl	Calculated

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CHOL HDL Ratio	5.9	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated
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NOTE : Elevated Triglyceride value is to be interpreted in the light of previous 72 hrs dietary intake of lipids.Repeat estimation with 72 hrs fat restricted diet followed by 12 hrs fasting, suggested for better evaluation .

PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM

PHOSPHORUS-INORGANIC,BLOOD	3.8	mg/dl	2.5-4.5 mg/dl	UV PHOSPHOMOLYBDATE
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THYROID PANEL (T3, T4, TSH) , GEL SERUM

T3-TOTAL (TRI IODOTHYRONINE)	0.98	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.6	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	3.79	µIU/mL	0.55-4.78 µIU/mL	CLIA

BIOLOGICAL REFERENCE INTERVAL : [ONLY FOR PREGNANT MOTHERS]**Trimester specific TSH LEVELS during pregnancy:**

FIRST TRIMESTER : 0.10 2.50 µ IU/mL
 SECOND TRIMESTER : 0.20 3.00 µ IU/mL
 THIRD TRIMESTER : 0.30 3.00 µ IU/mL

References :

- 1.Indian Thyroid Society guidelines for management of thyroid dysfunction during pregnancy. Clinical Practice Guidelines, New Delhi: Elsevier; 2012.
- 2.Stagnaro-Green A, Abalovich M, Alexander E, Azizi F, Mestman J, Negro R, et al. Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum. Thyroid 2011; 21: 1081-25.
- 3.Dave A, Maru L, Tripathi M. Importance of Universal screening for thyroid disorders in first trimester of pregnancy. Indian J Endocr Metab [serial online] 2014 [cited 2014 Sep 25]; 18: 735-8. Available from: <http://www.ijem.in/text.asp?2014/18/5/735/139221>.

***SODIUM, BLOOD , GEL SERUM**

SODIUM,BLOOD	139.00	mEq/L	136 - 145 mEq/L	ISE INDIRECT
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GLUCOSE, PP , BLOOD, NAF PLASMA

GLUCOSE,PP	141	mg/dl	75-140	Hexokinase Method
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UREA,BLOOD

UREA,BLOOD	13.0	mg/dl	12.8-42.8 mg/dl	UREASE-COLORIMETRIC
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URIC ACID, BLOOD , GEL SERUM

URIC ACID,BLOOD	5.12	mg/dl	2.6 - 6.0 mg/dl	URICASE ,COLORICMETRIC
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DR. SANJAY KR. AGARWALA
MD CONSULTANT BIOCHEMIST



MC-2176

Suraksha
DIAGNOSTICS

Lab No. : SR7284062

Name : KUMARI AKANKSHA PRABHA

Age/G : 37 Y 8 M 2 D / F

Date : 11-02-2023

Lab No. : SIL/11-02-2023/SR7284062

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Suraksha Diagnostic Private Limited

E-mail: info@surakshanet.com | Website: www.surakshanet.com

Lab No. : SR7284062 Name : KUMARI AKANKSHA PRABHA Age/G : 37 Y 8 M 2 D / F Date : 14-02-2023

BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD

ABO	B	Gel Card
RH	POSITIVE	Gel Card

Gel technology Dia Med ID Micro typing system is the latest technology in transfusion Medicine. It gives more reproducible and standardized test results. It more repaid, reliable, very sensitive and objective , and hence more consistent and comparable results are obtained. Single used cards are individualised for every patient and results can be photographed / scanned and stored for future use. Special instruments that are used only for this technology also reduce risk of any contamination.

Ref:- WHO technical manual on transfusion medicine-Second Edition 2003

(RESULTS ALSO VERIFIED BY : FORWARD AND REVERSE GROUPING (TUBE AND SLIDE METHOD))

TECHNOLOGY USED: GEL METHOD

ADVANTAGES :

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

Historical records check not performed.

ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD

1stHour	12	mm/hr	0.00 - 20.00 mm/hr	Westergren
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CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD

HEMOGLOBIN	12.1	g/dL	12 - 15	PHOTOMETRIC
WBC	7.2	*10 ³ /μL	4 - 10	DC detection method
RBC	4.53	*10 ⁶ /μL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE) COUNT	220	*10 ³ /μL	150 - 450*10 ³ /μL	DC detection method/Microscopy

DIFFERENTIAL COUNT

NEUTROPHILS	52	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	37	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	05	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	06	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy

CBC SUBGROUP

HEMATOCRIT / PCV	35.3	%	36 - 46 %	Calculated
MCV	81.0	fl	83 - 101 fl	Calculated
MCH	26.7	pg	27 - 32 pg	Calculated
MCHC	34.2	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	14.3	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	23.2	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	11.1		7.5 - 11.5 fl	Calculated
RBC	MILD MICROCYTIC HYPOCHROMIC.			
WBC.	WITHIN NORMAL LIMIT.			

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PLATELET ADEQUATE ON SMEAR.

URINE ROUTINE ALL, ALL , URINE

PHYSICAL EXAMINATION

COLOUR PALE YELLOW
 APPEARANCE CLEAR

CHEMICAL EXAMINATION

pH	6.5	4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015	1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	ABSENT	NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	ABSENT	NOT DETECTED	Dipstick (glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	ABSENT	NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	NEGATIVE	NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE	NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE	NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE	NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE	NEGATIVE	Dipstick (ester hydrolysis reaction)

MICROSCOPIC EXAMINATION

LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	8-10	/hpf	0-5	Microscopy
RED BLOOD CELLS	ABSENT	/hpf	0-2	Microscopy
CAST	ABSENT		NOT DETECTED	Microscopy
CRYSTALS	ABSENT		NOT DETECTED	Microscopy
BACTERIA	ABSENT		NOT DETECTED	Microscopy
YEAST	ABSENT		NOT DETECTED	Microscopy
OTHERS	ABSENT			

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can occur due to cell lysis.
8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria and/or yeast in the urine.

DEPARTMENT OF PATHOLOGY **REPORT ON EXAMINATION OF CERVICAL SMEAR** **FOR EXFOLIATIVE CYTOLOGY**

SPECIMEN TYPE :

Conventional cervical PAP smear.

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SPECIMEN ADEQUACY :

Satisfactory for evaluation. Endocervical cells not seen .

GENERAL DIAGNOSTIC CATEGORIZATION :

Negative for intraepithelial lesion / malignancy.

MICROSCOPY :

Smears examined show superficial and intermediate squamous cells with normal flora.

IMPRESSION:

Normal cervical smear.

Note: Reported as per. The 2014 Bethesda system of reporting cervical cytology.

ENCL : One (01) slide.



DR. BARNALI PAUL
MBBS, MD(PATH)

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Gender : F

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 11/Feb/2023 01:56PM



DEPARTMENT OF RADIOLOGY
X-RAY REPORT OF CHEST (PA)

FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhouette is smoothly outlined. Shape is within normal limit.
- **Prominence of bronchovascular marking is seen. No definite active lung lesion is seen.**
- Lateral costo-phrenic angles are clear.
- Domes of diaphragm are smoothly outlined. Position is within normal limits.

IMPRESSION :

Suggestive of bronchitis.

(Please correlate clinically & with other investigation .Follow up suggested).

□


DR. MUKTI SARKAR MD.
CONSULTANT RADIOLOGIST

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Lab Add. :
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DEPARTMENT OF ULTRASONOGRAPHY
REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER

Liver is normal in size having normal shape, regular smooth outline and of homogeneous echotexture. No focal parenchymal lesion is evident. Intrahepatic biliary radicles are not dilated. Branches of portal vein are normal

PORTA

The appearance of porta is normal. Common Bile duct is normal with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal at porta.

GALL BLADDER

Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected. Sonographic Murphys sign is negative.

PANCREAS

Echogenicity appears within limits, without any focal lesion. Shape, size & position appears normal. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

SPLEEN

Spleen is normal in size. Homogenous and smooth echotexture without any focal lesion. Splenic vein at hilum appears normal. No definite collaterals could be detected.

KIDNEYS

Both kidneys are normal in shape, size (Rt. kidney 100 mm. & Lt. kidney 101 mm.) axes & position. Cortical echogenicity appears normal maintaining cortico-medullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected. Visualised part of upper ureters are not dilated.

URINARY BLADDER

Urinary bladder is distended, wall thickness appeared normal.No intraluminal pathology (calculi/mass) could be detected.

UTERUS

Uterus is bulky in size (100 mm. x 38 mm. x 43 mm.). Endometrium (6 mm) is in midline. Myometrium appears smooth & homogenous without any detectable/sizable focal lesion. Cervix looks normal. Pouch of Douglas is free.

OVARIES

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Ovaries are normal in size, shape, position, margin and echotexture.

IMPRESSION :

Bulky uterus.

(Please correlate clinically & with other investigation .Follow up suggested).

Kindly note

- Ultrasound is not the modality of choice to rule out subtle bowel lesion.
- Please Intimate us for any typing mistakes and send the report for correction within 7 days.
- The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.

The report and films are not valid for medico-legal purpose.

Patient Identity not verified.

□


DR. MUKTI SARKAR MD.
CONSULTANT RADIOLOGIST



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Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 11/Feb/2023 03:02PM

DEPARTMENT OF CARDIOLOGY REPORT OF E.C.G.

HEART RATE : 67 /min.
RHYTHM : Regular sinus.
P-WAVE : Normal
P - R INTERVAL : 160 ms,
QRS DURATION : 80 ms
QRS CONFIGURATION : NORMAL
QRS VOLTAGE : R/S in V1 4/10 mm.
R/S in V6 20/1 mm.
QRS AXIS : Normal
Q- Waves : No significant Q-wave.
QCT INTERVAL : 406 ms
ST SEGMENT : Normal.
T WAVE : NORMAL
ROTATION : Normal.
OTHER FINDINGS : Nil.
IMPRESSION : ECG WITHIN NORMAL LIMIT.

ACRay

Dr. A C RAY
Department of Non-invasive
Cardiology