DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : XRAY

Patient Name	:	MR. VIVEK KUMAR	**IPD No.**	:	
Age	:	30 Yrs 8 Mth	**UHID**	:	APH000011875
Gender	:	MALE	**Bill No.**	:	APHHC230001136
Ref. Doctor	:	DR. FAROGH HAIDRYAsian Patna Hospital	**Bill Date**	:	05-10-2023 17:19:11
Ward	:		**Room No.**	:	
			Print Date	:	06-10-2023 15:50:12

CHEST PA VIEW:

Midexpiratory film.

Cardiac shadow appears normal.

Both lung fields appear clear.

Both domes of diaphragm and both CP angles are clear.

Both hila appear normal.

Soft tissues and bony cage appear normal.

Please correlate clinically.

.....End of Report.....

Prepare By.
MD.SALMAN

DR. MUHAMMAD SERAJ, MD
Radiodiagnosis,FRCR (London)
BCMR/46075
CONSULTANT

Note : The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

FINAL REPORT

Bill No.	:	APHHC230001136	**Bill Date**	:	05-10-2023 17:19			
Patient Name	:	**MR. VIVEK KUMAR**	**UHID**	:	**APH000011875**			
Age / Gender	:	30 Yrs 8 Mth / MALE	**Patient Type**	:	OPD	**If PHC**	:	
Ref. Consultant	:	DR. FAROGH HAIDRY	**Ward**	:				
Sample ID	:	**APH23027200**	**Current Bed**	:				
	:		**Reporting Date & Time**	:	07-10-2023 14:18			
	:		**Receiving Date & Time**	:	05/10/2023 20:31			

MICROBIOLOGY REPORTING

CULTURE AEROBIC

Specimen : URINE

Culture Line : No growth after 48 hours of incubation.

Microscopic Examination

Pus cells : : 1 - 2/hpf

End of the Report

DR. TRINAIN KUMAR CHAKRAVERTI
MBBS, MD (Micro)

DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : ULTRASOUND

Patient Name	:	MR. VIVEK KUMAR	**IPD No.**	:	
Age	:	30 Yrs 8 Mth	**UHID**	:	APH000011875
Gender	:	MALE	**Bill No.**	:	APHHC230001136
Ref. Doctor	:	DR. FAROGH HAIDRYAsian Patna Hospital	**Bill Date**	:	05-10-2023 17:19:11
Ward	:		**Room No.**	:	
			Print Date	:	06-10-2023 14:48:20

WHOLE ABDOMEN:

Both the hepatic lobes are normal in size and shows mildly increase in parenchymal echogenicity S/O grade I fatty liver infiltration. (Liver measures 11.7 cm).

No focal lesion seen. Intrahepatic biliary radicals are not dilated.

Portal vein is normal in calibre.

Gall bladder is well distended. Wall thickness is normal. No calculus seen.

CBD is normal in calibre.

Pancreas is normal in size and echotexture.

Spleen is normal in size (9.5 cm) and echotexture.

Both kidneys are normal in size and echotexture (Right kidney (9.9 cm), Left kidney (10.0 cm).

Cortico-medullary distinction is maintained. No calculus or hydronephrosis seen.

Urinary bladder appears normal.

Prostate appears normal in size (Vol. 13.4 cc), outline and echotexture.

No free fluid or collection seen. No basal pleural effusion seen.

No significant lymphadenopathy seen.

No dilated bowel loop seen.

IMPRESSION:- Grade I fatty infiltration of liver.

Please correlate clinically……

.....End of Report.....

Prepare By.
MD.SALMAN

DR. MUHAMMAD SERAJ, MD
Radiodiagnosis,FRCR (London)
BCMR/46075
CONSULTANT

Note : The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

FINAL REPORT

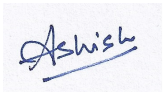
Bill No.	:	APHHC230001136	**Bill Date**	:	05-10-2023 17:19			
Patient Name	:	**MR. VIVEK KUMAR**	**UHID**	:	**APH000011875**			
Age / Gender	:	30 Yrs 8 Mth / MALE	**Patient Type**	:	OPD	**If PHC**	:	
Ref. Consultant	:	DR. FAROGH HAIDRY	**Ward / Bed**	:	/			
Sample ID	:	**APH23027199**	**Current Ward / Bed**	:	/			
	:		**Receiving Date & Time**	:	05-10-2023 19:23			
			Reporting Date & Time	:	05-10-2023 21:36			

HAEMATOLOGY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
Sample Type: EDTA Whole Blood				
FEVER PANEL PACKAGE				
CBC -1 (COMPLETE BLOOD COUNT)				
TOTAL LEUCOCYTE COUNT (Flow Cytometry)		5.4	thousand/cumm	4 - 11
RED BLOOD CELL COUNT (Hydro Dynamic Focussing)		4.6	million/cumm	4.5 - 5.5
HAEMOGLOBIN (SLS Hb Detection)		13.4	g/dL	13 - 17
PACK CELL VOLUME (Cumulative Pulse Height Detection)		40.5	%	40 - 50
MEAN CORPUSCULAR VOLUME		87.0	fL	83 - 101
MEAN CORPUSCULAR HAEMOGLOBIN		28.7	pg	27 - 32
MEAN CORPUSCULAR HAEMOGLOBIN CONCENTRATION		33.0	g/dL	31.5 - 34.5
PLATELET COUNT (Hydro Dynamic Focussing)		158	thousand/cumm	150 - 400
RED CELL DISTRIBUTION WIDTH (S.D - RDW) (Particle Size Distribution)	**H**	**47.0**	fL	39 - 46
RED CELL DISTRIBUTION WIDTH (C.V.)	**H**	**15.1**	%	11.6 - 14
DIFFERENTIAL LEUCOCYTE COUNT				
NEUTROPHILS	**H**	**86**	%	40 - 80
LYMPHOCYTES	**L**	**8**	%	20 - 40
MONOCYTES		5	%	2 - 10
EOSINOPHILS		1	%	1 - 5
BASOPHILS		0	%	0 - 1
ESR (Westergren)	**H**	**18**	mm 1st hr	0 - 10
MALARIAL PARASITE (RAPID CARD TEST)		NEGATIVE		

**** End of Report ****

IMPORTANT INSTRUCTIONS
CL - Critical Low, CH - Critical High, H - High, L - Low



DR. ASHISH RANJAN SINGH
MBBS,MD
CONSULTANT

FINAL REPORT

Bill No.	:	APHHC230001136	**Bill Date**	:	05-10-2023 17:19		
Patient Name	:	**MR. VIVEK KUMAR**	**UHID**	:	**APH000011875**		
Age / Gender	:	30 Yrs 8 Mth / MALE	**Patient Type**	:	OPD	**If PHC**	:
Ref. Consultant	:	DR. FAROGH HAIDRY	**Ward / Bed**	:	/		
Sample ID	:	**APH23027197**	**Current Ward / Bed**	:	/		
	:		**Receiving Date & Time**	:	05-10-2023 19:23		
			Reporting Date & Time	:	05-10-2023 21:23		

SEROLOGY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval

Sample Type: Serum

FEVER PANEL PACKAGE

DENGUE ANTIGEN NS 1 (Immunochromatographic Assay)		NEGATIVE		
DENGUE ANTIBODIES - IGM (Immunochromatographic Assay)		NEGATIVE		
DENGUE ANTIBODIES - IGG (Immunochromatographic Assay)		NEGATIVE		

NOTE : Test results are to be confirmed with ELISA based method as per National Vector Borne Disease Control Programme. (NVBDCP) guidelines

TYPHI DOT-IGM		POSITIVE		

INTERPRETATION:

1. THIS TEST IS DONE ON IGM RAPID TEST CASSETTE.
2. IT DETECTS IGM ANTIBODIES TO S.TYPHI SPECIFIC ANTIGEN THUS AID IN THE DETERMINATION OF CURRENT TO S.TYPHI.
3. THE RESULTS OBTAINED WITH THIS TEST SHOULD ONLY BE INTERPRETED IN CONJUNCTION WITH OTHER DIAGNOSTIC PROCEDURES AND CLINICAL FINDINGS.

**** End of Report ****

IMPORTANT INSTRUCTIONS

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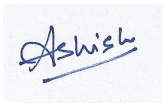

DR. ASHISH RANJAN SINGH
MBBS,MD
CONSULTANT

FINAL REPORT

Bill No.	:	APHHC230001136	**Bill Date**	:	05-10-2023 17:19		
Patient Name	:	**MR. VIVEK KUMAR**	**UHID**	:	**APH000011875**		
Age / Gender	:	30 Yrs 8 Mth / MALE	**Patient Type**	:	OPD	**If PHC**	:
Ref. Consultant	:	DR. FAROGH HAIDRY	**Ward / Bed**	:	/		
Sample ID	:	**APH23027198**	**Current Ward / Bed**	:	/		
	:		**Receiving Date & Time**	:	05-10-2023 19:23		
			Reporting Date & Time	:	06-10-2023 00:07		

CLINICAL PATH REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval

Sample Type: Urine

FEVER PANEL PACKAGE

URINE, ROUTINE EXAMINATION

PHYSICAL EXAMINATION

QUANTITY		30 mL		
COLOUR		Pale Straw		Pale Yellow
TURBIDITY		Clear		

CHEMICAL EXAMINATION

PH (Double pH indicator method)		6.5		5.0 - 8.5
PROTEINS (Protein-error-of-indicators)		Negative		Negative
SUGAR (GOD POD Method)		Negative		Negative
SPECIFIC GRAVITY, URINE (Apparent pKa change)		1.015		1.005 - 1.030

MICROSCOPIC EXAMINATION

LEUCOCYTES		1-2	/HPF	0 - 5
RBC's		Nil		
EPITHELIAL CELLS		1-2/HPF		
CASTS		Nil		
CRYSTALS		Nil		

**** End of Report ****

IMPORTANT INSTRUCTIONS

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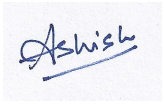

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