बैंक ऑफ़ बड़ौदा
Bank of Baroda

नाम दिव्या

Name Divya

कर्मचारी कूट क्र.

E.C. No. 111562

जारीकर्ता प्राधिकारी

Issuing Authority

धारक के हस्ताक्षर

Signature of Holder

Siddhivinayak Hospital

Hosp. Reg. No.: TMC - Zone C - 386

INDUSTRIAL HEALTH SERVICES

FITNESS CERTIFICATE

Name : Divya

Medical Date - 23-9-23

Gender : Female

AGE : 36 Y.

PHYSICAL EXMINATION		Cardiovascular System		Respiratory System		Alimentary System	
Height	167	Puls	71	Trachea :	Normal	Liver	NORMAL
Weight	51					Spleen	NORMAL
BMI	18.3	BP	120/80	RR		Kidney	NORMAL
SKIN	NAD					Hernia	NO
NOSE	NAD	Heart Sound:Normal		RS	NAD	Hydrocele	NO
EAR & Tonsils:	NAD						

Central Nervous System

X- Ray :- Normal

ECG :- WNL

PFT :- NA.

Employee Present History :-

NAD

Spects Without Glasses / With Glasses

VISION	RIGHT	LEFT
NEAR -	N / 6	N/ 6
DISTANT-	6/ 24	6/ 9

Colour Vision - NORMAL

Employee Family History :-

Father → HTN S 2-3 yrs

Mother → DM S 2-3 yrs

ADVICE :

Siddhivinayak H... Reg.No.TMC/ZONE-C/3... Vartak Nagar, Th...

REMARK :- Employee is free from any infectious contagious & communicable diseases and join his/her normal duties

S-1, Vedant Complex, Vartak Nagar, Thane (W) 400 606

E : ohs.svh@gmail.com W : www.siddhivinayakhospitals.org T. : 022 - 2588 3531 M. : 9769545533

Name – Mrs. Divya	**Age – 36 Y/F**
Ref by Dr.- Siddhivinayak Hospital	**Date – 23/09/2023**

USG ABDOMEN & PELVIS

Clinical details:- Routine

The Liver is normal in size and shows normal echogenicity. There is no obvious abnormal focal lesion seen. There is no IHBR dilatation seen in both the lobes of the liver.
The CBD and the Portal vein appear normal.
The Gall bladder is well distended & appears normal. No calculi or filling defects are seen. No evidence of Pericholecystic collection. The wall thickness is normal.
Right Kidney measures 9.2 x 4.0 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.
Left Kidney measures 9.3 x 4.1 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

The Pancreas is normal in size & shows homogenous echopattern. It shows no focal lesion.
The Spleen is normal in size (9.7 cm) with homogenous echotexture.
The urinary bladder is adequately distended and appears normal. There is no evidence of any obvious calculi or any mass lesion seen. Both Uretero-vesical junctions appear clear. No abnormal intraluminal lesion noted.
The Uterus is anteverted & measures approximately 7.8 x 3.6 x 4.5 cms with normal homogenous echotexture. The uterine outline is smooth and normal. No abnormal focal lesion noted. Endometrial thickness is normal
Both ovaries are normal in size and echotexture.
The right ovary measures 3.1 x 2.4 cms.
The left ovary measures 3.2 x 2.1 cms.
Bilateral adnexae appear normal. No focal lesion noted.
No obvious lymphadenopathy is seen in abdomen and pelvis.
Mild free fluid pouch of Douglas

IMPRESSION:

- **Mild free fluid pouch of Douglas**

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis. Second opinion is always advisable.

ECHOCARDIOGRAM

NAME	MRS. DIVYA
AGE/SEX	36 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE, DNB, DM (CARDIOLOGY)
DATE OF EXAMINATION	23/09/2023

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: • **AML**: Normal • **PML**: Normal • **Sub-valvular deformity**: Absent AORTIC VALVE: Normal • **No. of cusps**: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	**CHAMBERS:** LEFT ATRIUM: Normal LEFT VENTRICLE: Normal • **RWMA**: No • **Contraction**: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal • **RWMA**: No • **Contraction**: Normal
GREAT VESSELS: • **AORTA**: Normal • **PULMONARY ARTERY**: Normal	**SEPTAE:** • **IAS**: Intact • **IVS**: Intact
CORONARIES: Proximal coronaries normal	**VENACAVAE:** • **SVC**: Normal • **IVC**: Normal and collapsing >20% with respiration
CORONARY SINUS: Normal	
PULMONARY VEINS: Normal	**PERICARDIUM**: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	30 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	38.6 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	22.5 mm	RVEF	%
Ascending aorta	mm	IVSd	8.0 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.0 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	72 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	14 mm

Name – MRS. DIVYA	**Age - 36 Y/F**
Ref by Dr.- Siddhivinayak Hospital	**Date – 23/09/2023**

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- **No significant abnormality seen.**

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.

ID: 1900
Divya
Male Years 36 F
Req. No. :

23-09-2023 08:50:12 AM

HR	: 61	bpm
P	: 95	ms
PR	: 158	ms
QRS	: 86	ms
QT/QTcBz	: 413/416	ms
P/QRS/T	: 72/91/3	°
RV5/SV1	: 0.995/0.171	mV

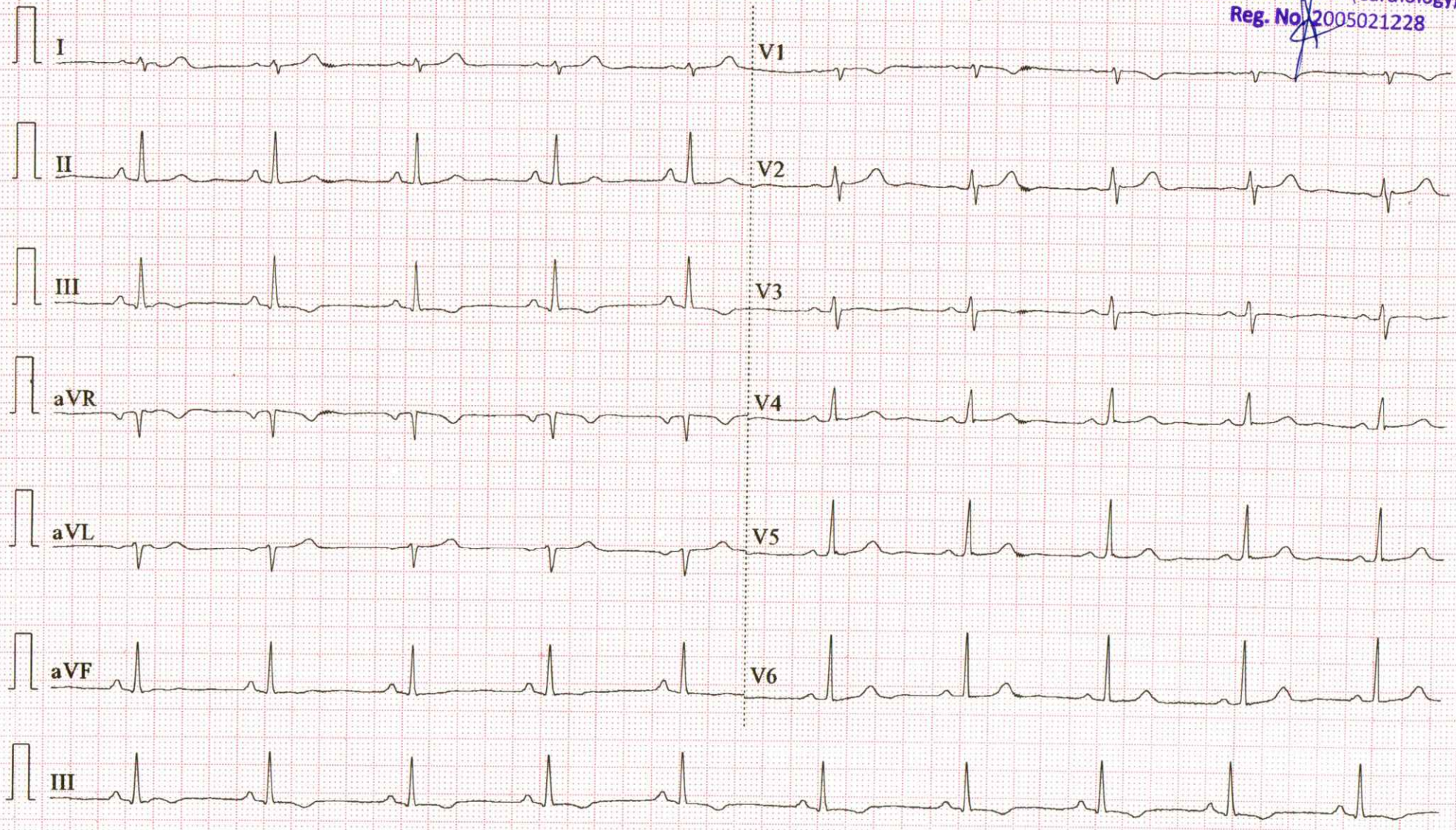
Diagnosis Information:
Sinus Rhythm
Right Axis Deviation

WNL

BP - 120/80 mm/hg
SpO_2 - 99 %
PR - 71 bpm

Report Confirmed by:

Dr. Anant Ramk[illegible] Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228



0.25~35Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE

COMPLETE PATHOLOGICAL SOLUTION

Name	: Mrs. DIVYA	Collected On	: 23/9/2023 10:42 am
Lab ID.	: 168420	Received On	: 23/9/2023 10:52 am
Age/Sex	: 36 Years / Female	Reported On	: 24/9/2023 2:10 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS .	Report Status	: INTERIM

168420

PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/161/23		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	Adequate		
CELL TYPE	Superficial, intermediate,squamous metaplastic cells		
BACKGROUND	Inflammatory		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Many neutrophils		
FINAL IMPRESION	Negative for intraepithelial lesion or malignancy.		

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

Checked By
Dr. smita.ranveer

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M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

24 HOURS 7

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168420

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDASE)	**228.0**	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)	42.7	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	82.9	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)	**169**	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)	3.96		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	5.34		<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 ----------

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SHAISTA Q

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168420

COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	**11.7**	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	**35.1**	%	36 - 46
RBC COUNT	**4.37**	x10^6/uL	4.5 - 5.5
MCV	80	fl	80 - 96
MCH	**26.8**	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	**14.8**	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	4880	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	60	%	40 - 80
LYMPHOCYTES	24	%	20 - 40
EOSINOPHILS	06	%	0 - 6
MONOCYTES	10	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	227000	/ cumm	150000 - 450000
MPV	10.6	fl	6.5 - 11.5
PDW	16	%	9.0 - 17.0
PCT	0.240	%	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.

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168420

HEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	10	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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168420

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
URINE ROUTINE EXAMINATION			
PHYSICAL EXAMINATION			
VOLUME	15 ml		
COLOUR	Pale yellow	Text	Pale Yellow
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION	Acidic		Acidic
(methyl red and Bromothymol blue indicator)			
SP. GRAVITY	1.010		1.005 - 1.022
(Bromothymol blue indicator)			
PROTEIN	Absent		Absent
(Protein error of PH indicator)			
BLOOD	Absent		Absent
(Peroxidase Method)			
SUGAR	Absent		Absent
(GOD/POD)			
KETONES	Absent		Absent
(Acetoacetic acid)			
BILE SALT & PIGMENT	Absent		Absent
(Diazonium Salt)			
UROBILINOGEN	Absent		Normal
(Red azodye)			
LEUKOCYTES	Absent	Text	Absent
(pyrrole amino acid ester diazonium salt)			
NITRITE	Absent		Negative
(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)			
MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	Absent		
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	1-3	/ HPF	0 - 5
CASTS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		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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* 1 6 8 4 2 0 *

IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TFT (THYROID FUNCTION TEST)			
SPACE		Space	-
SPECIMEN	Serum		
T3	98.13	ng/dl	84.63 - 201.8
T4	8.81	µg/dl	5.13 - 14.06
TSH	**6.06**	µIU/ml	0.270 - 4.20

T3 (Triido Thyronine) hormone)

AGE	RANGE
1-30 days	100-740
1-11 months	105-245
1-5 yrs	105-269
6-10 yrs	94-241
11-15 yrs	82-213
15-20 yrs	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 -12 months	7.8-16.5
1-5 yrs	7.3-15.0
5-10 yrs	6.4-13.3
11-15 yrs	5.6-11.7

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 wks -5 months	1.7-9.1
6 months-20 yrs	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 ----------

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Ref By	: **SIDDHIVINAYAK HOSPITAL CGHS /ESIS**	**Report Status**	: **FINAL**

168420

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'AB'		
RH FACTOR	POSITIVE		

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

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*BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	19.9	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	9.30	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.85	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.3	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	137.8	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.01	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	100.5	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.85	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.9	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.41	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.19	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.22	g/dl	1.9 - 3.5
A/G RATIO calculated	1.30		0 - 2

NOTE BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.

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

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

Checked By
SHAISTA Q

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24 HOURS 7
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Dr. Smita Ranveer`s

Radiance

CLINICAL DIAGNOSTIC CENTRE

COMPLETE PATHOLOGICAL SOLUTION

Name	: Mrs. DIVYA	**Collected On**	: 23/9/2023 10:42 am
Lab ID.	: 168420	**Received On**	: 23/9/2023 10:52 am
Age/Sex	: 36 Years / Female	**Reported On**	: 26/9/2023 1:32 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	**Report Status**	: FINAL

168420

PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/161/23		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	Adequate		
CELL TYPE	Superficial, intermediate,squamous metaplastic cells		
BACKGROUND	Inflammatory		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Many neutrophils		
FINAL IMPRESION	Negative for intraepithelial lesion or malignancy.		

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

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168420

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear.
	Neutrophils:58 %
	Lymphocytes:26 %
	Monocytes:10 %
	Eosinophils:06 %
	Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.

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

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.74	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.30	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.44	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	20.1	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	10.2	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	**38.0**	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.41	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.19	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.22	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.30		0 - 2

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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GLYCOCELATED HEMOGLOBIN (HBA1C)			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.6	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	114.0	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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 GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	95.6	mg/dL	70 - 110
BLOOD GLUCOSE PP	97.5	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

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE

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.

GAMMA GT	19.0	U/L	5 - 55

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

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