NABH ACCREDITED

PRAKASH

EYE HOSPITAL & LASER CENTRE

Dr. AMIT GARG

M.B.B.S., D.N.B. (Opth.)
I-Lasik (Femto) Bladefree Topical Micro Phaco & Medical Retina Specialist
Ex. Micro Phaco Surgeon
Venu Eye Institute & Research Centre, New Delhi

Name Koushal Devi Age/Sex 43 / F C/o Date 12/Dec/22

Routine Eye checkup

Dr. AMIT GARG
M.B.B.S., D.N.B.
Garg Pathology, Meerut

Accredited Eye Hospital Western U.P.

First NABH ECO

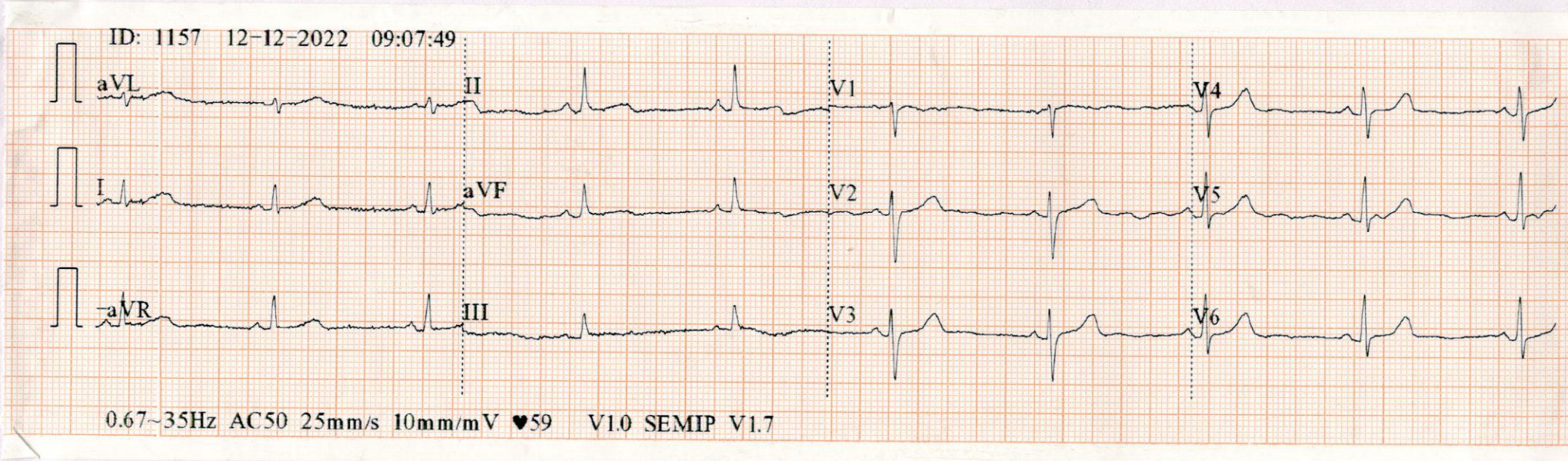
प्रकाश आँखो का अस्पताल एवं लेजर सैन्टर

PRAKASH EYE HOSPITAL

Website: www.prakasheyehospital.in
Facebook: http://www.prakasheyehospital.in

Counsellor 9837066186
7535832832
Manager 7895517715
OT 7302222373
TPA 9837897788
(पूर्व सूचना दिन तक लाना है)

Timings Morning : 9:30 am to 1:30 pm.
Evening : 5:00 pm to 7:00 pm.
Sunday : 9:30 am to 1:30 pm.
Near Nai Sarak, Garh Road, Meerut
E-mail : prakasheyehosp@gmail.com



ID: 1157

Female / kPa
43Years
cm kg

Diagnosis Information:
Sinus Bradycardia
Poor R Wave Progression(V4)

HR	: 56	bpm
P	: 92	ms
PR	: 128	ms
QRS	: 77	ms
QT/QTc	: 402/390	ms
P/QRS/T	: 40/62/9	°
RV5/SV1	: 0.777/0.510	mV

Report Confirmed by:

Dr MONIKA GARG
M.B.B.S., M.D. (Path.)
GARG PATHOLOGY

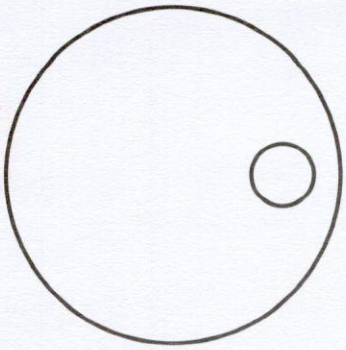
Vn — R 6/6, L 6/6

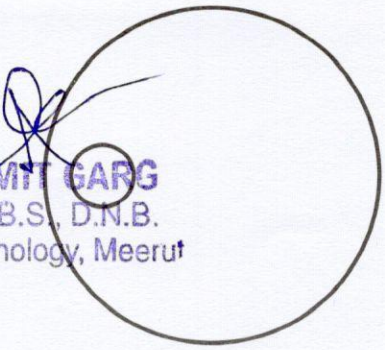
PH — R 6/6, L 6/6

IOP — R 15, L 18 mmhg

BE Colour Vision — NORMAL, NORMAL

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance		Plano.		6/6		Plano		6/6
Near Add BE	+1.50	——		N/6	+1.50	——		N/6.





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Garg Pathology, Meerut

भारत सरकार
GOVERNMENT OF INDIA

कौशल देवी
Koushal Devi
जन्म तारीख/DOB:10/05/1979
महिला Female

4489 8061 6987

मेरा आधार, मेरी पहचान

कौशल्या

Dr. MONIKA GARG
M.B.B.S., M.D. (Path.)
GARG PATHOLOGY

भारतीय विशिष्ट पहचान प्राधिकरण
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

AADHAAR

पता:
अर्धांगिनी: विरेन्द्र कुमार,
मकान6बी-63 गोकुल विहार
गली न-4, रोहटा रोड मेरठ,
मेरठ सिटी, मेरठ
उत्तर प्रदेश, 250002

Address:
W/O: Virendra Kumar, HN-B-63 GOKUL VIHAR GALI NO-4, ROHTA ROAD Meerut, meerut City, Meerut
Uttar Pradesh, 250002

4489 8061 6987

MERA AADHAAR, MERI PEHACHAN


PATHOLOGY
LAB
GARG PATHOLOGY
Dr MONIKA GARG
M.B.B.S., M.D. (Path.)
GARG PATHOLOGY
Dec 12, 2022 8:51:44 AM
205° SW
Tejgarhi
Meerut
Uttar Pradesh
Altitude:90.3m
Hotel Harmony Inn
334
709A
Nai Sarak
SECTOR 3
RTO Rd
Google

Garg Pathology

Certified by :
National Accreditation Board For Testing & Calibration Laboratories
ISO 9001:2008
Garden House Colony, Near Nai Sarak, Garh Road, Meerut
Ph.: 0121-2600454, 8979608687, 9837772828

DR. MONIKA GARG
M.D. (Path) Gold Medalist
Former Pathologist :
St. Stephan's Hospital, Delhi

PUID	: 221212/601	**C. NO:**	**601**	**Collection Time**	: **12-Dec-2022 8:48AM**
Patient Name	: **Mrs. KOUSHAL DEVI 43Y / Female**			**Receiving Time**	: **12-Dec-2022 8:58AM**
Referred By	: **Dr. BANK OF BARODA**			**Reporting Time**	: **12-Dec-2022 9:52AM**
Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval

HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	12.0	gm/dl	12.0-15.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	5440	*10^6/L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	60	%.	40-80
Lymphocytes	37	%.	20-40
Eosinophils	01	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	3.26	x 10^9/L	2.0-7.0(40-80%
Absolute lymphocyte count	2.01	x 10^9/L	1.0-3.0(20-40%)
Absolute eosinophil count	0.05	x 10^9/L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated / ESR (Autometed Wsetergren`s)	12	mm/1st hr	0.0 - 15.0
RBC Indices			
TOTAL R.B.C. COUNT (Electric Impedence)	**4.07**	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	37.6	%	26-50
MCV (Calculated)	92.4	fL	80-94
MCH (Calculated)	29.5	pg	27-32
MCHC (Calculated)	31.9	g/dl	30-35
RDW-SD	46.3	fL	37-54

***THIS TEST IS NOT UNDER NABL SCOPE**

Checked By Technician:

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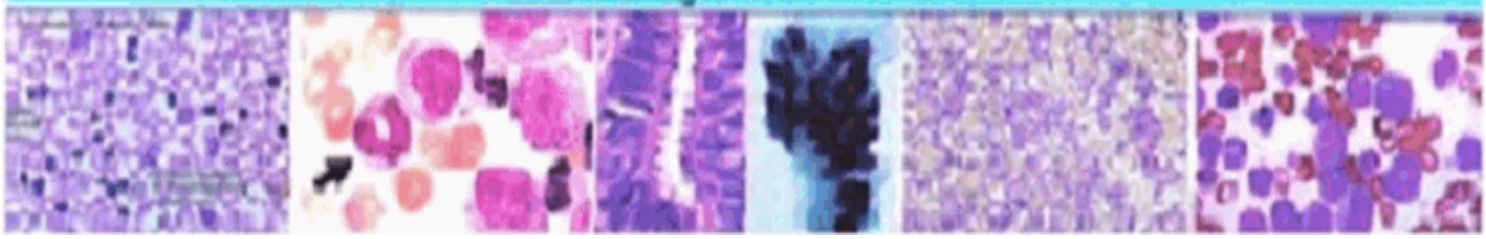
MBBS, MD(Path)
(Consultant Pathologist)



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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
(Calculated)			
RDW-CV	12.1	%	11.5 - 14.5
(Calculated)			
Platelet Count	2.29	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	11.5	%	7.5-11.5
(Calculated)			
NLR	1.62		1-3

6-9 Mild stres
7-9 Pathological cause

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.
-NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
-NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).
-With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP *	**"O" POSITIVE**	$	$

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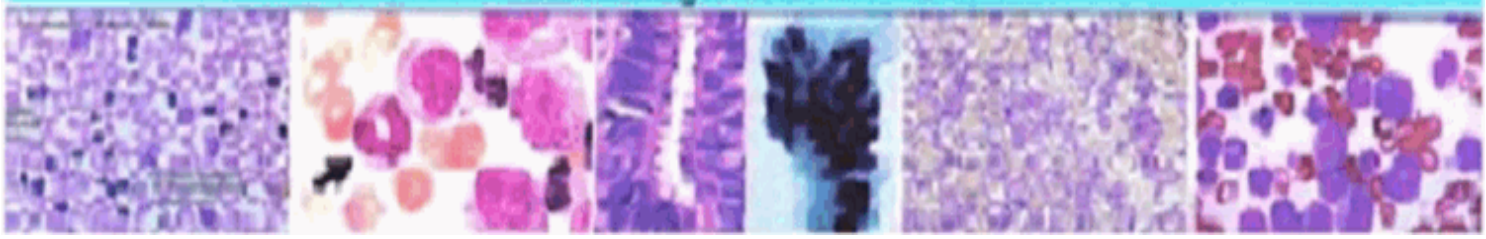

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
GLYCATED HAEMOGLOBIN (HbA1c)*	5.5	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	111.2	mg/dl	

EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics : 4.3% to 6.30%
Good Control of diabetes : 6.4% to 7.5%
Fair Control of diabetes : 7.5% to 9.0%
Poor Control of diabetes : 9.0 % and above

-Next due date for HBA1C test : After 3 months

-High HbF & Trig.level, iron def.anaemia result in high GHb

-Haemolyic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control.HbA1c represents average glycemia over the past six to eight weeks.Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3) Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.
As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.

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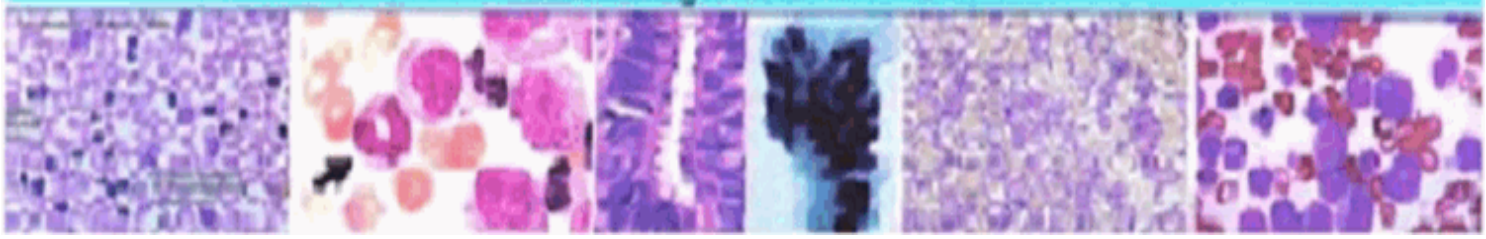

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
BIOCHEMISTRY (FLORIDE)			
PLASMA SUGAR FASTING (GOD/POD method)	94.0	mg/dl	70 - 110
PLASMASUGAR P.P. (GOD/POD method)	108.0	mg/dl	80-140

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
	BIOCHEMISTRY (SERUM)		
SERUM CREATININE (Enzymatic)	0.8	mg/dl	0.6-1.4
URIC ACID	6.7	mg/dL.	2.5-6.8
BLOOD UREA NITROGEN	15.30	mg/dL.	8-23

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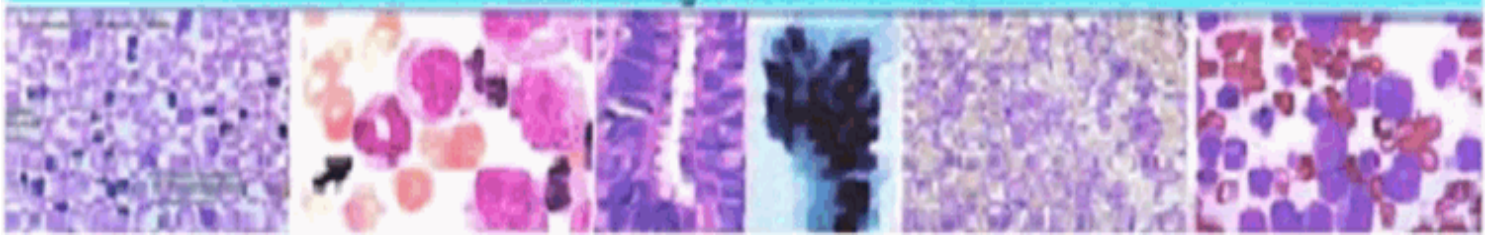

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Investigation	Results	Units	Biological Ref-Interval
LIVER FUNCTION TEST			
SERUM BILIRUBIN			
TOTAL (Diazo)	0.6	mg/dl	0.1-1.2
DIRECT (Diazo)	0.3	mg/dl	<0.3
INDIRECT (Calculated)	0.3	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	25.0	U/L	8-40
S.G.O.T. (IFCC method)	27.1	U/L	6-37
SERUM ALKALINE PHOSPHATASE (IFCC KINETIC)	95.6	IU/L.	37-103
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	6.8	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	4.0	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	2.8	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	**1.4**		1.5-2.5

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Investigation	Results	Units	Biological Ref-Interval
LIPID PROFILE			
SERUM CHOLESTEROL (CHOD - PAP)	162.0	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	129.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	42.3	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	25.8	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	93.9	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	02.2	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	3.8	ratio	3.8-5.9

Interpretation :
Paitient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE :
Lipid Profile Ranges As PER NCEP-ATP III :
SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated :> 240 mg/dl
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased :< 40 mg/dl
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

SERUM SODIUM (Na) *	139.0	mEq/litre	135 - 155
(ISE method)			
(ISE)			

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Investigation	Results	Units	Biological Ref-Interval
THYRIOD PROFILE*			
Triiodothyronine (T3) * (ECLIA)	1.102	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	9.645	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH (ECLIA)	3.713	uIU/ml	0.38-5.30

Normal Range:-
1 TO 4 DAYS 2.7-26.5
4 TO 30 DAYS 1.2-13.1

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disordes such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism,serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both incresed and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) * (ISE method)	4.0	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	9.3	mg/dl	9.2-11.0

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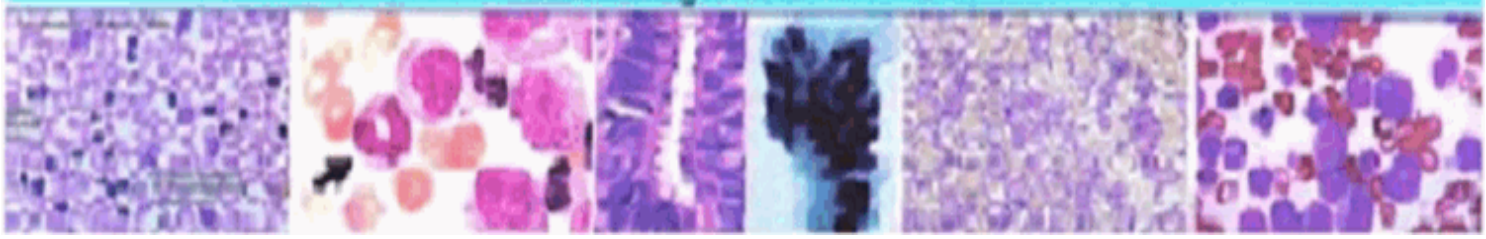

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Investigation	Results	Units	Biological Ref-Interval

CYTOLOGY EXAMINATION

SPECIMEN mg 903/22

Microscopic:

SITE OF SMEAR: ECTOCERVIX AND POSTERIOR FORNIX OF VAGINA
METHOD OF EVALUATION: BETHSEDA SYSTEM
EVALUATION OF SMEAR : SATISFACTORY
REPORT: CELLULAR SPREAD SHOWS DESQUAMATED EPITHELIAL CELLS PREDOMINANTLY SUPERFICIAL AND INTERMEDIATE CELLS. FAIR NUBER OF ENDOCERVICAL CELL CLUSTERS SEEN SHOWING REACTIVE CHANGES.
BACKROUND SHOWS SEVERE INFLAMMATORY REACTION.
THERE IS SHIFT IN VAGINAL FLORA. LACTOBACILLI ARE REDUCED.
ANY DYSKARYOTIC CELL IS NOT SEEN.
ANY BUDDING SPORES OR TROPHOZOITE IS NOT SEEN.
INFERENCE: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY INFLAMMATORY SMEARS
REPEAT AFTER A COURSE OF ANTIBIOTICS
NOTE: This test has its own limitations. Please interpret the findings in light of clinical picture. not for medicolegal use

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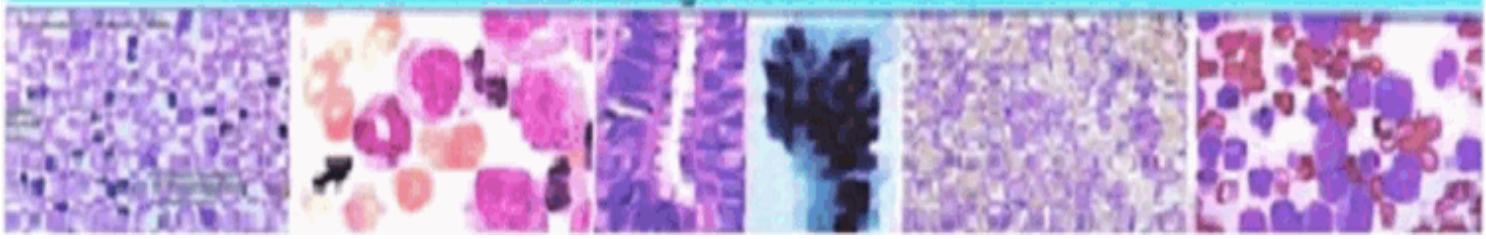

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PUID	: 221212/601	**C. NO:**	**601**	**Collection Time**	: **12-Dec-2022 8:48AM**
Patient Name	: **Mrs. KOUSHAL DEVI 43Y / Female**			**Receiving Time**	: **12-Dec-2022 8:58AM**
Referred By	: **Dr. BANK OF BARODA**			**Reporting Time**	: **12-Dec-2022 11:10AM**
Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval
	URINE		
PHYSICAL EXAMINATION			
Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.020		1.000-1.030
PH (Reaction)	Acidic		
BIOCHEMICAL EXAMINATION			
Protein	Nil		Nil
Sugar	Nil		Nil
MICROSCOPIC EXAMINATION			
Red Blood Cells	Nil	/HPF	Nil
Pus cells	2-3	/HPF	0-2
Epithilial Cells	3-4	/HPF	1-3
Crystals	Nil		
Casts	Nil		
@ Special Examination			
Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

----------{END OF REPORT }----------

***THIS TEST IS NOT UNDER NABL SCOPE**

Checked By Technician:

Dr. Monika Garg
MBBS, MD(Path)
(Consultant Pathologist)

Garg Pathology

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National Accreditation Board For Testing & Calibration Laboratories
ISO 9001:2008
Garden House Colony, Near Nai Sarak, Garh Road, Meerut
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Referred By	: **Dr. BANK OF BARODA**			**Reporting Time**	: **12-Dec-2022 9:52AM**
Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval

HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	12.0	gm/dl	12.0-15.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	5440	*10^6/L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	60	%.	40-80
Lymphocytes	37	%.	20-40
Eosinophils	01	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	3.26	x 10^9/L	2.0-7.0(40-80%
Absolute lymphocyte count	2.01	x 10^9/L	1.0-3.0(20-40%)
Absolute eosinophil count	0.05	x 10^9/L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated / ESR (Autometed Wsetergren`s)	12	mm/1st hr	0.0 - 15.0
RBC Indices			
TOTAL R.B.C. COUNT (Electric Impedence)	**4.07**	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	37.6	%	26-50
MCV (Calculated)	92.4	fL	80-94
MCH (Calculated)	29.5	pg	27-32
MCHC (Calculated)	31.9	g/dl	30-35
RDW-SD	46.3	fL	37-54

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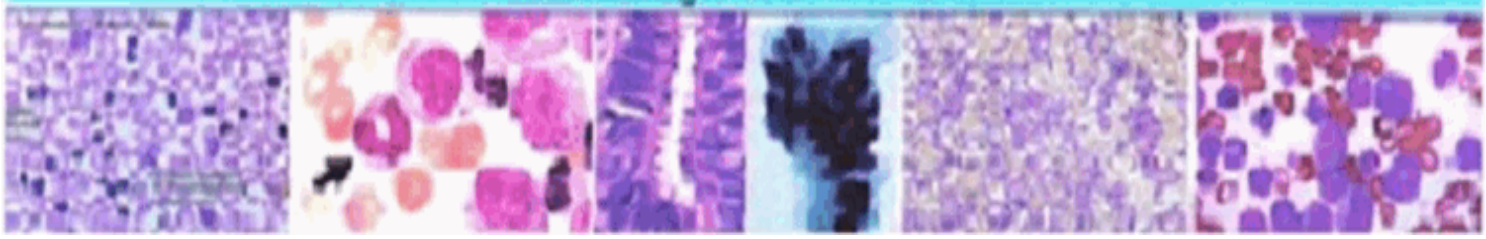

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
(Calculated)			
RDW-CV	12.1	%	11.5 - 14.5
(Calculated)			
Platelet Count	2.29	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	11.5	%	7.5-11.5
(Calculated)			
NLR	1.62		1-3

6-9 Mild stres
7-9 Pathological cause

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.
-NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
-NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).
-With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP *	**"O" POSITIVE**	$	$

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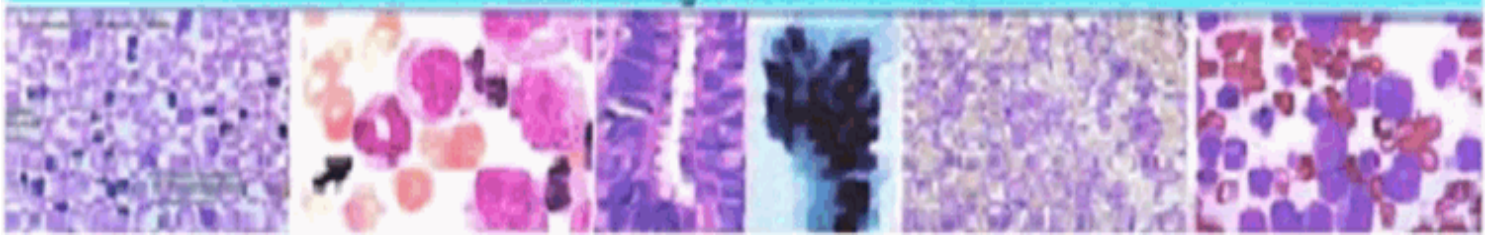

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Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval
GLYCATED HAEMOGLOBIN (HbA1c)*	5.5	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	111.2	mg/dl	

EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics : 4.3% to 6.30%
Good Control of diabetes : 6.4% to 7.5%
Fair Control of diabetes : 7.5% to 9.0%
Poor Control of diabetes : 9.0 % and above

-Next due date for HBA1C test : After 3 months

-High HbF & Trig.level, iron def.anaemia result in high GHb

-Haemolyic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control.HbA1c represents average glycemia over the past six to eight weeks.Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3) Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.
As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.

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Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval
BIOCHEMISTRY (FLORIDE)			
PLASMA SUGAR FASTING (GOD/POD method)	94.0	mg/dl	70 - 110
PLASMASUGAR P.P. (GOD/POD method)	108.0	mg/dl	80-140

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Investigation	Results	Units	Biological Ref-Interval
	BIOCHEMISTRY (SERUM)		
SERUM CREATININE (Enzymatic)	0.8	mg/dl	0.6-1.4
URIC ACID	6.7	mg/dL.	2.5-6.8
BLOOD UREA NITROGEN	15.30	mg/dL.	8-23

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
LIVER FUNCTION TEST			
SERUM BILIRUBIN			
TOTAL (Diazo)	0.6	mg/dl	0.1-1.2
DIRECT (Diazo)	0.3	mg/dl	<0.3
INDIRECT (Calculated)	0.3	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	25.0	U/L	8-40
S.G.O.T. (IFCC method)	27.1	U/L	6-37
SERUM ALKALINE PHOSPHATASE (IFCC KINETIC)	95.6	IU/L.	37-103
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	6.8	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	4.0	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	2.8	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	**1.4**		1.5-2.5

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
LIPID PROFILE			
SERUM CHOLESTEROL (CHOD - PAP)	162.0	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	129.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	42.3	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	25.8	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	93.9	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	02.2	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	3.8	ratio	3.8-5.9

Interpretation :
Paitient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE :
Lipid Profile Ranges As PER NCEP-ATP III :
SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated :> 240 mg/dl
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased :< 40 mg/dl
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

SERUM SODIUM (Na) * (ISE method)	139.0	mEq/litre	135 - 155

(ISE)

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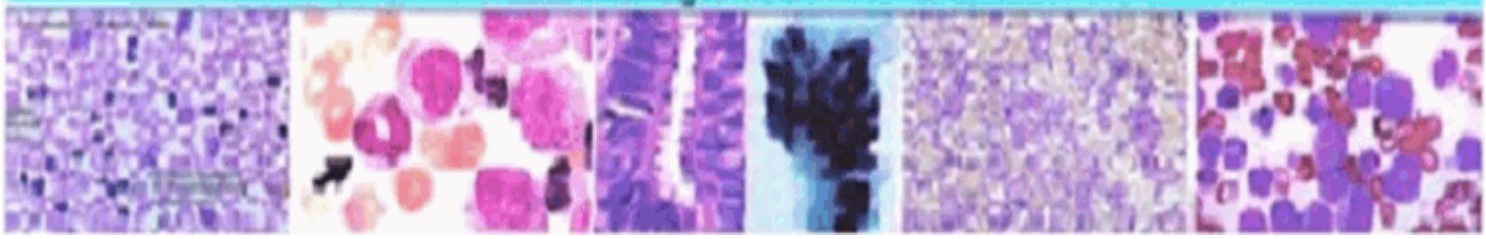

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Organization	:				

Investigation	Results	Units	Biological Ref-Interval
THYRIOD PROFILE*			
Triiodothyronine (T3) * (ECLIA)	1.102	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	9.645	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH (ECLIA)	3.713	uIU/ml	0.38-5.30

Normal Range:-
1 TO 4 DAYS 2.7-26.5
4 TO 30 DAYS 1.2-13.1

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disordes such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism,serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both incresed and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) * (ISE method)	4.0	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	9.3	mg/dl	9.2-11.0

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Sample By	:			**Centre Name**	: **Garg Pathology Lab - TPA**
Organization	:				

Investigation	Results	Units	Biological Ref-Interval
	URINE		
PHYSICAL EXAMINATION			
Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.020		1.000-1.030
PH (Reaction)	Acidic		
BIOCHEMICAL EXAMINATION			
Protein	Nil		Nil
Sugar	Nil		Nil
MICROSCOPIC EXAMINATION			
Red Blood Cells	Nil	/HPF	Nil
Pus cells	2-3	/HPF	0-2
Epithilial Cells	3-4	/HPF	1-3
Crystals	Nil		
Casts	Nil		
@ Special Examination			
Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

----------{END OF REPORT }----------

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DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE	: 12/12/2022	**REFERENCE NO.**	: 10061
PATIENT NAME	: KOUSHAL DEVI	**AGE/SEX**	: 43YRS/F
REFERRED BY	: DR. MONIKA GARG	**ECHOGENECITY**	: NORMAL

REFERRING DIAGNOSIS : To rule out structural heart disease.

ECHOCARDIOGRAPHY REPORT

DIMENSIONS		*NORMAL*			*NORMAL*
AO (ed)	*2.4 cm*	(2.1 - 3.7 cm)	*IVS (ed)*	*0.8 cm*	(0.6 - 1.2 cm)
LA (es)	*2.8 cm*	(2.1 - 3.7 cm)	*LVPW (ed)*	*0.8 cm*	(0.6 - 1.2 cm)
RVID (ed)	*1.1 cm*	(1.1 - 2.5 cm)	*EF*	*60%*	(62% - 85%)
LVID (ed)	*3.7 cm*	(3.6 - 5.2 cm)	*FS*	*30%*	(28% - 42%)
LVID (es)	*2.6 cm*	(2.3 - 3.9 cm)			

MORPHOLOGICAL DATA :

Mitral Valve: AML	: *Normal*	*Interatrial septum*	: *Intact*
PML	: *Normal*	*Interventricular Septum*	: *Intact*
Aortic Valve	: *Normal*	*Pulmonary Artery*	: *Normal*
Tricuspid Valve	: *Normal*	*Aorta*	: *Normal*
Pulmonary Valve	: *Normal*	*Right Atrium*	: *Normal*
Right Ventricle	: *Normal*	*Left Atrium*	: *Normal*
Left Ventricle	: *Normal*		

Cont. Page No. 2

2-D ECHOCARDIOGRAPHY FINDINGS :

LV normal in size with normal contractions. No LV regional wall motion abnormality seen. RV normal in size with adequate contractions. LA and RA normal. All cardiac valves are structurally normal. No chamber hypertrophy/ intracardiac mass. Estimated LV ejection fraction is 60%.

DOPPLER STUDIES :

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	No	0.90	3.0
Tricuspid Valve	No	0.85	2.5
Pulmonary Valve	No	0.79	2.3
Aortic Valve	No	0.69	2.1

IMPRESSION :

- *No RWMA.*
- *Normal LV Systolic Function (LVEF = 60%).*

DR. HARIOM TYAGI
MD, DM (CARDIOLOGY)
(Interventional Cardiologist)
for **Director, Lokpriya Heart Centre**

NOTE: Echocardiography report given is that of the procedure done on that day and needs to be correlated clinically. This is not for medico legal purpose, as patient's identity is not confirmed. No record of this report is kept in the Hospital

LOKPRIYA HOSPITAL

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Freedom from all Sickness

LOKPRIYA RADIOLOGY CENTRE

SAMRAT PALACE, GARH ROAD, MEERUT - 250003

PATIENT SAFETY & QUALITY OF CARE
NABH
PRE ACCREDITED

DATE	12.12.2022	REF. NO.	3758		
PATIENT NAME	KAUSHAL DEVI	AGE	43YRS	SEX:	F
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG (PATHOLOGY)		

REPORT

Liver – appears normal in size and echotexture. No mass lesion seen. Portal vein is normal.

Gall bladder – Wall thickness is normal. No calculus / mass lesion seen. CBD is normal.

Pancreas- appears normal in size and echotexture. No mass lesion seen.

Spleen- is normal in size and echotexture.

Right Kidney - Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Left Kidney – Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Urinary bladder – appears distended. Wall thickness is normal. No calculus / mass seen

Uterus - Normal in size shape & normal in echotexture. Endometrium appears normal. Myometrium appears normal.

Ovaries and adnexa are unremarkable.

IMPRESSION

Essentially normal study

Dr. P.D. Sharma
M.B.B.S., D.M.R.D. (VIMS & RC)
Consultant Radiologist and Head

1. Impression is a professional opinion & not a diagnosis
2. All modern machines & procedures have their limitations. if there is variance clinically this examination may be repeated or reevaluated by other investigations
   Ps. All congenital anomalies are not picked upon ultrasounds.
3. Suspected typing errors should be informed back for correction immediately.
4. Not for medico-legal purpose. Identity of the patient cannot be verified.

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Freedom from all Sickness

LOKPRIYA RADIOLOGY CENTRE

SAMRAT PALACE, GARH ROAD, MEERUT - 250003

PATIENT SAFETY & QUALITY OF CARE
NABH
PRE ACCREDITED

6

DATE	12.12.2022	REF. NO.	12947		
PATIENT NAME	KAUSHAL DEVI	AGE	43 YRS	SEX	F
INVESTIGATION	X-RAY CHEST PA VIEW	REF. BY	GARG (PATHOLOGY)		

REPORT

- Trachea is central in position.
- **Mildly prominent bronco vascular marking bilateral lung field.**
- **Cardia appears mildly prominent.**
- Both costophrenic angles are clear.
- Both domes of diaphragm are normal in contour and position.

IMPRESSION

Mildly prominent cardia.

Mildly prominent bronco vascular marking bilateral lung field.

Dr. P.D. Sharma
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Consultant Radiologist and Head

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   Ps. All congenital anomalies are not picked upon ultrasounds.
3. Suspected typing errors should be informed back for correction immediately.
4. Not for medico-legal purpose. Identity of the patient cannot be verified.