

Referred by

: Self

Date Patient's Id : 18/09/2021

: KP523

Age/Sex

Ref ID.

Reg. No Mobile

: 50 Years/Female

: 4143

: 9998925448

Fitness Certificate

GENERAL EXAMINATION

Height (cms): 149

Weight (kgs): 77.0

Blood Pressure: 128/78 mmHg

Pulse: 77/Min

No Clubbing/Cynosis/Pallor/Pedel Oedem

Systemic Examination:

Cardio vascular System - S1,S2 Normal, No Murmur

Respiratory system - AEBE

Central Nervous System - No FND

Abdomen - Soft, Non Tender, No Organomegaly

Comments: She is clinically fit on examination

This is an electronically authenticated report. Note:((LL-Very Low, L-Low, HH-Very High)

Approved On

: 18/09/2021 3:23:00 PM

Generated On : 18/09/2021 15:40

Dr Jinen M Shah DNB (Medicine)FCCS (USA)



To,

The Coordinator, Mediwheel (Arcofemi Healthcare Limited) Helpline number: 011- 41195959

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following spouse of our employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS OF HEALTH CHECK UP BENEFICIARY					
NAME KOKILABEN VASRAMBHAIPARMAR					
DATE OF BIRTH	03-05-1971				
PROPOSED DATE OF HEALTH CHECKUP FOR EMPLOYEE SPOUSE	18-09-2021				
BOOKING REFERENCE NO.	21S122649100003946S				
SPOUSE DETAILS					
EMPLOYEE NAME	MR. PARMAR VASHRAMBHAI				
EMPLOYEE EC NO.	122649				
EMPLOYEE DESIGNATION	SAHAYAK				
EMPLOYEE PLACE OF WORK	AHMEDABAD,AMBAWADI_DB				
EMPLOYEE BIRTHDATE	01-06-1968				

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from 13-09-2021 till 31-03-2022. The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a cashless facility as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee's spouse and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

Chief General Manager HRM Department Bank of Baroda

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact Mediwheel (Arcofemi Healthcare Limited))





બારતીય વિશિષ્ટ ઐળખાણ પાંધિકરણ

USCL सरधार Unique Identification Authority of India Covernment of India

નોંધણીની ઓળખ / Enrollment No 1308/22098/14034

પરમાર કોકીલાબેન વશરામભાઈ Parmar Kokilaben Vashrambhai W/O: Vashrambhai

926 Vankar Vas

Vinchhiya Vinchhiya Vinchhiya Sanand Ahmedabad **Gujarat 382110** 9998925448

Ref: 1243 / 22A / 1108447 / 1108451 / P

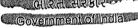


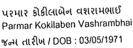


તમારો આધાર નંબર / Your Aadhaar No. :

7769 7557 0782











7769 7557 0782

આધાર – સામાન્ય માણસનો અધિકાર



DNB (Medicing

\$ 3 m or or on 42 m 12



Patient's name : KOKILABEN VASHRAMBHAI PARMAR Age/Sex : 50 Years/Female

Referred by : Self Reg. No : 4143

Date : 18/09/2021 Mobile : 9998925448
Patient's Id : KP523 Ref ID. :

HEMOGRAM REPORT

Performed on 5-Part Fully Auto Hematology Analyzer SIEMENS ADVIA 2120i)

Test	Result	Unit	Biological Reference Interval
Sample Type:	EDTA		
Haemoglobin: Total WBC Count: Platelets Count: Differential Count:	11.2 5200 322000	gm/dL /microlitre /microlitre	12.5 - 16.0 4000 - 10500 1,50,000 - 4,50,000
Neutrophils: Lymphocytes: Eosinophils: Monocytes: Basophils:	54 41 02 03 00	% % % %	40-80 20-40 Upto 6 2-10 <1-2
RBC indicies:			
RBC Count: HCT: MCV: MCH: MCHC: RDW:	4.19 35.6 85.0 26.7 31.5 14.4	*10^6 /microL % fL pg % %	3.8 - 4.8 36 - 46 83 - 101 27-32 31.5-34.5 11.6 - 14.0
Erythrocytes Sedimentation Rate(ESR): (By AUTO ESR-10, USA)			
ESR 1st Hr:	19	mm	2 - 20 mm in 1Hr.
Thick Smear Preparation: Haemoparasite: Peripheral Smear Examination:	Malarial parasites	are not seen.	
RBCs: Platelet:	Mild Microcytic & I Platelet adequate	* *	ear.

---- End of Report ---

Dr. KEYUR Patel M.B.DCP

This is an electronically authenticated report. Note:((LL-Very Low, L-Low, HH-Very High)

Approved On : 20/09/2021 10:52:00 Generated On : 20/09/2021 13:34 C PVE



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Age/Sex

Reg. No

: 50 Years/Female : 4143

Mobile Ref ID. : 9998925448

BLOOD GROUP

Sample Type:

EDTA

ABO Group:

"O"

Rh Type:

Positive

BLOOD GLUCOSE LEVEL

Test

Result

Unit

Biological Reference Interval

Sample Type:

Flouride

Collection Time:

Collection Time:

Post Prandial Blood Glucose (2 Hrs)

128.2

mg/dl

80-140

Tests Performed on Fully Auto DRY Chemistry Analyzer VITROS-250

----- End of Report

Dr. KEYUR Patel

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GLYCOSYLATED HAEMOGLOBIN (HbA1C) ESTIMATION

Test	Result	Unit	Biological Reference Interval
Sample Type: EDTA			
Glycosylated Haemoglobin (HbA1C)	5.90	%	Pre-Diabetic (Adult): 5.7 - 6.4 Diabetic (Adult): >6.5 Therapeutic goal for glycemic control: <7.0
Mean Blood Glucose Level (An average of 2 -3 Months)	122.63		

Method: HPLC on D-10, Bio-Rad, USA

INTERPRETATION:

* Blood sample can be drawn at any time. Fasting is not required.

* Reflects average blood sugar levels for the 2 to 3 months period before the test.

* Provides information for evaluating diabetic treatment modalities and tracks control of blood glucose of particular value in diabetic children, diabetics in whom the renal threshold for glucose is abnormal, unstable insulin dependent diabetics where blood sugars vary markedly from day to day.

* High value in poorly controlled DM and moves towards normal in patients with optimal control.

Dr. KEYUR Pate
M.B.DCP

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Patient's name : KOKILABEN VASHRAMBHAI PARMAR Age/Sex : 50 Years/Female

Referred by : Self Reg. No : 4143

Date : 18/09/2021 Mobile : 9998925448 Patient's Id : KP523

Ref ID.

LIPID PROFILE

	(Performed on Semi Auto Chemistry Analyzer BeneSphera)				
Test Sample Type: Fasting Serum	Result	Unit	Biological Reference Interval		
S.Cholesterol (Oxidase Peroxidase)	189	mg/dL	< 200 Desirable 200-239 Boderline High > 240 High		
S.HDLC (Direct) (Phosphotungsstic Acid)	66.0	mg/dL	< 40 Low > 60 High		
S.Triglyceride (GPO-POD)	75.8	mg/dL	< 150 mg/dl Normal 150-199 Boderline High 200-499 High > 500 Very High		
S.VLDL (Calculated)	15.16	mg/dL	10-40 Normal		
S.LDLC (Calculated)	107.84	mg/dL	< 100 Optimal 100-129 Near to above optimal 130-159 Boderline high 160-189 High		
S.Cholesterol / HDLC Ratio (Calculated)	2.86		>190 Very High < 4 Normal 4-6 Borderline 6-8 Risklevel		
S.LDLC / HDLC Ratio (Calculated)	1.63		> 8 High Risk < 3 Normal 3-4 Borderline 4-6 Risk Level		
Cholesterol / HDLC Ratio	2.86		> 6 High Risk < 3.5 Normal		
Triglyceride / HDLC Ratio (Calculated)	1.15		< 2 Normal > 4 Risk Level		
Non HDLC (Calculated)	123		 6 High Risk 130 Normal 130 - 159 Near Normal 160 - 189 Borderline 190 - 219 Risklevel 220 High Risk 		

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Approved On

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PENd of Report 30

Dr. KEYUR Patel M.B.DCP



Referred by Date

Patient's Id

: Self

: 18/09/2021

: KP523

Age/Sex

: 50 Years/Female

Reg. No : 4143

Mobile Ref ID. : 9998925448

LIVER FUNCTION TEST

(Performed on Fully Auto DRY Chemistry Analyzer VITROS-250)

Test Sample Type: Serum	Result	Unit	Biological Reference Interval
S.Billirubin			
Total Bilirubin (Azobillirubin)	0.68	mg/dl	0 - 1.2
Conjugated Bilirubin (Dual Wavelength spectrophotometric)	0.18	mg/dl	0 - 0.4
Unconjugated Bilirubin (Dual Wavelength spectrophotometric)	0.5	mg/dl	0.0 - 1.1
S.G.P.T. (ALT) (Kinetic with Pyridoxal 5-Phosphate)	10.1	IU/L	0 - 49
S.G.O.T. (AST) (Kinetic with Pyridoxal 5-Phosphate)	21.8	IU/L	Up to 46
S.ALP (Alkaline Phosphatase) (4-Nitrophenyl phosphate)	288.5	U/L	64 - 306
S.Protein			
Total Protein (Biuret)	7.43	gm/dl	6.3 ~ 8.2
Albumin (BCG)	4.43	gm/dl	3.5 - 5.2
Globulin (Calculated)	3	gm/dl	1.9 - 3.5
Albumin Globulin Ratio	1.48		
S.GammaGT (L-Gamma Glutamyl-4-Nitroanalide)	34.0	IU/L	12-43

SERUM LDH LEVEL

Test Result Unit **Biological Reference Interval** Sample Type: Serum LDH Activity(Lactate Dehydrogenase): 186.90 U/L 120 - 246 Pyruvate to lactate Kinetic Method

#Tests Performed on Fully Auto DRY Chemistry Analyzer VITROS-250

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End of Report

Dr. KEYUR Patel M.B.DCP



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: KP523

: 18/09/2021

Age/Sex Reg. No : 50 Years/Female

: 4143

Mobile Ref ID. : 9998925448

RENAL FUNCTION TEST

(Performed on Fully Auto DRY Chemistry Analyzer VITROS-250)

Test	Result	Unit	Biological Reference Interval
Sample Type: Serum			
S.Urea (Urease with indicator dye) S.Creatinine (Enzymatic)	38.5 0.77	mg/dl mg/dL	Male: 19.6-43.6 Female: 15.2-37.0 0.55 - 1.30
S.Uric Acid (Uricase)	5.09	mg/dL	Male: 3.5-8.5 Female: 2.5-6.2

----- End of Report -----

Dr. KEYUR Patel

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Age/Sex : 50 Years/Female

Reg. No

: 4143

Mobile Ref ID. : 9998925448

THYROID FUNCTION TEST

(by CLIA on SIEMENS ADVIA Centaur XP)

Test	Result	Unit	Biological Reference Interval
Sample Type: Serum			
S.T3 (Total Triidothyronine by CLIA)	1.22	ng/mL	1 - 23 Months: 1.17 - 2.39 2 - 12 Years: 1.05 - 2.07 13 - 20 Years: 0.86 - 1.92 Adult: 0.6 - 1.81
S.T4 (Total Thyroxine by CLIA)	9.00	mcg/dL	3.2 - 12.6
S.TSH (Thyroid Stimulating Hormone by CLIA)	1.625	microU/mL	0 -12 Yrs: 0.77 - 5.64 12-19 Yrs: 0.75-3.69 19-100 Yrs: 0.35 -5.50

Dr. KEYUR Patel
M.B.DCP

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Referred by : Self

Date : 18/09/2021 Patient's Id : KP523

Age/Sex

: 50 Years/Female

Reg. No : 4143

Absent

Absent

Absent

Mobile Ref ID. : 9998925448

LIRINE ROLLTINE ANALYSIS

	URINE ROUTINE ANAI	LYSIS
Sample Type: Fresh Urine		
Physical Examination (Naked Eye Observation)	Result	Biological Ref. Value
Amount	20 ml	>10 ml
Colour	Pale Yellow	Pale Yellow
Appearance	Clear	Clear
Chemical Examination		
рН	7	4.5-8.0
(Dip stick)	4.00	
Specific Gravity	1.025	1.002-1.030
(Bromothymol Blue) Albumin	Absent	Abaant
(Tetrabromophenol)	Absent	Absent
Glucose	Absent	Absent
(Specific Glucose Oxidase/Peroxidase)		
Bilirubin	Absent	Absent
(Azo-coupling reaction)		
Acetone	Absent	Absent
(Sodium Nitroprusside Reaction)	A1 .	A.
Urobilinogen	Absent	Absent
(Modified Ehrlich Reaction) Nitrites	Absent	Absent
(Diazotization Reaction)	Absent	Absent
•		
Microscopic Examination (After centrifugation at 1500 RPM for 10min./hpf)		
Pus Cells(WBCs)	Absent	Absent
Red Blood Cells(RBCs)	Absent	Absent
Epithelial cells	Absent	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
T.Vaginals	Absent	Absent
Spermatozoa	Absent	Absent
^ '		

Absent

Absent

Absent

Dr. KEYUR Patel -- End of Report -

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Amorphous Material

Casts

Crystals

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Age/Sex

: 50 Years/Female : 4143

Reg. No

Mobile Ref ID. : 9998925448

STOOL EXAMINATION

Sample Type: Stool **Physical Examination**

(Naked Eye Observation)

Colour

Consistency Blood

Mucus Pus

Worms

Semisolid Absent

Brownish

Absent Absent

Absent

Biochemical Examination

Occult Blood

(Non Benzidine Test)

рΗ

(Strip Test)

Absent

6.0

Microscopic Examination

Pus Cells

Red Blood Cells Macrophages

Epithelial Cells Starch

Fat Gloubles

Ova Cyst Absent

Absent Absent

Absent

Absent

Absent

Absent Absent

End of Report --

Dr. KEYUR Patel M.B.DCP

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Referred by

: Self

Date Patient's Id : 18/09/2021

: KP523

Age/Sex

Reg. No

: 4143

Mobile Ref ID. : 50 Years/Female

: 9998925448

Electrocardiogram

Findings

Normal Sinus Rhythm.

Within Normal Limit.

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Approved On : 18/09/2021 3:23:00 PM

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End of Report

Dr Jinen M Shah DNB (Medicine)FCCS (USA)





Patient's name : KOKILABEN VASHRAMBHAI PARMAR Age/Sex : 50 Years/Female

Referred by : Self Reg. No : 4143

Patient's Id : KP523 Ref ID.

2D Echo Colour Doppler

OBSERVATION:

2 D Echo and color flow studies were done in long and short axis, apical and Sub coastal views.

- 1. Normal LV size. No RWMA at rest.
- 2. Normal RV and RA. Concentric LVH.
- 3. All Four valves are structurally normal.
- 4. Good LV systolic function. LVEF = 55%.
- 5. Stage I diastolic dysfunction.
- 6. Mild TR. Mild MR. No AR.
- 7. Moderate PAH. RVSP = 54 mmHG.
- 8. Intact IAS and IVS.
- 9. No Clot, No Vegetation.
- 10. No pericardial effusion.

CONCLUSION

- 1. Normal LV size with Good LV systolic function.
- 2. Concentric LVH . Stage I diastolic dysfunction
- 3. Mild TR with Moderate PAH. Mild MR. No AR
- 4. No RWMA at rest.

This echo doesn't rule out any kind of congenital cardiac anomalies.

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End of Reports

Dr Jinen M Shah DNB (Medicine)FCCS (USA)



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Patient's Id

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: KP523

Age/Sex

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: 50 Years/Female

: 4143

: 9998925448

Mobile Ref ID.

X RAY CHEST PA

Both lung fields appear clear.

No evidence of any active infiltrations or consolidation.

Cardiac size appears within normal limits.

Both costo-phrenic angles appear free of fluid.

Both domes of diaphragm appear normal.

Bony thorax appears normal.

COMMENT: No significant abnormality is detected.

----- End of Report -----DMRD

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Approved On : 18/09/2021 3:48:00 PM

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Cunsaltant Radiologist



Referred by Date

: Self

Patient's Id

: 18/09/2021 : KP523

Age/Sex Reg. No : 50 Years/Female

: 4143

: 9998925448

Mobile Ref ID.

USG ABDOMEN

Liver appears normal in size, show homogenous increased parenchymal echo, show 10 mm to 12 mm cysts in right lobe of liver. No evidence of dilatation of intra-hepatic billiary or portal radicals. PV is normal in caliber.

Gall bladder is partially filled, No evidence of calculus or mass seen. Gall bladder wall thickness appears normal.

Pancreas Visualized portion appears normal in size and echopattern. No evidence of focal lesions.

Spleen appears normal in size & echopattern. No evidence of focal lesions.

Both kidney are normal in size, shape and position. C.M. differentiation on both sides is maintained. No evidence of hydronephrosis or solid mass seen. Both kidneys show small 3 mm, calycel calculi.

Urinary bladder is partially distended. No evidence of calculus or mass.

Uterus not seen.

No evidence of free fluid in peritoneal cavity. No evidence of para-aortic lymph adenopathy. No evidence of dilated small bowel loops.

COMMENTS:

Liver: fatty changes. Liver cysts (10 mm to 12 mm) Bil.renal calculi.

Dr. Jaimin Shah ----- End of Report -----

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Cunsaltant Radiologist



Patient's name : KOKILABEN VASHRAMBHAI PARMAR Age/Sex : 50 Years/Female

Referred by : Self

Date : 18/09/2021

Patient's Id : KP523

Age/Sex : 50 Years/Femal Reg. No : 4143

Mobile : 9998925448

Ref ID.

BILATERAL MAMMOGRAM:

Dedicated lowdose digital mammography with Craniocaudal and media lateral oblique view was performed.

Normal dense and fibroglandular breast parenchyma is noted in breast on either side.

No evidence of mass or architectural distortion is seen.

No evidence of skin thickening or nipple retraction is seen.

Vascular calcification seen on both side.

Left axillary lymphnodes seen(non specific).

COMMENT:

- Vascular calcification seen.Left axillary lymphnodes are seen.
- No significant abnormality detected. (BIRADS I).
- · No direct or indirect sign of malignancy seen.

BIRADS Categories:

- 0 Need imaging evaluation.
- Negative
- II Benign finding
- III probably benign finding.
- IV Suspicious abnormality.
- V Highly suggestive of malignancy.

The false negative mammography is approximately 10%. Management of a palpable abnormality must be based upon clinical grounds.

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Cunsaltant Radiologist

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Patient's Id : KP523 Ref ID.

Eye Check - Up

RIGHT EYE

SP: +2.00 CY: -0.50

AX: 29

LEFT EYE

SP: +2.25 CY: -1.00AX: 06

Without Glasses

With Glasses

Right Eye

6/12

N.A

Left Eye

6/12

N.A

Near Vision:

Right Eye - N/6, Left Eye - N/6

Fundus Examination: Within Normal Limits.

Colour Vision:

Normal

Comments:

Normal

Dr.Kejal Patel MB,DO(Ophth)

Approved On : 18/09/2021 3:19:00 PM

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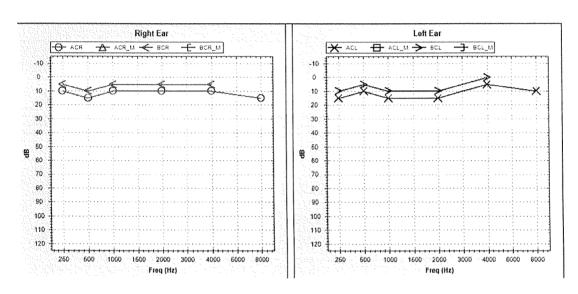


CLIENT NAME:- KOKILABEN PARMAR.

AGE:- 50Y/ F

DATE: 18/09/2021

AUDIOGRAM



MODE	Air Cor	duction	Bone Co	onduction	1 1	Threshold In dB	DICHT	
EAR	Masked	UnMasked	1	UnMasked		Threshold in db	RIGHT	LEFT
LEFT		X		>	Blue	AIR CONDUCTION	11	11
RIGHT	Δ	0	С	<	Red	BONE CONDUCTION		
NO RESPONS	E: Add	↓ below t	he respe	ctive symb	ols	SPEECH		

Comments:-

Bilateral Hearing Sensitivity Within Normal Limits.

