
UNION OF INDIA Driving Licence
RJ
NT
Date of Issue
20/02/2019
19/02/2039
Date of Birth
01/07/1992
Blood Group
O+
VANDANA MAMODIA
CHAJU RAM MAMODIA


UNION OF INDIA **Driving Licence** (RJ) (NT)

RJ52 20190000886

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20/02/2019

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(NT) 19/02/2039

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Blood Group
O+

VANDANA MAMODIA

S/D/W of
CHAJJURAM MAMODIA

Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No. -037041


RJ52 20190000886

LMV
20/02/2019

MCWOG
20/02/2019

(RJ)

Form 7 Rule 14(1)

Bagawas Chaurasi
Viratnagar Jaipur,RJ
303119

Holder's Signature

Issuing Authority Sign

SHAHPURA

P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave-II, Near Axix Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

General Physical Examination

Date of Examination: 25/09/23

Name: VANDANA MAMODIA Age: 51 YRS DOB: 01/07/1972 Sex: Female

Referred By: BANK OF BARODA

Photo ID: DRIVING LIC ID #: RJ50 20150000 88C

Ht: 148 (cm) Wt: 50 (Kg)

Chest (Expiration): 96 (cm) Abdomen Circumference: 89 (cm)

Blood Pressure: 120/80 mm Hg PR: 73/ min RR: 18/ min Temp: Afebrile

BMI 22.8

Eye Examination: RE - EG, NG, NCB
LE - EG, NG, NCB

Other: No

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examine : ---------- Name of Examinee: VANDANA MAMODIA

Signature Medical Examiner : ---------- Name Medical Examiner - DR. PIYUSH GOYAL

Dr. PIYUSH GOYAL
MBBS, DMRD (Radiologist)
RMC No. 037041

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NAME :- Mrs. VANDANA MAMODIA	Patient ID :-12234243	Date :- 25/12/2023	09:29:51
Age :- 31 Yrs 5 Mon 25 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 25/12/2023 16:31:44

HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGLOBIN (Hb)	13.3	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	5.70	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	60.0	%	40.0 - 80.0
LYMPHOCYTE	34.0	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.61	x10^6/uL	3.80 - 4.80
HEMATOCRIT (HCT)	41.20	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	89.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	28.9	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.3	g/dL	31.5 - 34.5
PLATELET COUNT	277	x10^3/uL	150 - 410
RDW-CV	13.3	%	11.6 - 14.0

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR) Method - Westergreen	16	mm in 1st hr	00 - 20

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as

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(CBC): **Methodology**: TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	96.7	mg/dl	70.0 - 115.0

Impaired glucose tolerance (IGT)	111 - 125 mg/dL
Diabetes Mellitus (DM)	> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm,
hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin
therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) Method:- GOD PAP	99.1	mg/dl	70.0 - 140.0

Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders.Decreased glucose levels(hypoglycemia) may result from excessive insulin therapy or various liver diseases .

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HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
GLYCOSYLATED HEMOGLOBIN (HbA1C) Method - CAPILLARY with EDTA	5.4	mg%	Non-Diabetic < 6.0 Good Control 6.0-7.0 Weak Control 7.0-8.0 Poor control > 8.0
MEAN PLASMA GLUCOSE Method - Calculated Parameter	106	mg/dL	68 - 125

INTERPRETATION

AS PER AMERICAN DIABETES ASSOCIATION (ADA)
Reference Group HbA1c in %
Non diabetic adults >=18 years < 5.7
At risk (Prediabetes) 5.7 - 6.4
Diagnosing Diabetes >= 6.5

CLINICAL NOTES

In vitro quantitative determination of HbA1c in whole blood is utilised in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings
Some of the factors that influence HbA1c and its measurement (Adapted from Gallagher et al.)

1. Erythropoiesis
- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c

3. Glycation
- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH.
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction
- Increased HbA1c: increased erythrocyte life span. Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone

5. Others
- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use,chronic renal failure
- Decreased HbA1c: hypertriglyceridemia,reticulocytosis, chronic liver disease, aspirin, vitamin C and E,splenomegaly, rheumatoid arthritis or drugs

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HAEMATOLOGY

BLOOD GROUP ABO Method:- Haemagglutination reaction	"O" POSITIVE

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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
LIPID PROFILE			
TOTAL CHOLESTEROL Method - CHOD-PAP methodology	149.00	mg/dl	Desirable <200 Borderline 200-239 High> 240
InstrumentName MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.			
TRIGLYCERIDES Method - GPO-PAP	110.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
InstrumentName Randox Rx Imola **Interpretation** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.			
DIRECT HDL CHOLESTEROL Method - Direct clearance Method	34.60	mg/dl	MALE- 30-70 FEMALE - 30-85
Instrument Name Rx Daytona plus **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods			
LDL CHOLESTEROL Method - Calculated Method	96.07	mg/dl	Optimal <100 Near Optimal/above optimal 100-129 Borderline High 130-159 High 160-189 Very High > 190
VLDL CHOLESTEROL Method - Calculated	22.00	mg/dl	0.00 - 80.00
T.CHOLESTEROL/HDL CHOLESTEROL RATIO Method - Calculated	4.31		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method - Calculated	2.78		0.00 - 3.50
TOTAL LIPID Method - CALCULATED	465.67	mg/dl	400.00 - 1000.00

1 Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.

2 As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is

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BIOCHEMISTRY

recommended

3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated fromperipheral tissues.

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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL.) Method:- DMSO/Diazo	0.56	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.15	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.41	mg/dl	0.30-0.70
SGOT Method:- IFCC	28.0	U/L	0.0 - 40.0
SGPT Method:- IFCC	32.2	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	74.50	U/L	42.00 - 110.00
SERUM GAMMA GT Method - Szasz methodology Instrument Name Randox Rx Imola Interpretation Elevations in GGT levels measure earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 10 times normal levels in extra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal)are observed with infectious hepatitis	26.50	U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	6.45	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.00	g/dl	3.50 - 5.50
SERUM GLOBULIN Method - CALCULATION	2.45	gm/dl	2.20 - 3.50
A/G RATIO	1.63		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA Method:- Urease/GLDH	26.50	mg/dl	10.00 - 50.00

InstrumentName: HORIBA CA 60 **Interpretation** : Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE Method:- Jaffe's Method	1.12	mg/dl	Males : 0.6-1.50 mg/dl Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID	5.52	mg/dl	2.40 - 7.00

InstrumentName:HORIBA YUMIZEN CA60 Daytona plus **Interpretation**: **Elevated Urate**:High purine diet,Alcohol• Renal insufficiency,Drugs , Polycythaemia vera, Malignancies,Hypothyroidism,Rare enzyme defects ,Downs syndrome,Metabolic syndrome, Pregnancy,Gout.

SODIUM Method - ISE	**133.4** L	mmol/L	135.0 - 150.0
POTASSIUM Method - ISE	3.67	mmol/L	3.50 - 5.50
CHLORIDE Method - ISE	95.2	mmol/L	94.0 - 110.0
SERUM CALCIUM Method:- Arsenazo III Method	9.56	mg/dl	8.80 - 10.20

InstrumentName:MISPA PLUS **Interpretation**: Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN Method - Direct Biuret Reagent	6.45	g/dl	6.00 - 8.40
SERUM ALBUMIN Method - Bromocresol Green	4.00	g/dl	3.50 - 5.50
SERUM GLOBULIN Method - CALCULATION	2.45	gm/dl	2.20 - 3.50
A/G RATIO	1.63		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of dis[illegible] liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

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INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR. in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs

Low serum creatinine values are rare, they almost always reflect low muscle mass

Apart from renal failure Blood Urea can increase in dehydration and GI bleed

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CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
PHYSICAL EXAMINATION			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
CHEMICAL EXAMINATION			
REACTION(PH)	6.5		5.0 - 7.5
SPECIFIC GRAVITY	1.015		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
MICROSCOPY EXAMINATION			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		

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CLINICAL PATHOLOGY

URINE SUGAR (FASTING) Collected Sample Received	Nil	Nil

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TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
THYROID-TRIIODOTHYRONINE T3 Method - ECLIA	1.13	ng/mL	0.70 - 2.04

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measuremen of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis9.Normal or ↑T3 & ↑ 10.Normal T3 & T4 along with ↑ TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & ↑ T4 along with ↑ TSH is seen in Hypothyroidism .12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

THYROID-THYROXINE (T4) Method - ECLIA	7.79	µIU/mL	5.10 - 14.10

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
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TSH Method - ECLIA	1.580	µIU/mL	0.350 - 5.500

NOTE-TSH levels are subject to circardian variation,reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration.Dose and time of drug intake also influence the test result.
Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions,simoultaneous measurement of TSH with free T4 is use

Technologist
VIKARANTJI

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

P3 HEALTH SOLUTIONS LLP
(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

NAME :- Mrs. VANDANA MAMODIA		Patient ID :-12234243	Date :- 25/12/2023 09:29:51
Age :-	31 Yrs 5 Mon 25 Days	Ref. By Doctor:-BANK OF BARODA	
Sex :-	Female	Lab/Hosp :-	
		Company :-	Mr.MEDIWHEEL

Final Authentication : 25/12/2023 16:31:44

IMMUNOASSAY

evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay
1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
2.Low TSH,High FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease
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4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis
5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency
6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels.
8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
9.Normal or↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propanolol.
14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,rarely they can result from TSH secreting pituitary tumours.

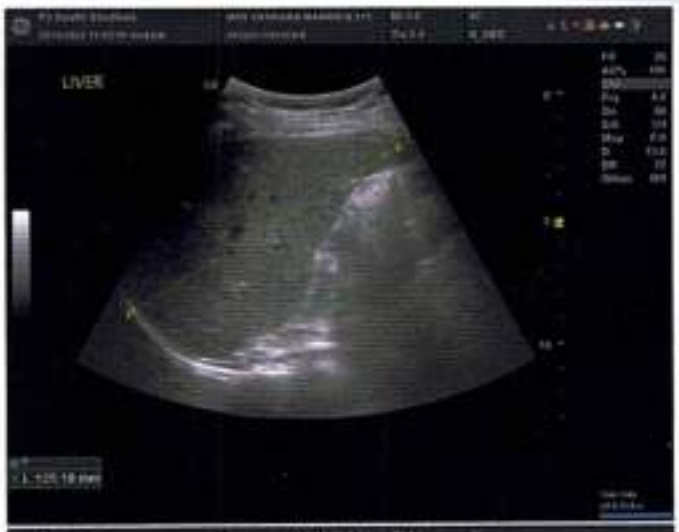
DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester : 0.10-2.50 uIU/mL
2nd Trimester : 0.20-3.00 uIU/mL
3rd Trimester : 0.30-3.00 uIU/mL
The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

*** End of Report ***

Technologist
VIKARANTJI

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226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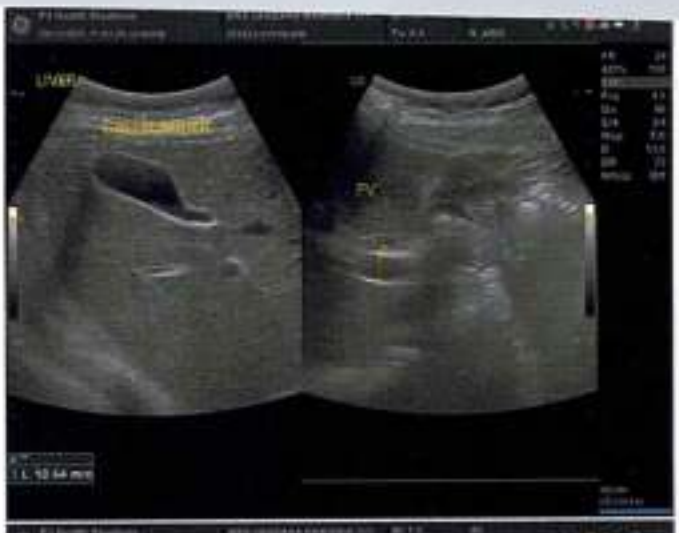
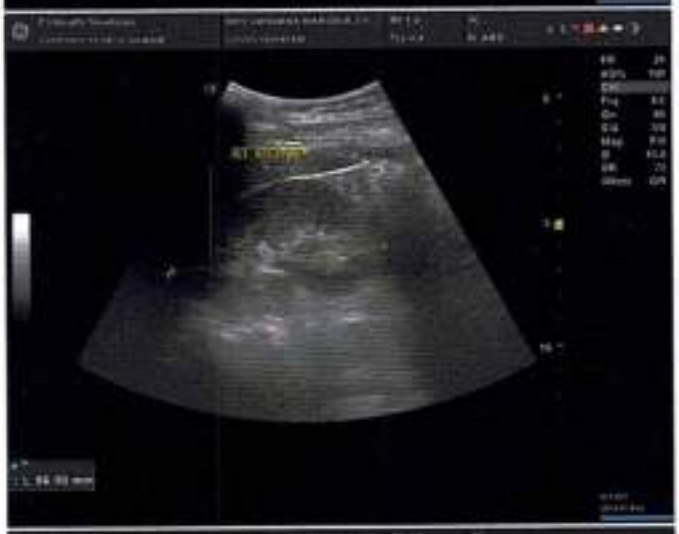
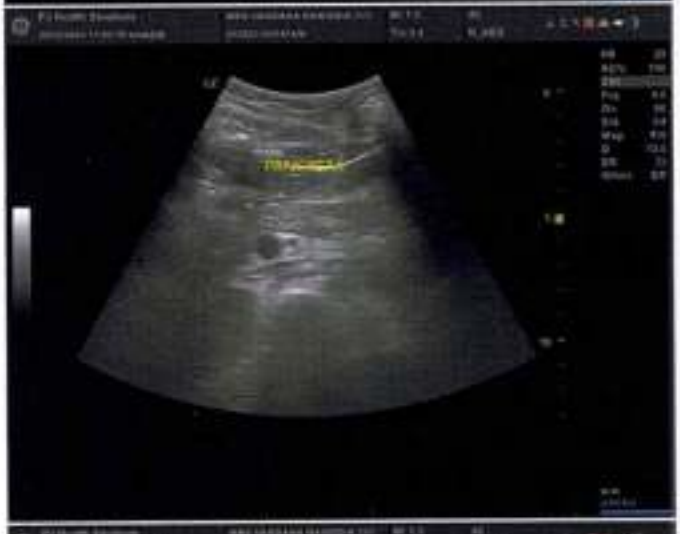
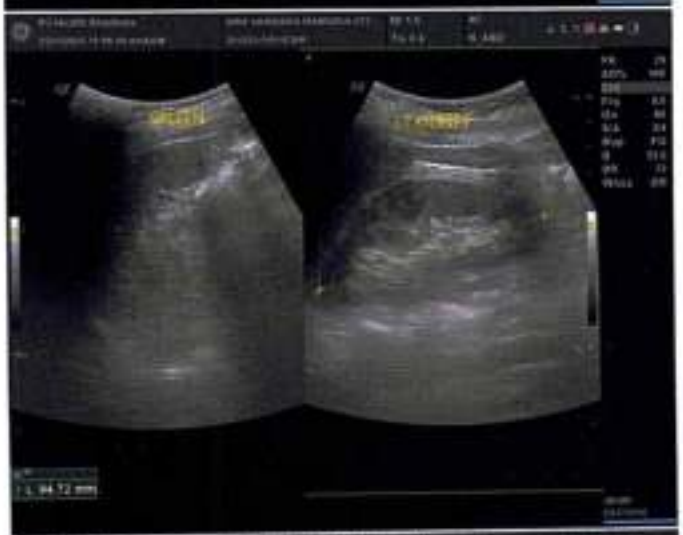

LIVER
PV



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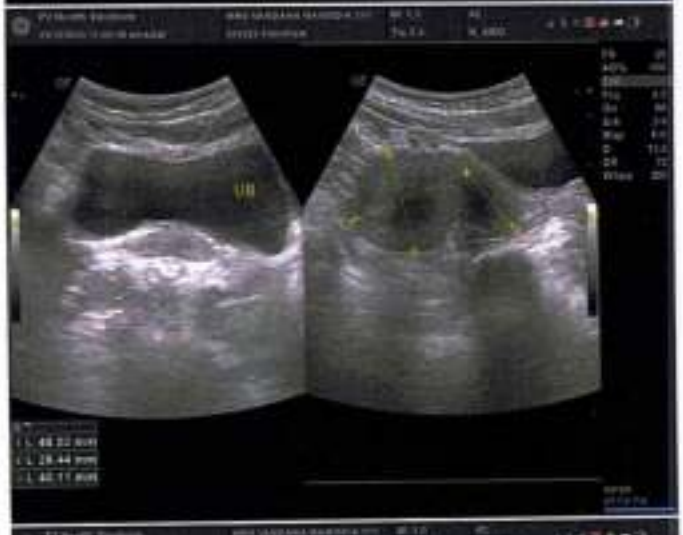
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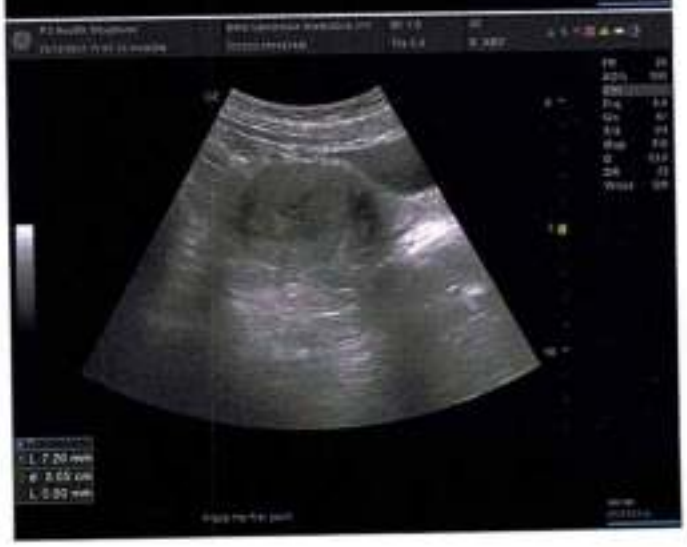

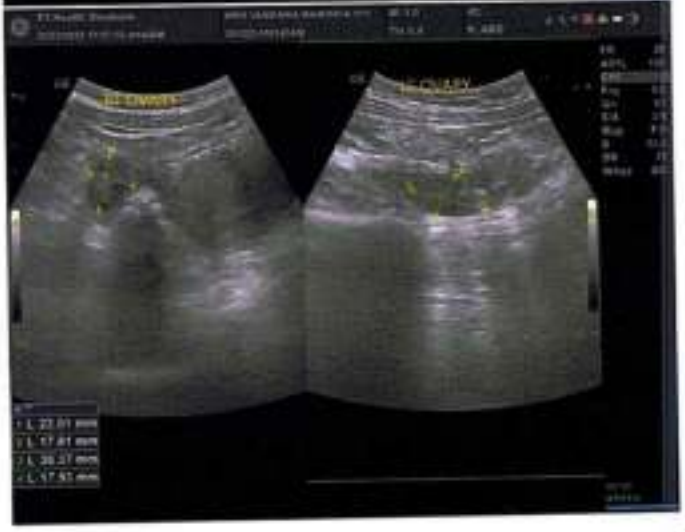

P3 HEALTH SOLUTIONS LLP

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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

MRS. VANDANA MAMODIA	Age : 31 Y/Female
Registration Date: 25/12/2023	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (125 mm). Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.
Right kidney is measuring approx. 85 mm.
Left kidney is measuring approx. 94 mm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is retroflexed, normal in size (measuring approx. 76 x 40 mm).
Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 7.2 mm.

Both ovaries are visualized and are normal. No adnexal mass lesion is seen.

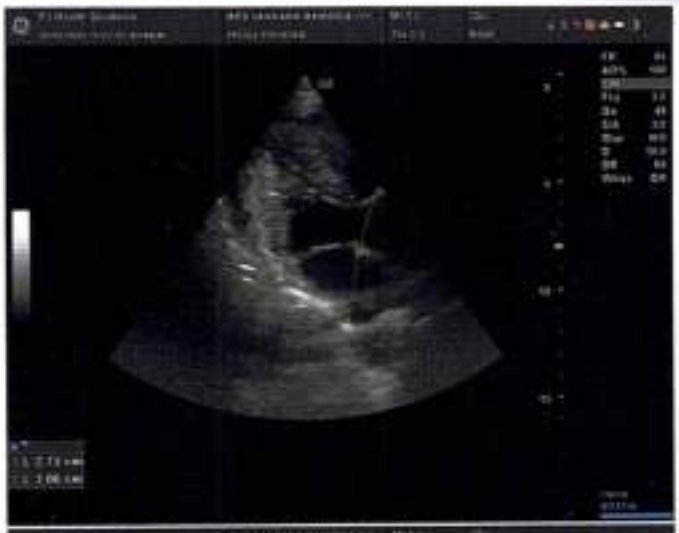
No enlarged nodes are visualized. No retro-peritoneal lesion is identified.
No significant free fluid is seen in pouch of Douglas.

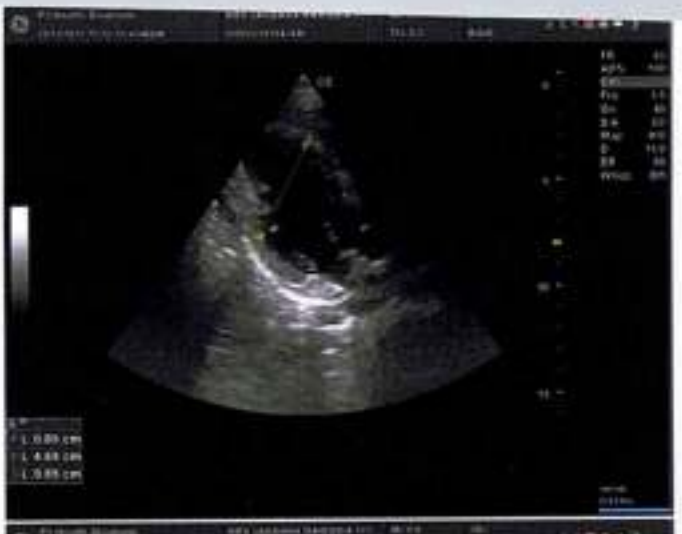
IMPRESSION:

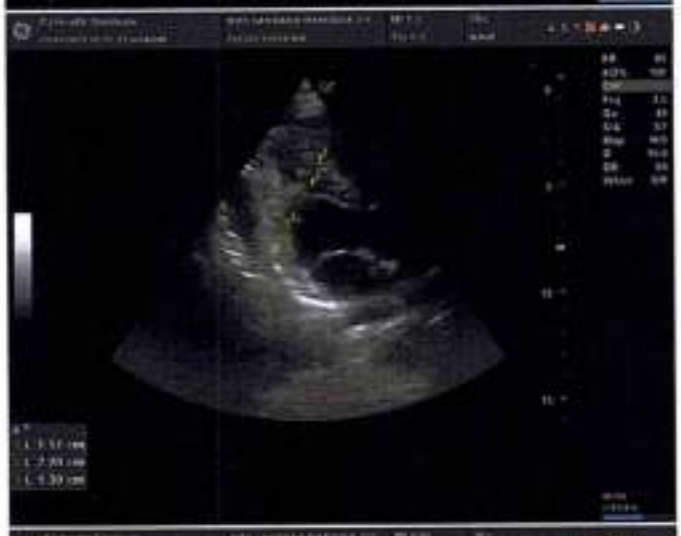
- **Solid abdominal organs appear normal.**
- **No free fluid or lymphadenopathy.**

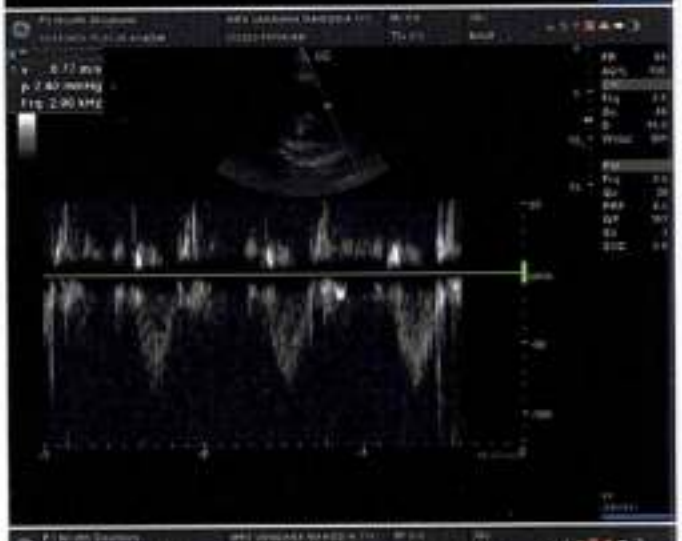
Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

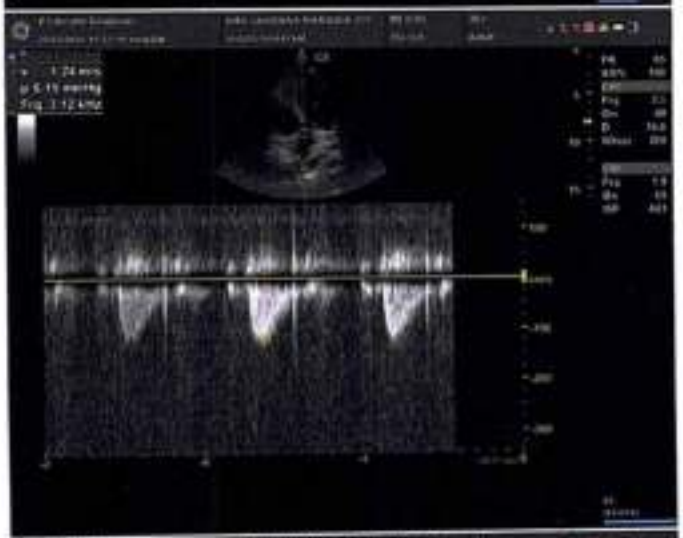
Dr. MUKESH SHARMA
M.B.B.S., M.D.(Radiodiagnosis)
RMC No. : 43418/17437
P3 Health Solutions LLP

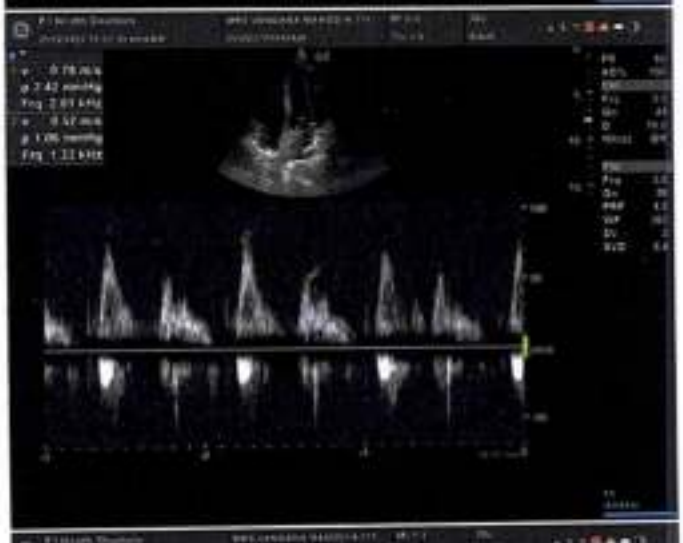


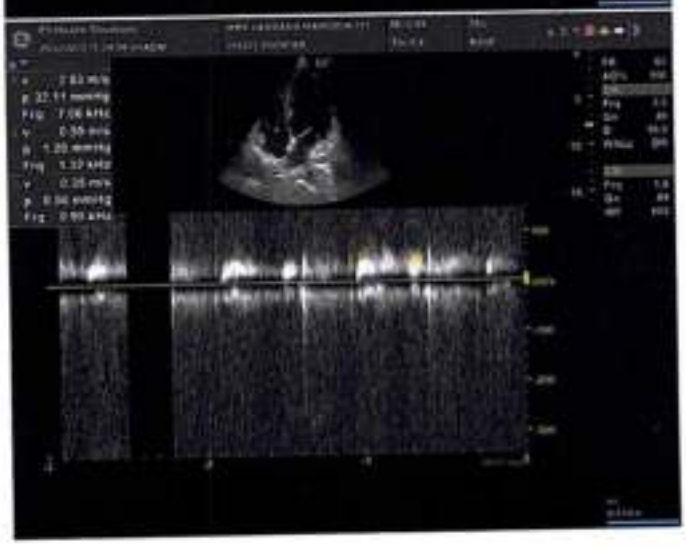


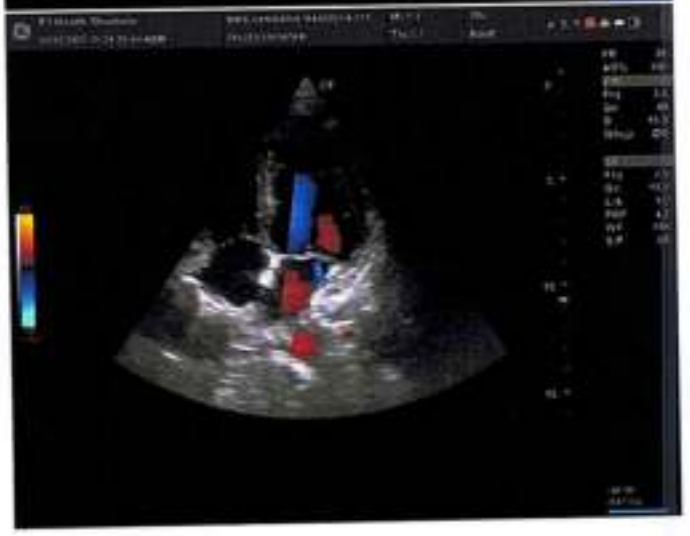












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MRS. VANDANA MAMODIA	31 Y/F
Registration Date: 25/12/2023	Ref. by: BANK OF BARODA

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:

FAIR TRANSTHORACIC ECHOCARIDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMITATION:

AO	2.7	Cm	LA	3.0	cm	IVS-D	0.8	cm
IVS-S	1.1	cm	LVID	4.7	cm	LVSD	2.2	cm
LVPW-D	0.8	cm	LVPW-S	1.3	cm	RV		cm
RVWT		cm	EDV		Ml	LVVS		ml
LVEF	55-60%			RWMA		ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM		NORMAL	

COLOUR DOPPLER:

MITRAL VALVE					
E VELOCITY	0.78	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.52	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION			ABSENT		
AORTIC VALVE					
PEAK VELOCITY	1.24	m/sec	PEAK GRADIENT		mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION			ABSENT		
TRICUSPID VALVE					
PEAK VELOCITY	0.55	m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY	0.35	m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION			MILD		
PULMONARY VALVE					
PEAK VELOCITY	0.77	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VALOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION			ABSENT		

Impression—

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 55-60%.
- MILD TR/ PAH (RVSP 32 MMHG+ RAP).
- NORMAL DIASTOLIC FUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

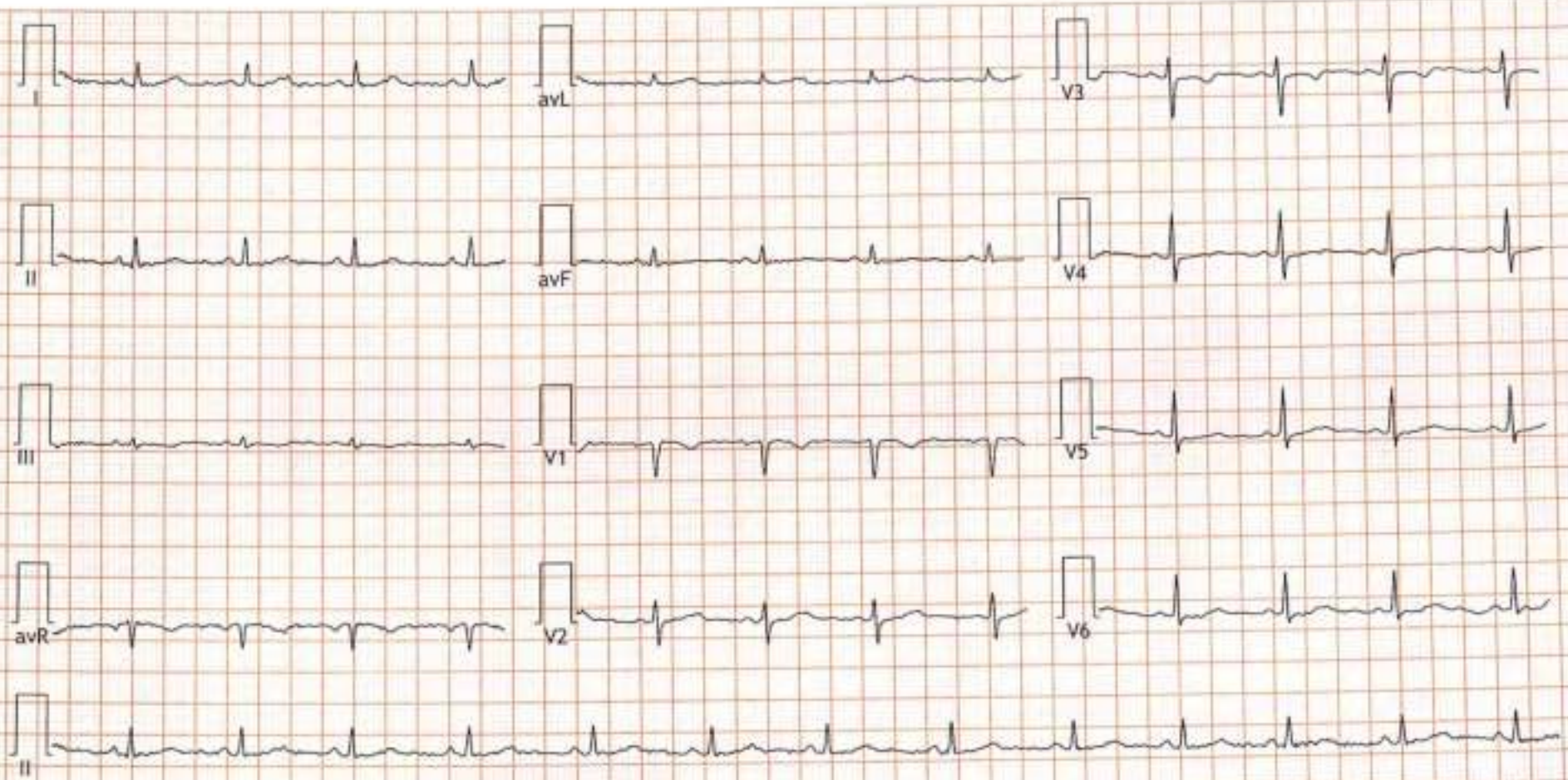
Dr. JYOTI AGARWAL
M.D.(Cardiology) (Cardiologist)
RMC No.- 27255

Tems (P) Ltd
#P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar , Jaipur
1285419254589/Mrs Vandana Mamodia 31Yrs/Female Kgs/31 Cms BP: ___/___ mmHg
Ref.: BANK OF BARODA Test Date: 25-Dec-2023(10:07:53) Notch: 50Hz 0.05Hz - 35Hz 10mm/mV 25mm/Sec

HR: 78 bpm

PR Interval: 120 ms
QRS Duration: 122 ms
QT/QTc: 309/353ms
P-QRS-T Axis: 37 - 29 - 16 (Deg)

RMS



TWMG

FINDINGS: Normal Sinus Rhythm
Vent Rate : 78 bpm; PR Interval : 120 ms; QRS Duration: 122 ms; QT/QTc Int : 309/353 ms
P-QRS-T axis: 37• 29• 16• (Deg)
Comments :

Dr. Naresh Kumar Mohanka
RMC No.. 35703
MBBS, DIP CARDIO (T... ORTS)
Dr. NARESH MOHNKA
D.E.M.TRCP...NKT


GPS Map Camera
Jaipur, Rajasthan, India
CANTEEN, SHANKARA EYE HOSPITAL, 6/168, Sector 2, Sector 6,
Vidyadhar Nagar, Jaipur, Rajasthan 302032, India
Lat 26.964505°
Long 75.782535°
25/12/23 09:48 AM GMT +05:30
Google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