



भारत सरकार
Government of India



रचना
Rachna
वर्ग: महिला/DOB: 02/02/1987
लिंग: महिला/ FEMALE

~~9176 8430~~ 6410

VID : 9189 3600 3218 8577

भारत आंतरिक्ष सेवा परियोजना

DR. PIYUSH GOYAL
MBBS, DNB (Radiologist)
RMC No.-037041

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📍 B-14, Vidhyadhar Enclave-II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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General Physical Examination

Date of Examination: 14/10/23

Name: RACHNA Age: 36 YRS DOB: 09/09/1987 Sex: Female

Referred By: BANK OF BARODA

Photo ID: AADHAR CARD ID #: 6410

Ht: 160 (cm)

Wt: 86 (Kg)

Chest (Expiration): 93 (cm)

Abdomen Circumference: 97 (cm)

Blood Pressure: 100/80 mm Hg PR: 78/min RR: 18/min Temp: Afebrile

BMI 25.8

Eye Examination: with glass
R/E - 6/6, NIG, NCB

L/E - 6/6, NIG, NCB

Other: No

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

Signature Of Examinee: [Signature] Name of Examinee: RACHNA

Signature Medical Examiner: [Signature] Name Medical Examiner: DR. PIYUSH GOYAL

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



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NAME :- Mrs. RACHNA

Age :- 36 Yrs 8 Mon 11 Days

Sex :- Female

Patient ID :-12233726

Date :- 14/10/2023 09:47:23

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 15/10/2023 10:48:18

HAEMOGARAM

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGLOBIN (Hb)	12.0	g/dL	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	8.20	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	53.0	%	40.0 - 80.0
LYMPHOCYTE	40.0	%	20.0 - 40.0
EOSINOPHIL	3.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	4.16	$\times 10^6/\mu\text{L}$	3.80 - 4.80
HEMATOCRIT (HCT)	38.00	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	91.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	28.8	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	31.5	g/dL	31.5 - 34.5
PLATELET COUNT	272	$\times 10^3/\mu\text{L}$	150 - 410
RDW-CV	13.2	%	11.6 - 14.0

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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

14

mm in 1st hr

00 - 20

Method :- Westergren

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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09:47:23

Ref. By Doctor:-BANK OF BARODA

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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-1,Japan





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BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method - GOD POD	89.4	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	131.0	mg/dl	70.0 - 140.0
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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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Name : Mrs. RACHNA
 B-14, Vidhyadhar Enclave-II, Near Axis Bank
 Age/Gender : 36 Mts / Female
 Address : Vidhyadhar Enclave-II, Jaipur - 302023
 Referred By : N/A
 Doctor Name :
 Sample Type : Serum - RJ249488, - RJ249490

Patient UID. : 3737991
 Visit No. : 27842310140008
 Collected on : 14-Oct-2023 11:06PM
 Received on : 14-Oct-2023 12:20PM
 Reported on : 14-Oct-2023 06:29PM



PAP SMEAR- CYTOLOGY - GYNECOLOGICAL

SLIDE NO.	L684/23
SPECIMEN RECEIVED	Conventional cervical cytology smears (PAP smear), Received unstained smears.
ADEQUACY OF SPECIMEN	Satisfactory for evaluation. Transformation zone component seen.
GENERAL CATEGORIZATION	Smears studied show dispersed population of superficial, and intermediate cells with normal N : C ratio. Superficial and intermediate squamous cells show reactive changes. Mild neutrophilic infiltrate present. No atypical cells/ features of malignancy noted.
INTERPRETATION	Negative For Intra-Epithelial Lesion or Malignancy (NILM)-Inflammatory Smear
ADVICE	Gynecology correlation

PLEASE CORRELATE CLINICALLY

Disclaimer : Gynaecological cytology is a screening procedure subject to both false negative and false positive result . It is most reliable when a satisfactory sample is obtained on regular and repetitive basis .Result must be interpreted in context of the historic and current clinical information.

Reporting System-2014 BETHESDA system for reporting cervical cytology.

*** End Of Report ***

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 CONSULTANT PATHOLOGIST

DR. MD ARIF
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 LAB DIRECTOR





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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	188.00	mg/dl	Desirable <200 Borderline 200-239 High > 240
<i>InstrumentName MISPA PLUS Interpretation: Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.</i>			
TRIGLYCERIDES Method - GPO-PAP	110.00	mg/dl	Normal <150 Borderline high 150-199 High 200-499 Very high >500
<i>InstrumentName Randax 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.</i>			
DIRECT HDL CHOLESTEROL Method - Direct clearance Method	45.00	mg/dl	MALE- 30-70 FEMALE - 30-85
<i>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.</i>			
LDL CHOLESTEROL Method - Calculated Method	124.67	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	4.18		0.00 - 4.90
LDL / HDL CHOLESTEROL RATIO Method - Calculated	2.77		0.00 - 3.50
TOTAL LIPID Method - CALCULATED	554.20	mg/dl	400.00 - 1000.00
1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.			

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BIOCHEMISTRY

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 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 from peripheral tissues.

Comments: 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all atherogenic lipoproteins (mainly LDL & VLDL). The Non HDL Cholesterol is used as a secondary target of therapy in persons with triglycerides ≥ 200 mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL, above that set for LDL Cholesterol.

2 -For calculation of CHD risk, history of smoking, any medication for hypertension & current B.P. levels are required.



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BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazot	0.62	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazot	0.23	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.39	mg/dL	0.30-0.70
SGOT Method:- IFCC	19.2	U/L	0.0 - 40.0
SGPT Method:- IFCC	20.3	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	102.30	U/L	42.00 - 110.00
SERUM GAMMA GT Method:- Srasr methodology Instrument Name: Rankin Rx Imolo Interpretation: Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 2 to 10 times normal levels in late or post-hepatic biliary obstruction. This moderate elevation in the enzyme level (2 to 5 times normal) is observed with infectious hepatitis.	32.20 H	U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method:- Direct Biorad Reagent	6.68	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	4.12	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.56	gm/dl	2.20 - 3.50
A/G RATIO	1.61		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 29.80 mg/dl 10.00 - 50.00
Method - Urease-GLDH

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

SERUM CREATININE 0.87 mg/dl Males : 0.6-1.50 mg/dl
Females : 0.6 -1.40 mg/dl
Method - Jaffe's Method

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 5.10 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, Down's syndrome, Metabolic syndrome, Pregnancy, Gout.

SODIUM 140.2 mmol/L 135.0 - 150.0
Method - ISE
Interpretation

Electrolytes are minerals that are found in body tissues and blood in the form of dissolved salts. As electrically charged particles, electrolytes help move nutrients into and wastes out of the body's cells, maintain a healthy water balance, and help stabilize the body's acid/base (pH) level. The electrolyte panel measures the blood levels of the main electrolytes in the body. *

* **Sodium**—most of the body's sodium is found in the fluid outside of the body's cells, where it helps to regulate the amount of water in the body. *

POTASSIUM 4.22 mmol/L 3.50 - 5.50
Method - ISI

* **Potassium**—this electrolyte is found mainly inside the body's cells. A small but vital amount of potassium is found in the plasma, the liquid portion of the blood. Potassium plays an important role in regulating muscle contraction. Monitoring potassium is important as small changes in the potassium level can affect the heart's rhythm and ability to contract

CHLORIDE 100.3 mmol/L 94.0 - 110.0
Method - ISI

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BIOCHEMISTRY

* **Chloride**—this electrolyte moves in and out of the cells to help maintain electrical neutrality (concentrations of positively charged cations and negatively charged anions must be equal) and its level usually mirrors that of sodium. Due to its close association with sodium, chloride also helps to regulate the distribution of water in the body.

SERUM CALCIUM	9.52	mg/dL	8.80 - 10.20
<small>Method- Arsenazo III Method</small>			

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	6.68	g/dl	6.00 - 8.40
<small>Method- Direct Buret Reagent</small>			

SERUM ALBUMIN	4.12	g/dl	3.50 - 5.50
<small>Method- Bromocresol Green</small>			

SERUM GLOBULIN	2.56	gm/dl	2.20 - 3.50
<small>Method- CALCULATION</small>			

A/G RATIO	1.61		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.

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-hour collections 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 blood increases. 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.

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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
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THYROID-TRIiodothyronine T3
Method - ECLIA

1.20 ng/mL

0.70 - 2.04

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 8-10 PM. The variation is the order of 50%. Hence time of the day has influence on the measured 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, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis.

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hypothyroidism 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.High TSH/Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis. 5.High TSH/Low FT4 and Thyroid microsomal antibody normal seen in patients with iodine deficiency/Congenital T4 synthesis deficiency. 6.Low TSH/Low FT4 and TRAb elevation test -Delayed response seen in patients with Tertiary hypothyroidism.

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 degradation 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 radioactive 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 uncorrected thyroid disease in the elderly. ** 5.10 - 14.10

THYROID-THYROXINE (T4)
Method - ECLIA

1.612 uIU/mL

0.350 - 5.500

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 8-10 PM. The variation is the order of 50%. Hence time of the day has influence on the measured 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, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis.

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hypothyroidism 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.High TSH/Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis. 5.High TSH/Low FT4 and Thyroid microsomal antibody normal seen in patients with iodine deficiency/Congenital T4 synthesis deficiency. 6.Low TSH/Low FT4 and TRAb elevation test -Delayed response seen in patients with Tertiary hypothyroidism.

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 degradation 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 radioactive 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 uncorrected thyroid disease in the elderly.

TSH

1.612 uIU/mL

0.350 - 5.500

Method - ECLIA

4th Generation Assay, Reference ranges vary between laboratories

Tanu

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

Technologist
VIKARAN JOSHI
Page No. 15 of 17



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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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NAME :- Mrs. RACHNA

Age :- 36 Yrs 8 Mon 11 Days

Sex :- Female

Patient ID :-42233726

Date :- 14/10/2023 09:47:23

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 15/10/2023 10:48:18

IMMUNOASSAY

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.

NOTE-TSH levels are subject to circadian 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.

INTERPRETATION

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 3.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 4.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

COMMENTS: 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.

Disclaimer-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

Reference ranges are from Teitz fundamental of clinical chemistry 8th ed (2018)

Test performed by Instrument : Beckman coulter Dxi 800

Note : The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease, it has to be correlated with

4th Generation Assay,Reference ranges vary between laboratories

PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

1st Trimester : 0.10-2.50 uIU/mL

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3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

NOTE-TSH levels are subject to circadian 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.

INTERPRETATION

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
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- 5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

Tanu Rungta

DR.TANU RUNGTA
MD (Pathology)
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Technologist
VIKARANTSI
Page No. 15 of 17



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(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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



NAME :- Mrs. RACHNA

Age :- 36 Yrs 8 Mon 11 Days

Sex :- Female

Patient ID :-42233726

Date :- 14/10/2023 09:47:23

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 15/10/2023 10:48:18

COMMENTS: 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.

Disclaimer: 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.

Reference ranges are from Teltz fundamental of clinical chemistry 8th ed (2018)
Test performed by Instrument : Beckman coulter Dxi 800

Note: The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease. It has to be correlated with clinical data for interpretation.

*** End of Report ***



Technologist
VIRAJ KANTH
Page No. 17 of 17

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



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



NAME :- Mrs. RACHNA

Age :- 36 Yrs 8 Mon 11 Days

Sex :- Female

Patient ID :-12233726

Date :- 14/10/2023 09:47:23

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 15/10/2023 10:46:18

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	1.010		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		ABSENT

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

Technologist
VIKARANTSI
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NAME:	MRS. RACHNA	AGE	36 YRS/F
REF.BY	BANK OF BARODA	DATE	14/10/2023

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected

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





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● +91 141 4824885 ● maxcarediagnostics1@gmail.com



MRS. RACHANA	Age: 36 Y/F
Registration Date: 14/10/2023	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (132 mm) with **bright parenchymal echotexture**. 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. **A calculus measuring 4.3 mm is seen in mid pole of right kidney. A calculus measuring 3.1 mm is seen in lower pole of left kidney.** Collecting system does not show any dilatation bilaterally.

Right kidney is measuring approx. 97 mm.

Left kidney is measuring approx. 95 mm.

Urinary bladder is sub optimally distended.

Uterus is anteverted and normal in size (measuring approx. 70 x 42 mm).

Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 9.0 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:

- Grade I hepatic steatosis.
- Bilateral nephrolithiasis.
- No free fluid or lymphadenopathy.

Dr. Mukesh Sharma

M.B.B.S; M.D. (Radiodiagnosis)

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

Terms (P) Ltd

#P3 HEALTH SOLUTIONS LLP B-14, Vidhyadhar nahar, Jaipur

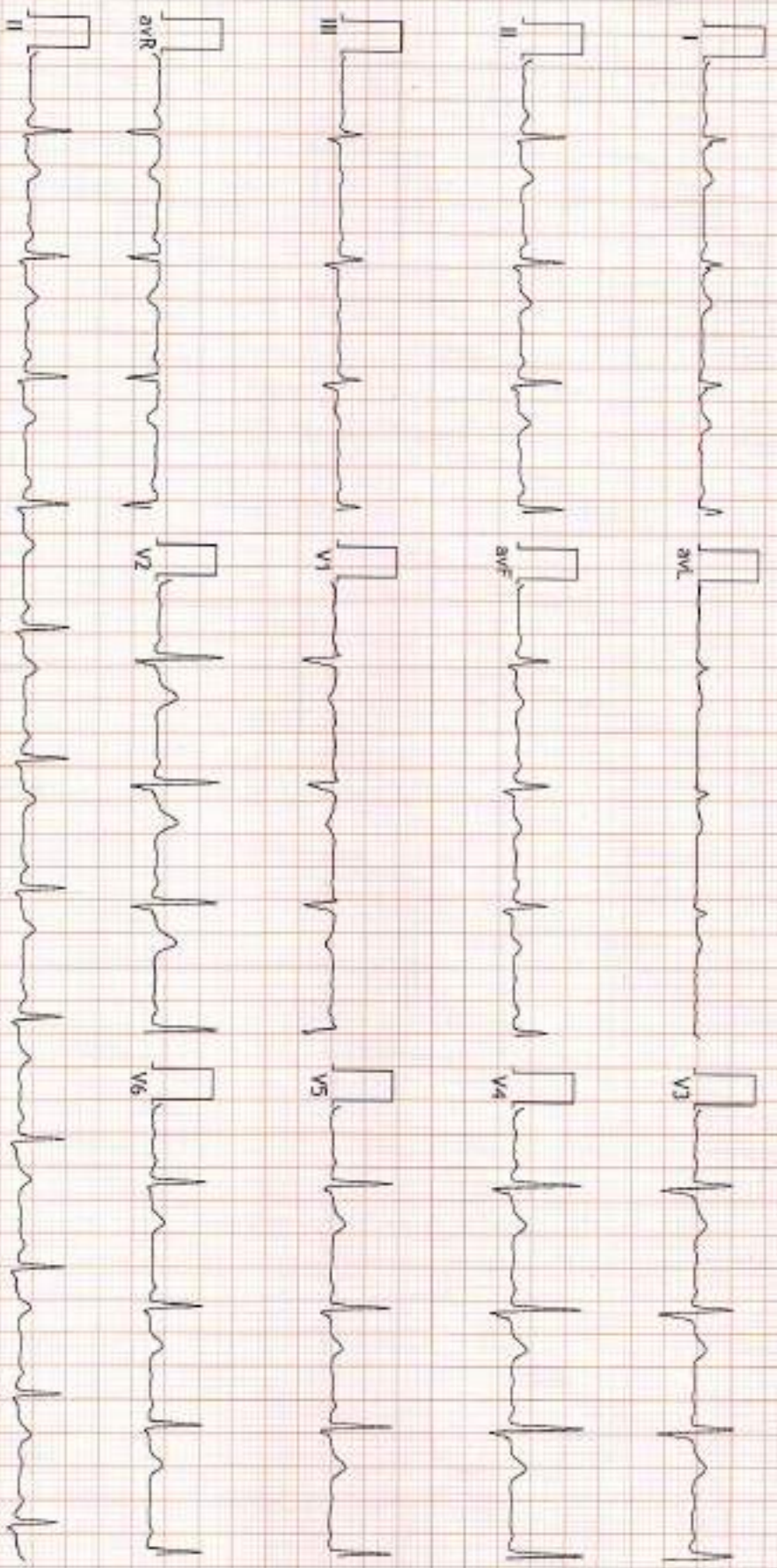
122233722/Mrs Rachna 36Yrs/Female Kgs/31 Cms BP: / / mmHg

Ref.: BANK OF BARODA Test Date: 14-Oct-2023 11:17:28) Noctil: 50-9 0.05Hz - 35Hz 10mm/mv 25mm/Sec

HR: 71 bpm



PR Interval: 160 ms
QRS Duration: 118 ms
QT/QTc: 383/418ms
P-QRS-T Axis: 47 - 31 - 29 (Deg)



FINDINGS: Normal Sinus Rhythm
Vent Rate : 71 bpm; PR Interval : 160 ms; QRS Duration: 118 ms; QT/QTc Int : 383/418 ms
P-QRS-T axis: 47 - 31 - 29 (Deg)
Comments :

WNL

Dr. NARESH MOHINKA
REG. No.: 35705
MBBS, DIP. CARDIO (ESCORIS)
D.E.M. (RCGP-UK)

Dr. NARESH MOHINKA

B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur

12233716/MS RACHNA 36 Yrs/Female 0 Kg/0 Cms

Date: 14-Oct-2023 11:21:52 AM

Ref. By : BANK OF BARODA

Medication : Nil

Protocol : DEUCE

History : Nil

Objective :

Stage	StageTime (minutes)	PhaseTime (minutes)	Speed (m/s)	Grade (%)	METS	H.R. (bpm)	B.P. (mmHg)	R.P.P. (mmHg)	PVC	Comments
Supine					1.0	76	120/80	91	-	
Standing					1.0	76	120/80	91	-	
HV					1.0	87	120/80	104	-	
EXStart					1.0	92	120/80	110	-	
Stage 1	3:01	3:02	1.7	10.0	4.7	127	130/80	165	-	
Stage 2	3:01	6:02	2.5	12.0	7.1	153	140/85	214	-	
PeakEx	0:47	6:48	3.4	14.0	7.9	164	140/85	229	-	
Recovery	1:00		0.0	0.0	1.2	130	140/85	182	-	
Recovery	2:00		0.0	0.0	1.0	111	150/85	166	-	
Recovery	3:00		0.0	0.0	1.0	99	140/85	138	-	
Recovery	4:00		0.0	0.0	1.0	98	130/85	127	-	

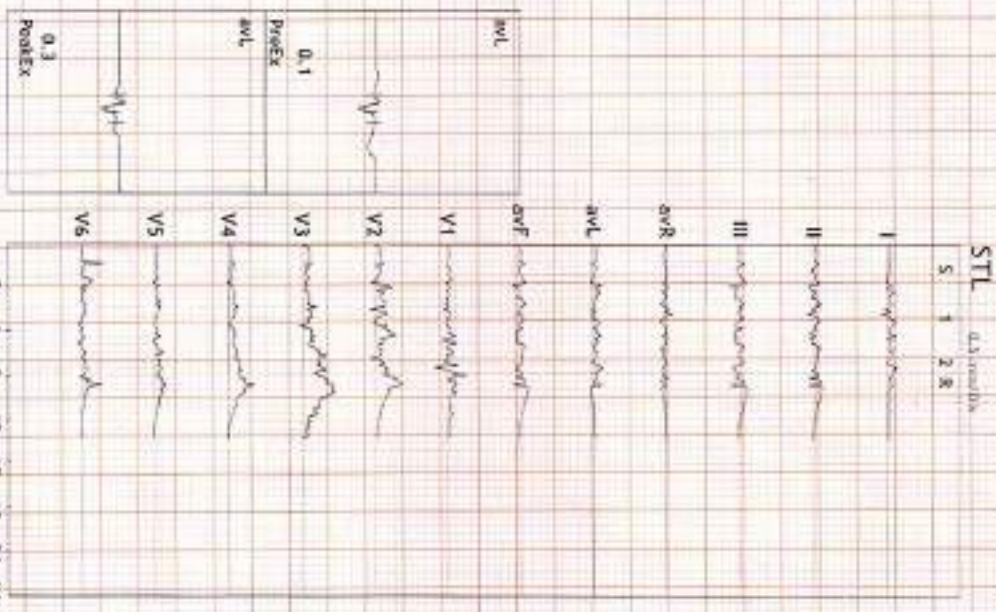
Findings :

Exercise Time : 06:47

Max HR Attained : 164 bpm 89% of Max Predictable HR 184

Max BP : 150/85(mmHg)

Max Workload attained : 7.9/Fair Effort Tolerance)



Tmd is Negative for RMYE

Advice/Comments:

DR. NARESH MOHINKA
 M.B.B.S. DIP. CARDIO (ESCORTS)
 D.Ortho (PG-CG-PAU)



B-14, Vidhyadhar Enclave-2, Vidhyadhar Nagar, Jaipur

12233716/MRS RACHNA

36 Yrs/Female

Date: 14-Oct-2023 11:21:52 AM

HR: 76 bpm

MEFS: 1.0

SP: 120/80

APHR: 41% of 184

Speed: 0.0 mmh

Grade: 0.08

Raw ECG

BRUTE

PR: 05-100Hz

Ex Time 00:31

ELC - On

Notch 10s

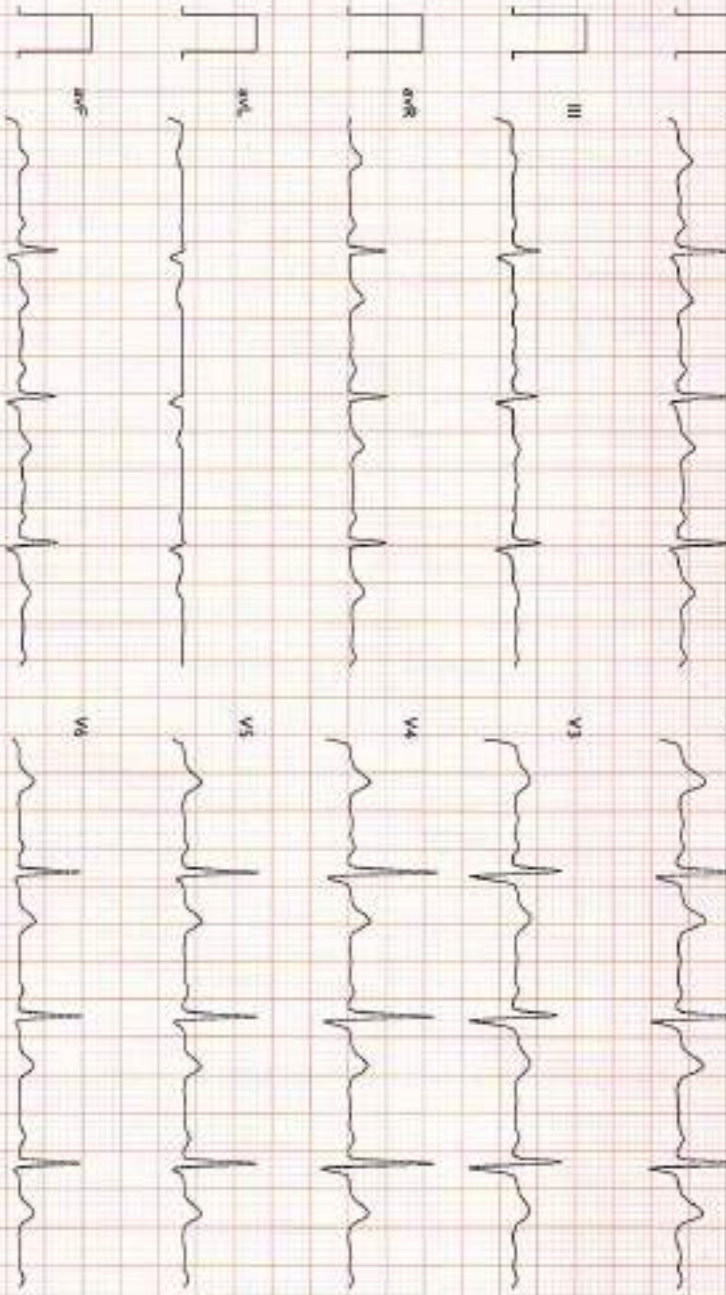
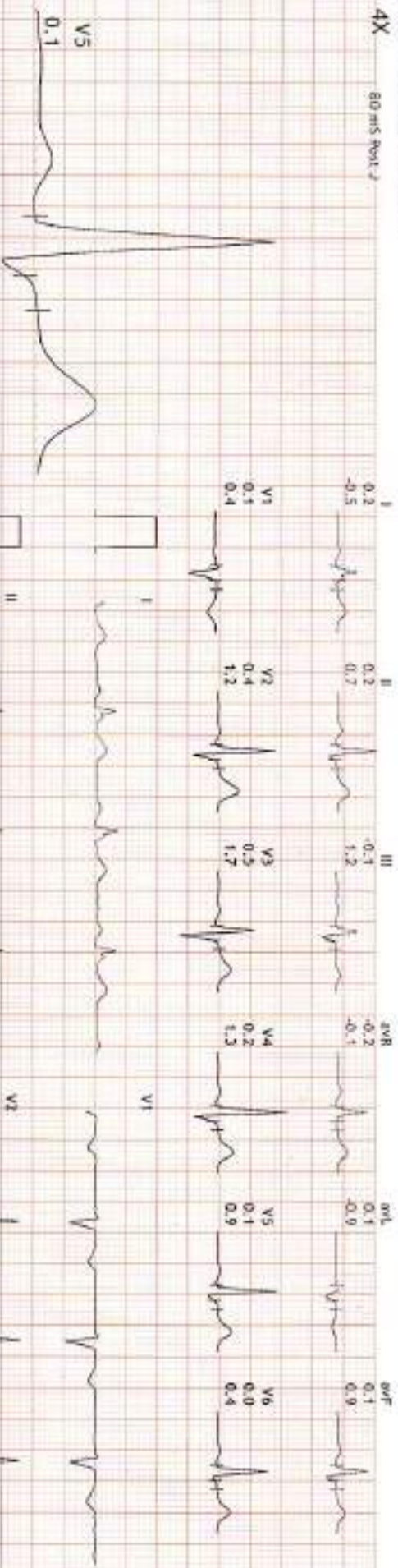
Supine

10.0 mm/ev

25 mm/Sec

4X

80 mS Print 2



4X

80 ms/Proc. 1

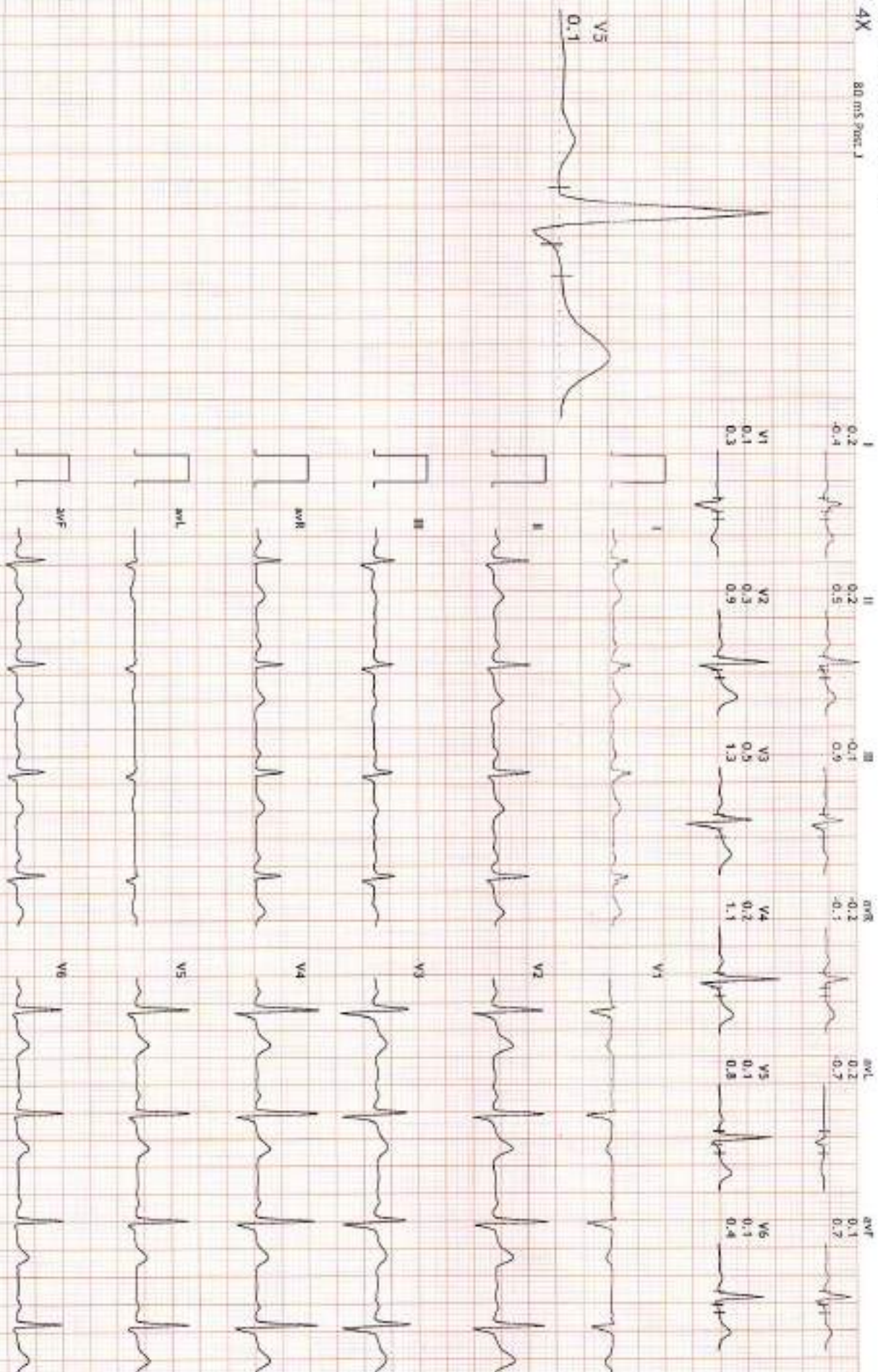
HR: 75 bpm
RTS: 1.0
PR: 160/100

MP-R4-003 of 184
Speed: 0.0 mm/s
Gain: 0.05

Raw ECG
BRUCE
10.05-1001Fz

Ex Time 00:48
SILC : On
Motion : On

Standing
10.0 mm/mV
25 mm/Sec.



HR: 86 bpm

MEFS: 1.0

SP: 270/80

MPHR: 65% of 184

Speed: 0.0 mm/s

Grade: 1.00

Raw ECG

BRUCE

10.0% (0.00 Hz)

Ex Time 01:50

BLC: On

Filter: On

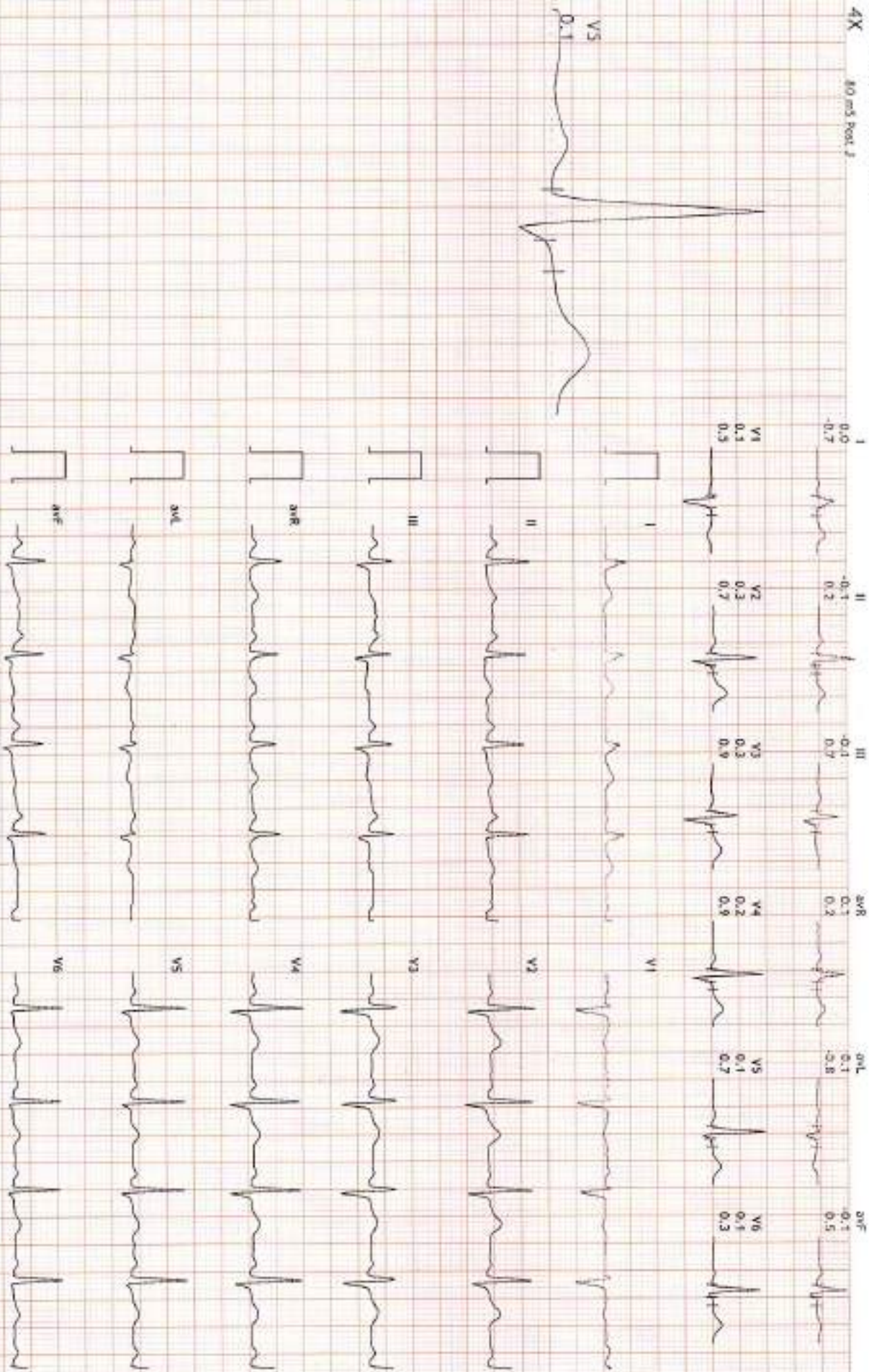
HV

10.0 mm/mV

25 mm/Sec.

4X

80 ms Post J



HR: 92 bpm

MEFS: 1.0

SP: 220/80

APHR: 50% of 184

Speed: 0.0 mm/s

Gain: 0.05

Raw ECG

BRUCE

ID: 05-100214

Ex Time 02:03

BLC-On

Match: 0%

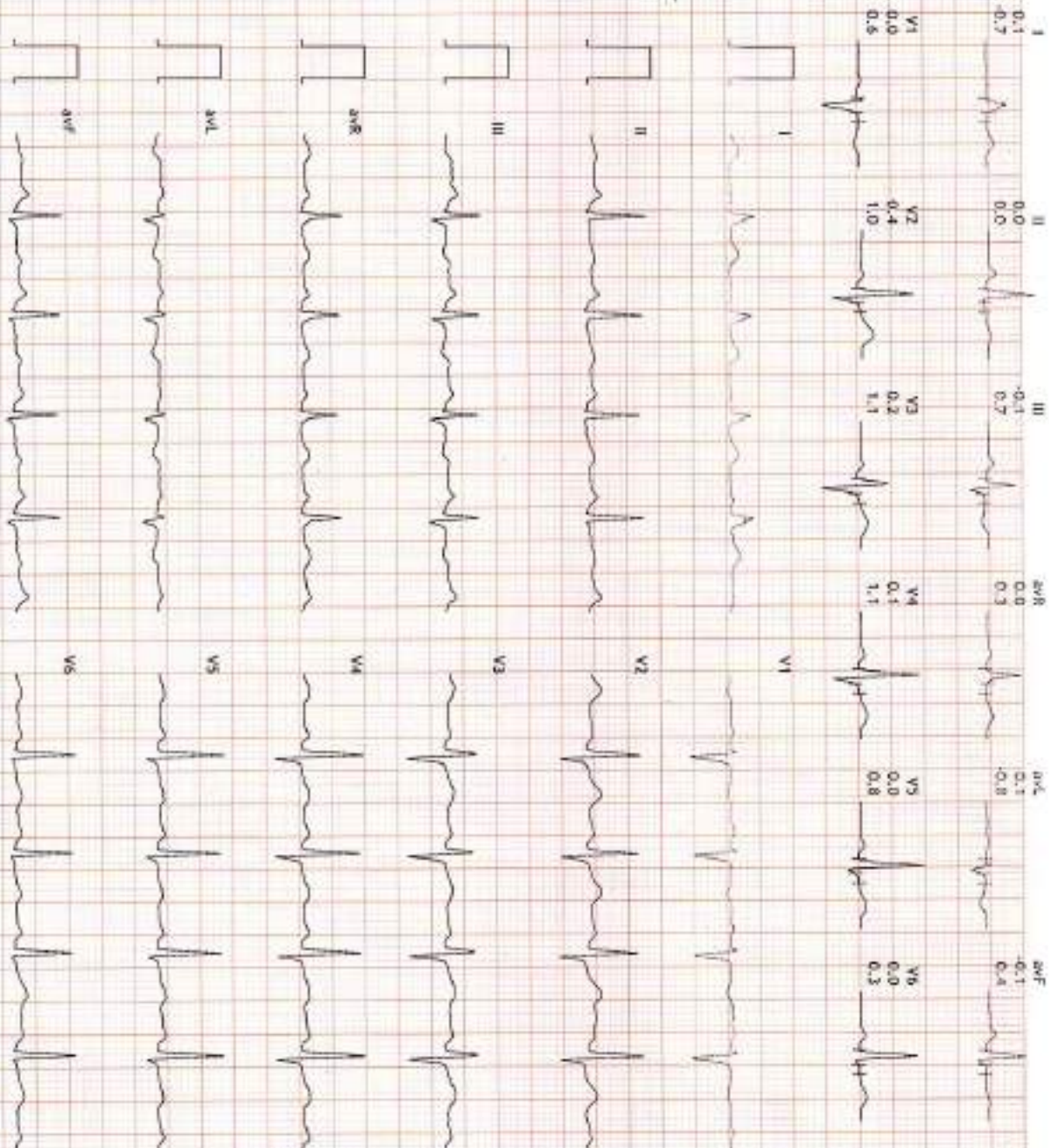
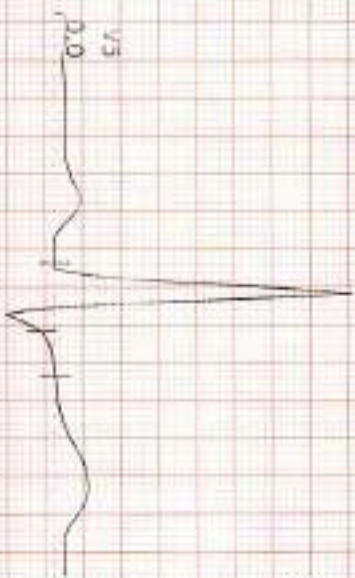
ExStart

10.0 mm/mV

25 mm/Sec



4X 80 ms Post J



HR: 127 bpm
METV: 4.7
RIP: 120/90

MPHC: 69% of 184
Speed: 1.7 mm/s
Filter: 10.0Hz

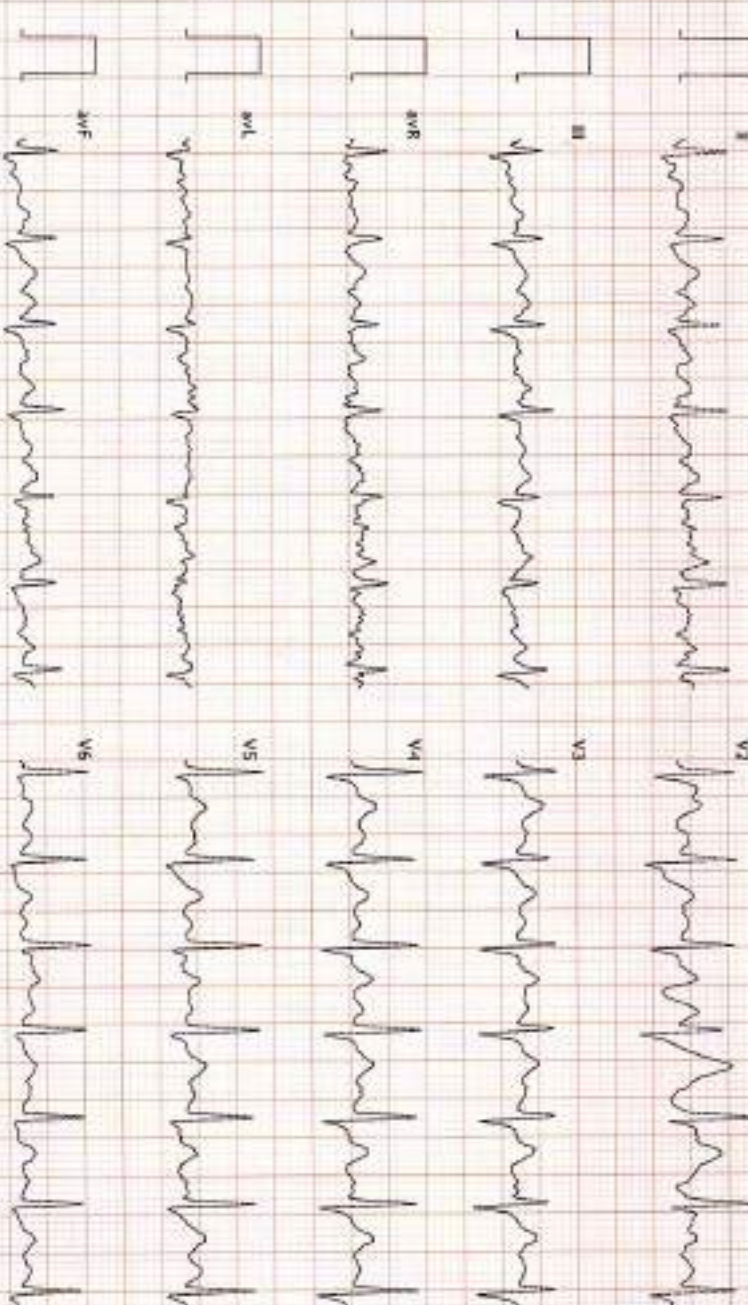
Raw ECG
BRUCE

Ex Time: 02:59
SIC: ON
Modch: ON

BRUCE: Stage 1 (3:00)
10.0 mm/mV
25 mm/Sec.

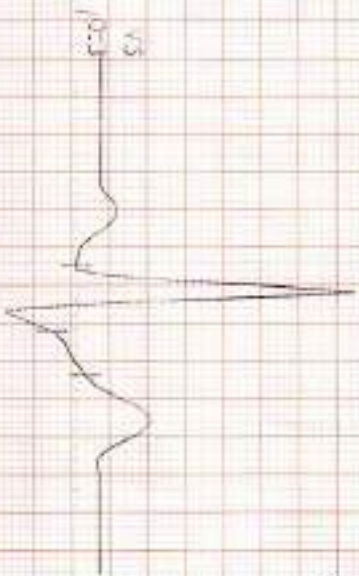


4X 80 ms Paper J





4X 80 (0.5 Sec)



I

0.4

-0.3

0.2

V1

-0.2

0.2

0.2

V2

0.4

0.4

1.9

V3

1.0

2.9

V4

0.7

2.8

V5

0.3

1.9

V6

0.3

1.4

V6

0.5

1.5

0.5

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II

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0.0

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V7

V8

V9

V10

V11

V12

V13

V14

V15

V16

V17

V18

V19

V20

V21

V22

V23

V24

V25

V26

V27

V28

V29

V30

V31

V32

V33

V34

V35

V36

V37

V38

V39

V40

V41

1

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V7

V8

V9

V10

V11

V12

V13

V14

V15

V16

V17

V18

V19

V20

V21

V22

V23

V24

V25

V26

V27

V28

V29

V30

V31

V32

V33

V34

V35

V36

V37

V38

V39

1

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V7

V8

V9

V10

V11

V12

V13

V14

V15

V16

V17

V18

V19

V20

V21

V22

V23

V24

V25

V26

V27

V28

V29

V30

V31

V32

V33

V34

V35

V36

V37

V38

V39

1

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V7

V8

V9

V10

V11

V12

V13

V14

V15

V16

V17

V18

V19

V20

V21

V22

V23

V24

V25

V26

V27

V28

V29

V30

V31

V32

V33

V34

V35

V36

V37

V38

V39

1

II

III

aVR

aVL

aVF

V1

V2

V3

V4

V5

V6

V7

V8

V9

V10

V11

V12

V13

V14

V15

V16

V17

V18

V19

V20

V21

V22

V23

V24

V25

V26

V27

V28

V29

V30

V31

V32

V33

V34

V35

V36

V37

V38

V39

1

II

III

aVR

HR: 129 bpm

QRS: 1.3

BP: 140/85

Speed: 25 mm/Sec

Grade: 0.05

Raw ECG

BRUCE

10.00-100.00 Hz

Ex Time 06:47

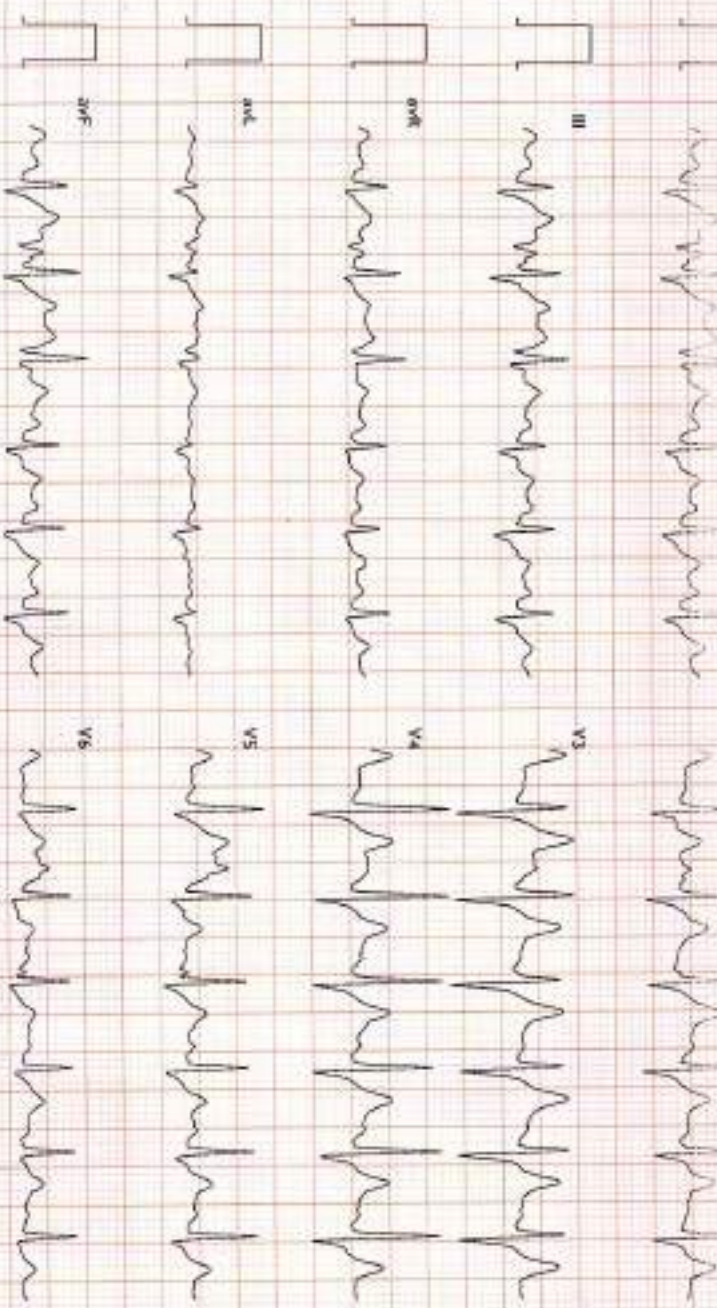
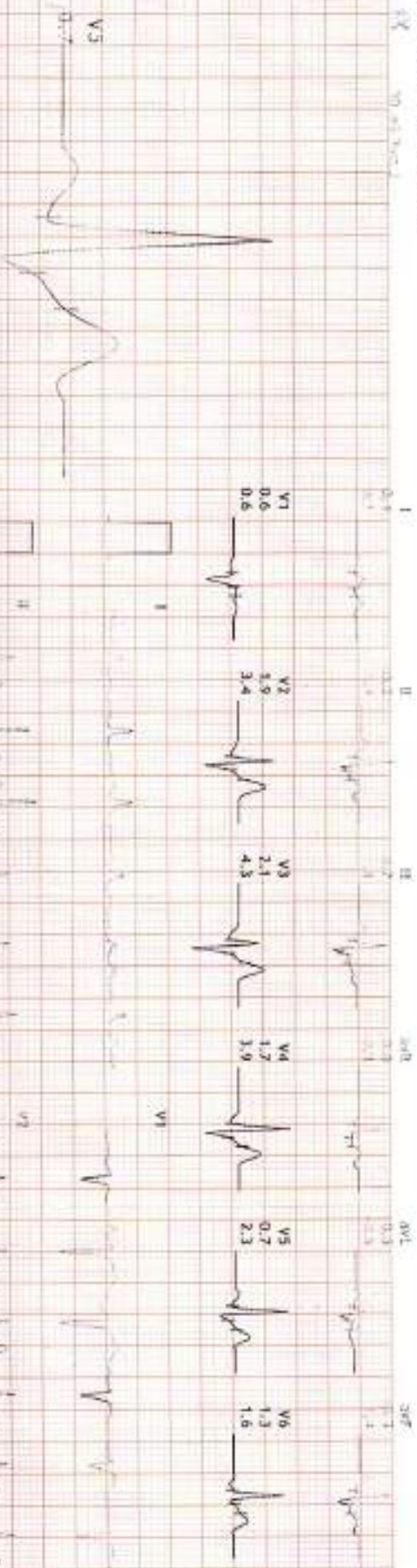
SIG: ON

Recd: On

Recovery(1:00)

10.0 mm/mV

25 mm/Sec.



HR: 112 bpm

ECG: 1.0

Sp: 150/85

PRV: 60% at 184

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BIAS: 0

12.05-100Hz

Ex Time: 06:47

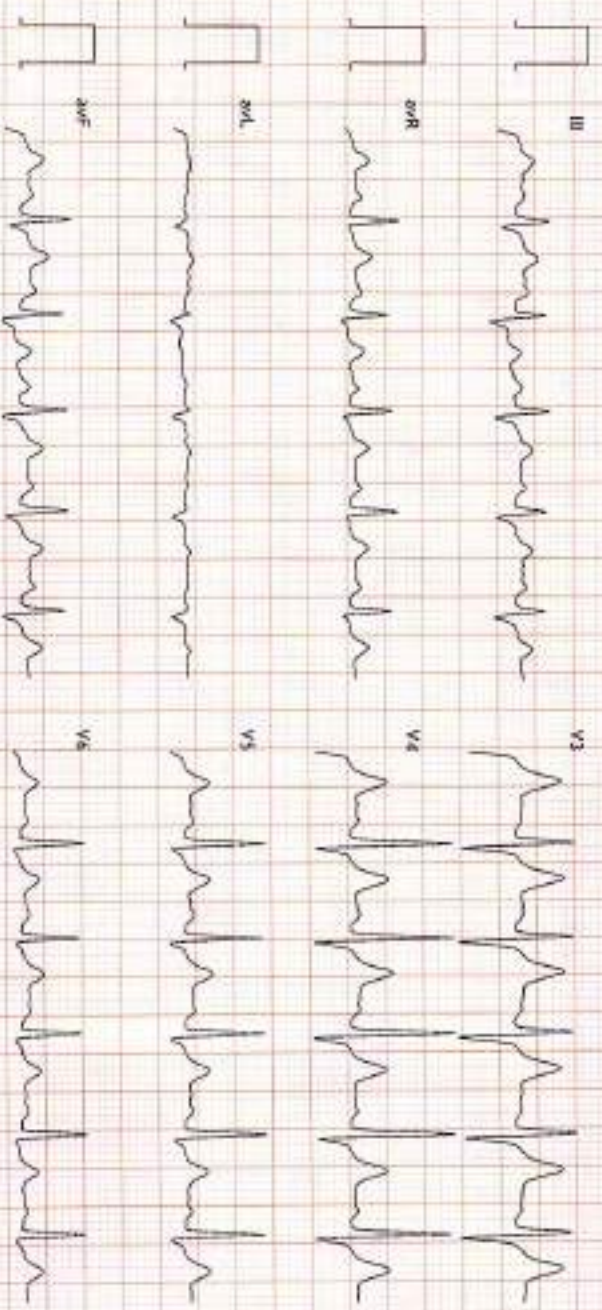
SIL: On

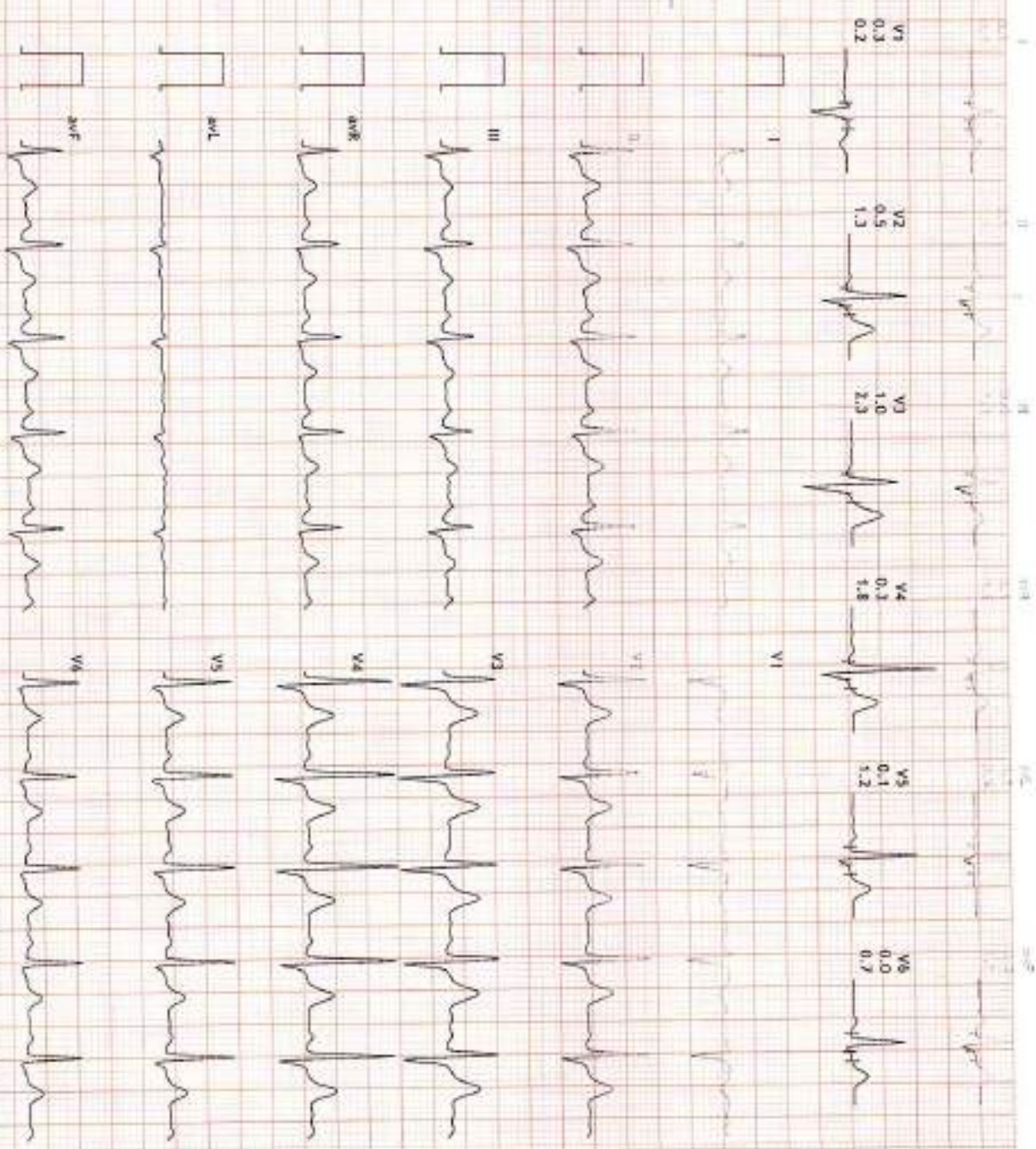
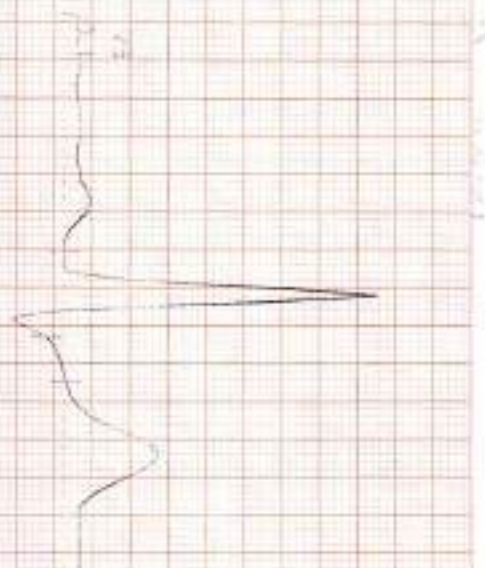
March: On

Recovery(2:00)

10.0 mm/mv

25 mm/Sec.





V1 0.3
0.2

V2 0.5
1.3

V3 1.0
2.3

V4 0.3
1.8

V5 0.1
1.2

V6 0.0
0.7

I

V1

II

V2

III

V3

aVR

V4

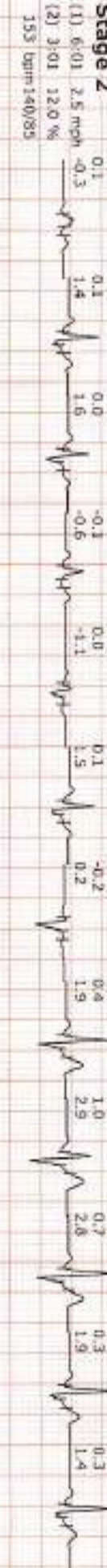
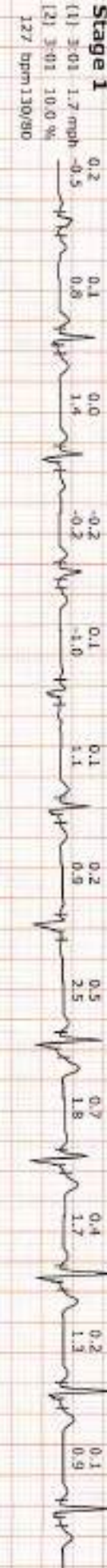
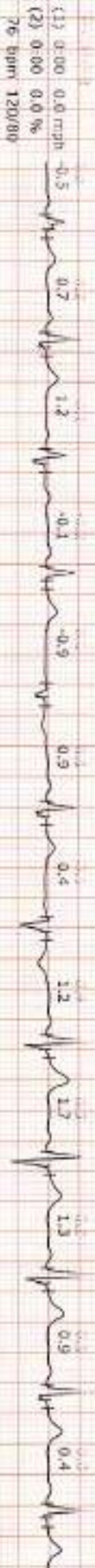
aVL

V5

aVF

V6

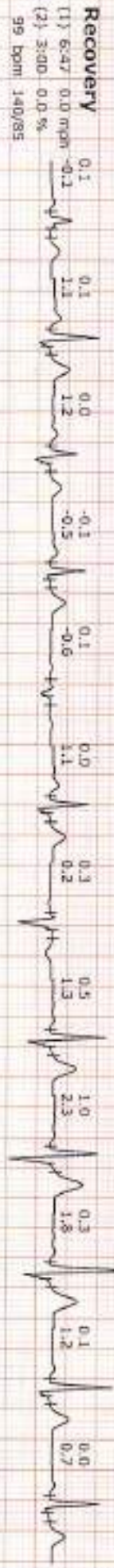
C TT TIT TVR TVL RVF V1 V2 V3 V4 V5 VS



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25



(2) 0-47 14.0 %
154 bpm/140/85





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14 OCT 2023
MAXCARE DIAGNOSTIC (ASSOCIATES OF P3 HEALTH SOLUTIONS LLP)

