

NABH ACCREDITED

PRAKASH

EYE HOSPITAL & LASER CENTRE

Dr. AMIT GARG


M.B.B.S., D.N.B. (Oph.)

I-Lasik (Femto) Bladefree Topical Micro Phaco
& Medical Retina Specialist

Ex. Micro Phaco Surgeon

Venu Eye Institute & Research Centre, New Delhi

Name Mr. Anuj Kumar Age/Sex 32 / M : C/o Date 30/May/23


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



Accredited Eye Hospital Western U.P.

First NABH ECO

प्रकाश आँखों का अस्पताल एवं लेजर सेंटर



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

Counsellor 9837066186
7535832832
Manager 7895517715
OT 7302222373
TPA 9837897788

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

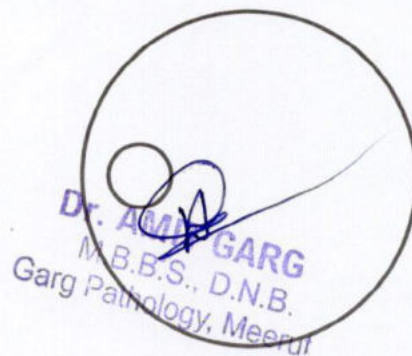
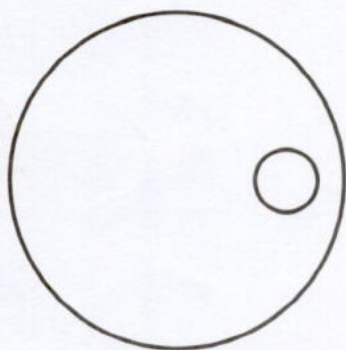
Vn
 R 6/12
 UA L 6/12

PH
 R 6/6
 L 6/6

IOP
 R 17
 L 17
 w/f/g

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance	-1.50	—	—	6/6	-1.50	—	—	6/6
Near	—	—	—	N6	—	—	—	N6

(ov) Calor Vu Norm



ID: 540 30-03-2023 08:28:09

0.67~35Hz AC50 25mm/s 10mm/mV 72 V10 SEMIP V1.7

[-] CARDIOPRINT



ID: 540

Male
32 Years
cm kg

Diagnosis Information:
Sinus Rhythm
Slight ST Depression(V3)

HR	75	bpm
P	117	ms
PR	142	ms
QRS	90	ms
QT/QTc	363/406	ms
P/ORS/ST	41/42/45	ms
RV5/SV1	1.483/0.468	mV

Report Confirmed by:

Handwritten signature



DR. MONIKA GARG
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GARG PATHOLOGY

भारत सरकार
Government of India

अनुज कुमार
Anuj Kumar
जन्म तिथि/DOB: 05/02/1991
पुरुष/ MALE

6052 0530 0858

मेरा आधार, मेरी पहचान



Anmol

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भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

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Sultanpur Dehat, Saharanpur,
Uttar Pradesh - 247231

पता:
S/O राम किशन, कांजीमल, सुल्तानपुर
देहात, सहारनपुर,
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PATHOLOGY,
LAB

RESTRICTED
AREA
AUTHORIZED
PERSONNEL ONLY

GARG PATHOLOGY
SHRINAGAR - 192001-01 9877710107
LAB ADDRESS - 82/1001/10/10/10/10
SUSTAINING MEMBERS

D. VISHVA GARG
M.D. (Path.)
GARG PATHOLOGY



30/03/2023 8:21:56 am
205° SW
Altitude: 192.0m



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

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

PUID : 230330/601 **C. NO:** 601 **Collection Time** : 30-Mar-2023 8:19AM
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Organization :



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HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	14.3	gm/dl	13.0-17.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	8890	*10 ⁶ /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	66	%.	40-80
Lymphocytes	25	%.	20-40
Eosinophils	06	%.	1-6
Monocytes	03	%.	2-10
Absolute neutrophil count	5.87	x 10 ⁹ /L	2.0-7.0(40-80%)
Absolute lymphocyte count	2.22	x 10 ⁹ /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.53	x 10 ⁹ /L	0.02-0.5(1-6%)
Method:-((EDTA Whole blood,Automated /			
ESR (Automated Wsetergren`s)	04	mm/1st hr	0.0 - 10.0
RBC Indices			
TOTAL R.B.C. COUNT (Electric Impedence)	5.81	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	46.7	%	26-50
MCV (Calculated)	80.4	fL	80-94
MCH (Calculated)	24.6	pg	27-32
MCHC (Calculated)	30.6	g/dl	30-35
RDW-SD (Calculated)	46.7	fL	37-54



*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

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

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RDW-CV (Calculated)	14.3	%	11.5 - 14.5
Platelet Count (Electric Impedence)	2.10	/Cumm	1.50-4.50
MPV (Calculated)	9.3	%	7.5-11.5
NLR 6-9 Mild stres 7-9 Pathological cause	2.64		1-3

-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 * "B" POSITIVE \$ \$



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GLYCATED HAEMOGLOBIN (HbA1c)*	4.9	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	93.9	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

-Haemolytic 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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Investigation	Results	Units	Biological Ref-Interval
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BIOCHEMISTRY (SERUM)

SERUM CREATININE (Enzymatic)	1.0	mg/dl	0.6-1.4
URIC ACID	7.8	mg/dL.	3.6-7.7
BLOOD UREA NITROGEN	12.40	mg/dL.	8-23

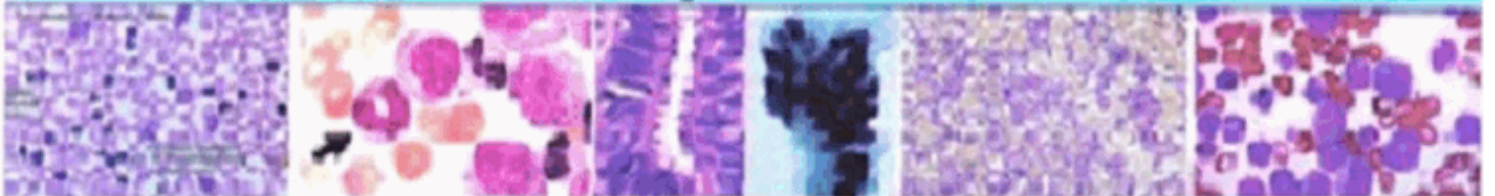


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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL (Diazo)	1.4	mg/dl	0.1-1.2
DIRECT (Diazo)	0.5	mg/dl	<0.3
INDIRECT (Calculated)	0.9	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	37.0	U/L	8-40
S.G.O.T. (IFCC method)	31.0	U/L	6-37
SERUM ALKALINE PHOSPHATASE (IFCC KINETIC)	99.5	IU/L.	50-126
SERUM PROTEINS			
TOTAL PROTEINS (Biuret)	6.9	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	3.8	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	3.1	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	1.2		1.5-2.5



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



Investigation	Results	Units	Biological Ref-Interval
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PSA*	0.520	ng/ml	
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ECLIA
NORMAL VALUE

Age (years)	Median (ng/ml)
<49	<2.0
50-59	<3.5
60-69	<4.5
70-79	<6.5

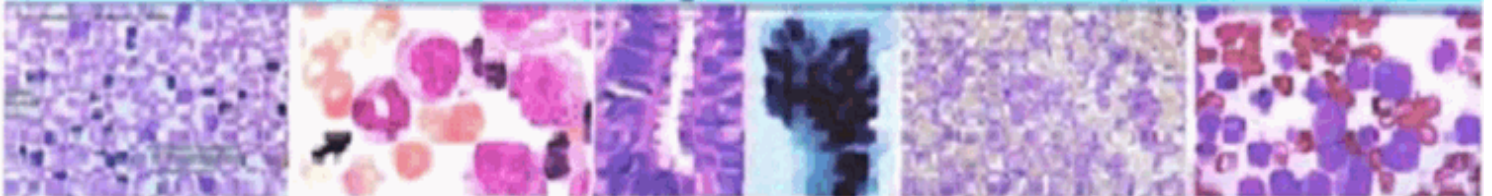


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---------------	---------	-------	-------------------------

LIPID PROFILE

SERUM CHOLESTEROL (CHOD - PAP)	156.0	mg/dl	150-250
SERUM TRIGLYCERIDE (GPO-PAP)	111.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	44.5	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	22.2	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	89.3	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	02.0	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	3.5	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) * 138.0 mEq/litre 135 - 155
(ISE method)
(ISE)



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THYRIOD PROFILE*

Triiodothyronine (T3) * (ECLIA)	1.052	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	9.463	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) (ECLIA)	4.417	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 increased 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)	4.1	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	9.5	mg/dl	9.2-11.0



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URINE

PHYSICAL EXAMINATION

Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.010		1.000-1.030
PH (Reaction)	Acidic		

BIOCHEMICAL EXAMINATION

Protein	Nil		Nil
Sugar	Nil		Nil

MICROSCOPIC EXAMINATION

Red Blood Cells	0-2	/HPF	Nil
Pus cells	3-4	/HPF	0-2
Epithelial Cells	1-2	/HPF	1-3
Crystals	Nil		
Casts	Nil		

@ Special Examination

Bile Pigments	Absent
Blood	Present
Bile Salts	Absent

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



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DATE	30.03.2023	REF. NO.	5817		
PATIENT NAME	ANUJ KUMAR	AGE	32 YRS	SEX:	M
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG		

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.

Both kidneys show few echogenic foci, largest measuring 3.2 mm on right side & 7.5 mm on left side.

Left Kidney - Normal in size and echotexture. Show well maintained corticomedullary differentiation.

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

Prostate - Normal in size (16g) & echotexture.

IMPRESSION

Bilateral renal calculi

ADV - CT Abdomen (plain) for better evaluation of renal calculus

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
3. Suspected typing errors should be informed back for correction immediately.
4. Not for medico-legal purpose. Identity of the patient cannot be verified.

DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE : 30/03/2023 REFERENCE NO. : 11057
PATIENT NAME : ANUJ KUMAR AGE/SEX : 32YRS/M
REFERRED BY : DR. MONIKA GARG ECHOGENECITY : NORMAL
REFERRING DIAGNOSIS : To rule out structural heart disease.

ECHOCARDIOGRAPHY REPORT

DIMENSIONS	NORMAL	NORMAL
AO (ed) 2.8 cm	(2.1 - 3.7 cm)	IVS (ed) 1.0 cm (0.6 - 1.2 cm)
LA (es) 3.2 cm	(2.1 - 3.7 cm)	LVPW (ed) 1.0 cm (0.6 - 1.2 cm)
RVID (ed) 1.1 cm	(1.1 - 2.5 cm)	EF 60% (62% - 85%)
LVID (ed) 3.6 cm	(3.6 - 5.2 cm)	FS 30% (28% - 42%)
LVID (es) 2.5 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 ::

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 Hypotrophy/ intracardiac mass. Estimated LV ejection fraction is 60%.

DOPPLER STUDIES :

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	No	0.76	2.3
Tricuspid Valve	No	0.85	2.5
Pulmonary Valve	No	0.67	2.1
Aortic Valve	No	0.92	3.2

IMPRESSION :

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

DR. SANJEEV KUMAR BANSAL
MD, Dip. CARD (Cardiology) FCCS
(Non-Invasive Cardiology)
Lokpriya Heart Centre

DR. HARIOM TYAGI
MD, DM (Cardiology)
(Interventional Cardiologist)
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.

24 घण्टे इमरजेन्सी सेवा

DATE	30.03.2023	REF. NO.	17708		
PATIENT NAME	ANUJ KUMAR	AGE	32 YRS	SEX	M
INVESTIGATION	X-RAY CHEST PA VIEW	REF. BY	GARG		

REPORT

- Trachea is central in position.
- Bilateral lung field show normal broncho vascular markings.
- Cardiac size is within normal limits.
- Both costophrenic angles are clear.
- Both domes of diaphragm are normal in contour and position.

IMPRESSION

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.