



भारत सरकार

Government of India



मोनिका

Monica

प्रा.सं.पं./DOB: 27/10/1988

स्त्री/ FEMALE

8065 7609 8615

VID : 9153 2812 4341 2961

अपने अधिकार, अपनी अज्ञानता



विशिष्ट पहचान प्राधिकरण

Identification Authority of India



उत्पत्ति :

श्री रोहित कुमार प्रसाद, इन्द्रपुरी रोड नं - 6, रातु रोड,  
हेहल, रांची,  
झारखंड - 834005

Address:

C/O: Rohit Kumar Prasad, Indrapuri Road No  
- 6, Ratu Road, Hehal, Ranchi,  
Jharkhand - 834005



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VID : 9153 2812 4341 2961



1947



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भारत सरकार

Government



आतल



मोनिका गुप्ता

Monica Gupta

व्युक्त लिंग/DOB: 27/10/1988

स्त्री/ FEMALE

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VID : 9153 2812 4341 2961

भारत सरकार, आतल योजना





भारतीय विशिष्ट पञ्चम अधिकरण

Unique Identific

Authority of India

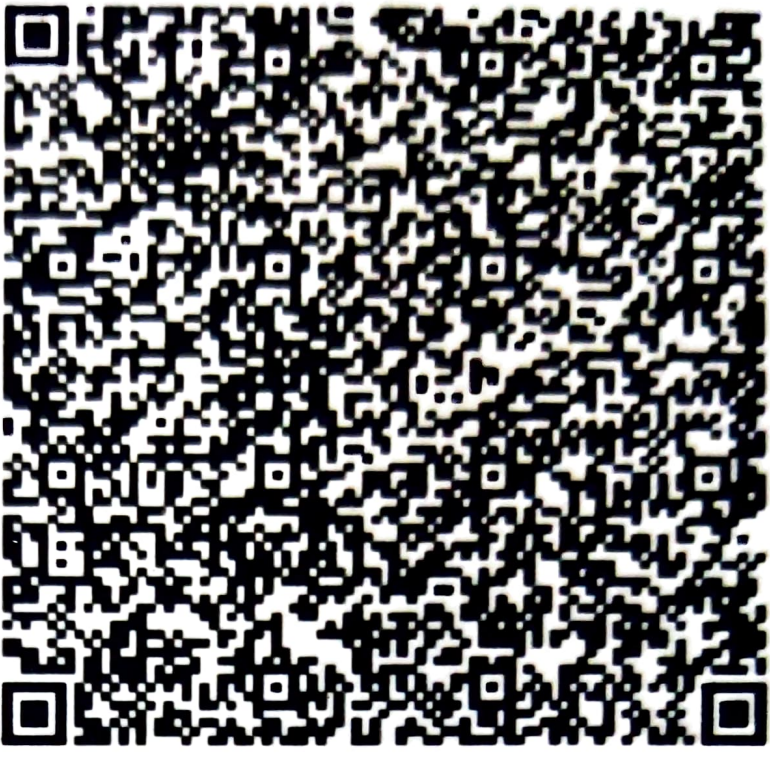


अरनाम्यु :

ना बारा: रोहित कुमार प्रसाद, इन्द्रपुरी रोड नं - 6, रातु रोड,  
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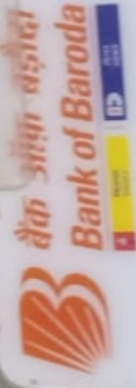


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नाम Name Rohit Kumar Prasad

कर्मचारी कूट क्र. Employee Code No. 161967

जारीकर्ता प्राधिकारी Issuing Authority



धारक के हस्ताक्षर Signature of Holder

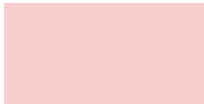
Handwritten signature of the cardholder.



## Health Check up Booking Confirmed Request(bobS13956),Package Code-PKG10000241, Beneficiary Code-68976



**From** Mediwheel <customercare@policywheel.com>  
**To** tpa@aashkahospitals.in <tpa@aashkahospitals.in>  
**Cc** Mediwheel CC <customercare@mediwheel.in>, Mediwheel CC <mediwheelwellness@gmail.com>  
**Date** 2022-07-18 06:00



**011-41195959**  
**Email:wellness@mediwheel.in**

Hi **Aashka Multispeciality Hospital,**

Diagnostic/Hospital Location :**Between Sargasan & Reliance Cross Road, City:Gandhi Nagar**

We have received the confirmation for the following booking .

**Beneficiary Name** : PKG10000241

**Beneficiary Name** : Monica Gupta

**Member Age** : 33

**Member Gender** : Female

**Member Relation** : Spouse

**Package Name** : Medi-Wheel Metro Full Body Health Checkup Female Below 40

**Location** : HIMATNAGAR,Gujarat-NULL

**Contact Details** : 9555972527

**Booking Date** : 17-07-2022

**Appointment Date** : 23-07-2022

### Instructions to undergo Health Check:

1. Please ensure you are on complete fasting for 10-To-12-Hours prior to check.
2. During fasting time do not take any kind of medication, alcohol, cigarettes, tobacco or any other liquids (except Water) in the morning.
3. Bring urine sample in a container if possible (containers are available at the Health Check centre).
4. Please bring all your medical prescriptions and previous health medical records with you.
5. Kindly inform the health check reception in case if you have a history of diabetes and cardiac problems.



**For Women:**

1. Pregnant Women or those suspecting are advised not to undergo any X-Ray test.
2. It is advisable not to undergo any Health Check during menstrual cycle.

We request you to facilitate the employee on priority.

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**DR. JIGISHA VADODARIYA**  
**M.D., IDCCM.**  
**CRITICAL CARE MEDICINE**  
**R.NO.G-27131**

<b>UHID:</b>		<b>Date:</b>		<b>Time:</b>									
<b>Patient Name:</b> Monica Gupta				<b>Height:</b>									
<b>Age /Sex:</b> 33/F		<b>LMP:</b>		<b>Weight:</b>									
<b>History:</b>													
<b>Medical History:</b>		<b>Surgical History:</b>		<b>C/C/O:</b>									
M _____ HTN _____ COPD _____ CKD _____ Hypothyroidism _____ CAD _____  ? puod.		0/40 LSCS 0/40 appendix.  Others:		Hair fall 01 month									
<b>Allergy History:</b> —			<b>Addiction:</b>										
<b>Nutritional Screening:</b> Well-Nourished / Malnourished / Obese													
<b>Examination:</b>				<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><b>Temp</b></td><td></td></tr> <tr><td><b>Pulse</b></td><td>70/min</td></tr> <tr><td><b>BP</b></td><td>100/60 mmHg</td></tr> <tr><td><b>SPO2</b></td><td></td></tr> </table>		<b>Temp</b>		<b>Pulse</b>	70/min	<b>BP</b>	100/60 mmHg	<b>SPO2</b>	
<b>Temp</b>													
<b>Pulse</b>	70/min												
<b>BP</b>	100/60 mmHg												
<b>SPO2</b>													
<b>RS:</b>		<b>CNS:</b>		<b>General:</b>									
BLA (+)													
<b>CVS:</b>		<b>PA:</b>											
S1 (+)													
<b>Provisional Diagnosis:</b>													





Aashka Hospitals Ltd.  
Between Sargasan and Reliance Cross Roads  
Sargasan, Gandhinagar - 382421. Gujarat, India  
Phone: 079-29750750, +91-7575006000 / 9000  
Emergency No.: +91-7575007707 / 9879752777  
www.aashkahospitals.in  
CIN: L85110GJ2012PLC072647



**DR.UNNATI SHAH**  
**B.D.S. (DENTAL SURGEON)**  
**REG. NO. A-7742**  
**MO.NO- 9904596691**

<b>UHID:</b>	<b>Date:</b>	<b>Time:</b>
<b>Patient Name:</b> Monica Gupta		<b>Age /Sex:</b> 33/F.
		<b>Height:</b>
		<b>Weight:</b>
<b>History:</b>		
<b>Examination:</b> Carious $\frac{67}{7}$		
<b>Diagnosis:</b>		



Treatment:

Rest

157  
7

Dr. V. M. M.

LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Whole Blood EDTA Mobile No : 9555972527  
 Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
 Report Date and Time : 23-Jul-2022 09:57 Acc. Remarks : Normal Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin (Colorimetric)	12.2	G%	12.00 - 15.00
RBC (Electrical Impedance)	4.06	millions/cumm	3.80 - 4.80
PCV(Calc)	38.73	%	36.00 - 46.00
MCV (RBC histogram)	95.4	fL	83.00 - 101.00
MCH (Calc)	30.0	pg	27.00 - 32.00
MCHC (Calc)	31.5	gm/dL	31.50 - 34.50
RDW (RBC histogram)	15.80	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

Total WBC Count	7780	/μL	4000.00 - 10000.00
	[ % ]	EXPECTED VALUES	[ Abs ] EXPECTED VALUES
Neutrophil	68.0	% 40.00 - 70.00	5290 /μL 2000.00 - 7000.00
Lymphocyte	25.0	% 20.00 - 40.00	1945 /μL 1000.00 - 3000.00
Eosinophil	3.0	% 1.00 - 6.00	233 /μL 20.00 - 500.00
Monocytes	4.0	% 2.00 - 10.00	311 /μL 200.00 - 1000.00
Basophil	0.0	% 0.00 - 2.00	0 /μL 0.00 - 100.00

PLATELET COUNT (Optical)

Platelet Count	199000	/μL	150000.00 - 410000.00
Neutrophil to Lymphocyte Ratio (NLR)	2.72		0.78 - 3.53

SMEAR STUDY

RBC Morphology	Normocytic Normochromic RBCs.
WBC Morphology	Total WBC count within normal limits.
Platelet	Platelets are adequate in number.
Parasite	Malarial Parasite not seen on smear.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



**Dr. Manoj Shah**  
 M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
 M.D. (Pathologist)

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Between Sargasan and Reliance Cross Roads  
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CIN: L85110GJ2012PLC072647



**LABORATORY REPORT**



Name : <b>MONICA R GUPTA</b>	Sex/Age : <b>Female/ 34 Years</b>	Case ID : <b>20702200672</b>
Ref.By : HOSPITAL,	Dis. At :	Pt. ID : 2186983
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Whole Blood EDTA	Mobile No : 9555972527
Sample Date and Time : 23-Jul-2022 08:59	Sample Coll. By :	Ref Id1 : OSP28285
Report Date and Time : 23-Jul-2022 09:57	Acc. Remarks : Normal	Ref Id2 : O22232789

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
M.D. (Pathologist)

LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
Ref.By : **HOSPITAL,** Dis. At : Pt. ID : **2186983**  
Bill. Loc. : **Aashka hospital** Pt. Loc :

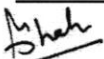
Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Whole Blood EDTA	Mobile No : 9555972527
Sample Date and Time : 23-Jul-2022 08:59	Sample Coll. By :	Ref Id1 : OSP28285
Report Date and Time : 23-Jul-2022 11:00	Acc. Remarks : Normal	Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**HAEMATOLOGY INVESTIGATIONS**

<b>ESR</b>	<b>09</b>	mm after 1hr 3 - 20		
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Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
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Bill. Loc. : **Aashka hospital** Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Whole Blood EDTA	Mobile No : 9555972527
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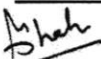
TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**HAEMATOLOGY INVESTIGATIONS**

**BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology)  
(Both Forward and Reverse Group )**

ABO Type	A
Rh Type	POSITIVE

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : **HOSPITAL,** Dis. At : Pt. ID : **2186983**  
 Bill. Loc. : **Aashka hospital** Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Spot Urine	Mobile No : 9555972527
Sample Date and Time : 23-Jul-2022 08:59	Sample Coll. By :	Ref Id1 : OSP28285
Report Date and Time : 23-Jul-2022 09:57	Acc. Remarks : Normal	Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**URINE EXAMINATION (STRIP METHOD AND FLOWCYTOMETRY)**

Physical examination

**Colour** Pale yellow

**Transparency** Clear

Chemical Examination By Sysmex UC-3500

**Sp.Gravity** 1.030 1.005 - 1.030

**pH** 5.0 5 - 8

**Leucocytes (ESTERASE)** NEGATIVE Negative

**Protein** TRACE Negative

**Glucose** Negative Negative

**Ketone Bodies Urine** Negative Negative

**Urobilinogen** Negative Negative

**Bilirubin** Negative Negative

**Blood** PRESENT [+++] Negative

**Nitrite** Negative Negative

Flowcytometric Examination By Sysmex UF-5000

**Leucocyte** OCCASIONAL /HPF Nil

**Red Blood Cell** 25-30 /HPF Nil

**Epithelial Cell** Present + /HPF Present(+)

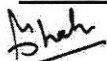
**Bacteria** Nil /ul Nil

**Yeast** Nil /ul Nil

**Cast** Nil /LPF Nil

**Crystals** Negative Negative

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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LABORATORY REPORT



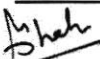
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 Ref.By : **HOSPITAL,** Dis. At : Pt. ID : **2186983**  
 Bill. Loc. : **Aashka hospital** Pt. Loc :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : **Spot Urine** Mobile No : **9555972527**  
 Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : **OSP28285**  
 Report Date and Time : 23-Jul-2022 09:57 Acc. Remarks : **Normal** Ref Id2 : **O22232789**

Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.8-7.4					
SG	-	1.016-1.022					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Result/Notifications				
			Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Pus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Plasma Fluoride F, Plasma Fluoride PP Mobile No : 9555972527  
Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
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TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

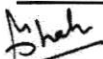
BIOCHEMICAL INVESTIGATIONS

Biochemical Investigations by Dimension EXL (Siemens)

Plasma Glucose - F	H	102.2	mg/dL	70.0 - 100
Plasma Glucose - PP		94.0	mg/dL	70.0 - 140.0

Reference range has been changed as per recent guidelines of ISPAD 2018.  
<100 mg/dL : Normal level  
100-<126 mg/dL: Impaired fasting glucoseer guidelines  
>=126 mg/dL: Probability of Diabetes, Confirm as per guidelines

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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 Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Serum Mobile No : 9555972527  
 Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
 Report Date and Time : 23-Jul-2022 12:11 Acc. Remarks : Normal Ref Id2 : O22232789

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

**BIOCHEMICAL INVESTIGATIONS**

**Lipid Profile**

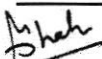
<b>Cholesterol</b>		<b>169.84</b>	mg/dL	110 - 200
<b>HDL Cholesterol</b>	L	<b>40.85</b>	mg/dL	48 - 77
<b>Triglyceride</b>	H	<b>207.56</b>	mg/dL	40 - 200
<b>VLDL</b> <i>Calculated</i>	H	<b>41.51</b>	mg/dL	10 - 40
<b>Chol/HDL</b> <i>Calculated</i>	H	<b>4.16</b>		0 - 4.1
<b>LDL Cholesterol (Direct)</b> <i>CALC</i>		<b>94.14</b>	mg/dL	65 - 100

**NEW ATP III GUIDELINES (MAY 2001). MODIFICATION OF NCEP**

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal <100	Desirable <200	Low <40	Normal <150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-189	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment
- For LDL Cholesterol level Please consider direct LDL value  
 Risk assessment from HDL and Triglycende has been revised. Also LDL goals have changed.
- Detail test interpretation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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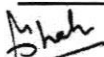
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**BIOCHEMICAL INVESTIGATIONS**

**Liver Function Test**

<b>S.G.P.T.</b>	<b>11.82</b>	U/L	0 - 31	
<b>S.G.O.T.</b>	<b>15.39</b>	U/L	15 - 37	
<b>Alkaline Phosphatase</b>	<b>90.98</b>	U/L	35 - 105	
<b>Gamma Glutamyl Transferase</b>	<b>9.96</b>	U/L	5 - 36	
<b>Proteins (Total)</b>	<b>7.86</b>	gm/dL	6.4 - 8.2	
<b>Albumin</b>	<b>H 5.03</b>	gm/dL	3.4 - 5	
<b>Globulin</b> <i>Calculated</i>	<b>2.83</b>	gm/dL	2 - 4.1	
<b>A/G Ratio</b> <i>Calculated</i>	<b>1.8</b>		1.0 - 2.1	
<b>Bilirubin Total</b>	<b>0.36</b>	mg/dL	0.2 - 1.0	
<b>Bilirubin Conjugated</b>	<b>0.15</b>	mg/dL		
<b>Bilirubin Unconjugated</b> <i>Calculated</i>	<b>0.21</b>	mg/dL	0 - 0.8	

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Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
Bill. Loc. : Aashka hospital Pt. Loc. :

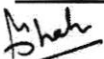
Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Serum Mobile No : 9555972527  
Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
Report Date and Time : 23-Jul-2022 12:11 Acc. Remarks : Normal Ref Id2 : O22232789

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

**BIOCHEMICAL INVESTIGATIONS**

<b>BUN (Blood Urea Nitrogen)</b> <i>GLDH</i>	<b>19.79</b>	mg/dL	6.00 - 20.00	
<b>Creatinine</b>	<b>0.79</b>	mg/dL	0.50 - 1.50	
<b>Uric Acid</b>	<b>4.80</b>	mg/dL	2.6 - 6.2	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



**Dr. Manoj Shah**  
M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
M.D. (Pathologist)

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LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : HOSPITAL, Dis. At : Pt. ID : **2186983**  
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Whole Blood EDTA	Mobile No : 9555972527
Sample Date and Time : 23-Jul-2022 08:59	Sample Coll. By :	Ref Id1 : OSP28285
Report Date and Time : 23-Jul-2022 10:25	Acc. Remarks : Normal	Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**BIOCHEMICAL INVESTIGATIONS**

**Glycated Haemoglobin Estimation**

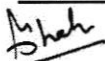
<b>HbA1C</b>	<b>4.53</b>	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes
<b>Avg. PI Glucose (Last 3 Months)</b> <i>Calculated</i>	<b>83.31</b>	mg/dL	80.00 - 140.00

Please Note change in reference range as per ADA 2021 guidelines.

**Interpretation :**

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.  
 Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.  
 Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.  
 Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.  
 In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.  
 The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



**Dr. Manoj Shah**  
 M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
 M.D. (Pathologist)

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LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : **HOSPITAL,** Dis. At : Pt. ID : **2186983**  
 Bill. Loc. : **Aashka hospital** Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Serum Mobile No : 9555972527  
 Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
 Report Date and Time : 23-Jul-2022 13:53 Acc. Remarks : Normal Ref Id2 : O22232789

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

**BIOCHEMICAL INVESTIGATIONS**  
**TOTAL IRON BINDING CAPACITY**

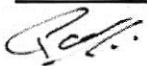
**Iron** L **45.00** µg/dL 50 - 170  
 (Ferrozyme)  
**Unsaturated Iron Binding Capacity** **271.00** µg/dL 135 - 392  
**Total Iron Binding Capacity** **316.00** µg/dL 259 - 388  
 Calculated

**Interpretation :**

1. Serum iron exhibits significant diurnal variation and may transiently rise after dietary or iron supplements & post blood transfusion.
2. Presence of acute & chronic inflammatory processes significantly affects the concentrations of iron and transferrin, as part of the acute phase response irrespective of the iron stores in the body. Hence, Concurrent measurement of biomarkers mentioned in the below table provides a reliable work up for microcytic hypochromic anaemia.

Tests	Iron Deficiency anaemia	Anaemia of Chronic disease	Iron overload (Sideroblastic)	Hemoglobinopathy (especially Trait- BTT)
Serum Iron	Decreased	Decreased	Increased	Normal
Serum Total Iron Binding Capacity	Increased	Decreased or Normal	Increased or Normal	Normal
% Transferrin Saturation	Decreased	Decreased or Normal	Increased or Normal	Normal
Serum UIBC	Increased	Decreased or Normal	Decreased	Normal
Serum Ferritin	Decreased	Increased	Increased or Normal	Normal
Other specific tests	Serum Soluble Transferrin receptor (sTfr) Increased	Serum Hcpidin Increased	Bone marrow examination	Hemoglobin electrophoresis

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

  
**Dr. Pavan Dave**  
 DCP, DNB (PATH)

**Dr. Sandip Shah**  
 M.D. (Path. & Bact.)  
 Consultant Pathologist

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Printed On : 23-Jul-2022 14:14

LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59 Sample Type : Serum Mobile No : 9555972527  
 Sample Date and Time : 23-Jul-2022 08:59 Sample Coll. By : Ref Id1 : OSP28285  
 Report Date and Time : 23-Jul-2022 10:26 Acc. Remarks : Normal Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	TEST REMARK
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**Thyroid Function Test**

Triiodothyronine (T3)	91.27	ng/dL	70 - 204	
Thyroxine (T4) CMA	6.7	ng/dL	5.5 - 11.0	
TSH CMA	4.1825	µIU/mL	0.4 - 4.2	

**Interpretation Note:**

Ultra sensitive-thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). When the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.

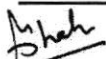
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormones vary according trimester in pregnancy.

TSH ref range in Pregnancy	Reference range (microIU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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 M.D. (Path. & Bact.)

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 M.D. (Pathologist)

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LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
 Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Serum	Mobile No : 9555972527
Sample Date and Time : 23-Jul-2022 08:59	Sample Coll. By :	Ref Id1 : OSP28285
Report Date and Time : 23-Jul-2022 10:26	Acc. Remarks : Normal	Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**BIOCHEMICAL INVESTIGATIONS**

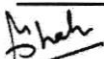
<b>25 OH Cholecalciferol (D2+D3)</b>	<b>L 2.9</b>	<b>ng/mL</b>	<b>20 - 32 Normal Level</b> <b>10 - 20 Insufficiency</b> <b>&lt; 10 Deficiency</b> <b>&gt; 160 Toxicity</b>	
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25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

**INTERPRETATION**

- Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.
- Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)<sub>2</sub>-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)<sub>2</sub>-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.
- Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH-VitD into the active form, 1,25 (OH)<sub>2</sub>-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.
- Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)<sub>2</sub>-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients. CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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 M.D. (Path. & Bact.)

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LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
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Report Date and Time : 23-Jul-2022 10:26 Acc. Remarks : Normal Ref Id2 : O22232789

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

**BIOCHEMICAL INVESTIGATIONS**

**Vitamin B - 12 Level** **283.00** pg/mL 180 - 914

**Introduction :**

Vitamin B12, a member of the corrin family, is a cofactor for the formation of myelin, and along with folate, is required for DNA synthesis. Levels above 300 or 400 are rarely associated with B12 deficiency induced hematological or neurological disease.

**Clinical Significance :**

Causes of Vitamin B12 deficiency can be divided into three classes: Nutritional, malabsorption syndromes and gastrointestinal causes. B12 deficiency can cause Megaloblastic anemia (MA), nerve damage and degeneration of the spinal cord. Lack of B12 even mild deficiencies damages the myelin sheath. The nerve damage caused by a lack of B12 may become permanently debilitating.

The relationship between B12 and MA is not always clear that some patients with MA will have normal B12 levels; conversely, many individuals with B12 deficiency are not afflicted with MA.

**Decreased in:**

Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraception, parasitic competition, pancreatic deficiency, treated epilepsy and advancing age.

**Increased in:**

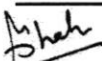
Renal failure, liver disease and myeloproliferative diseases.

Variations due to age Increases: with age.

Temporarily Increased after Drug.

Falsely high in Deteriorated sample.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



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M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
M.D. (Pathologist)

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Printed On : 23-Jul-2022 14:14

LABORATORY REPORT



Name : **MONICA R GUPTA** Sex/Age : **Female/ 34 Years** Case ID : **20702200672**  
Ref.By : HOSPITAL, Dis. At : Pt. ID : 2186983  
Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Jul-2022 08:59	Sample Type : Serum	Mobile No : 9555972527
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Report Date and Time : 23-Jul-2022 10:26	Acc. Remarks : Normal	Ref Id2 : O22232789

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**BIOCHEMICAL INVESTIGATIONS**

<b>Ferritin</b> <small>CLIA</small>	<b>51.16</b>	ng/mL	4.63 - 204	
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**Introduction :**

Ferritin is a high-molecular weight iron-containing protein that functions in the body as an iron storage compound. It has been demonstrated that the Ferritin molecule, when fully saturated, may consist of over 20% iron by weight. Approximately 25% of the iron in a normal adult is present in various storage forms. About two-thirds of the iron stores in the human body exist in the form of Ferritin.

**Use :**

Diagnosis of iron deficiency or excess; correlates with total body iron stores

- Predict and monitor iron deficiency
- Determine response to iron therapy or compliance with treatment.
- Differentiate iron deficiency from chronic disease as cause of anaemia.
- Monitor iron status in patients with chronic renal disease with or without dialysis.
- Detect iron overload states and monitor rate of iron accumulation and response to iron depletion therapy.
- Population studies of iron levels and response to iron supplement.

**Clinical Significance :**

1. Increased ferritin is seen in iron overload as in multiple blood transfusions, hemochromatosis and anemia of chronic disorders.
2. Decreased ferritin levels are seen in iron deficiency anemia, early stage before iron deficiency manifests as anemia.
3. Levels of ferritin are used for monitoring of iron levels during pregnancy, dialysis and during iron therapy.

Serum Ferritin may not be decreased when iron deficiency coexists with these conditions.

Variations due to age Increases:

with age, higher in men than women, in women on OCP, in person who eat red meat compared to vegetarians

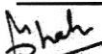
**DILUTION PROTOCOL: (on request):**

At our lab with kit, manual dilution protocol has been validated for FERRITIN up to 1:20 dilution and result up to 33000 NG/ML. After above dilution, it will be done manually and because of Ag-Ab reaction curve it may be erroneous if diluted after validated dilution.

----- End Of Report -----

# For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)



**Dr. Manoj Shah**  
M.D. (Path. & Bact.)

**Dr. Shreya Shah**  
M.D. (Pathologist)

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Printed On : 23-Jul-2022 14:14

PATIENT NAME: MONICA R GUPTA  
GENDER/AGE: Female / 33 Years  
DOCTOR: DR. HASIT JOSHI  
OPDNO: OSP28285

DATE: 23/07/22

**2D-ECHO**

MITRAL VALVE : GRADE II MVP  
AORTIC VALVE : NORMAL  
TRICUSPID VALVE : NORMAL  
PULMONARY VALVE : NORMAL  
AORTA : 36mm  
LEFT ATRIUM : 32mm  
LV Dd / Ds : 36/23mm EF 60%  
IVS / LVPW / D : 10/9mm  
IVS : INTACT  
IAS : FLOPPY  
RA : NORMAL  
RV : NORMAL  
PA : NORMAL  
PERICARDIUM : NORMAL  
VEL : PEAK MEAN  
M/S : Gradient mm Hg Gradient mm Hg  
MITRAL : 1/0.7m/s  
AORTIC : 1.3m/s  
PULMONARY : 1.2m/s  
COLOUR DOPPLER : MILD MR / TR  
RVSP : 32mmHg  
CONCLUSION : GRADE II MVP ; MILD MR;  
NORMAL LV SIZE / SYSTOLIC FUNCTION;  
MILD TR / NO PAH;  
IAS FLOPPY.



CARDIOLOGIST  
DR. HASIT JOSHI (9825012235)



**PATIENT NAME: MONICA R GUPTA**

**GENDER/AGE: Female / 33 Years**

**DATE: 23/07/22**

**DOCTOR:**

**OPDNO: OSP28285**

**SONOGRAPHY OF ABDOMEN AND PELVIS**

**LIVER:** Liver appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen. No evidence of dilated IHBR is seen. Intrahepatic portal radicals appear normal. No evidence of solid or cystic mass lesion is seen.

**GALL BLADDER:** Gall bladder is physiologically distended and appears normal. No evidence of calculus or changes of cholecystitis are seen. No evidence of pericholecystic fluid collection is seen. CBD appears normal.

**PANCREAS:** Pancreas appears normal in size and shows normal parenchymal echoes. No evidence of pancreatitis or pancreatic mass lesion is seen.

**SPLEEN:** Spleen appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen.

**KIDNEYS:** Both kidneys are normal in size, shape and position. Both renal contours are smooth. Cortical and central echoes appear normal. Bilateral cortical thickness appears normal. No evidence of renal calculus, hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 9.4 x 4.0 cms in size.

Left kidney measures about 9.6 x 4.1 cms in size.

No evidence of suprarenal mass lesion is seen on either side.

Aorta, IVC and para aortic region appears normal.

No evidence of ascites is seen.

**BLADDER:** Bladder is normally distended and appears normal. No evidence of bladder calculus, diverticulum or mass lesion is seen. Prevoid bladder volume measures about 340 cc.

**UTERUS:** Uterus is anteverted and appears normal in size, shape and position. Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 7 mm. No evidence of uterine mass lesion is seen.

**OVARIES:** Both ovaries appear normal in size and shows few follicular cysts. No evidence of solid or cystic ovarian mass lesion is seen. No other pelvic mass lesion is seen. No evidence of free fluid in cul-de-sac is seen.

**COMMENT:** Few follicular cysts in both ovaries.

Normal sonographic appearance of liver, GB, pancreas, spleen, kidneys, para aortic region, bladder and uterus.

  
**DR. SNEHAL PRAJAPATI**  
CONSULTANT RADIOLOGIST

Aashka Hospitals Ltd.  
Between Sargasan and Reliance Cross Roads  
Sargasan, Gandhinagar - 382421. Gujarat, India  
Phone: 079-29750750, +91-7575006000 / 9000  
Emergency No.: +91-7575007707 / 9879752777  
www.aashkahospitals.in  
CIN: L85110GJ2012PLC072647



**PATIENT NAME: MONICA R GUPTA**

**GENDER/AGE: Female / 33 Years**

**DATE: 23/07/22**

**DOCTOR:**

**OPDNO: OSP28285**

### X-RAY CHEST PA

Both lung fields show increased broncho-vascular markings.

**No evidence of collapse, consolidation, mediastinal lymph adenopathy, soft tissue infiltration or pleural effusion is seen.**

Both hilar shadows and C.P. angles are normal.

Heart shadow appears normal in size. Aorta appears normal.

Bony thorax and both domes of diaphragm appear normal.

No evidence of cervical rib is seen on either side.

  
**DR. SNEHAL PRAJAPATI**  
**CONSULTANT RADIOLOGIST**

23.07.2022 10:07:55 AM  
AASHKA HOSPITAL LTD.  
SARGASAN  
GANDHINAGAR

Location: 1  
Order Number:  
Indication:  
Medication 1:  
Medication 2:  
Medication 3:

Room:

83 bpm  
-- / -- mmHg

Technician:  
Ordering Ph:  
Referring Ph:  
Attending Ph:

QRS : 74 ms  
QT / QTcBaz : 338 / 397 ms  
PR : 132 ms  
P : 104 ms  
RR / PP : 724 / 722 ms  
P / QRS / T : 62 / 91 / 62 degrees

Normal sinus rhythm  
Rightward axis  
Borderline ECG

*monical Gupta*

