

Health Check up Booking Confirmed Request(bob550006),Package Code-PKG10000241,
Beneficiary Code-9885

Wellness - Mediwheel : New Delhi <wellness@mediwheel.in>

04-11-2023 11:23

To: pravinfaneja57@gmail.com <pravinfaneja57@gmail.com>

CC: Customer Care - Mediwheel - New Delhi <customercare@mediwheel.in>



Mediwheel
Your wellness partner



011-41195959

Email:wellness@mediwheel.in

Dear Hemalata ben,

Please find the confirmation for following request.

Booking Date : 04-11-2023
Package Name : Medi-Wheel Metro Full Body Health Checkup Female Below 40
Name of Diagnostic/Hospital : Aashka Multispeciality Hospital
Address of Diagnostic/Hospital : Between Sargasan & Reliance Cross Road
Contact Details : 9879752777/7577500900
City : Gandhi Nagar
State : Gujarat
Pincode : 382315
Appointment Date : 25-11-2023
Confirmation Status : Confirmed
Preferred Time : 8:00am-8:30am
Comment : APPOINTMENT TIME 8:30AM

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.

Request you to reach half an hour before the scheduled time.

In case of further assistance, Please reach out to Team Mediwheel.





LABORATORY REPORT



Name : HEMLATABEN	Sex/Age : Female/ 39 Years	Case ID : 31102200531
Ref By : HOSPITAL	Dis. At :	Pl. ID : 3150503
Bill Loc : Aashka hospital		Pl. Loc :
Reg Date and Time : 25-Nov-2023 09:03	Sample Type :	Mobile No :
Sample Date and Time : 25-Nov-2023 09:03	Sample Coll. By :	Ref Id1 : OSP32391
Report Date and Time :	Acc. Remarks : Normal	Ref Id2 : O23247822

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Blood Glucose Fasting & Postprandial			
Plasma Glucose - F	111.45	mg/dL	70 - 100
Haemogram (CBC)			
RBC (Electrical Impedance)	5.63	millions/cu mm	3.80 - 4.80
MCV (RBC histogram)	68.2	fL	83.00 - 101.00
MCH (Calc)	21.3	pg	27.00 - 32.00
MCHC (Calc)	31.2	gm/dL	31.50 - 34.50
Monocyte	193	/ μ L	200.00 - 1000.00
Lipid Profile			
HDL Cholesterol	46.8	mg/dL	48 - 77
LDL Cholesterol	120.10	mg/dL	0.00 - 100.00

Abnormal Result(s) Summary End

FORM 011 Very Low L Low H-High HRF-Very High A-Abnormal

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LABORATORY REPORT



Name : **HEMLATABEN** Sex/Age : **Female/ 39 Years** Case ID : **31102200531**
 Ref By : **HOSPITAL** Dis. At : Pt. ID : **3150503**
 Bill. Loc. : **Aashka hospital** Pt. Loc. :

Reg Date and Time : 25-Nov-2023 09:03 Sample Type : **Whole Blood EDTA** Mobile No :
 Sample Date and Time : 25-Nov-2023 09:03 Sample Coll. By : Ref Id1 : **OSP32391**
 Report Date and Time : 25-Nov-2023 09:23 Acc. Remarks : **Normal** Ref Id2 : **O23247822**

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin	12.0	G%	12.0 - 15.0
RBC (Electrical Impedance)	H 5.63	millions/cumm	3.80 - 4.80
PCV(Calc)	38.40	%	36.00 - 46.00
MCV (RBC histogram)	L 68.2	fL	83.00 - 101.00
MCH (Calc)	L 21.3	pg	27.00 - 32.00
MCHC (Calc)	L 31.2	gm/dL	31.50 - 34.50
RDW (RBC histogram)	15.10	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

TEST	RESULTS	UNIT	EXPECTED VALUES	[Abs]	EXPECTED VALUES
Total WBC Count	6430	/μL	4000.00 - 10000.00		
Neutrophil	L 60.0	%	40.00 - 70.00	3858	/μL 2000.00 - 7000.00
Lymphocyte	35.0	%	20.00 - 40.00	2251	/μL 1000.00 - 3000.00
Eosinophil	1.0	%	1.00 - 6.00	64	/μL 20.00 - 500.00
Monocytes	3.0	%	2.00 - 10.00	L 193	/μL 200.00 - 1000.00
Basophil	1.0	%	0.00 - 2.00	64	/μL 0.00 - 100.00

PLATELET COUNT (Optical)

Platelet Count	259000	/μL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	1.71		0.78 - 3.53

SMEAR STUDY

RBC Morphology : Microcytic hypochromic RBCS.
WBC Morphology : Total WBC count within normal limits.
Platelet : Platelets are adequate in number.
Parasite : Malarial Parasite not seen on smear.

Note : L - Very Low L - Low H - High HH - Very High A - Abnormal

Dr. Shreya Shah

MD Hematology

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LABORATORY REPORT



Name : **HEMLATABEN** Sex/Age : **Female/ 39 Years** Case ID : **31102200531**
 Ref By : **HOSPITAL** Dis. At : Pt. ID : **3150503**
 Bill. Loc. : **Aashka hospital** Pt. Loc. :

Reg Date and Time : 25-Nov-2023 09:03	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 25-Nov-2023 09:03	Sample Coll. By :	Ref Id1 : OSP32391
Report Date and Time : 25-Nov-2023 10:08	Acc. Remarks : Normal	Ref Id2 : O23247822

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR Westgren Method	06	mm after 1hr	3 - 20	

Note: L: Very Low L: Low H: High HH: Very High A: Abnormal

Dr. Shreya Shah

MD (Pathologist)

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	Female/ 39 Years	Case ID	: 31102200531
Ref By	HOSPITAL	Dis. At	:	Pt. ID	: 3150503
Bill Loc	Aashka hospital			Pt. Loc	:
Reg Date and Time	: 25-Nov-2023 09:03	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	: 25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	: 25-Nov-2023 09:23	Acc. Remarks	: Normal	Ref Id2	: O23247822

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	B
Rh Type	POSITIVE

Note (L: Very Low, H: High, HH: Very High, A: Abnormal)


Dr. Shreya Shah

MB (Pathology)

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	: Female/ 39 Years	Case ID	: 31102200531
Ref By	HOSPITAL	Dis. At	:	Pt. ID	: 3150503
Bill Loc	Aashka hospital			Pt. Loc	:
Reg Date and Time	: 25-Nov-2023 09:03	Sample Type	: Spot Urine	Mobile No	:
Sample Date and Time	: 25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	: 25-Nov-2023 09:24	Acc. Remarks	: Normal	Ref Id2	: O23247822

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	>1.025		1.005 - 1.030
pH	5.50		5 - 8
Leucocytes (ESTERASE)	Negative		Negative
Protein	Negative		Negative
Glucose	Negative		Negative
Ketone Bodies Urine	Negative		Negative
Urobilinogen	Negative		Negative
Bilirubin	Negative		Negative
Blood	Negative		Negative
Nitrite	Negative		Negative

Flowcytometric Examination By Sysmex UF-5000

Leucocyte	Nil	/HPF	Nil
Red Blood Cell	Nil	/HPF	Nil
Epithelial Cell	Present +	/HPF	Present(+)
Bacteria	Nil	/ul	Nil
Yeast	Nil	/ul	Nil
Cast	Nil	/LPF	Nil
Crystals	Nil	/HPF	Nil

Note (L - Very Low, LL - Low, H - High, HH - Very High, A - Abnormal)


 Dr. Shreya Shah

MD (Hematology)

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LABORATORY REPORT



Name: **HEMLATABEN** Sex/Age: **Female/ 39 Years** Case ID: **31102200531**
 Ref By: **HOSPITAL** Dis. At: Pt. ID: **3150503**
 Ref Loc: **Aashka hospital** Pt. Loc:
 Reg Date and Time: **25-Nov-2023 09:03** Sample Type: **Spot Urine** Mobile No:
 Sample Date and Time: **25-Nov-2023 09:03** Sample Coll. By: Ref Id1: **OSP32391**
 Report Date and Time: **25-Nov-2023 09:24** Acc. Remarks: **Normal** Ref Id2: **O23247822**

Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
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	-	-	-	-	-
Casts (Microscopic)	/lpf	<2	-	-	-	-	-

Abbrev: W (WBC) Low H (Hb) High HH (Hct) Very High A (Abnormal)

Dr. Shreya Shah

MD (Pathologist)

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	Female/ 39 Years	Case ID	: 31102200531
Ref.By	HOSPITAL	Dis. At	:	Pt. ID	: 3150503
Bill. Loc.	Aashka hospital			Pt. Loc	:
Reg Date and Time	: 25-Nov-2023 09:03	Sample Type	: Plasma Fluoride F, Plasma Fluoride PP	Mobile No	:
Sample Date and Time	: 25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	: 25-Nov-2023 13:12	Acc. Remarks	: Normal	Ref Id2	: O23247822
TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS	

BIOCHEMICAL INVESTIGATIONS

Blood Glucose Level (Fasting & Post Prandial)

Plasma Glucose - F <small>(Fasting Plasma Glucose)</small>	H	111.45	mg/dL	70 - 100
Plasma Glucose - PP <small>(Post Prandial Plasma Glucose)</small>		89.36	mg/dL	70.0 - 140.0

Reference range has been changed as per recent guidelines of ISPAD 2018.

- < 100 mg/dL - Normal level
- 100 - 125 mg/dL - Impaired fasting glucose guidelines
- > 125 mg/dL - Probability of Diabetes, Confirm as per guidelines.

Note: L - Very Low | Low | High | HH - Very High | A - Abnormal

Dr. Shreya Shah

MD, Pathologist

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LABORATORY REPORT



Name: **HEMLATABEN** Sex/Age: **Female/ 39 Years** Case ID: **31102200531**
 Ref By: **HOSPITAL** Dis. At: Pt. ID: **3150503**
 Bill Loc: **Aashka hospital** Pt. Loc:

Reg Date and Time: **25-Nov-2023 09:03** Sample Type: **Serum** Mobile No:
 Sample Date and Time: **25-Nov-2023 09:03** Sample Coll. By:
 Report Date and Time: **25-Nov-2023 10:07** Acc. Remarks: **Normal** Ref Id1: **OSP32391**
 Ref Id2: **O23247822**

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol <small>Calculated CHOD-PAP</small>		179.38	mg/dL	110 - 200
HDL Cholesterol	L	46.8	mg/dL	48 - 77
Triglyceride <small>Colorimetric GPOase</small>		62.39	mg/dL	<150
VLDL <small>Calculated</small>		12.48	mg/dL	10 - 40
Chol/HDL <small>Calculated</small>		3.83		0 - 4.1
LDL Cholesterol <small>Calculated</small>	H	120.10	mg/dL	0.00 - 100.00

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

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

- LDL cholesterol is primary goal for treatment and varies with risk category and assessment
- LDL cholesterol level Please consider direct LDL value
- LDL cholesterol level has been revised. Also LDL goals have changed.
- LDL cholesterol interpretation available from the lab.
- LDL cholesterol according to NCEP guidelines and with FDA approved kits.
- LDL cholesterol level is primary goal for treatment and varies with risk category and assessment

N: Normal L: Low H: High HL: Very High A: Abnormal

Dr. Shreya Shah

MD, Hematologist

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	Female/ 39 Years	Case ID	: 31102200531
Ref By	HOSPITAL	Dis. At	:	Pl. ID	: 3150503
Bill Loc	Aashika hospital			Pl. Loc	:
Reg Date and Time	25-Nov-2023 09:03	Sample Type	: Serum	Mobile No	:
Sample Date and Time	25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	25-Nov-2023 10:07	Acc. Remarks	: Normal	Ref Id2	: O23247822

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T <small>U/L with MP</small>	33.66	U/L	14 - 59	
S.G.O.T. <small>U/L with MP</small>	34.31	U/L	15 - 37	
Alkaline Phosphatase <small>U/L with MP</small>	90.46	U/L	46 - 116	
Gamma Glutamyl Transferase <small>U/L with MP</small>	33.56	U/L	0 - 38	
Proteins (Total) <small>g/dL</small>	7.12	gm/dL	6.40 - 8.30	
Albumin <small>g/dL</small>	4.57	gm/dL	3.4 - 5	
Globulin <small>g/dL</small>	2.55	gm/dL	2 - 4.1	
A/G Ratio <small>Calculated</small>	1.8		1.0 - 2.1	
Bilirubin Total <small>mg/dL</small>	0.33	mg/dL	0.3 - 1.2	
Bilirubin Conjugated <small>mg/dL</small>	0.11	mg/dL	0 - 0.50	
Bilirubin Unconjugated <small>mg/dL</small>	0.22	mg/dL	0 - 0.8	

Note: LL-Very Low, L-Low, H-High, HH-Very High, A-Abnormal



Dr. Shreya Shah

MP: 3150503

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LABORATORY REPORT



Name: **HEMLATABEN** Sex/Age : **Female/ 39 Years** Case ID : **31102200531**
 Ref By: **HOSPITAL** Dis. At : Pt. ID : **3150503**
 Bill Loc: **Aashka hospital** Pl. Loc :

Reg Date and Time: **25-Nov-2023 09:03** Sample Type : **Serum** Mobile No :
 Sample Date and Time: **25-Nov-2023 09:03** Sample Coll. By : Ref Id1 : **OSP32391**
 Report Date and Time: **25-Nov-2023 10:07** Acc. Remarks : **Normal** Ref Id2 : **O23247622**

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BUN (Blood Urea Nitrogen) <small>GLU</small>	13.3	mg/dL	7.00 - 18.70	
Creatinine	0.60	mg/dL	0.50 - 1.50	
Uric Acid <small>URIC</small>	3.68	mg/dL	2.6 - 6.2	

Note: (L - Very Low L - Low H - High HH - Very High A - Abnormal)

Dr. Shreya Shah

(M) - Pathologist

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	Female/ 39 Years	Case ID	: 31102200531
Ref By	HOSPITAL	Dis. At	:	PL ID	: 3150503
Ref. Lab	Aashka hospital			PL Loc	:
Req Date and Time	25-Nov-2023 09:03	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	25-Nov-2023 09:36	Acc. Remarks	: Normal	Ref Id2	: O23247822

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C	5.38	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) <small>Calculated</small>	107.71	mg/dL	Not available	

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.
- HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.
- Unusually high values may be found in patients with polycythemia or post splenectomy patients.
- Patients with hemoglobin forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.
- In some circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.
- HbA1c 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.

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

Dr. Shreya Shah

M.D. (Pathologist)

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Ref By	HOSPITAL	Dis. At	:	Pt. ID	: 3150503
Bill Loc	Aashka hospital			Pt. Loc	:
Reg Date and Time	25-Nov-2023 09:03	Sample Type	: Serum	Mobile No	:
Sample Date and Time	25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	25-Nov-2023 10:08	Acc. Remarks	: Normal	Ref Id2	: O23247822

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Thyroid Function Test				
Triiodothyronine (T3)	94.48	ng/dL	70 - 204	
Thyroxine (T4)	8.70	ng/dL	4.87 - 11.72	
TSH	1.52	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipient hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a suppressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone. Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy

First trimester
Second trimester
Third trimester

Reference range (microIU/ml)

0.24 - 2.00
0.43-2.2
0.8-2.5

Note: (L-Very Low, I-Low, H-High, HH-Very High, A-Abnormal)

Dr. Shreya Shah

MD, MBBS (General)

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LABORATORY REPORT



Name	HEMLATABEN	Sex/Age	Female/ 39 Years	Case ID	: 31102200531
Ref By	HOSPITAL	Dis. At	:	Pt. ID	: 3150503
Ref Lab	Aashka hospital			Pt. Loc	:
Reg. Date and Time	: 25-Nov-2023 09:03	Sample Type	: Serum	Mobile No	:
Sample Date and Time	: 25-Nov-2023 09:03	Sample Coll. By	:	Ref Id1	: OSP32391
Report Date and Time	: 25-Nov-2023 10:08	Acc. Remarks	: Normal	Ref Id2	: O23247822

Interpretive Note:

s-TSH is thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH is the primary 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 screening test for 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 T4 concentrations.

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

TSH Reference in Pregnancy	Reference range (microIU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43 - 2.7
Third trimester	0.8 - 2.5

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

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

* If 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: L=Low H=High LL=VeryLow HH=VeryHigh A=Abnormal

Dr. Shreya Shah
MD (Pathologist)

Printed On : 25-Nov-2023 13:24



At: 25/11/2023



Name: Hemlataben faneja . Age: 39 yrs .

Complaints:
clo Nil.

No of deliveries: ~~2~~ 1 FTND. twins. | 20 | 10 yrs each

Last Delivery: 10 yrs back

History of abortion:

H/O medical conditions associated:

Last abortions:

DM	<input checked="" type="checkbox"/>
HTN	<input checked="" type="checkbox"/>
Thyroid	<input checked="" type="checkbox"/>

MH: Regular Reg:

LMP: P/A:

P/S: Cx NAD. 1 pap taken.

P/V: WTAU @ size BILfx clear

Sample:-
Vagina
Cervix

Doctors Sign:- DR. HEETA MEHTA

PATIENT NAME:HEMLATABEN

GENDER/AGE:Female / 39 Years

DATE:25/11/23

DOCTOR:

OPDNO:OSP32391

X-RAY CHEST PA

Both lung fields appear clear

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.

Impression: Normal Chest X-ray examination.



RADIOLOGIST

DR.MEHUL PATELIYA

REPORT REPORT REPORT REPORT REPORT

PATIENT NAME:HEMLATABEN

GENDER/AGE:Female / 39 Years

DATE:25/11/23

DOCTOR:

OPDNO:OSP32391

SONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: Liver appears normal in size and normal parenchymal echoes. No evidence of focal 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, renal hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 10.4 x 4.1 cms in size.

Left kidney measures about 10.2 x 4.0 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 normal wall thickening. No evidence of bladder calculus, diverticulum or mass lesion is seen.

UTERUS: Uterus is anteverted and appears normal in size, shape and position. Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 8 mm. No evidence of uterine mass lesion is seen.

OVARIES: Both ovaries appear normal in size and shape. No e/o any adnexal mass seen. No e/o free fluid seen in cul-de-sac.

COMMENT: Normal sonographic appearance of liver, GB, pancreas, spleen, kidneys, para aortic region, bladder, uterus



RADIOLOGIST

DR.MEHUL PATELIYA

REPORT

ADDRESSOGRAPH

COLOUR DOPPLER ECHOCARDIOGRAPH REPORT

Patient's Name: Hemlata Bee Age: _____ Sex: _____
 Ref. by Doctor: _____ IP/OP No.: OSP32291 Date: 25/11/23

COLOUR DOPPLER ECHOCARDIOGRAPH REPORT

MITRAL VALVE : Mild MVP
 AORTIC VALVE :
 TRICUSPID VALVE : (h)
 PULMONARY VALVE :
 AORTA : 30
 LEFT ATRIUM : 32
 LV Dd/ Ds : 39/26 . EF 60%
 IVS / LVPW / D : 10/9
 IVS : Intact
 IAS : Floppy
 RA :
 RV : (h) no RVOT
 PA :
 PERICARDIUM : h

VEL	:	PEAK	MEAN
M/S	:	Gradient mm Hg	Gradient mm Hg

MITRAL : 0.9/0.6
 AORTIC : 1.2
 PULMONARY : 1.3
 COLOUR DOPPLER : Trivial MR / mild TR
 RSVP : (h) Intact
 CONCLUSION : Mild MVP / Trivial MR
 Mild TR / PAH Ad. Suggest TEE for R/O ASD
 (h) LV f

25.1.2023 10:48:09 AM
AASHVA HOSPITAL LTD.
SANGHAN
GANDHINAGAR

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

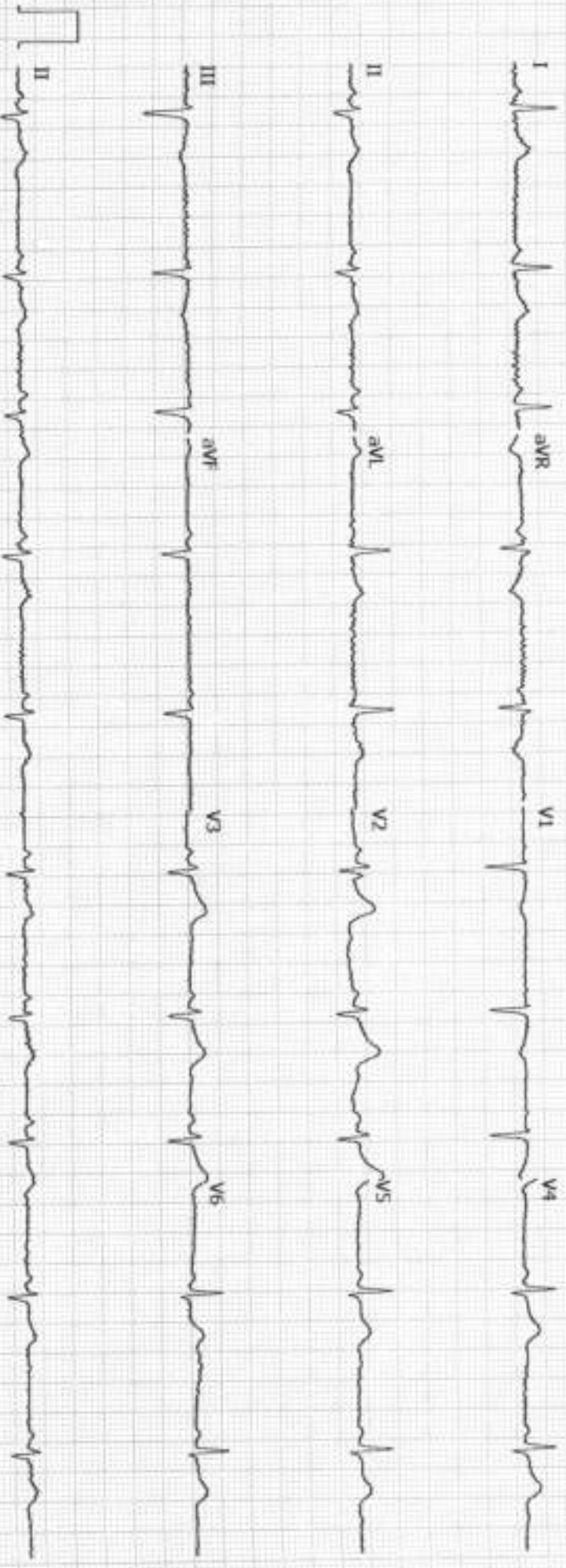
Room: 0459 107 B H42 #

60 bpm
-- / -- mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 74 ms
QT / QTcBaz : 410 / 410 ms
PR : 122 ms
P : 86 ms
RR / PP : 998 / 1000 ms
P / QRS / T : 20 / -25 / 1 degrees

Normal sinus rhythm with sinus arrhythmia
Normal ECG





DR. SEJAL J AMIN
B.D.S , M.D.S (PERIODONTIST)
IMPLANTOLOGIST
REG NO: A-12942

UHID: QSP32391	Date: 25/11/23	Time:
Patient Name: Hema Laxee ben	Age /Sex: 38 / F	Height:
	Weight:	
Chief Complain:	Routine dental check up.	
History:		
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination:		
Extra oral :		
Intra oral – Teeth Present :	Stain + Caries +	
Teeth Absent :		
Diagnosis:		

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Other Advice:

① Sensing

Follow-up:

Consultant's Sign:

[Signature]



DR. HEETA MEHTA
 M.S, OBST- GYNEC
 CONSULTANT OBSTETRICIAN
 AND GYNECOLOGIST
 Regi. No G-29736

UHID: <u>OSP 3239</u>	Date: <u>25/11/22</u>	Time: <u>3:30 pm</u>
Patient Name: <u>Hemlataben faneja</u>	Age: <u>39 yrs</u>	Mobile No:
Complaint and duration: <u>do. vulvar itching</u>		
History: Menstrual history: Cycles <u>regular</u> Flow <u>moderate</u> Duration of Bleeding <u>8 days</u> Presence of pain <u>(-)</u> LMP: <u>18/11/2023</u> till <u>21/11/2023</u> . H/O Associated illnesses: HTN: Thyroid disorder: <u>NAD</u> DM: Others: <u>(+)</u> Family History:		
Medication history:		
Obstetric History: <u>ATND < 03 01 10 yrs (Twins)</u> No of deliveries: <u>1</u> Last child:		
Allergy History:		
Nutritional Screening: <u>Well-Nourished</u> / Malnourished / Obese		
General Examination: CVS <u>clear</u> BP: <u>110/70 mmHg</u> Oedema of ft RS Wt: <u>61kg</u> Tongue <u>(+)</u> Breast examination: <u>BL Breasts</u> <u>(+)</u>		

P/ *soft*

A

L/E *← Cx NAAD pap smear taken.*

P/S- cervix

P/V *← UTAW, (n) size, BIL fx clear.*

Provisional Diagnosis: *⊖*

Investigation: *① pap smear*
② mammography / USG Breast if mammography is not available.

Plan of care:

Rx						
No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration
<i>1)</i>	<i>P.O.</i>	<i>T. FAR-3 kit</i>	<i>⊖</i>		<i>⊖</i>	
<i>2)</i>	<i>P.O</i>	<i>T. Conf @ C-Dib-1</i>	<i>1-0-1</i>	<i>x</i>	<i>⑩ tablets</i>	

Follow-up: *c pap report*

Consultant's Sign: *(Signature)*

DR. PRERAK TRIVEDI
 M.D., IDCCM
 CRITICAL CARE MEDICINE
 REG.NO.G-59493


UHID: <u>OSP32391</u>		Date: <u>28/11/23</u>	Time: <u>4:25pm</u>
Patient Name: <u>Hemal Kaben</u>		Height:	Weight:
Age/Sex: <u>28y/F</u> LMP:			
History:		History:	
C/C/O: <u>NAD</u>		<u>ADD</u> <u>Plulo Diabetes - 6 months</u> <u>By tablet for 1 month</u>	
Allergy History: <u>—</u>		Addiction: <u>—</u>	
Nutritional Screening: <u>Well-Nourished / Malnourished / Obese</u>			
Vitals & Examination: Temperature: <u>Normal</u> Pulse: <u>62/min</u> BP: <u>102/70 mmHg</u> SPO2: <u>98% on RA</u>			
Provisional Diagnosis:			

Advice:

57

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Insulin Scale	RBS-	hourly	Diet Advice:	
< 150 -	300-350 -		Follow-up:	
150-200 -	350-400 -		Sign:	
200-250 -	400-450 -			
250-300 -	> 450 -			

DR. TAPAS RAVAL
MBBS . D.O
(FELLOW IN PHACO & MEDICAL
RATINA)
REG.NO.G-21350

UHID: 05832391	Date: 25/11/23	Time: 11:20
Patient Name: Hemantaben	Age/Sex: 38/F	Height: 152cm
	Weight: 61.7 kg	
History: Compl. Headache about.		
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination: Vn - 6/6 6/6 N/6 Color of vision - Normal		
Diagnosis:		