

Mukesh K. Dave
Age - 60

BP - 150/90

P - 90 b/m

H - 258

wt - 61



EXAMINATION OF EYES :- (BY OPHTHALMOLOGIST)

Patient Name Mr. Mulesh

Date 4/11/23

Sex/Age 50/M

MR No

Employee Id

EXTERNAL EXAMINATION

SQUINT - NO

NYSTAGMUS - NO

COLOUR VISION - normal

FUNDUS:(RE):- well (LE):- well

INDIVIDUAL COLOUR IDENTIFICATION

DISTANT VISION:(RE):- 6/6 (LE):- 6/6

NEAR VISION:(RE):- EPG N/6 (LE):- EPG N/6

NIGHT BLINDNESS

	SPH	CYL	AXIS	ADD
RIGHT	—	—	—	+2.50 DS
LEFT	—	—	—	+2.50 DS

REMARKS :-

vn < 6/6
6/6
new EPG < N/6
N/6

Dr. Vinita Mishra
MBBS, MS (Ophthalmologist)
Reg. No. 021/2006



Dr. Sweety Lath

BDS (Cosmetic Dental Surgeon)



Dr. Vivek Lath

Chief Dental Consultant
BDS, MDS, Diplomate (WCOI, Japan)
Professor, MCDRC - Durg
Reg. No. CGDC/14/PG/45

- Consult for : Digital Dentistry • Fixed Teeth • RCT • Dental Implants • Gums Diseases • Dentures • Cosmetic Filling • Tooth Jewellery
- Digital OPG • Braces Treatment • Tooth Removal • Kids Dental Treatment • All Kind of Dental Surgeries

Mr. Mukesh Dave
60/M

4/11/23

Pt has come for routine dental checkup

O/E → Stains +++

Mobility ± 17

Missing ± 6/6

Generalised Attention.

Adv → Oral Prophylaxis

1
yeche



Apollo Clinic

LICENSEE : SAMRIDHI AROGYAM PVT. LTD

Apollo Clinic @ Tiara Complex A.T. Classic Near Ashoka Ratan, VIP Estate, Raipur (C.G.)

Email : raipur1@apolloclinic.com

Online appointments: www.askapollo.com | Online reports: https://phr.apolloclinic.com



www.apolloclinic.com

Patient Name : MR MUKESH KUMAR DAVE
UHID/ MR No : 7491
Visit Date : 04/11/2023
Sample Collected On : 04/11/2023 04:12PM
Ref. Doctor : SELF
Sponsor Name :

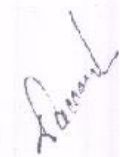
Age/Gender : 60 Y Male
OP Visit No : OPD-UNIT-II-2
Reported On : 05/11/2023 01:35PM

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
CBC - COMPLETE BLOOD COUNT			
Haemoglobin(HB) Method: CELL COUNTER	15.6	gm/dl	12 - 17
Erythrocyte (RBC) Count Method: CELL COUNTER	4.40	mill/cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	46.80	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	106.4	fL	76.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	35.5	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	13.2	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	9.76	cells/cumm	3.50 - 10.00
Neutrophils Method: CELL COUNTER	53	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	36	%	15.0 - 45.0
Monocytes	06	%	4.0 - 12.0
Eosinophils Method: CELL COUNTER	05	%	1-6%
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report
Results are to be correlated clinically

Lab Technician / Technologist
 path



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HAEMATOLOGY


Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count	238	lacs/cu.mm	150-400
Method: CELL COUNTER			

1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.
2. Test conducted on EDTA whole blood.

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DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

Patient Name : MR MUKESH KUMAR DAVE
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HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	10	mm /HR	0 - 10

1. It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
2. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
3. Also increased in pregnancy, multiple myeloma, menstruation & hypothyroidism


Blood Group (ABO Typing)

Blood Group (ABO Typing) O
RhD factor (Rh Typing) POSITIVE

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Sample Collected On : 04/11/2023 04:12PM
Ref. Doctor : SELF
Sponsor Name :

Age/Gender : 60 Y. Male
OP Visit No : OPD-UNIT-II-7
Reported On : 05/11/2023 01:35PM


BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
GLUCOSE - (POST PRANDIAL)			
Glucose -Post prandial Method: REAGENT GRADE WATER	113.0	mg/dl	70-140
GLUCOSE (FASTING)			
Glucose- Fasting SUGAR REAGENT GRADE WATER	79.0	mg/dl	70 - 120
KFT - RENAL PROFILE - SERUM			
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	10	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	0.92	mg/dl	0.6-1.4
Uric Acid Method: Spectrophotometric	3.6	mg/dL	2.6 - 7.2

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Ref. Doctor : SELF
Sponsor Name :

Age/Gender : 60 Y. Male
OP Visit No : OPD-UNIT-II-2
Reported On : 05/11/2023 01:35PM

BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
HbA1c (Glycosalated Haemoglobin)	5.6	%	Non-diabetic: ≤5.6, Pre-Diabetic 5.7-6.4, Diabetic: ≥6.5

- HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
 - HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
 - Trends in HbA1c are a better indicator of diabetic control than a solitary test.
 - Low glyated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflam
- HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
 - HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
 - Trends in HbA1c are a better indicator of diabetic control than a solitary test.
 - Low glyated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
 - To estimate the eAG from the HbA1C value, the following equation is used: $eAG(mg/dl) = 28.7 * A1c - 46.7$
 - Interference of Haemoglobinopathies in HbA1c estimation.
 - For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
 - Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
 - Heterozygous state dete

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	156.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	132.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotometric			
HDL Cholesterol	45.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotometric			
LDL Cholesterol	84.60	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=190
Method: Spectrophotometric			
VLDL Cholesterol	26.40	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	3.47		3.5-5
Method: Spectrophotometric			

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	0.8	mg/dl	0.1- 1.2
Bilirubin - Direct Method: Spectrophotometric	0.2	mg/dl	0.05-0.3
Bilirubin (Indirect) Method: Calculated	0.60	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	22	U/L	0 - 40
SGPT (ALT) Method: Spectrophotometric	28	U/L	0 - 41
ALKALINE PHOSPHATASE	78	U/L	
Total Proteins Method: Spectrophotometric	6.6	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.2	mg/dl	3.4 - 5.0
Globulin Method: Calculated	2.4	g/dl	1.8 - 3.6
A/G Ratio Method: Calculated	1.75	%	1.1 - 2.2

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CLINICAL PATHOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
URINE ROUTINE EXAMINATION			
Physical Examination			
Volum of urine	30ML		
Appearance	Clear		Clear
Colour	Pale Yellow		Colourless
Specific Gravity	1.020		1.001 - 1.030
Reaction (pH)	6.0		
Chemical Examination			
Protein(Albumin) Urine	Absent		Absent
Glucose(Sugar) Urine	Absent		Absent
Blood	Absent		Absent
Leukocytes	Absent		Absent
Ketone Urine	Absent		Absent
Bilirubin Urine	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite (Urine)	Absent		Absent
Microscopic Examination			
RBC (Urine)	NIL	/hpf	0 - 2
Pus cells	2-4	/hpf	0 - 5
Epithelial Cell	Occasional	/hpf	0 - 5
Crystals	Not Seen	/hpf	Not Seen
Bacteria	Not Seen	/hpf	Not Seen
Budding yeast	Not Seen	/hpf	

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DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

Patient Name : Mr.MUKESH KUMAR DAVE	Collected : 05/Nov/2023 11:59AM
Age/Gender : 60 Y 0 M 0 D /M	Received : 05/Nov/2023 12:14PM
UHID/MR No : DSUS.00C0005457	Reported : 05/Nov/2023 02:25PM
Visit ID : DSUSOPV6299	Status : Final Report
Ref Doctor : APOLLO CLINIC	Client Name : PLP APOLLO CLINIC SAMRIDDHI AR
IP/OP NO :	Patient location : Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
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THYROID PROFILE TOTAL (T3, T4, TSH) , SERUM

TRI-iodothyronine (T3, TOTAL)	1.59	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	14.10	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	2.850	µIU/mL	0.35-5.5	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 - 3.0
Third trimester	0.3 - 3.0

- TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
- TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
- Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
- Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

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Visit ID : DSUSOPV6299	Status : Final Report
Ref Doctor : APOLLO CLINIC	Client Name : PUP APOLLO CLINIC SAMRIDDI AR
IP/OP NO :	Patient location : Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
TOTAL PROSTATIC SPECIFIC ANTIGEN (tPSA) , SERUM	0.930	ng/mL	0-4	CLIA

*** End Of Report ***

Sandhya Verma
Dr. SANDHYA VERMA
MBBS, MD,(Fathology)
Consultant Pathologist

