

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

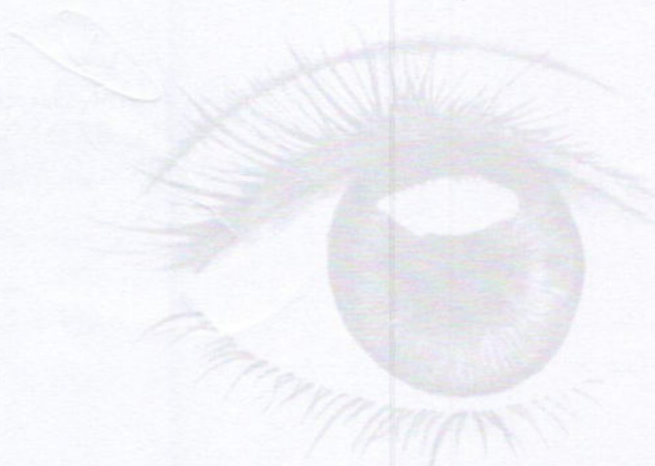
Venu Eye Institute & Research Centre, New Delhi

Name Deepmala Singh Age/Sex 32 / F C/o ..... Date 10/sep/22

Go. Regular eye check up



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](http://www.prakasheyehospital.in)  
Facebook: <http://www.prakasheyehospital.in>

Counsellor 9837066186  
7535832832  
Manager 7895517715  
OT 730222373  
TPA 9837897788

Timings Morning : 10:00 am to 2:00 pm.  
Evening : 5:00 pm to 8:00 pm.  
Sunday : 10:00 am to 2:00 pm.  
Near Nai Sarak, Garh Road, Meerut  
E-mail : [prakasheyehosp@gmail.com](mailto:prakasheyehosp@gmail.com)





भारत सरकार  
Government of India



श्रीमती डीप माला सिंघ  
Deep Mala Singh

आधार आईडी : 4840 1009 1766  
लिंग : Female



4840 1009 1766

आधार - आम आदमी का अधिकार

*Dr. MONIKA GARG*  
*M.B.B.S. M.D. (Path.)*  
*GARG PATHOLOGY*



भारतीय डिजिटल पहचान प्राधिकरण

Unique Identification Authority of India

एन सी आई नंबर: 4840 1009 1766  
आधार आईडी: 4840 1009 1766  
पिन कोड: 250004

Address: D/O Babu Ram  
489/7/3 mangai pandey  
nagar meerut, Meerut, U.P.  
R M Med college, Uttar  
Pradesh 250004

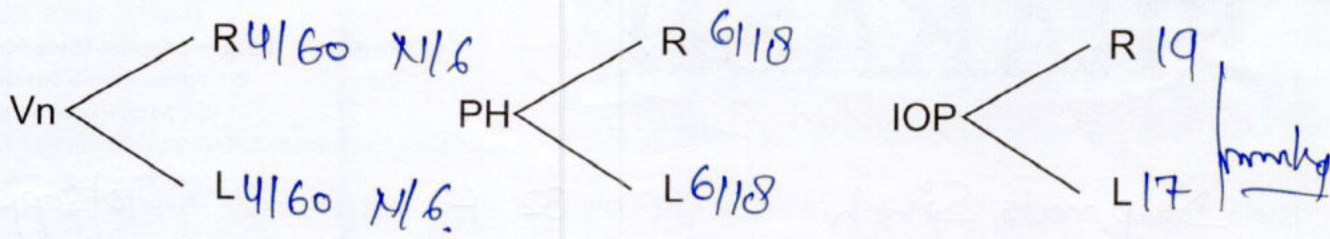
4840 1009 1766

1947  
1800 300 1947

help@uidai.gov.in

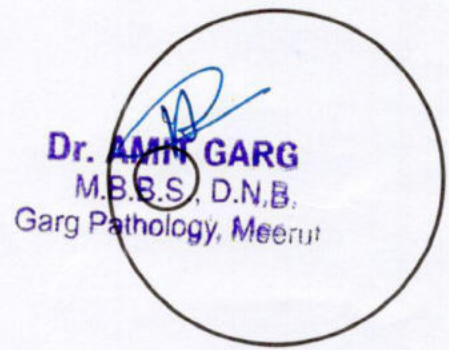
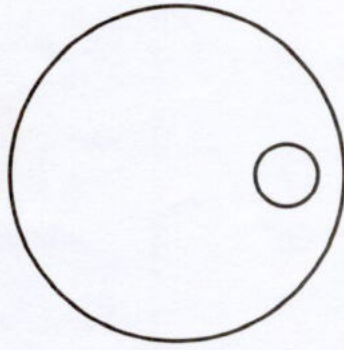
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*Deepmala Singh*  
*Deepmala Singh*



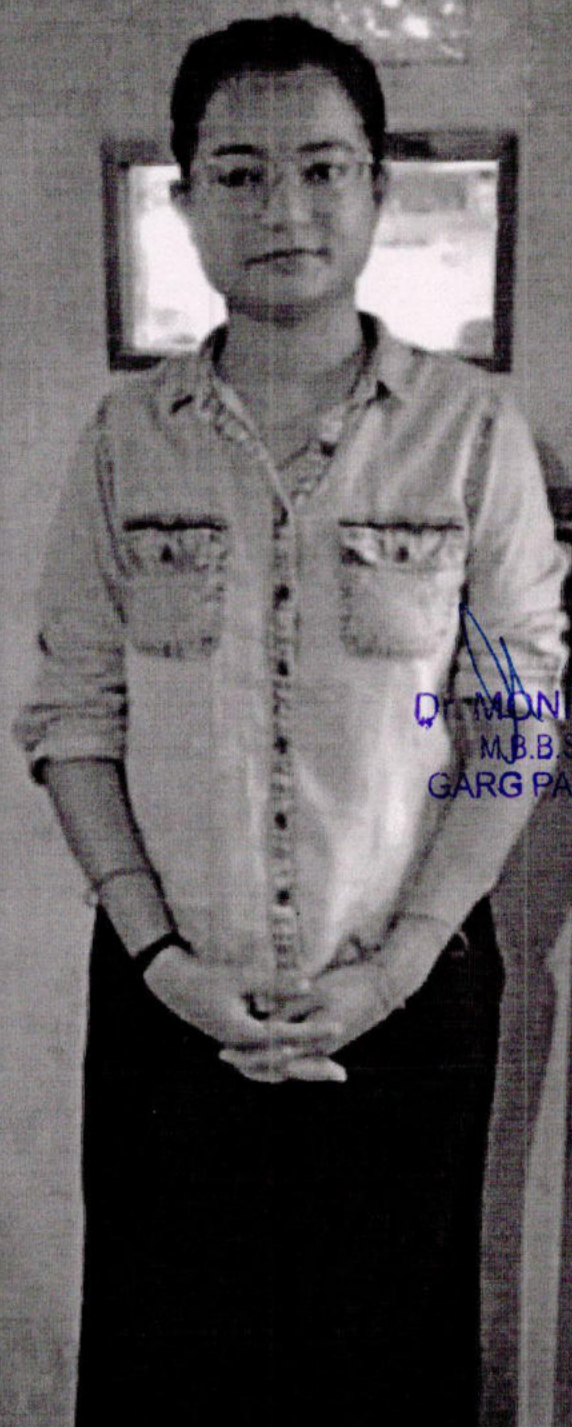
BE colour vision  $\left\{ \begin{array}{l} \text{NORMAL} \\ \text{NORMAL} \end{array} \right.$

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance	-4.25	-0.75	10°	6/6	-4.50	-0.75	140°	6/6
Near	—————			N/6	—————			N/6

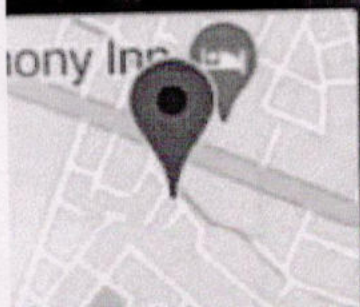




PATHOLOGY  
LAB



Dr. MONIKA GARG  
M.B.B.S. & M.D. (Path.)  
GARG PATHOLOGY



**Meerut, Uttar Pradesh, India**

XP8J+P97, Sector 3, Tejgarhi, Meerut, Uttar Pradesh 250004,  
India

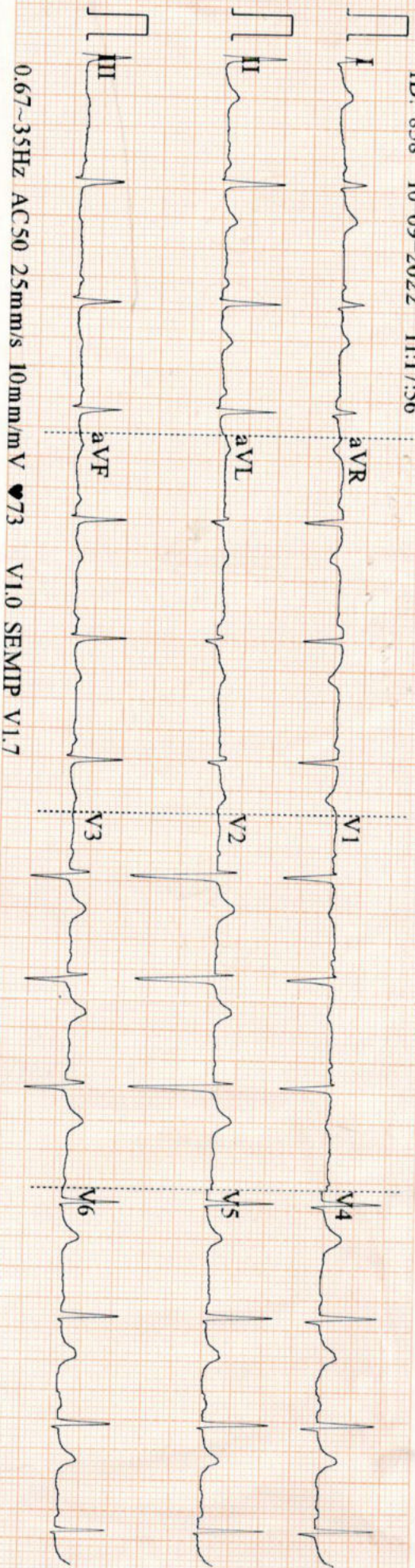
Lat 28.966207°

Long 77.731458°





ID: 858 10-09-2022 11:17:56



0.67~35Hz AC50 25mm/s 10mm/mV 73 V1.0 SEMIP V1.7

ID: 858

Female  
32 Years  
cm

kg

kPa

Diagnosis Information:  
Sinus Rhythm  
\*\*\*Normal ECG\*\*\*

HR	:	80	bpm
P	:	93	ms
PR	:	139	ms
QRS	:	76	ms
QT/QTc	:	361/417	ms
P/QRS/T	:	54/69/33	°
RV5/SV1	:	1.087/0.826	mV

Report Confirmed by:

*Dejwella*

**DR MONIKA GARG**  
M.B.B.S. M.D. (Path.)  
GARG PATHOLOGY



## DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE : 10.09.2022 REFERENCE NO. : -----  
 PATIENT NAME : DEEPMALA SINGH AGE/SEX : 32YRS/F  
 REFERRED BY : DR. MONIKA GARG ECHOGENECITY : NORMAL  
 REFERRING DIAGNOSIS : To rule out structural heart disease.

### **ECHOCARDIOGRAPHY REPORT**

DIMENSIONS	NORMAL	NORMAL
AO (ed) 2.0 cm	(2.1 - 3.7 cm)	IVS (ed) 1.0 cm (0.6 - 1.2 cm)
LA (es) 2.4 cm	(2.1 - 3.7 cm)	LVPW (ed) 0.9 cm (0.6 - 1.2 cm)
RVID (ed) 1.3 cm	(1.1 - 2.5 cm)	EF 60% (62% - 85%)
LVID (ed) 3.8 cm	(3.6 - 5.2 cm)	FS 30% (28% - 42%)
LVID (es) 2.7 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 :**

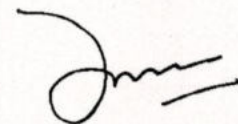
LV normal in size with normal contractions. No LV regional wall motion abnormality seen. RV normal in size with adequate contractions. LA and RA normal. All cardiac valves are structurally normal. No chamber hypertrophy/intracardiac mass. Estimated LV ejection fraction is 60%.

## **DOPPLER STUDIES :**

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	No	0.93	3.3
Tricuspid Valve	No	0.74	2.3
Pulmonary Valve	No	0.82	2.2
Aortic Valve	No	0.69	2.1

## **IMPRESSION :**

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



**DR. HARIOM TYAGI**  
MD, DM (CARDIOLOGY)  
(Interventional Cardiologist)  
for 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



DATE	10.09.2022	REF. NO.	8840		
PATIENT NAME	DEEPMALA SINGH	AGE	32 YRS	SEX	F
INVESTIGATION	X-RAY CHEST PA VIEW	REF. BY	GARG (PATHOLOGY)		

### REPORT

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

### IMPRESSION

*Both lung show mildly prominent broncho vascular marking.*

**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.



DATE	10.09.2022	REF. NO.	2175		
PATIENT NAME	DEEPMALA SINGH	AGE	32YRS	SEX:	F
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG (PATHOLOGY)		

### 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. No calculus / hydronephrosis is noted.

**Left Kidney** – Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

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

**Uterus** - Normal in size shape & normal in echotexture. Endometrium appears normal.  
Myometrium appears normal.

Ovaries and adnexa are unremarkable.

### IMPRESSION

*Essentially normal study*

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Consultant Radiologist and Head

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# 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

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

**PUID** : 220910/607 **C. NO:** 607 **Collection Time** : 10-Sep-2022 11:02AM  
**Patient Name** : Mrs. DEEPMALA SINGH 31Y / Female **Receiving Time** : 10-Sep-2022 11:10AM  
**Referred By** : Dr. BANK OF BARODA **Reporting Time** : 10-Sep-2022 5:03PM  
**Sample By** : **Centre Name** : Garg Pathology Lab - TPA  
**Organization** :



Investigation	Results	Units	Biological Ref-Interval
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## HAEMATOLOGY (EDTA WHOLE BLOOD)

### COMPLETE BLOOD COUNT

<b>HAEMOGLOBIN</b> (Colorimetry)	12.9	gm/dl	12.0-15.0
<b>TOTAL LEUCOCYTE COUNT</b> (Electric Impedence)	7440	*10 <sup>6</sup> /L	4000 - 11000
<b>DIFFERENTIAL LEUCOCYTE COUNT</b> (Microscopy)			
<b>Neutrophils</b>	70	%.	40-80
<b>Lymphocytes</b>	27	%.	20-40
<b>Eosinophils</b>	02	%.	1-6
<b>Monocytes</b>	<b>01</b>	%.	2-10
<b>Absolute neutrophil count</b>	5.21	x 10 <sup>9</sup> /L	2.0-7.0(40-80%)
<b>Absolute lymphocyte count</b>	2.01	x 10 <sup>9</sup> /L	1.0-3.0(20-40%)
<b>Absolute eosinophil count</b>	0.15	x 10 <sup>9</sup> /L	0.02-0.5(1-6%)

Method:-((EDTA Whole blood,Automa

### RBC Indices

<b>TOTAL R.B.C. COUNT</b> (Electric Impedence)	4.79	Million/Cumm	4.5 - 6.5
<b>Haematocrit Value (P.C.V.)</b>	41.4	%	26-50
<b>MCV</b> (Calculated)	86.4	fL	80-94
<b>MCH</b> (Calculated)	<b>26.9</b>	pg	27-32
<b>MCHC</b> (Calculated)	31.2	g/dl	30-35
<b>RDW-SD</b> (Calculated)	48.1	fL	37-54



\*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

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

२१ सँदे सुविधा उपलब्ध है।







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<b>RDW-CV</b> (Calculated)	13.6	%	11.5 - 14.5
<b>Platelet Count</b> (Electric Impedence)	1.92	/Cumm	1.50-4.50
<b>MPV</b> (Calculated)	<b>11.7</b>	%	7.5-11.5

## GENERAL BLOOD PICTURE

<b>NLR</b> 6-9 Mild stres 7-9 Pathological cause	2.59		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.

<b>Erythrocyte Sedimentation Rate end o</b>	15	mm	0-15
<b>BLOOD GROUP *</b>	"B" POSITIVE	\$	\$



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<b>GLYCATED HAEMOGLOBIN (HbA1c)*</b>	4.7	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	88.2	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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Page 3 of 13

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Investigation	Results	Units	Biological Ref-Interval
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### BIOCHEMISTRY (FLORIDE)

<b>PLASMA SUGAR FASTING</b> (GOD/POD method)	75.0	mg/dl	70 - 110
<b>PLASMASUGAR P.P.</b> (GOD/POD method)	106.0	mg/dl	80-140



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<b>Organization</b> :		

Investigation	Results	Units	Biological Ref-Interval
---------------	---------	-------	-------------------------

### BIOCHEMISTRY (SERUM)

<b>URIC ACID</b>	3.6	mg/dL.	2.5-6.8
<b>BLOOD UREA NITROGEN</b>	18.20	mg/dL.	8-23



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## LIVER FUNCTION TEST

### SERUM BILIRUBIN

**TOTAL** 0.6 mg/dl 0.1-1.2  
(Diazo)

**DIRECT** 0.3 mg/dl <0.3  
(Diazo)

**INDIRECT** 0.3 mg/dl 0.1-1.0  
(Calculated)

**S.G.P.T.** 28.0 U/L 8-40  
(IFCC method)

**S.G.O.T.** 35.0 U/L 6-37  
(IFCC method)

**SERUM ALKALINE PHOSPHATASE** 85.1 IU/L 37-103  
(IFCC KINETIC)

### SERUM PROTEINS

**TOTAL PROTEINS** 6.8 Gm/dL 6-8  
(Biuret)

**ALBUMIN** 3.5 Gm/dL 3.5-5.0  
(Bromocresol green Dye)

**GLOBULIN** 3.3 Gm/dL 2.5-3.5  
(Calculated)

**A : G RATIO** 1.1 1.5-2.5  
(Calculated)



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**Organization** : 

Investigation	Results	Units	Biological Ref-Interval
<b>KIDNEY FUNCTION TEST</b>			
UREA (Urease-GLDH)	39.0	mg / dl	10 - 50
CREATININE (Enzymatic)	0.9	mg/dl	0.6 - 1.4
S.CALCIUM Method:-Arsenazo	<b>8.5</b>	mg/dl	9.2-11.0
SODIUM (NA)* (ISE)	138.0	m Eq/litre.	135 - 155
POTASSIUM (K)* (ISE)	4.0	m Eq/litre.	3.5 - 5.5



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**Patient Name** : Mrs. DEEPMALA SINGH 31Y / Female **Receiving Time** : 10-Sep-2022 11:10AM  
**Referred By** : Dr. BANK OF BARODA **Reporting Time** : 10-Sep-2022 5:09PM  
**Sample By** : **Centre Name** : Garg Pathology Lab - TPA  
**Organization** :



Investigation	Results	Units	Biological Ref-Interval
<b>LIPID PROFILE</b>			
<b>SERUM CHOLESTEROL</b> (CHOD - PAP)	161.2	mg/dl	150-250
<b>SERUM TRIGYCEIDE</b> (GPO-PAP)	100.0	mg/dl	70-150
<b>HDL CHOLESTEROL *</b> (PRECIPITATION METHOD)	42.6	mg/dl	30-60
<b>VLDL CHOLESTEROL *</b> (Calculated)	20.0	mg/dl	10-30
<b>LDL CHOLESTEROL *</b> (Calculated)	98.6	mg/dL.	0-100
<b>LDL/HDL RATIO *</b> (Calculated)	02.3	ratio	<3.55
<b>CHOL/HDL CHOLESTROL RATIO*</b> (Calculated)	<b>3.8</b>	ratio	3.8-5.9

Interpretation :

\*Patient 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.



\*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

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

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# 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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### THYRIOD PROFILE\*

**Triiodothyronine (T3) \*** 1.052 ng/dl 0.79-1.58  
(ECLIA)

**Thyroxine (T4) \*** 8.490 ug/dl 4.9-11.0  
(ECLIA)

**THYROID STIMULATING HORMONE (T)** 1.910 uIU/ml 0.38-5.30  
(ECLIA)

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 disorders 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 incresed 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 CALCIUM** 8.5 mg/dl 9.2-11.0  
(Arsenazo)



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## CYTOLOGY EXAMINATION

### SPECIMEN

Microscopic:

665/22

SITE OF SMEAR: ECTOCERVIX AND POSTERIOR FORNIX OF VAGINA

METHOD OF EVALUATION: BETHSEDA SYSTEM

EVALUATION OF SMEAR : SATISFACTORY

REPORT: CELLULAR SPREAD SHOWS DESQUAMATED EPITHELIAL CELLS PREDOMINANTLY SUPERFICIAL AND INTERMEDIATE CELLS. FEW ENDOCERVICAL CELLS SEEN IN CLUSTERS. BACKGROUND SHOWS MILD INFLAMMATORY REACTION. LACTOBACILLI ARE SEEN.

ANY DYSKARYOTIC CELL IS NOT SEEN.

ANY BUDDING SPORES OR TROPHOZOITE IS NOT SEEN.

INFERENCE: NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

NOTE: This test has its own limitations. Please interpret the findings in light of clinical picture. not for medicolegal use



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Page 10 of 13

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**EEG**

**ECHO**

OK



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### X-RAY

**X-RAY CHEST P.A (VIEW)**

OK



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## ULTRA SOUND

### USG LOWER ABDOMEN [F]

OK

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



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