

NABH ACCREDITED

PRAKASH

EYE HOSPITAL & LASER CENTRE

Dr. AMIT GARG

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

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

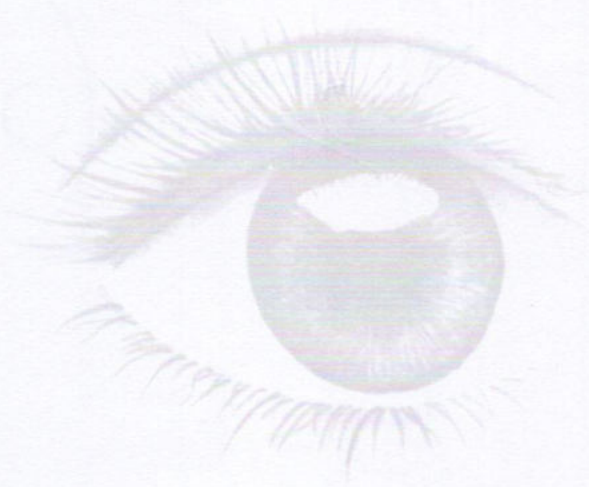
Ex. Micro Phaco Surgeon

Venu Eye Institute & Research Centre, New Delhi

Name Mr. Puncet Ku. Jain Age/Sex 36 / m C/o Date 25/may/23

Routine eye checkup

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



Accredited Eye Hospital Western U.P.

First NABH ECO

प्रकाश आँखों का अस्पताल एवं लेजर सेंटर



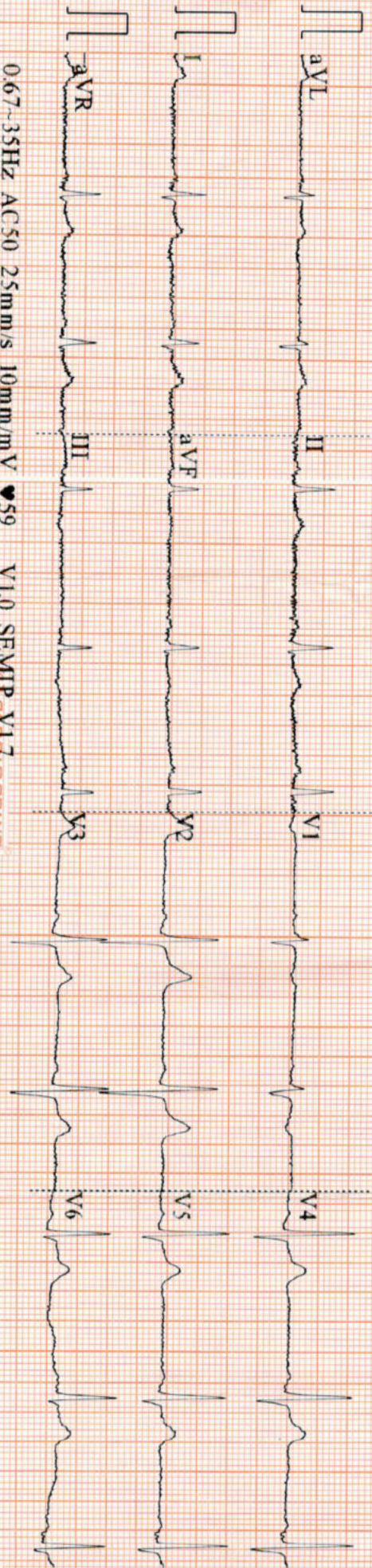
Website: www.prakasheyehospital.in
Facebook: <http://www.prakasheyehospital.in>

Counsellor 9837066186
7535832832
Manager 7895517715
OT 730222373
TPA 9837897788

Timings Morning : 9:30 am to 1:30 pm.
Evening : 5:00 pm to 7:00 pm.
Sunday : 9:30 am to 1:30 pm.
Near Nai Sarak, Garh Road, Meerut
E-mail : prakasheyehosp@gmail.com

ID: 501 25-03-2023 09:46:26

0.67-35Hz AC50 25mm/s 10mm/mV ♣59 V1.0 SEMIP cX1.7 DIOPRINT



ID: 501

Male
36 Years

cm

kg

kPa

Diagnosis Information:

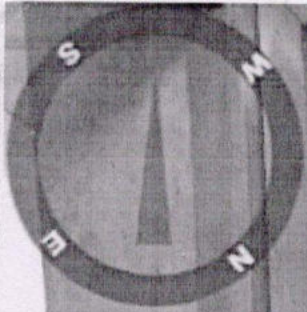
Sinus Rhythm

Normal ECG

HR	:	60	bpm
P	:	116	ms
PR	:	153	ms
QRS	:	86	ms
QT/QTc	:	376/377	ms
P/ORS/ST	:	38/65/24	ms
RV5/SV1	:	1.14/0.375	mV

Report Confirmed by:

Dr. MONIKA GARG
M.D. (Path)
GARG PATHOLOGY



PATHOLOGY



GARG PATHOLOGY
MEDICAL & DIAGNOSTIC SERVICES
GEN. PHYSICIAN - PEDIATRIAN - GYN
LABORATORY





D. MONIKA GARG
M.B.B.S., M.D. (Path.)
GARG PATHOLOGY



Mar 25, 2023 9:00:55 AM
221° SW

Tejgarhi
Meerut Division
Uttar Pradesh
Altitude: 192.2m
Index number: 547

 ಭಾರತ ಸರ್ಕಾರ
Government of India
ಪುನೀತ್ ಕುಮಾರ್ ಜೈನ್
Puneet Kumar Jain
ಜನ್ಮ ದಿನಾಂಕ / DOB : 13/07/1986
ಪುರುಷ / Male




5643 7085 3970

ಆಧಾರ್ - ಶ್ರೀಸಾಮಾನ್ಯನ ಅಧಿಕಾರ

Puneet

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

 ಆಧಾರ್
ಭಾರತೀಯ ವಿಶಿಷ್ಟ ಗುರುತು ಪ್ರಾಧಿಕಾರ
Unique Identification Authority of India

ವಿಳಾಸ:
S/O: ಧರಂಪಾಲ್ ಜೈನ್, #290, ಕೆ ಕೆ
ಪಬ್ಲಿಕ್ ಶಾಲೆಯ ಹತ್ತಿರ, ಜೈನ್ ನಗರ
ಖತೌಲಿ, ಮುಜಫರ್ನಗರ, ಉತ್ತರ
ಪ್ರದೇಶ, 251201

Address:
S/O: Dharampal Jain, #290, Near
K K Public School, Jain Nagar
Khatauli, Muzaffarnagar, Khatauli,
Uttar Pradesh, 251201

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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 : 230325/606 **C. NO:** 606 **Collection Time** : 25-Mar-2023 9:14AM
Patient Name : Mr. PUNEET KUMAR JAIN 36Y / Male **Receiving Time** : 25-Mar-2023 9:34AM
Referred By : Dr. BANK OF BARODA **Reporting Time** : 25-Mar-2023 12:01PM
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

HAEMOGLOBIN (Colorimetry)	13.2	gm/dl	13.0-17.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	5590	*10 ⁶ /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	60	%.	40-80
Lymphocytes	36	%.	20-40
Eosinophils	02	%.	1-6
Monocytes	02	%.	2-10
Basophils	00	%.	<1-2
Band cells	00	%	0-5
Absolute neutrophil count	3.35	x 10 ⁹ /L	2.0-7.0(40-80%)
Absolute lymphocyte count	2.01	x 10 ⁹ /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.11	x 10 ⁹ /L	0.02-0.5(1-6%)

Method:-((EDTA Whole blood,Automated /

RBC Indices

TOTAL R.B.C. COUNT (Electric Impedence)	4.51	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	40.3	%	26-50
MCV (Calculated)	89.4	fL	80-94
MCH (Calculated)	29.3	pg	27-32
MCHC (Calculated)	32.8	g/dl	30-35
RDW-SD	47.9	fL	37-54



*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

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MBBS, MD(Path)
(Consultant Pathologist)

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(Calculated)			
RDW-CV	13.0	%	11.5 - 14.5
(Calculated)			
Platelet Count	2.16	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	10.5	%	7.5-11.5
(Calculated)			
NLR	1.67		1-3
6-9 Mild stres			
7-9 Pathological cause			

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.
-NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
-NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).
-With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP * "B" POSITIVE \$ \$



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GLYCATED HAEMOGLOBIN (HbA1c)*	5.2	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	102.5	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 9

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Referred By : Dr. BANK OF BARODA		Reporting Time : 25-Mar-2023 10:59AM
Sample By :		Centre Name : Garg Pathology Lab - TPA
Organization :		

Investigation	Results	Units	Biological Ref-Interval
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BIOCHEMISTRY (FLORIDE)

PLASMA SUGAR FASTING (GOD/POD method)	105.0	mg/dl	70 - 110
PLASMASUGAR P.P. (GOD/POD method)	131.0	mg/dl	80-140



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BIOCHEMISTRY (SERUM)

SERUM CREATININE (Enzymatic)	0.8	mg/dl	0.6-1.4
URIC ACID	6.8	mg/dL.	3.6-7.7
BLOOD UREA NITROGEN	13.20	mg/dL.	8-23



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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL (Diazo)	1.5	mg/dl	0.1-1.2
DIRECT (Diazo)	0.8	mg/dl	<0.3
INDIRECT (Calculated)	0.7	mg/dl	0.1-1.0
S.G.P.T. (IFCC method)	31.0	U/L	8-40
S.G.O.T. (IFCC method)	33.9	U/L	6-37

SERUM PROTEINS

TOTAL PROTEINS (Biuret)	6.8	Gm/dL.	6-8
ALBUMIN (Bromocresol green Dye)	3.9	Gm/dL.	3.5-5.0
GLOBULIN (Calculated)	2.9	Gm/dL.	2.5-3.5
A : G RATIO (Calculated)	1.3		1.5-2.5

PSA* 0.565 ng/ml

ECLIA

NORMAL VALUE

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



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LIPID PROFILE

SERUM CHOLESTEROL (CHOD - PAP)	221.0	mg/dl	150-250
SERUM TRIGYCEIDE (GPO-PAP)	141.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	43.9	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	28.2	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	148.9	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	03.4	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	5.0	ratio	3.8-5.9

Interpretation :

Paitient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE :

Lipid Profile Ranges As PER NCEP-ATP III :

SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated :> 240 mg/dl
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased :< 40 mg/dl
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High :>500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

SERUM SODIUM (Na) * (ISE method) (ISE)	141.0	mEq/litre	135 - 155
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PUID : 230325/606 **C. NO:** 606 **Collection Time** : 25-Mar-2023 9:14AM
Patient Name : Mr. PUNEET KUMAR JAIN 36Y / Male **Receiving Time** : 25-Mar-2023 9:34AM
Referred By : Dr. BANK OF BARODA **Reporting Time** : 25-Mar-2023 10:59AM
Sample By : **Centre Name** : Garg Pathology Lab - TPA
Organization :



Investigation	Results	Units	Biological Ref-Interval
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THYRIOD PROFILE*

Triiodothyronine (T3) * (ECLIA)	1.471	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	8.965	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) (ECLIA)	1.409	uIU/ml	0.38-5.30
Normal Range:-			
1 TO 4 DAYS	2.7-26.5		
4 TO 30 DAYS	1.2-13.1		

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare 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 increased and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) * (ISE method)	4.8	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	10.2	mg/dl	9.2-11.0



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Referred By : Dr. BANK OF BARODA **Reporting Time** : 25-Mar-2023 1:54PM
Sample By : **Centre Name** : Garg Pathology Lab - TPA
Organization :



Investigation	Results	Units	Biological Ref-Interval
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URINE

PHYSICAL EXAMINATION

Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.020		1.000-1.030
PH (Reaction)	Acidic		

BIOCHEMICAL EXAMINATION

Protein	Nil		Nil
Sugar	Nil		Nil

MICROSCOPIC EXAMINATION

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

@ Special Examination

Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

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



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DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE : 25/03/2023 REFERENCE NO. : 10988
PATIENT NAME : PUNEET KUMAR JAIN AGE/SEX : 36YRS/M
REFERRED BY : DR. MONIKA GARG ECHOGENECITY : NORMAL
REFERRING DIAGNOSIS : To rule out structural heart disease.

ECHOCARDIOGRAPHY REPORT

DIMENSIONS	NORMAL	NORMAL
AO (ed) 2.4 cm	(2.1 - 3.7 cm)	IVS (ed) 0.8 cm (0.6 - 1.2 cm)
LA (es) 2.6 cm	(2.1 - 3.7 cm)	LVPW (ed) 0.8 cm (0.6 - 1.2 cm)
RVID (ed) 1.2 cm	(1.1 - 2.5 cm)	EF 55% (62% - 85%)
LVID (ed) 3.8 cm	(3.6 - 5.2 cm)	FS 27% (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 : Thickened 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. Aortic valve is thickened and rest other cardiac valves are structurally normal. No chamber hypertrophy/ intracardiac mass. Estimated LV ejection fraction is 55%.

DOPPLER STUDIES :

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	No	0.76	2.3
Tricuspid Valve	No	0.89	2.9
Pulmonary Valve	No	0.67	2.1
Aortic Valve	No	1.0	4.5

IMPRESSION :

- No RWMA.
- Normal LV Systolic Function (LVEF = 55%).

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

DR. HARIOM TYAGI
MD, DM (Cardiology)
(Interventional Cardiologist)
Director, Lokpriya Heart Centre

NOTE: Echocardiography report given is that of the procedure done on that day and needs to be correlated clinically. This is not for medico legal purpose, as patient's identity is not confirmed. No record of this report is kept in the Hospital.

DATE	25.03.2023	REF. NO.	5705		
PATIENT NAME	PUNEET KUMAR JAIN	AGE	36YRS	SEX:	M
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG (PATHOLOGY)		

REPORT

Liver – appears normal in size and increased in echotexture. No mass lesion seen. Portal vein is normal.

Gall bladder – Distended & show evidence of few echogenic foci, largest measuring (7.5) mm.

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.

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

IMPRESSION

1. Fatty changes liver.
2. Cholelithiasis.

Dr. P.D. Sharma
M.B.B.S., D.M.R.D. (VIMS & RC)
Consultant Radiologist and Head

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DATE	25.03.2023	REF. NO.	17462		
PATIENT NAME	PUNEET KUMAR JAIN	AGE	36 YRS	SEX	M
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.