

Aashka Hospitals Ltd.

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



DR. PRAKASH D MAKWANA
M.D.
REG.NO.G-29078
MO.NO-9722116164

UHID:		Date: 30/1/23	Time:
Patient Name: SHIWALI		Height:	
Age/Sex: 42Y81F LMP:		Weight:	
History:			
C/C/O: ROUTINE CHEC OP		History: -	
Allergy History:		Addiction:	
Nutritional Screening: Well-Nourished / Malnourished / Obese			
Vitals & Examination:			
Temperature: Afebrile			
Pulse: 98/Min			
BP: 90/60 mm Hg			
SPO2: 99% O2 Room Air			
Provisional Diagnosis:			

Advice:

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration
		- All SI NOHL				
		- USG Abdomen + Mammography				} change explor
		<u>Referral - Gynec</u>				

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

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

UHID:	Date: 28/1/23	Time:
Patient Name: Shivali Singh	Age/Sex: 40/F	Height:
		Weight:
History:		
Examination: calculus ++ Buffy calculus $\frac{R}{8} / 8$ missed $\frac{\quad}{5}$ caries $\frac{7}{7} / \frac{7}{7}$		
Diagnosis:		

Treatment:

Adv
extra of $\frac{8}{8}$

PPR 1507

Scalby

Resin $\frac{7}{7}$

Dr. Anant

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

UHID:	Date: 28/1/23	Time:
Patient Name: VIRAJ PRADIP SETHI	Age / Sex: 26 M	Height:
	Weight:	
History: c/o Rupture chn. ur.		
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination: D.V. { G1G G1C => color within redness N.V. { G1G G1G [N.V + 1.50]		
Diagnosis:		

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

Eye examination:

	RIGHT			LEFT		
	S	C	A	S	C	A
D						
N	* 1.50	-	-	+ 1.50	-	-

Other Advice:

Follow-up:

Consultant's Sign:

DR. MUPPURU MALLESWARI
 MBBS, DGO
 CONSULTANT OBSTETRICIAN
 AND GYNECOLOGIST
 Regi. No G-32860

UHID:	Date:	Time: 1.10 PM
Patient Name: SHIWALI SINGH	Age: 43 yrs	Mobile No:
Complaint and duration: <i>came for check</i>		
History: Menstrual history: Cycles <i>reg</i> Flow <i>S-6</i> Duration of Bleeding <i>NF</i> Presence of pain <i>+ 2 days since 1 yr.</i> LMP: <i>2 days</i> H/O Associated illnesses: HTN: <i>=</i> DM: <i>-</i> Thyroid disorder: <i>=</i> Others: <i>-</i> Family History: <i>DM + AT +</i>		
Medication history:		
Obstetric History: <i>2 children ND</i> No of deliveries: <i>13 yrs</i> Last child:		
Allergy History: <i>Not known</i>		
Nutritional Screening: Well-Nourished / Malnourished / Obese <i>Well-Nourished</i>		
General Examination: CVS <i>NS</i> BP <i>110/70 mmHg</i> Oedema of ft RS <i>NS</i> Wt <i>64 kg</i> Tongue <i>Mild Pallor</i> Breast examination:		

To come after period completion

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 **aashka**
HOSPITALS LTD.



28/1/23

BP measurement

28/1/23 - GPM : 90/52 mmHg.

28.01.2023 12:46:40 PM
AASHKA HOSPITAL LTD.
SARGASAN
GANDHINAGAR

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

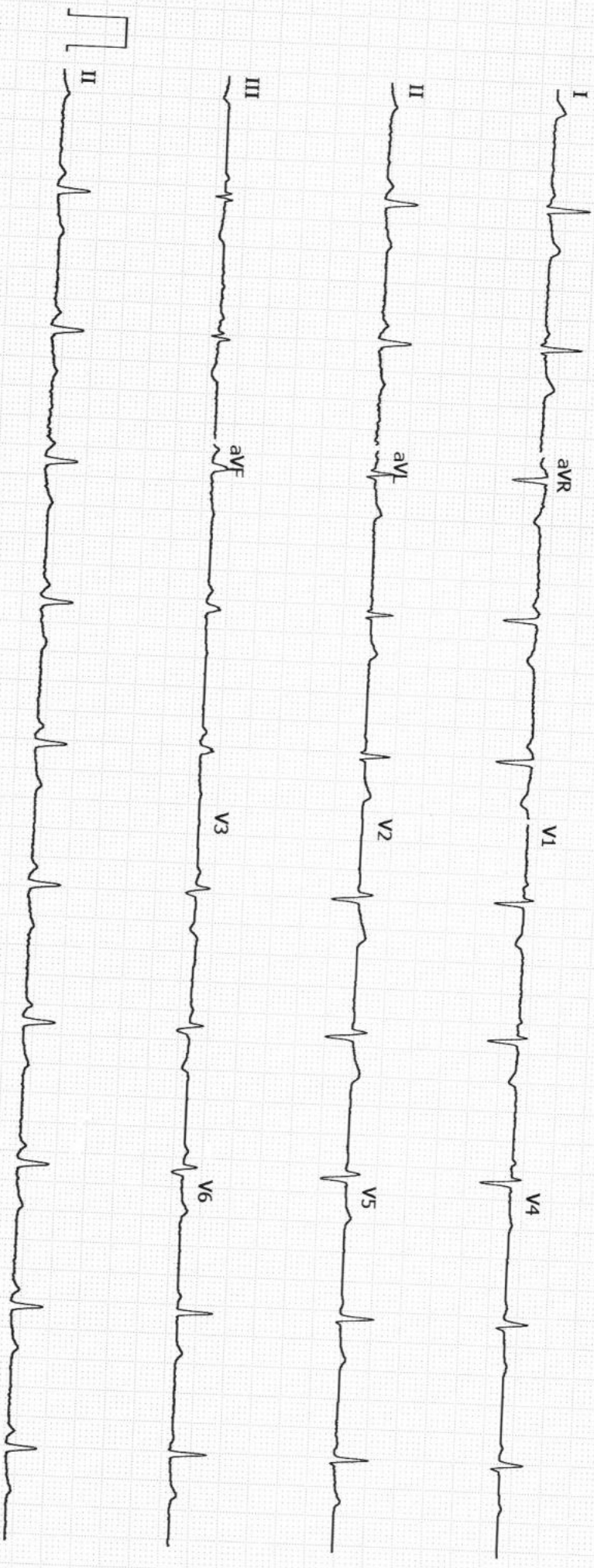
QRS : 72 ms
QT / QTcBaz : 394 / 403 ms
PR : 128 ms
p : 102 ms
RR / PP : 948 / 952 ms
P / QRS / T : 53 / 37 / 15 degrees

Normal sinus rhythm
Normal ECG

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

Room: 101 D 942 H

63 bpm
-- / -- mmHg



GE MAC2000 1.1 12SL™ V241

25 mm/s 10 mm/mV

ADS 0.56-20.1.4 50 Hz

Unconfirmed
4x2.5x3_25_R1 1/1



LABORATORY REPORT



Name : SHIWALI SINGH	Sex/Age : Female/ 43 Years	Case ID : 30102200850
Ref.By : hospital health checkup	Dis. At :	Pt. ID : 2528323
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type :	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time :	Acc. Remarks : Normal	Ref Id2 : 022238526

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Haemogram (CBC)			
Haemoglobin (Colorimetric)	8.9	G%	12.00 - 15.00
RBC (Electrical Impedance)	3.79	millions/cu mm	3.80 - 4.80
PCV(Calc)	28.43	%	36.00 - 46.00
MCV (RBC histogram)	75.0	fL	83.00 - 101.00
MCH (Calc)	23.5	pg	27.00 - 32.00
MCHC (Calc)	31.3	gm/dL	31.50 - 34.50
RDW (RBC histogram)	17.90	%	11.00 - 16.00
Eosinophil	8.0	%	1.00 - 6.00
Eosinophil	554	/ μ L	20.00 - 500.00
Lipid Profile			
HDL Cholesterol	42.9	mg/dL	48 - 77
Stool Examination			
Consistency	Solid		
Urine Examination			
Blood	Present (+)		Negative
ESR	29	mm after 1hr	3 - 20
Plasma Glucose - F	104.13	mg/dL	70.0 - 100

Abnormal Result(s) Summary End

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

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LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
 Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : O0123136
Report Date and Time : 28-Jan-2023 18:17	Acc. Remarks : Normal	Ref Id2 : O22238526

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin (Colorimetric)	L 8.9	G%	12.00 - 15.00
RBC (Electrical Impedance)	L 3.79	millions/cumm	3.80 - 4.80
PCV(Calc)	L 28.43	%	36.00 - 46.00
MCV (RBC histogram)	L 75.0	fL	83.00 - 101.00
MCH (Calc)	L 23.5	pg	27.00 - 32.00
MCHC (Calc)	L 31.3	gm/dL	31.50 - 34.50
RDW (RBC histogram)	H 17.90	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

Total WBC Count	6930	/μL	4000.00 - 10000.00
Neutrophil	[%] 47.0	%	EXPECTED VALUES 40.00 - 70.00 [Abs] 3257 /μL
Lymphocyte	40.0	%	EXPECTED VALUES 20.00 - 40.00 2772 /μL
Eosinophil	H 8.0	%	1.00 - 6.00 H 554 /μL
Monocytes	5.0	%	2.00 - 10.00 347 /μL
Basophil	0.0	%	0.00 - 2.00 0 /μL

PLATELET COUNT (Optical)

Platelet Count	250000	/μL	150000.00 - 410000.00
Neutrophil to Lymphocyte Ratio (NLR)	1.18		0.78 - 3.53

SMEAR STUDY

RBC Morphology	Microcytic hypochromic RBCs.
WBC Morphology	Eosinophilia
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. Shreya Shah
M.D. (Pathologist)

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

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LABORATORY REPORT



Name : SHIWALI SINGH	Sex/Age : Female/ 43 Years	Case ID : 30102200850
Ref.By : hospital health checkup	Dis. At :	Pt. ID : 2528323
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 18:17	Acc. Remarks : Normal	Ref Id2 : 022238526

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

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LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
Bill. Loc. : Aashka hospital Pt. Loc. :
Reg Date and Time : 28-Jan-2023 17:26 Sample Type : Whole Blood EDTA Mobile No :
Sample Date and Time : 28-Jan-2023 17:26 Sample Coll. By : Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 20:03 Acc. Remarks : Normal Ref Id2 : 022238526

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR	H 29	mm after 1hr	3 - 20	

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

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LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 17:50	Acc. Remarks : Normal	Ref Id2 : 022238526

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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LABORATORY REPORT



Name : SHIWALI SINGH	Sex/Age : Female/ 43 Years	Case ID : 30102200850
Ref.By : hospital health checkup	Dis. At :	Pt. ID : 2528323
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Stool	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 29-Jan-2023 09:28	Acc. Remarks : Normal	Ref Id2 : 022238526

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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Clinical Pathology STOOL EXAMINATION

Physical Examination

Colour Stool	Brownish		
Consistency	Solid		
Blood	Absent		Absent
Mucous	Absent		Absent
Parasites	Not Detected		Absent
Reaction	Acidic		

Microscopic Examination

Pus Cells	Not Detected	/HPF	Absent
Red Cells	Not Detected	/HPF	Absent
Macrophages	Not detected		Absent
Epithelial Cells	Not Detected	/HPF	
Starch Granules	Absent		
Neutral Fat	Absent		
Yeast	Not Detected		Absent
<u>By Direct Saline and Iodine wet mount</u>			
Trophozoites	Not Detected		Absent
Ova	Not Detected		Absent
Cysts	Not Detected		Absent

Chemical Test

Occult Blood <i>Biochemical</i>	Negative		Negative
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Name : SHIWALI SINGH	Sex/Age : Female/ 43 Years	Case ID : 30102200850
Ref.By : hospital health checkup	Dis. At :	Pt. ID : 2528323
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Spot Urine	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 18:34	Acc. Remarks : Normal	Ref Id2 : 022238526

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

Physical examination

Colour	Pale yellow
Transparency	Slight Turbid

Chemical Examination By Sysmex UC-3500

Sp.Gravity	1.020	1.005 - 1.030
pH	8.00	5 - 8
Leucocytes (ESTERASE)	Negative	Negative
Protein	Negative	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	1-2	/HPF	Nil
Red Blood Cell	1-2	/HPF	Nil
Epithelial Cell	Present +	/HPF	Present(+)
Bacteria	Nil	/ul	Nil
Yeast	Nil	/ul	Nil
Cast	Nil	/LPF	Nil
Crystals	Nil	/HPF	Nil

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 Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 28-Jan-2023 17:26 Sample Type : Spot Urine Mobile No :
 Sample Date and Time : 28-Jan-2023 17:26 Sample Coll. By : Ref Id1 : 00123136
 Report Date and Time : 28-Jan-2023 18:34 Acc. Remarks : Normal Ref Id2 : 022238526

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	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

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LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
 Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 28-Jan-2023 17:26 Sample Type : Plasma Fluoride F,Plasma Fluoride PP,Serum Mobile No :
 Sample Date and Time : 28-Jan-2023 17:26 Sample Coll. By : Ref Id1 : 00123136
 Report Date and Time : 28-Jan-2023 19:20 Acc. Remarks : Normal Ref Id2 : 022238526
TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

Plasma Glucose - F	H	104.13	mg/dL	70.0 - 100	
Plasma Glucose - PP		116.34	mg/dL	70.0 - 140.0	
Creatinine		0.54	mg/dL	0.50 - 1.50	
Uric Acid		4.34	mg/dL	2.6 - 6.2	

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LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
 Ref.By : **hospital health checkup** Dis. At : Pt. ID : **2528323**
 Bill. Loc. : **Aashka hospital** Pt. Loc :
 Reg Date and Time : **28-Jan-2023 17:26** Sample Type : **Serum** Mobile No :
 Sample Date and Time : **28-Jan-2023 17:26** Sample Coll. By : Ref Id1 : **00123136**
 Report Date and Time : **29-Jan-2023 09:59** Acc. Remarks : **Normal** Ref Id2 : **022238526**

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol	150.57	mg/dL	110 - 200
HDL Cholesterol	L 42.9	mg/dL	48 - 77
Triglyceride	100.68	mg/dL	40 - 200
VLDL <i>Calculated</i>	20.14	mg/dL	10 - 40
Chol/HDL <i>Calculated</i>	3.51		0 - 4.1
LDL Cholesterol <i>Calculated</i>	87.53	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 assesment from HDL and Triglyceride 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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Ref.By : hospital health checkup	Dis. At :	Pt. ID : 2528323
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Serum	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 19:21	Acc. Remarks : Normal	Ref Id2 : 022238526

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T.	27.26	U/L	0 - 31	
S.G.O.T.	20.72	U/L	15 - 37	
Alkaline Phosphatase	87.99	U/L	35 - 105	
Gamma Glutamyl Transferase	23.33	U/L	5 - 36	
Proteins (Total)	7.74	gm/dL	6.4 - 8.2	
Albumin	4.29	gm/dL	3.4 - 5	
Globulin <i>Calculated</i>	3.45	gm/dL	2 - 4.1	
A/G Ratio <i>Calculated</i>	1.2		1.0 - 2.1	
Bilirubin Total	0.37	mg/dL	0.2 - 1.0	
Bilirubin Conjugated	0.10	mg/dL		
Bilirubin Unconjugated <i>Calculated</i>	0.27	mg/dL	0 - 0.8	

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Bill. Loc. : Aashka hospital		Pt. Loc. :
Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : O0123136
Report Date and Time : 28-Jan-2023 18:11	Acc. Remarks : Normal	Ref Id2 : O22238526

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C	5.69	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) <i>Calculated</i>	116.60	mg/dL		

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.

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LABORATORY REPORT



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 Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Serum	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
Report Date and Time : 28-Jan-2023 19:21	Acc. Remarks : Normal	Ref Id2 : 022238526

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
------	---------	------	----------------------	---------

BIOCHEMICAL INVESTIGATIONS

Proteins (Total)	7.74	gm/dL	6.4 - 8.2	
Albumin	4.29	gm/dL	3.4 - 5	
Globulin <i>Calculated</i>	3.45	gm/dL	2 - 4.1	
A/G Ratio <i>Calculated</i>	1.2		1.0 - 2.1	

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

Dr. Shreya Shah
M.D. (Pathologist)

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

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Neuberg Supratech Reference Laboratories Private Limited

"KEDAR" Opposite Krupa Petrol Pump, Near Parimal Garden, Ahmedabad - 380006

Phone : 079-40408181 / 61618181 | Email : contact@supratechlabs.com | Website : www.neubergsupratech.com



LABORATORY REPORT



Name : **SHIWALI SINGH** Sex/Age : **Female/ 43 Years** Case ID : **30102200850**
 Ref.By : hospital health checkup Dis. At : Pt. ID : **2528323**
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 28-Jan-2023 17:26	Sample Type : Serum	Mobile No :
Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
------	---------	------	----------------------	---------

Thyroid Function Test

Triiodothyronine (T3)	105.31	ng/dL	70 - 204	
Thyroxine (T4) <small>CMA</small>	7.7	ng/dL	5.5 - 11.0	
TSH <small>CMA</small>	1.681	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), PRTN 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:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : SHIWALI SINGH	Sex/Age : Female/ 43 Years	Case ID : 30102200850
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Sample Date and Time : 28-Jan-2023 17:26	Sample Coll. By :	Ref Id1 : 00123136
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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/↑	↓

----- 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)

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www.aashkahospitals.in
CIN: L85110GJ2012PLC072647



PATIENT NAME: SHIWALI SINGH

GENDER/AGE: Female / 42 Years

DOCTOR:

DATE: 28/01/23

OPDNO: 00123136

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

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 **aashka**
HOSPITAL



PATIENT NAME: SHIWALI SINGH

GENDER/AGE: Female / 42 Years

DOCTOR:

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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 radicles appear normal. No evidence of solid or cystic mass lesion is seen.

GALL BLADDER: H/O SURGEY.

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 10.1 x 4.6 cms in size.
Left kidney measures about 10.6 x 4.8 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 190 cc.

UTERUS: Uterus is anteverted and appears bulky and shows Adenomyotic changes. (93 x 54 x 49 mm) Large intra mural fibroid is seen in posterior wall of uterus (57 x 56 mm). Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 5 mm. No evidence of uterine mass lesion is seen.

COMMENT: Bulky Adenomyotic uterus with posterior wall fibroid.

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


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**PATIENT NAME:SHIWALI SINGH****GENDER/AGE:Female / 42 Years****DATE:28/01/23****DOCTOR:DR.HASIT JOSHI****OPDNO:O0123136****2D-ECHO**

MITRAL VALVE	: MINIMALLY THICK, MILD MVP	
AORTIC VALVE	: NORMAL	
TRICUSPID VALVE	: NORMAL	
PULMONARY VALVE	: NORMAL	
AORTA	: 34mm	
LEFT ATRIUM	: 34mm	
LV Dd / Ds	: 40/27mm	EF 60%
IVS / LVPW / D	: 10/9mm	
IVS	: INTACT	
IAS	: INTACT	
RA	: NORMAL	
RV	: NORMAL	
PA	: NORMAL	
PERICARDIUM	: NORMAL	
VEL	: PEAK	MEAN
M/S	: Gradient mm Hg	Gradient mm Hg
MITRAL	: 0.9/0.5m/s	
AORTIC	: 1.3m/s	
PULMONARY	: 1.2m/s	
COLOUR DOPPLER	: MILD MR/TR	
RVSP	: 30mmHg	
CONCLUSION	: MILD MVP / MILD MR; NORMAL LV SIZE / SYSTOLIC FUNCTION; MILD TR.	

CARDIOLOGIST
DR.HASIT JOSHI (9825012235)

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HOSPITAL



PATIENT NAME: SHIWALI SINGH

GENDER/AGE: Female / 42 Years

DOCTOR:

DATE: 28/01/23

OPDNO: 00123136

BILATERAL MAMMOGRAM WITH USG OF BREAST

Dedicated digital mammography with Craniocaudal and medio lateral oblique view was performed.

Fibrofatty and dense parenchyma is noted on either side. **Well defined lobulated soft tissue opacities are seen in upper outer inner quadrant of left breast suggestive of benign etiology most likely.** No definite evidence of abnormal microcalcification or architectural distortion is seen. No evidence of skin thickening or nipple retraction is seen.

On sonography, normal breast parenchyma is seen on right side. Well defined hypoechoic lesions with echogenic capsules are seen in upper outer inner quadrant of left breast. No evident abnormal vascularity is seen within the lesion. The largest measures about 23 x 11 mm in size. The above findings are suggestive of benign etiology. **Fibroadenoma most likely.**

A few subcentimeters sized lymphnodes with preserved fatty hilum are seen in axilla.

COMMENT: Fibro adenoma in left breast as described above. (BIRADS - Category - II).

BIRADS Categories:

- 0 Need imaging evaluation.
- I Negative.
- II Benign finding.
- III Probably benign finding.
- IV Suspicious abnormality.
- V Highly suggestive of malignancy.
- VI Biopsy proven malignancy.

The false negative mammography is approximately 10%. Management of a palpable abnormality must be based upon clinical grounds.

Screening mammogram:

Women with no symptoms

AGE: 35-39: Baseline study.

AGE: 40-49: Every 1-2 years

AGE: 50 and above: Every year


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST



To,

The Coordinator,
Mediwheel (Arcofemi Healthcare Limited)
Helpline number: 011- 41195959

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following spouse of our employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS OF HEALTH CHECK UP BENEFICIARY	
NAME	SHIWALI SINGH
DATE OF BIRTH	14-10-1980
PROPOSED DATE OF HEALTH CHECKUP FOR EMPLOYEE SPOUSE	28-01-2023
BOOKING REFERENCE NO.	22M66235100034942S
SPOUSE DETAILS	
EMPLOYEE NAME	MR. SINGH VIJAY PRATAP
EMPLOYEE EC NO.	66235
EMPLOYEE DESIGNATION	FOREX BACK OFFICE
EMPLOYEE PLACE OF WORK	GANDHINAGAR,GIFT CITY,NATIONAL
EMPLOYEE BIRTHDATE	15-07-1976

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from **26-12-2022** till **31-03-2023**.The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a **cashless facility** as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee's spouse and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

Chief General Manager
HRM Department
Bank of Baroda

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact Mediwheel (Arcofemi Healthcare Limited))