



**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

<b>Patient Name</b> : Mrs. SHRUTI SURESH SHIGVAN	<b>Age /Gender</b> : 40 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60620/NMU0047036	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 08-Mar-24 10:29 am	<b>Report Date</b> : 08-Mar-24 01:51 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
HDL CHOLESTEROL		37	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		92	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL	Direct-Enzymatic colorimetric
VLDL		28		
SERUM TRYGLYCERIDES		138	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.0	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.49		
SERUM URIC ACID		3.6	2.4 - 5.7 mg/dL	uricase
<b>T3,T4 AND TSH</b>				
T3		109.6	70 - 204 ng/dL	Method : ECLIA
T4		7.72	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.89	0.270 - 4.20 uIU/mL	Method : ECLIA
<b>SERUM ELECTROLYTES</b>				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.8	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>				
HBA1C		6.3	< 5.7 Normal Prediabetic 5.7 TINIA - 6.4 & >/=6.5 Diabetic %	
MPG(Mean Plasma Glucose)		134	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

\*\*\* End Of Report \*\*\*

**THIS IS A MODIFIED REPORT**



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<b>Received Dt</b> : 08-Mar-24 10:29 am	<b>Report Date</b> : 08-Mar-24 01:51 pm

### FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
ESR	CITRATED BLOOD	15	0 - 20 mm/1st hour	WESTERGREN'S METHOD
<b>COMPLETE BLOOD COUNT</b>				
<b><u>RBC</u></b>				
R B C COUNT	Blood	4.90	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		12.5	12.0 - 15.0 g/dl	
PCV/HCT		38.5	40 - 50 %	
MCV		79	36 - 46 %	
MCH		25.6	83 - 101 fl	
MCHC		32.6	83 - 101 fl	
RDW(cv)		13.5	27 - 32 pg	
			31.5 - 34.5 g/dL	
			11.6 - 14.0 %	
<b><u>PLATELETS</u></b>				
PLATELET COUNT	Blood	328	150 - 400 $10^3/\mu\text{L}$	
MPV		8.2	7.5 - 11.5 fl	
<b><u>WBC</u></b>				
TC (TOTAL LEUCOCYTE COUNT)	Blood	10.5	4.0 - 11.0 $10^3/\mu\text{l}$	
<b><u>DIFFERENTIAL COUNT</u></b>				
NEUTROPHILS	Blood	68	40 - 80 %	
LYMPHOCYTES		24	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	

\*\*\* End Of Report \*\*\*



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<b>Bill No/ UMR No</b> : NMBC60620/NMU0047036	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 08-Mar-24 10:29 am	<b>Report Date</b> : 08-Mar-24 07:21 pm

### FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)</b>				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	88	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		SNR		
<b>SERUM CREATININE</b>				
CREATININE		0.59	0.6 - 1.2 mg/dl	Method : jaffe
<b>BUN / CREATININE RATIO</b>				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.59	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.5	10 - 20	
<b>LFT(LIVER FUNCTION TEST)</b>				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		11	<= 33 U/L	Method : UV without P5P
SGOT (AST)		16	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		67	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.8	3.5 - 5.2 g/dL	Method : Bromocresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.66	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		15	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
<b>BUN(BLOOD UREA NITROGEN)</b>				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
<b>TOTAL PROTEIN</b>				
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL		148	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric



**MEDICOVER**  
HOSPITALS

**DEPARTMENT OF LABORATORY**

**NAVI MUMBAI**

<b>Patient Name</b> : Mrs. SHRUTI SURESH SHIGVAN	<b>Age /Gender</b> : 40 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60620/NMU0047036	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 08-Mar-24 10:29 am	<b>Report Date</b> : 09-Mar-24 09:11 am

**Parameters**                      **Specimen**    **Result**                      **Biological Reference In Method**

**Lab Incharge**

**Dr. VISHAL MEHROTRA, MD Pathology**  
Consultant Hematology Services

Verified By : : 022315

Test results related only to the item tested.

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**MEDICAL HEALTH CHECK- UP ASSESMENT FORM**

NAME : Mr / (Mrs) Shouti Shivvan

DATE: 08/03/24

AGE : 40yrs / F

SEX: Male / (Female)

NMU: NMU00047036

DOCTOR'S NAME:

TEMP :	<u>97.4</u>	° f	BP :	<u>120/90</u>	mmHg
PULSE :	<u>92</u>	b/m	HEIGHT :	<u>162</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>58.2</u>	kg
SPO2 :	<u>97</u>	%	HGT:	<u>—</u>	

REMARK:



# DEPARTMENT OF OPHTHALMOLOGY

# MEDICOVER HOSPITALS

DATE: 08/03/24

PATIENT NAME: Mrs Shreeta Shingon

AGE / SEX: 40 / F. NAVI MUMBAI

UMR NO: NMR00047036

	RE	LE
VA (DISTANCE)	6/6	6/6
VA (NEAR)	N8	N8
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA	
MRx	O	D	Plano	_____		6/6	<u>Acen</u> +1.00 → NG
	(R)						
	O	S	Plano	_____		6/6	+1.00 → NG
	(L)						

## HISTORY :

• Nil/O systemic illness (DM, HTN, thyroid) • Nil/O ocular illness Allergic rhinitis present  
 • Nil/O spectacle use.

## OCULAR FINDINGS :

(BE) - Ant seg WNL  
 (undilated) Disc  $\leq 0.5$   
 $0.5$

## ADVICE:

Refresh Tears eld qid 1777 X 1month

AS  
 CDR. ANUSHREE VANVAKAR





<b>Patient ID:</b>	<b>NMU0047036</b>	<b>Patient Name:</b>	<b>SHRUTI SURESH SHIGVAN</b>
<b>Age:</b>	<b>40 Years</b>	<b>Sex:</b>	<b>F</b>
<b>Accession Number:</b>	<b>NMBC60620</b>	<b>Modality:</b>	<b>DX</b>
<b>Referring Physician:</b>	<b>DR.DMO</b>	<b>Study:</b>	<b>CHEST</b>
<b>Study Date:</b>	<b>08-Mar-2024</b>	<b>Study Time:</b>	<b>11:12:48</b>

**X RAY CHEST PA VIEW**

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

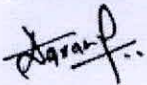
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

**Impression:**

- **No significant abnormality is seen.**



DR. ANUPKUMAR AGRAWAL  
Consultant & HOD Radiology  
MBBS, MD

Date: 08-Mar-2024 20:23:16

<b>Patient ID:</b>	<b>NMU0047036</b>	<b>Patient Name:</b>	<b>SHRUTI SURESH SHIGVAN</b>
<b>Age:</b>	<b>40 Years</b>	<b>Sex:</b>	<b>F</b>
<b>Accession Number:</b>	<b>NMBC60620</b>	<b>Modality:</b>	<b>US</b>
<b>Referring Physician:</b>	<b>DR.DMO</b>	<b>Study:</b>	<b>USG ABDOMEN WHOLE</b>
<b>Study Date:</b>	<b>08-Mar-2024</b>	<b>Study Time:</b>	<b>12:01:19</b>

### USG WHOLE ABDOMEN (TAS)

LIVER is normal in size (14.7 cm), normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

GALL BLADDER appears partially distended with normal wall thickness. There is no obvious calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size (10.6 cm) and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. **No hydronephrosis or calculi or mass seen.**

RIGHT KIDNEY measures 9.0 x 4.3 cm. LEFT KIDNEY measures 10.0 x 4.1 cm.

URINARY BLADDER is adequately distended; no e/o wall thickening or mass or calculi seen. Post-void residue is not significant.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 10.9 mm.

Both ovaries are normal in size, shape and position.

RIGHT OVARY: 3.6 x 1.5 cm, LEFT OVARY: 3.0 x 1.8 cm.

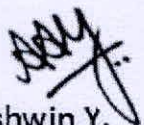
Visualised bowel loops appear normal. There is no free fluid seen.

*NB:- This scan does not rule out all pathologies related to bowel and appendix.*

### **IMPRESSION –**

- **No significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



**Dr. Ashwin Y.**  
M.D. (Radio-Diagnosis)





**MEDICOVER**  
HOSPITALS

NAVI MUMBAI

## 2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

*Name* : Mrs. Shruti Shigvan

Date:-08/03/2024

*Age / Sex* : 40 Yrs / Female

UMR No. 0047036

*Referred By* : Health Check-up

### **FINDINGS:**

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.  
PASP = 20 mm Hg.
- Intact IAS and IVS.
- No left ventricle clot / vegetation / pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

### **IMP:**

- No RWMA.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

**DR. KESHAV KALE**

DNB (Cardiology), MD (Medicine), MBBS

PhD (Cardiology), MNAMS, LL.B (Law)

FSCAI (USA), AFACC (USA), FESC (EU)

Consultant & Interventional Cardiologist







**MEDICOVER**  
HOSPITALS

NAVI MUMBAI

**M-MODE MEASUREMENTS:**

LA	33	mm
AO root	27	mm
AO CUSP SEP	18	mm
LVID( s)	33	mm
LVID(d)	43	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	32	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	8.4			Nil
TRICUSPID	20			Trivial
PULMONERY	4.3			Nil





NMU0047036  
40 Years

SHRUTI SHIGVAN  
Female

3/8/2024 1:57:42 PM

Rate 70 . Sinus rhythm.....normal P axis, V-rate 50- 99  
. Borderline short PR interval.....PR int <120ms  
PR 116  
QRSD 85  
QT 365  
QTc 394

--AXIS--

P 60  
QRS 52  
T 49

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

*Wmz*

