



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. BORA ALEKHYA	Age /Gender : 22 Y(s)/Female
Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:49 am	Report Date : 08-Mar-24 03:54 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
CUE(COMPLETE URINE EXAMINATION)				
<u>PHYSICAL EXAMINATION</u>				
VOLUME	Urine	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.025	1.000 - 1.030	Dipstick
PH		5.0	5.0 - 8.0	Dipstick
PROTEIN		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
GLUCOSE		ABSENT	ABSENT	Dipstick/Benedict's test
UROBILINOGEN		NORMAL	NORMAL	Dipstick
KETONE		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
BILIRUBIN		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
BILE SALT		NEGATIVE	NEGATIVE	Hay's sulphur powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>				
PUS CELLS	Urine	0-1	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***





MEDICOVER HOSPITALS

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Received Dt : 08-Mar-24 09:49 am	Report Date : 08-Mar-24 03:54 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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DEPARTMENT OF LABORATORY

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Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:49 am	Report Date : 08-Mar-24 01:44 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
ESR	CITRATED BLOOD	38	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		
RH TYPE		POSITIVE		TUBE AGGLUTINATION
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.83	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		13.1	12.0 - 15.0 g/dl	
PCV/HCT		39.5	40 - 50 % 36 - 46 %	
MCV		82	83 - 101 fl 83 - 101 fl	
MCH		27.1	27 - 32 pg	
MCHC		33.1	31.5 - 34.5 g/dL	
RDW(cv)		14.0	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	262	150 - 400 $10^3/\mu\text{L}$	
MPV		8.6	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.0	4.0 - 11.0 $10^3/\mu\text{L}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	56	40 - 80 %	
LYMPHOCYTES		35	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	

*** End Of Report ***





MEDICOVER HOSPITALS

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NAVI MUMBAI

Patient Name : Mrs. BORA ALEKHYA	Age / Gender : 22 Y(s)/Female
Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:49 am	Report Date : 09-Mar-24 09:31 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. BORA ALEKHYA	Age / Gender : 22 Y(s)/Female
Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:50 am	Report Date : 08-Mar-24 05:38 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE	PLASMA AND URINE	81	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.7	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
SERUM CREATININE				
CREATININE		0.66	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.66	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		16.6	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.8	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.6	<= 1.0 mg/dL	
SGPT (ALT)		18	<= 33 U/L	Method : UV without P5P
SGOT (AST)		19	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		132	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.72	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		19	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		11	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.9	6.0 - 8.0 g/dL	Method : Biuret method





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. BORA ALEKHYA	Age /Gender : 22 Y(s)/Female
Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:49 am	Report Date : 08-Mar-24 03:31 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
LIPID PROFILE			
TOTAL CHOLESTEROL		154	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		33	Low : : < 40 mg/dL High : : > 60 mg/dL Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		106	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		17	
SERUM TRYGLYCERIDES		86	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.67	Normal : - < 3.5 High Risk : - > 5.0
LDL/HDL RATIO		3.21	
SERUM URIC ACID		6.5	2.4 - 5.7 mg/dL uricase
T3,T4 AND TSH			
T3		129.7	70 - 204 ng/dL Method : ECLIA
T4		9.25	5.1 - 14.1 ug/dL Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.18	0.270 - 4.20 uIU/mL Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)		90	110 - 180 mg/dL Hexokinase
URINE SUGAR		NIL	Dipstick
HBA1C (GLYCOSYLATED HAEMOGLOBIN)			
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic % TINIA
MPG(Mean Plasma Glucose)		114	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL

*** End Of Report ***

THIS IS A MODIFIED REPORT





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. BORA ALEKHYA	Age / Gender : 22 Y(s)/Female
Bill No/ UMR No : NMBC60601/NMU0047019	Referred By : Dr. DMO
Received Dt : 08-Mar-24 09:49 am	Report Date : 09-Mar-24 09:12 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head of Laboratory Services
Consultant Hematopathologist

Verified By : : 022315

Test results related only to the item tested.

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 08/03/24
PATIENT NAME: Mrs Bosa Alekya
UMR NO: Nmm0047019

AGE / SEX: 22/F NAVI MUMBAI

	RE	LE
VA (DISTANCE)	6/6	6/6
VA (NEAR)	N6	N6
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O D Ⓡ	plano	_____		6/6 N6
	O S Ⓛ	plano	_____		6/6 N6

HISTORY :

• Nil systemic illness (DM, HTN, Thyroid). Nil spectacle use.
 • Nil ocular trauma, Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant seg WNL
 (undilated) Disc - appears ⊕

ADVICE:

yearly eye examination (BE)

AS
 (DR-ANUSHREE VAN KAR)



Patient ID:	NMU0047019	Patient Name:	BORA ALEKHYA
Age:	22 Years	Sex:	F
Accession Number:	NMBC60601	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	08-Mar-2024	Study Time:	11:51:29

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

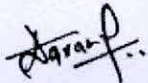
Both hilar shadows are normal in position and density.

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 20:26:55

Patient ID:	NMU0047019	Patient Name:	BORA ALEKHYA
Age:	22 Years	Sex:	F
Accession Number:	NMBC60601	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	08-Mar-2024	Study Time:	11:18:57

UPT :- Negative

USG WHOLE ABDOMEN

LIVER is mildly enlarged in size (16.4 cm) with bright 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 (11.6 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.

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

UTERUS is anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 5.9 x 4.9 x 3.0 cm; ET measures – 6.4 mm. No evidence of any obvious gestational sac or sac like structure in the endometrial cavity or in pelvis.

Both ovaries are normal in size, shape and position.

RIGHT OVARY: 3.8 x 2.2 cm, LEFT OVARY: 3.1 x 1.8 cm.

RIGHT OVARY Vol: 8 - 9 ml. LEFT OVARY Vol: 7 - 8 ml.

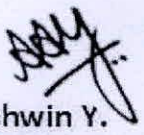
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **Mild hepatomegaly with grade I fatty liver.**
- **No other 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

<i>Name</i>	: Ms. Alekhya Bora	<i>Date</i>	: -08/03/2024
<i>Age / Sex</i>	: 22 Yrs / Female	<i>UMR No.</i>	: 0047019
<i>Referred By</i>	: Health Check-up		

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- Trivial 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 MR and 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	28	mm
AO CUSP SEP	19	mm
LVID(s)	34	mm
LVID(d)	42	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	32	mm
RA	31	mm
LVEF	60	%

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



Rate 72 . Sinus rhythm.....normal P axis, V-rate 50- 99

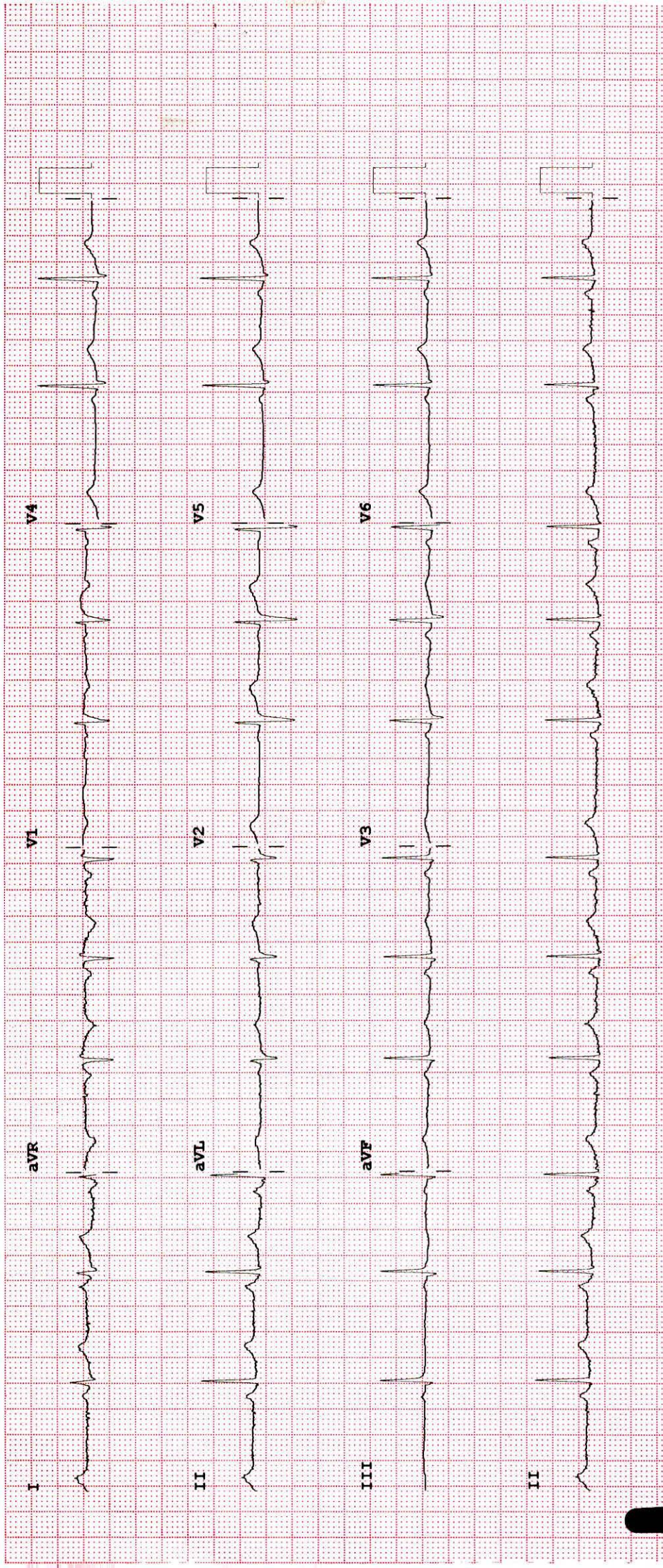
PR 142
QRSD 83
QT 382
QTc 419

--AXIS--
P 76
QRS 81
T 29

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CL P?

