

Patient Name : MR. PRASHANT

Age / Gender : 39 years / Male

MR No. / IPD No. : /

Patient Type / Bed No. : /

Referred By : ARCOFEMI HEALTH CARE
 PVT.LIMITED (MEDIWHEEL)

Registration Time : Oct 26, 2024, 10:43 a.m.

Receiving Time : Oct 26, 2024, 10:44 a.m.

Reporting Time : Oct 26, 2024, 12:55 p.m.


241026081

Panel : Dr Arcofemi Health Care PVT.limited (MediWheel)

Client Code : ACROFEMI HEALTH CARE PVT.
 LTD. (MEDIWHEEL)

Test Description	Value(s)	Unit(s)	Reference Range
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HAEMATOLOGY

Complete Haemogram - Hb RBC count and indices, TLC, DLC, PLATELET, ESR.

Hemoglobin (Hb) Method : Whole Blood, SLS-haemoglobin	14.7	g/dL	13.0 - 17.0
Erythrocyte (RBC) Count Method : Whole Blood, DC detection	4.97	x 10 ⁶ /uL	4.5 - 5.5
HCT Method : Whole Blood, RBC pulse height detection	45.1	%	42 - 52
Mean Cell Volume (MCV) Method : Whole Blood, Electrical Impedence	90.7	fL	78 - 100
Mean Cell Haemoglobin (MCH) Method : Whole Blood, Calculated	29.6	pg	27 - 31
Mean Corpuscular Hb Concn. (MCHC) Method : Whole Blood, Calculated	32.6	g/dL	32.0 - 35.0
Red Cell Distribution Width (RDW) CV Method : Whole Blood, Calculated	13.5	%	11.5 - 14.0
Total Leucocytes (WBC) Count Method : Whole Blood, Flow cytometry	6.5	x 10 ³ /uL	4 - 10
DLC (Differential Leucocytes Count)			
Neutrophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	64.7	%	40 - 80
Lymphocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	27.8	%	20 - 40
Monocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	5.8	%	2 - 10
Eosinophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	1.4	%	1 - 6
Basophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	0.3	%	0 - 2
Absolute Neutrophil Count Method : Whole Blood, Calculated	4.21	x 10 ³ /uL	2.0 - 7.0
Absolute Lymphocyte Count Method : Whole Blood, Calculated	1.81	x 10 ³ /uL	1 - 3

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Test Description	Value(s)	Unit(s)	Reference Range
Absolute Monocyte Count Method : Whole Blood, Calculated	0.38	x 10 ³ /uL	0.2-1.0
Absolute Eosinophil Count Method : Whole Blood, Calculated	0.09	x 10 ³ /uL	0.02 - 0.5
Absolute Basophils Count Method : Whole Blood, Calculated	0.02	x 10 ³ /uL	0.02 - 0.1
Platelet Count Method : Whole Blood, DC Detection	142	x 10 ³ /uL	150 - 450
ESR - Erythrocyte Sedimentation Rate Method : Whole blood , Modified Westergren Method	46	mm/hr	<10

Interpretation:

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Tests done on Automated Six Part Cell Counter.

END OF REPORT


 Dr. Arti Tripathi
 MD Pathology
 Chief Consultant, Pathology
 DMC No: 43012

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Test Description	Value(s)	Unit(s)	Reference Range
<u>CLINICAL PATHOLOGY</u>			
<u>Urine Glucose (Fasting & PP)</u>			
Glucose Fasting (Urine) Method : Oxidase Reaction/ Manual	Negative		Negative
Glucose Post Prandial (Urine) Method : Oxidase Reaction/ Manual	Negative		Negative

END OF REPORT



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Test Description	Value(s)	Unit(s)	Reference Range
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HAEMATOLOGY

Blood Group (ABO)

Blood Group	"B"		
Method : Forward and Reverse by Slide method			
RH Factor	Positive		

Methodology

This is done by forward and reverse grouping by slide agglutination method.

Interpretation

Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2-4 years).

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Test Description	Value(s)	Unit(s)	Reference Range
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BIOCHEMISTRY

LFT (Liver Function Test,Serum)

Total Protein Method : Biuret Method	7.6	g/dL	6.4-8.3
Albumin Method : Bromocresol Green	4.3	g/dL	3.5 - 5.2
Globulin Method : Calculated	3.30	g/dL	1.8 - 3.6
A/G Ratio Method : Calculated	1.30	ratio	1.2 - 2.2
SGOT Method : IFCC without Pyridoxal Phosphate	24	U/L	0 to 40
SGPT Method : IFCC without Pyridoxal Phosphate	27	U/L	0 to 41
Alkaline Phosphatase-ALP Method : PNP AMP Kinetic	113	U/L	40-129
GGT-Gamma Glutamyl Transferase Method : IFCC	10	U/L	0 to 60
Bilirubin Total Method : Colorimetric Diazo Method	0.60	mg/dL	0.0-1.20
Bilirubin - Direct Method : Colorimetric Diazo Method	0.20	mg/dL	Adults and Children: < 0.30
Bilirubin - Indirect Method : Calculated	0.40	mg/dL	0.1 - 1.0

Interpretation :

SGOT/ SGPT: Increased in Acute viral hepatitis, Biliary tract obstruction (cholangitis, choledocholithiasis), Alcoholic hepatitis and Cirrhosis, liver abscess, metastatic or primary liver cancer; non-alcoholic steatohepatitis; right heart failure. Decreased in Pyridoxine (vit B6) deficiency.

Alkaline Phosphatase: Increased in Obstructive hepatobiliary disease, Bone disease (physiologic bone growth, Paget disease, Osteomalacia, Osteogenic sarcoma, Bone metastases), Hyperparathyroidism, Rickets, Pregnancy (third trimester). Decreased in Hypophosphatasia.

GGT: Increased in Liver disease Acute viral or toxic hepatitis, Chronic or subacute hepatitis, Alcoholic hepatitis, Cirrhosis, Biliary tract obstruction.

Protein: Moderate-to-marked hyperproteinemia maybe due to multiple myeloma and other malignant paraproteinemias, Hypoproteinemia may be due to decreased production or increased protein loss.

Albumin: Increased in Dehydration, Shock, Hemoconcentration. Decreased in hepatic synthesis(Chronic liver disease, malnutrition, malabsorption, malignancy), Increased losses (Nephrotic syndrome, Burns, Trauma, Hemorrhage with fluid replacement, acute or chronic glomerulonephritis), Hemodilution (pregnancy, CHF) and Drugs (estrogens).

Bilirubin: A substance produced during the normal breakdown of red blood cells.Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

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Test Description	Value(s)	Unit(s)	Reference Range
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END OF REPORT



Dr. Anil Tripathi
MD Pathology
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Test Description	Value(s)	Unit(s)	Reference Range
BIOCHEMISTRY			
Lipid Profile,Serum			
Cholesterol-Total Method : Enzymatic Colorimetric,CHOD-POD	185	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.
Triglycerides Method : Enzymatic Colorimetric ,GOD-POD	131	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500
Cholesterol-HDL Direct Method : CHOD-POD (Homogenous Enzymatic)	40	mg/dL	No Risk - >55 mg/dL Moderate risk - 35-55 mg/dL High risk - < 35 mg/dL
LDL Cholesterol Method : Calculated	118.80	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190
Non - HDL Cholesterol, Serum Method : Calculated	145	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL
VLDL Cholesterol Method : Serum, Calculated	26.20	mg/dL	0 - 30
CHOL/HDL RATIO Method : Calculated	4.63	Ratio	3.5 - 5.0
LDL/HDL RATIO Method : Calculated	2.97	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0
HDL/LDL RATIO Method : Calculated	0.34	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

Note: 10-12 hours fasting sample is required.

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Test Description	Value(s)	Unit(s)	Reference Range
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END OF REPORT



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Test Description	Value(s)	Unit(s)	Reference Range
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BIOCHEMISTRY

KFT (Renal Function Test,Serum)

Urea <small>Method : kinetic (urease-GLDH)</small>	24	mg/dL	16.6-48.5
BUN <small>Method : Calculated</small>	11.21	mg/dL	6-20
Creatinine <small>Method : Kinetic Colorimetric (Jaffe Method)</small>	0.90	mg/dL	0.70-1.30
Uric Acid <small>Method : Enzymatic Colorimetric: Uricase-POD</small>	7.4	mg/dL	3.4-7.0

Interpretation :

Urea:- Increased in renal diseases,urinary obstructions, shock, congestive heart failure .Decreased in liver failure and pregnancy.

Creatinine :- Elevated in renal dysfunction, reduced renal blood flow shock, dehydration, Congestive heart failure, Diabetes Acromegaly. Decreased levels are found in Muscular Dystrophy.

Uric acid:- Increased in Gout, Arthritis, impaired renal functions and starvation.Decreased in Wilson's disease, Fanconis Syndrome and Yellow Atrophy of Liver.

Sodium:-Increased in Excessive dietary salt ,Diuretic therapy,Adrenal insufficiency,Salt-wasting nephropathy and Vomiting.Decreased levels are seen in Hyperaldsteronism ,Hyponatremia,Prerenal Azotemia,Renal Failure and Glomerulonephritis.

Potassium:- Low levels is common in vomiting, diarrhea, alcoholism, and folic acid deficiency. Increase level are seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid potassium infusion.

Chloride:- Increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis, diabetes insipidus, adrenocortical hyperfuction. Decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis.

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Test Description	Value(s)	Unit(s)	Reference Range
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BIOCHEMISTRY

Glucose (Fasting)

Glucose Fasting Method : Plasma,Enzymatic Hexokinase	96	mg/dL	Normal: 72-106 Impaired Tolerance: 100-125 Diabetes mellitus: ≥ 126 (on more than one occasion) (American diabetes association guidelines 2018)
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Interpretation

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

END OF REPORT



Dr. Arti Tripathi
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Test Description	Value(s)	Unit(s)	Reference Range
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BIOCHEMISTRY

Glucose (PP)

Blood Glucose-Post Prandial	71	mg/dL	70 - 140
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Method : Plasma, Enzymatic Hexokinase
 Interpretation

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

END OF REPORT



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MR No. / IPD No. : /	Reporting Time : Oct 26, 2024, 12:12 p.m.
Patient Type / Bed No. : /	 241026081
Referred By : ARCOFEMI HEALTH CARE PVT.LIMITED (MEDIWHEEL)	Panel : Dr Arcofemi Health Care PVT.limited (MediWheel)
	Client Code : ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)

Test Description	Value(s)	Unit(s)	Reference Range
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BIOCHEMISTRY

Glycated Hb (HbA1c)

HbA1c (Glycated Hemoglobin)	5.4	%	Non-Diabetic : <5.7
Method : EDTA Whole blood, HPLC, NGSP certified			Pre Diabetes : 5.7 - 6.4
			Diabetes : ≥ 6.5

Estimated Average Glucose : 108.28 mg/dL

Interpretations

- HbA1c has been used as one of the key biomarkers in identifying patients with Diabetes . American Diabetes Association (ADA) and several clinical groups have endorsed utility of HbA1c testing using a cut off value of 6.5%. The average concentration of blood glucose(eBG) is reflected in this test over a period of the past three months.
- Therapeutic goals for monitoring Diabetes.
 - Goal of therapy < 7% HbA1c.
 - Action suggested > 8 % HbA1c
- Patients with shortened red cell survival(hemolytic disease), recent significant blood loss have lower HbA1c values .
- High HbA1c is associated with Iron deficiency ,patients with polycythemia or post splenectomy.

Note : The presence of hemoglobin variants can interfere with measurement of HbA1c.

END OF REPORT



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Test Description	Value(s)	Unit(s)	Reference Range
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IMMUNOLOGY

Thyroid Function Test (Free),Serum

Free triiodothyronine (FT3) <small>Method : ECLIA</small>	1.28	pg/ml	2.0 - 4.40
Free Thyroxine (FT4) <small>Method : ECLIA</small>	7.75	ng/dL	0.93 - 1.70
TSH-Ultrasensitive <small>Method : ECLIA</small>	5.48	uIU/mL	0.27-4.20

Interpretation

The Biological reference interval provided is for Adults.
 For age specific reference interval, please refer to the table given below.

TSH	T3/FT3	T4/FT4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hypothyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non Thyroidal illness/Secondary Hyperthyroidism

TSH (mU/mL)			
Children	New Born	0.7	15.2
	6 days - 3 Months	0.72	11
	4 -12 Months	0.73	8.35
	1-6 Years	0.7	5.97
	7-11 Years	0.6	4.84
	12-20 years	0.51	4.3
Adults		0.27	4.2

TSH levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentration are observed during the afternoon. diurnal variation in TSH levels is approx 50%+/-, hence time of the day can influence the measured serum concentration.

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CLINICAL PATHOLOGY

Urine (RE/ME)

Physical Examination :

Volume	40		mL
Method : Visual Observation			
Colour	Pale Yellow		Pale Yellow
Method : Visual Observation			
Transparency (Appearance)	Clear		Clear
Method : Visual Observation			
Deposit	Absent		Absent
Method : Visual Observation			
Reaction (pH)	6.0		4.5 - 8.0
Method : Double Indicator method			
Specific Gravity	1.015		1.010 - 1.030
Method : Ionic Concentration			

Chemical Examination (Dipstick Method) Urine

Urine Protein	Absent		Absent
Method : Protein Ionisation/ Manual			
Urine Glucose (sugar)	Absent		Absent
Method : Oxidase Reaction/ Manual			
Blood (Urine)	Absent		Absent
Method : Peroxidase Reaction			

Microscopic Examination Urine

Pus Cells (WBCs)	2 - 4	/hpf	0 - 5
Method : Microscopy			
Epithelial Cells	1 - 2	/hpf	0 - 4
Method : Microscopy			
Red blood Cells	Absent	/hpf	Absent
Method : Microscopy			
Crystals	Absent		Absent
Method : Microscopy			
Cast	Absent		Absent
Method : Microscopy			
Yeast Cells	Absent		Absent
Method : Microscopy			
Amorphous Material	Absent		Absent
Method : Microscopy			

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Test Description	Value(s)	Unit(s)	Reference Range
Bacteria Method : Microscopy	Absent		Absent
Others	Absent		

Remarks:-

Epithelial cells	Urolithiasis bladder carcinoma or hydronephrosis ,ureteric stents or bladdercatheters for prolonged periods of time.
Granular casts	Low intratubular pH,high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration,acute congestive heart failure, renal diseases.
Calcium Oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of VitaminC, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit(A verrhoa carambola)or its juice
Uric acid	Artharitis
Bacteria	Urinary infection when present in significant numbers and with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

END OF REPORT


 Dr. Arti Tripathi
 MD Pathology
 Chief Consultant, Pathology
 DMC No: 43012



Name Mrs. Prashant Age 39y Sex M
 Deptt. _____ Ref by _____ Date 10/10/20
 M.R. No. _____ H/O Drug Allergy Y/N _____

Deptt. of General & Laparoscopic Surgery

Dr. Vinay Sabharwal

M.B.B.S., M.S., F.I.C.A.
 Hon. Surgeon to Fmr. President of India
 Sir Ganga Ram Hospital
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Vinc 6/9
 Vnk 6/6
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 N6

Dr. Malvika Sabharwal

M.B.B.S., D.C.C., F. C.P.S.C., F.R.P. (Linc. Surgery) (USA)
 Awarded Padmashri by the President of India
 Chief Deptt. of Gynae, Laparoscopic, Endoscopy Surgery
 President, Delhi Gynae Endoscopy Society (2018)
 Founder-Chairperson, Indian Ass. of Gynae-Endoscopy
 International Society of Gynae. Laparoscopic
 American Association Gynae. Laparoscopic
 Federation of Obst. & Gynae. Societies of India
 International College of Obst. & Gynae.
 E-mail: malvika@jmh.in
 Website: www.malvika@malvika.com
 DMC No. 4000

Dist. Segment B10-NAD
 Funulus B10-NAD

Deptt. of E.N.T.

Dr. R.K. Trivedi

M.B.B.S., M.D., M.S. (ENT)
 Senior Consultant
 D.M.C. No. 2547

Colour vision on Ishihara charts
 - N8 read

Dr. Rajeesh Nangia

M.B.B.S., M.S. (ENT)
 Senior Consultant Surgeon
 DMC No. 4051

[Signature]
Dr. S. C. PAHWA
 M.B.B.S., M.S. (Ophth)
 EYE SURGEON
 Reg. No. 8424 (D.M.C.)

[Signature]
Dr. S. C. PAHWA
 M.B.B.S., M.S. (Ophth)
 EYE SURGEON
 Reg. No. 8424 (D.M.C.)

Deptt. of Ophthalmology

Dr. Ashwani Seth

M.D. (S.), M.S.
 Senior Consultant Eye Surgeon
 D.M.C. No. 3702

Dr. S.C. Pahwa

M.B.B.S., M.S. (Ophth)
 Eye Surgeon
 D.M.C. No. 8424

Adv. Refraction.

Deptt. of Dentistry

Dr. Varun Aggarwal

B.D.S., M.D.S., D.A.C., M.D.C.A.
 Consultant Impedologist
 S. Unit Head

Dr. Neha Gupta

B.D.S., PGDCHM, F.I.C.D., M.D.C.A.
 Senior Consultant
 Deptt. of Dentistry

Treatment Adv for: _____ days Next follow up visit on: _____

JEEWAN MALA HOSPITAL

"Tradition of Trust & Care Since 1929"

Mark of Excellence



Name: Mr. Prashant Age: _____ Sex: _____ Date: _____

Ref by: _____ H/O Drug Allergy - Yes / No _____

Deptt. of Medicine

Dr. Vineet Sabharwal
M.B.B.S. (MD) (MED)
Senior Physician
DPO No. 1000

Dr. Rakesh Sharma
M.B.B.S. (MD) (MED)
Senior Physician
DPO No. 1000

Dr. Vishal Garg
M.B.B.S., M.D. (Internal Medicine)
Senior Consultant (2014)
Senior Consultant (2006)
The Med Sciences (PVT) (USA)
DPO No. 1000

Dr. Pankaj Kumar
M.B.B.S. (MD) (MED)
Senior Physician
Fellowship of A-Hospitalist
DPO No. 1000

Dr. Glosy Sabharwal
M.B.B.S. (MD) (Internal Medicine)
Clinical and Interventional Radiologist
Ultrasonology (M.D.) (2011)
Fellow - Ultrasound (M.D.) (2008)
Fellow - Ultrasound (M.D.) (2007)
Fellow - Ultrasound (M.D.) (2006)
Fellow - Ultrasound (M.D.) (2005)
Fellow - Ultrasound (M.D.) (2004)
Fellow - Ultrasound (M.D.) (2003)
Fellow - Ultrasound (M.D.) (2002)
Fellow - Ultrasound (M.D.) (2001)
Fellow - Ultrasound (M.D.) (2000)

Member
SOGG (USA)
RA (India)
SPO (UK)
IFIM (USA)
SOGG (USA)
Fellow - Ultrasound (M.D.) (2011)
Fellow - Ultrasound (M.D.) (2008)
Fellow - Ultrasound (M.D.) (2007)
Fellow - Ultrasound (M.D.) (2006)
Fellow - Ultrasound (M.D.) (2005)

Dr. Laxmi Kant Tomar
M.B.B.S. (MD) (Internal Medicine)
Senior Physician
DPO No. 1000

Dr. Jatin Anand
M.B.B.S. (MD) (Internal Medicine)
Senior Physician
DPO No. 1000

Dr. Maulit Gupta
M.B.B.S.
Senior Physician (Internal Medicine)
Senior Physician (Internal Medicine)
DPO No. 1000

Dr. Avinash Bansal
M.B.B.S. (MD) (Internal Medicine)
Senior Physician (Internal Medicine)
DPO No. 1000

Dr. Sandeep Bhagat
M.B.B.S.
Senior Physician (Internal Medicine)
Senior Physician (Internal Medicine)
DPO No. 1000

Dr. Sandeep Garg
M.B.B.S.
Senior Physician (Internal Medicine)
Senior Physician (Internal Medicine)
DPO No. 1000

Dr. Nikhil Sharma
M.B.B.S. (MD)
Senior Physician (Internal Medicine) & Gastroenterology
DPO No. 1000

BP -> 110/60
PR -> 59b/min
SpO2 - 99%
Temp - 97.1 F
W - 87.8 kg

According to the preliminary reports patient is vitally stable

Also

- Repeat Thyroid profile after 15 days
- 1 exercise
- healthy balanced diet

DR. ABUS SAQUIE
JEEWAN MALA HOSPITAL
Senior Physician

Treatment Adv for _____ days - Next Follow up visit on _____
6/1, New Rohjak Road, New Delhi-110 005 (India) Tel: 4774141, 921167897
E-mail: info@jmh.in Website: www.jmh.in



Name PRASHANT Age 39y Sex M
 Dept. _____ Ref by _____ Date 22/1/24
 M.R. No. _____ H/O Drug Allergy Nil

Deptt. of General & Laparoscopic Surgery

Dr. Vinay Sabharwal

M.B.B.S., M.S., F.R.C.S.
 Hon. Surgeon to Fmr, President of India
 Sir Ganga Ram Hospital
 Sr. Member: Association of Surgeons of India
 Indian Association of Gastro-Intest. Surgeons
 Indian Hernia Society
 Association of Min. Access Surgeons of India
 E-mail: drvinay@jmh.in
 Website: www.drvinay@sabharwal.com
 DMC No. 4557

*Fos Scattered
SMT Examination*

Dr. Malvika Sabharwal

M.B.B.S., DGO, F.I.C.O.S., Dpl. F&K Surgery (USA)
 Awarded Padmashri by the President of India
 Chief Dept. of Gynae, Laparoscopic, Endoscopy Surgery
 President, Delhi Gynae Endoscopy Society (2018)
 Founder-Chairperson, Indian Ass. of Gynae Endoscopists
 International Society of Gynae. Laparoscopists
 American Association Gynae. Laparoscopic
 Federation of Indian Gynae. Societies of India
 International College of Obst. & Gynae.
 E-mail: drmalvika@jmh.in
 Website: drmalvika@sabharwal.com
 DMC No. 4556

*Dr. Malvika Sabharwal
SMT Examination*

Deptt. of E.N.T.

Dr. R.K. Trivedi

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 Senior Consultant
 D.M.C. No. 12547

Dr. Rajeev Nangia

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 Senior-Ortho-otic Surgeon
 DMC No. 4551

Deptt. of Ophthalmology

Dr. Ashwani Seth

M.B.B.S., M.S.
 Senior Consultant Eye Surgeon
 D.M.C. No. 12702

Dr. S.C. Pahwa

M.B.B.S., M.S. (Opth)
 Eye Surgeon
 D.M.C. No. 8424

Deptt. of Dentistry

Dr. Varun Aggarwal

B.D.S., M.D.S., D.M.D., M.D.A.
 Consultant Periodontologist
 & UHI HSG

Dr. Neha Gupta

B.D.S., M.D.S., F.I.C.D., M.D.A.
 Senior Consultant
 Deptt. of Dentistry

Treatment/Adv for _____ days Next followup visit on _____

Atrial Rate:
 Ventricular Rate:
 Rhythm:
 Axis:
 P Wave:
 P-R Interval:
 QRS Duration:
 Q-T Duration:
 Q-T Interval:
 Conclusion:

Mr. [unclear] - 11/11/11
 [unclear]

ST Segment:
 T Wave:
 -Others:

Signature:
 Doctor J/C



ID: 270410210011515
 Name: [unclear]
 26-10-2024 10:31:22 AM
 Sinus rhythm
 Interpretation made without knowing patient's gender/age
 Inferior T wave abnormality is for respect to C
 Born: [unclear] ECG
 Unsymmetrical Digress:

Heart Rate (bpm)	57
P-R Interval (ms)	140
QRS Duration (ms)	86
QT Interval (ms)	426
QTc Interval (ms)	371
P-QRS-T Axis (deg)	121/1-5

P-R-T
 [unclear]



Name : PRASHANT
Recpt No : 8035
Reported on : 26-Oct-24

Age/Sex : 39YRS/F

S.NO: -8035

X-RAY CHEST PA

Bilateral lung fields are normal.
Bilateral costophrenic and cardiophrenic angles are clear.
Heart and mediastinum appear normal.

Impression: -

- No significant abnormality is seen.

Please correlate clinically

DR. GLOSSY B SABHARWAL, MD
CONSULTANT RADIOLOGIST

Note: This is only a professional opinion and not the final diagnosis. Not valid for medico-legal purposes

JEEWAN MALA HOSPITAL PVT. LTD.

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GSTIN No. 07AABCJ0920A1ZD / CIN No. U74899DL1991PTC043833

F.No.- 103



Ashutosh

29/10/2024 at 5:07 pm





Mr Prashant

Age: 39 Y/ Sex: M

Date: October 26, 2024

ULTRASOUND WHOLE ABDOMEN

Limited visibility due to excessive bowel gases noted in abdomen.

Liver is normal in size and shows diffuse increase in echogenicity s/o grade-I fatty infiltration. No focal lesion seen in the liver.

Intrahepatic bile ducts and portal radicals are normal in caliber.

Portal vein is normal in caliber

Gall bladder does not show any evidence of cholecystitis or cholelithiasis.

- CBD- proximal visualized part: - is not dilated.
- CBD- Mid and distal segment is obscured due to technical limitation.
- Central IHBR:- normal in caliber

Both kidneys are of normal size, shape and echopattern. No calculus, growth or hydronephrotic changes seen in either kidney. The parenchymal thickness is normal & cortico-medullary differentiation is well maintained.

Spleen is normal in size and echotexture.

Pancreas does not show any pathology.

Urinary bladder is distended and shows no mural or intraluminal pathology.

Prostate is normal in size and shape. No focal lesion is seen.

No free fluid or pelvic collection seen.

Please correlate clinically

DR. GLOSSY B SABHARWAL, MD
CONSULTANT RADIOLOGIST

This report is only a professional opinion and it is not valid for medico-legal purposes.

JEEWAN MALA HOSPITAL PVT. LTD.

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