



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. AARTI SURESH RAMANE	Age /Gender : 30 Y(s)/Female
Bill No/ UMR No : NMBC63359/NMU0048921	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:04 am	Report Date : 23-Mar-24 05:26 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	10 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.015	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microscopy
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	8-10	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		4-6	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		+		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION





MEDICOVER
HOSPITALS

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Received Dt : 23-Mar-24 09:04 am	Report Date : 23-Mar-24 05:26 pm

Parameters
NOTE

Specimen

Result

Biological Reference In Method

Microscopic examination of urine is carried out on centrifuged urinary sediment.

*** End Of Report ***





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Patient Name : Mrs. AARTI SURESH RAMANE	Age /Gender : 30 Y(s)/Female
Bill No/ UMR No : NMBC63359/NMU0048921	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:04 am	Report Date : 23-Mar-24 02:19 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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COMPLETE BLOOD COUNT

RBC

R B C COUNT	Blood	4.37	3.8 - 4.8 10 ⁶ /μL	
HEMOGLOBIN		12.4	12.0 - 15.0 g/dl	
PCV/HCT		37.6	40 - 50 % 36 - 46 %	
MCV		86	83 - 101 fl 83 - 101 fl	
MCH		28.3	27 - 32 pg	
MCHC		32.8	31.5 - 34.5 g/dL	
RDW(cv)		12.7	11.6 - 14.0 %	

PLATELETS

PLATELET COUNT	Blood	198	150 - 400 10 ³ /μL	
MPV		9.1	7.5 - 11.5 fl	

WBC

TC (TOTAL LEUCOCYTE COUNT)	Blood	5.7	4.0 - 11.0 10 ³ /μl	
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DIFFERENTIAL COUNT

NEUTROPHILS	Blood	51	40 - 80 %	
LYMPHOCYTES		37	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	

PERIPHERAL SMEAR
EXAMINATION
RBC
PLATELETS

BLOOD GROUPING AND RH

BLOOD GROUP	Blood	" AB "	TUBE AGGLUTINATION
RH TYPE		POSITIVE	
ESR		36	WESTERGREN`S METHOD
		0 - 20 mm/1st hour	

*** End Of Report ***





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Bill No/ UMR No : NMBC63359/NMU0048921	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:04 am	Report Date : 23-Mar-24 04:06 pm

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





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Patient Name : Mrs. AARTI SURESH RAMANE	Age / Gender : 30 Y(s)/Female
Bill No/ UMR No : NMBC63359/NMU0048921	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:05 am	Report Date : 23-Mar-24 01:53 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		82	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.5	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		111	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
T3,T4 AND TSH				
T3		149.0	70 - 204 ng/dL	Method : ECLIA
T4		7.23	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.09	0.270 - 4.20 uIU/mL	Method : ECLIA
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		78	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
SERUM CREATININE				
CREATININE		0.46	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		6	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.46	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		9	<= 33 U/L	Method : UV without P5P
SGOT (AST)		15	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		98	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.2	6.0 - 8.0 g/dL	Method : Biuret method





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Bill No/ UMR No : NMBC63359/NMU0048921	Referred By : Dr. DMO
Received Dt : 23-Mar-24 09:04 am	Report Date : 25-Mar-24 10:18 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromocresol Green (BCG)
GLOBULINS		3.5	2.5 - 3.5 g/dL	
A/G RATIO		1.34	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		21	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		6	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		8.2	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		174	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		36	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		110	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		29		
SERUM TRYGLYCERIDES		146	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.83	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.06		
SERUM URIC ACID		2.6	2.4 - 5.7 mg/dL	uricase
SERUM ELECTROLYTES				
SERUM SODIUM		142	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		3.6	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT

*** End Of Report ***





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Received Dt : 23-Mar-24 09:04 am	Report Date : 25-Mar-24 10:18 am

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

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Consultant Hematopathologist

Verified By : : 026560

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.



Rate 71 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
 . Sinus rhythm.....normal P axis, V-rate 50- 99
 PR 115 . Borderline short PR interval.....PR int <120ms
 QRSD 88 . RSR' in V1 or V2, probably normal variant.....small R' only
 QT 412 . Baseline wander in lead(s) V1
 QTc 448

WIR
2

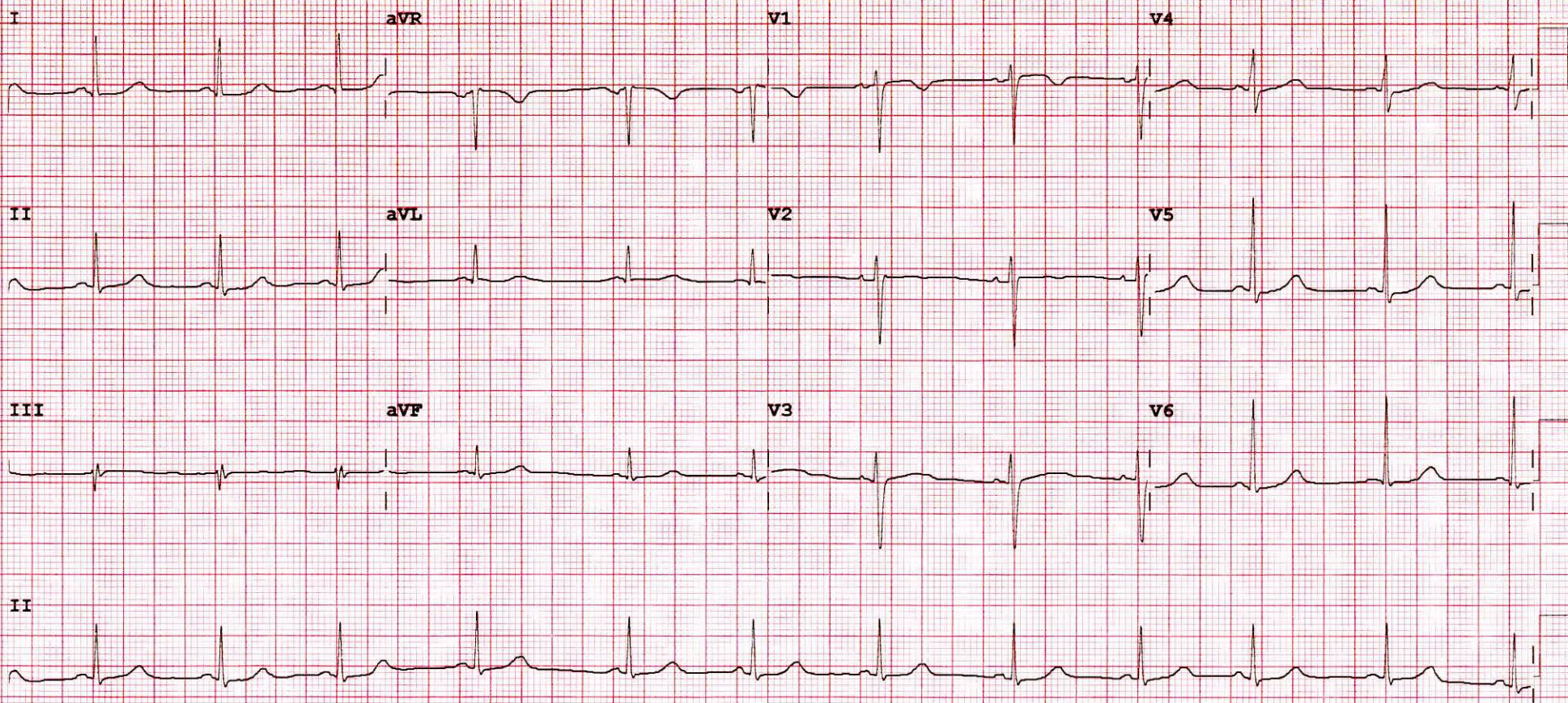
--AXIS--

P 27
QRS 21
T 37

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

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?

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name : Mrs. Aarti Ramane

Date:- 23/03/2024

Age / Sex : 30 Yrs / Female

UMR No. 0048921

Referred By : Health Checkup

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP - 25 mmHg.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- Thinned IAS.
- Normal right atrium and right 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
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M-MODE MEASUREMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	44	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	11			Nil
TRICUSPID	25			Trivial
PULMONERY	5.3			Nil



Patient ID:	NMU0048921	Patient Name:	AARTI SURESH RAMANE
Age:	30 Years	Sex:	F
Accession Number:	NMBC63359	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	23-Mar-2024	Study Time:	11:23:25

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: 23-Mar-2024 12:17:10

Patient ID:	NMU0048921	Patient Name:	AARTI SURESH RAMANE
Age:	30 Years	Sex:	F
Accession Number:	NMBC63359	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	23-Mar-2024	Study Time:	11:52:52

USG ABDOMEN & PELVIS

The Liver is normal in size (13.9 cm) and shows normal echotexture. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is physiologically distended with normal wall thickness. There is no evidence of gallstones. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size (9.0 cm). No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.

The Right Kidney measures 10.0 x 4.0 cm.

The Left Kidney measures 10.0 x 4.0 cm.

There is no evidence of a calculus, hydronephrosis, or hydroureter.

The Urinary bladder is adequately distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

The uterus is normal in size and echotexture. It measures 7.2 x 4.3 x 3.3 cm. No focal lesion is seen. The Endometrial thickness is 9.4 mm.

Both ovaries are well visualized and appear normal in size and echotexture.

The Right ovary measures 3.0 x 1.7 cm

The Left ovary measures 2.6 x 1.6 cm

There is no evidence of any ovarian or adnexal mass lesion.

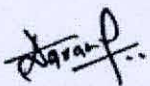
Visualised bowel loops are unremarkable.

There is no evidence of significant lymphadenopathy.

No ascitis is seen.

IMPRESSION:

- No significant abnormality is seen.



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 23-Mar-2024 12:13:57



MEDICOVER HOSPITALS

MEDICAL HEALTH CHECK-UP ASSESMENT FORM

NAME : Mr / Mrs Mr Wadei Ramona

DATE: 23/3/24

AGE : 30y

SEX: Male / Female

NMU: NMU000 48921

DOCTOR'S NAME:

Health-keage

TEMP :	<u>97.4 F</u>	° f	BP :	<u>90/60</u>	mmHg
PULSE :	<u>81</u>	b/m	HEIGHT :	<u>140</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>49.1</u>	kg
SPO2 :	<u>98</u> %	RA	HGT:	-	

REMARK:



MEDICOVER
HOSPITALS

NAVI MUMBAI

Aarti Rawal .

8/B :- Dr. mandira kamble .

0/E :- Deep caries \bar{c} $\frac{875}{67}$

Stain⁺ calculus⁺ -

Adria :- Restoration \bar{c} $\frac{875}{67}$

Oral prophylaxis .

Mskamble .

Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43282

