Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823

Hiranandani HOSPITAL

HEALTH CHECKUP CONSULTATION SUMMARY

Patient's Name :

UHID NO :

Age : Sex:

Date of Consultation

BP: HEIGHT: WEIGHT:

Allergies : (if Any)

INVESTIGATION

PATHOLOGY

RADIOLOGY

NIC

OTHERS

Chief Complaints :

Hiranandani HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 22/10/22

Name: Khushboo Dubey Age: 32 yrs Sex: M / F

BP: 110/70 Height (cms): 154.9 cms Weight(kgs): 67.7 Kg BMI: 28

Monthly

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese				Extremely Obese				
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
A Fortis network hospital

UHID	**12078051**	**Date**	**22/10/2022**
Name	**Mrs.Khushboo Dubey**	**Sex**	**Female** **Age** **32**
OPD	**PAP**	**Health Check Up**	

32yrs / Polo.

Drug allergy:
Sys illness:

LMP: 5.10.22

Pmc: 3-5/45-60days -

Pap - cx ng/(H) pap

-Breast exmn (M)

Adv

- Fnc reports
- Pap smear - 3yrly
- Self breast exmn - mthl

Isha

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Hiranandani HOSPITAL
A Fortis Network Hospital

UHID	12078051	Date	22/10/2022		
Name	Mrs.Khushboo Dubey	Sex	Female	Age	32
OPD	Opthal 14	Health Check Up			

Drug allergy: → Not known
Sys illness: → No

Cbc. No.

Nbc. No.

Unaided Va → Re 6/12P
→ Le 6/12P

Refr → Re −0.75 DS 6/6.
→ Le −0.75 DS 6/6.

NV → Re N6
→ Le N6

IOP → Re 13.5
→ Le 13.4

C.V. ...

20-20 rule
20 min / 30 min
20 sec / 30 sec

[illegible]

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UHID	**12078051**	**Date**	**22/10/2022**		
Name	**Mrs.Khushboo Dubey**	**Sex**	**Female**	**Age**	**32**
OPD	**Dental 12**	**Health Check Up**			

Drug allergy:
Sys illness:

1) Stain++
Calculus+++

Adv

Oral prophylaxis

BAI

PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

ACCESSION NO : **0022VJ004562** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : 22/10/2022 09:49:00 RECEIVED : 22/10/2022 09:55:25 REPORTED : 22/10/2022 14:53:08

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12078051 REQNO-1311181
CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results		Biological Reference Interval	Units
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	12		6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE	0.61		0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE	32			years
GLOMERULAR FILTRATION RATE (FEMALE)	121.74			mL/min/1.73
BUN/CREAT RATIO				
BUN/CREAT RATIO	**19.67**	**High**	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	3.1		2.6 - 6.0	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.9		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN	3.9		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				
GLOBULIN	4.0		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	139		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM	4.84		3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE	105		98 - 107	mmol/L
METHOD : ISE INDIRECT				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
METHOD : PHYSICAL				
APPEARANCE	**SLIGHTLY HAZY**			

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000080

PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

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CORP-OPD
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Test Report Status **Final**	Results	Biological Reference Interval	Units
METHOD : VISUAL			
SPECIFIC GRAVITY	1.025	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
CHEMICAL EXAMINATION, URINE			
PH	6.5	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
PUS CELL (WBC'S)	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	**5-7**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			

PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

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CLINICAL INFORMATION :

UID:12078051 REQNO-1311181
CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.	

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI-
GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equati especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
URIC ACID, SERUM-
Causes of Increased levels
Dietary
• High Protein Intake.
• Prolonged Fasting,
• Rapid weight loss.
Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin an globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremi metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion a

PATIENT NAME : MRS. KHUSHBOO DUBEY

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CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval

prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of fo can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

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BILLNO-150122OPCR053018
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Test Report Status **Final**	Results		Biological Reference Interval	
HAEMATOLOGY				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	**22**	**High**	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN	12.1		12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL COUNT	4.61		3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL COUNT	6.03		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	267		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT	36.6		36 - 46	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME	**79.5**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN	**26.3**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.1		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	17.3			
RED CELL DISTRIBUTION WIDTH	**16.0**	**High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MEAN PLATELET VOLUME	**12.6**	**High**	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT - NLR				
NEUTROPHILS	57		40 - 80	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT	3.44		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				

LABORATORY REPORT

Fortis | SRL Diagnostics

PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

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Test Report Status **Final**	Results		Biological Reference Interval	
LYMPHOCYTES	27		20 - 40	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE LYMPHOCYTE COUNT	1.63		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.1			
METHOD : CALCULATED PARAMETER				
EOSINOPHILS	06		1 - 6	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT	0.36		0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER				
MONOCYTES	10		2 - 10	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE MONOCYTE COUNT	0.60		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
BASOPHILS	00		0 - 2	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR			
MORPHOLOGY				
RBC	NORMOCHROMIC, MILD MICROCYTOSIS, MILD ANISOCYTOSIS			
METHOD : MICROSCOPIC EXAMINATION				
WBC	NORMAL MORPHOLOGY			
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS	ADEQUATE			
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) tha are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

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Patient Ref. No. 22000000803

PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

ACCESSION NO : **0022VJ004562** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : 22/10/2022 09:49:00 RECEIVED : 22/10/2022 09:55:25 REPORTED : 22/10/2022 14:53:08

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12078051 REQNO-1311181
CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference fo the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
RBC AND PLATELET INDICES-
Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT - NLR-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID posit patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 10650
This ratio element is a calculated parameter and out of NABL scope.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE A
METHOD : TUBE AGGLUTINATION	
RH TYPE	POSITIVE
METHOD : TUBE AGGLUTINATION	

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIO CHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.33	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.11	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.22	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.9	6.4 - 8.2	g/dL
METHOD : BIURET			

LABORATORY REPORT

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval	
ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	4.0	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.0	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	20	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	22	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	66	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	19	5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	137	100 - 190	U/L
METHOD : LACTATE -PYRUVATE			
CORONARY RISK PROFILE(LIPID PROFILE), SERUM			
CHOLESTEROL, TOTAL	170	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	53	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	47	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	111	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	123	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219	mg/dL

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results		Biological Reference Interval	
			Very high: > or = 220	
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	3.6		3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO	2.4		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	10.6		</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	94		74 - 99	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**5.8**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)	**119.8**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirub may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.A is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstructio

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CLINICAL INFORMATION :

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Test Report Status **Final**	Results	Biological Reference Interval

Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seer in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-norm levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be due t Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Huma serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumi levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
CORONARY RISK PROFILE(LIPID PROFILE), SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don''''''''''''''''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''''''''''''''''t need into triglycerides, which are stored in fat cells. Hi triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or hav diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumptior and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also bee implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both prim and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Th glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaem index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

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LABORATORY REPORT

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PATIENT NAME : MRS. KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

ACCESSION NO : **0022VJ004562** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : 22/10/2022 09:49:00 RECEIVED : 22/10/2022 09:55:25 REPORTED : 22/10/2022 14:53:08

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12078051 REQNO-1311181
CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval

1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

****End Of Report****

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Rekha. N

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Dr. Rekha Nair, MD
Microbiologist

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LABORATORY REPORT

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PATIENT NAME : MRS. MRS.KHUSHBOO DUBEY

PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

ACCESSION NO : **0022VJ004611** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : 22/10/2022 12:19:00 RECEIVED : 22/10/2022 12:22:17 REPORTED : 22/10/2022 14:36:40

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

CLINICAL INFORMATION :

UID:12078051 REQNO-1311181
CORP-OPD
BILLNO-150122OPCR053018
BILLNO-150122OPCR053018

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIO CHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**141**	**High** 70 - 139	mg/dL
METHOD : HEXOKINASE			

Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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LABORATORY REPORT

Fortis | SRL Diagnostics

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PATIENT ID : **FH.12078051** CLIENT PATIENT ID : UID:12078051

ACCESSION NO : **0022VJ004562** AGE : 32 Years SEX : Female ABHA NO :

DRAWN : 22/10/2022 09:49:00 RECEIVED : 22/10/2022 09:55:25 REPORTED : 22/10/2022 15:54:05

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Test Report Status **Final**	Results	Biological Reference Interval	Unit

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	130.8	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	7.77	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH 3RD GENERATION	1.940	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)
THYROID PANEL, SERUM-Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabo body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of th circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3 (ng/dL)	T4 (µg/dL)
New Born: 75 - 260	1-3 day: 8.2 - 19.9
.	1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley""s Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

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Patient Ref. No. 220000008

12078051
32 Years

mrs.khushboo
Female

10/22/2022 12:11:55 PM

HC

Rate	67	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline T abnormalities, anterior leads.....T flat or neg, V2-V4
PR	145	. Baseline wander in lead(s) II
QRSD	94	
QT	389	
QTc	411	

Sinus rhythm
normal
d

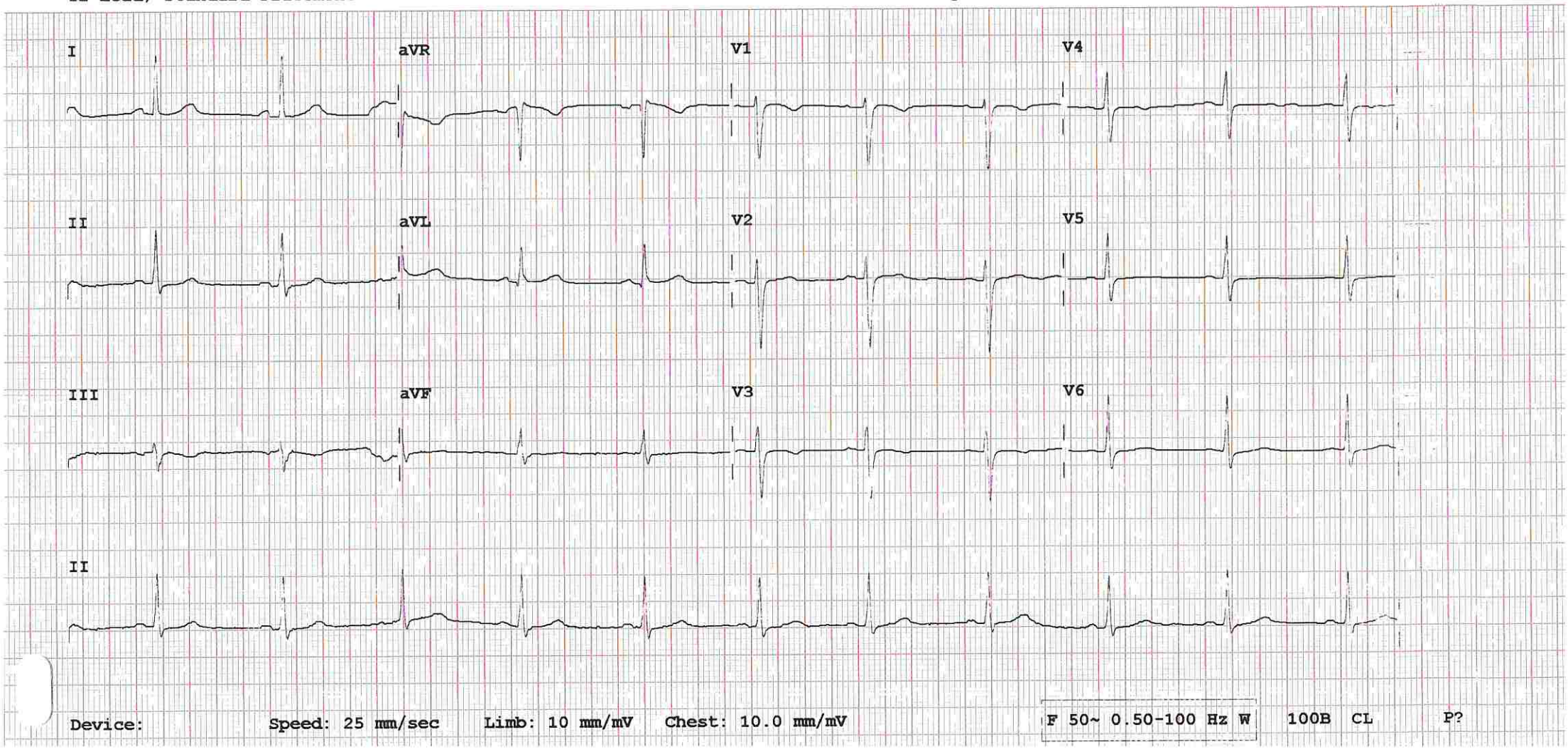
--AXIS--

P	-5
QRS	16
T	7

- BORDERLINE ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hosp

(For Billing/Reports & Discharge Summary only)

Date: 22/Oct/2022

DEPARTMENT OF NIC

Name: Mrs. Khushboo Dubey
Age I Sex: 32 YEAR(S) I Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12078051 | 52544/22/1501
Order No I Order Date: 1501/PN/OP/2210/111507 I 22-Oct-2022
Admitted On I Reporting Date : 22-Oct-2022 15:44:03
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	35	mm
AO Root	29	mm
AO CUSP SEP	18	mm
LVID (s)	31	mm
LVID (d)	43	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.5 m/sec
E/A RATIO:1.4

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

DR.PRASHANT PAWAR,
DNB(MED), DNB(CARDIOLOGY)

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DEPARTMENT OF RADIOLOGY

Date: 22/Oct/2022

Name: Mrs. Khushboo Dubey
Age | Sex: 32 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12078051 | 52544/22/1501
Order No | Order Date: 1501/PN/OP/2210/111507 | 22-Oct-2022
Admitted On | Reporting Date : 22-Oct-2022 14:25:55
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax are unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)

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DEPARTMENT OF RADIOLOGY

Date: 22/Oct/2022

Name: Mrs. Khushboo Dubey
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Bed Name :

UHID | Episode No : 12078051 | 52544/22/1501
Order No | Order Date: 1501/PN/OP/2210/111507 | 22-Oct-2022
Admitted On | Reporting Date : 22-Oct-2022 18:51:02
Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size (12.8 cm) and echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein is normal.

GALL BLADDER is partially distended. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.
CBD appears normal in caliber.

SPLEEN is normal in size (7.9 cm) and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 9.8 x 4.4 cm.
Left kidney measures 10.6 x 4.5 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical mass/calculi.

UTERUS is normal in size, measuring 6.8 x 2.8 x 3.6 cm.

Endometrium in the body of the uterus bifurcating cranially into two horns with intervening tissue consistent with normal myometrium. These seems extending upto the cervical region. Both the horns appear to be widely separated. Endometrial thickness measures 5.5 mm on right and 6.1 mm on left.

Both ovaries are normal.
Right ovary measures 1.8 x 1.8 x 2.7 cm, volume 5.0 cc.
Left ovary measures 2.2 x 2.5 x 1.9 cm, volume 5.8 cc.

No evidence of ascites.

IMPRESSION:

- **Endometrium in the body of the uterus bifurcating cranially into two horns with intervening tissue consistent with normal myometrium. These seems extending upto the cervical region. Both the horns appear to be widely separated.**

These findings are most likely s/o bicornuate bicollis uterus.
Suggest: MRI Pelvis for better delineation.

DR. VIVEK MANE
MBBS., DMRE. (Radiologist)