



Patient Details

UHID : AFD000012682
Patient Name : MRS. SUNITA
Age / Gender : 47 Yrs 2 Mth / FEMALE / 10-12-1975
Company : Acrofemi Healthcare Ltd
Address : FLAT NO-1204 TOWER-B7 RPS SAVANA, SEC-88, FARIDABAD, HARYANA, INDIA, Zip No.-121014

Bill Date : 21-02-2023 09:28:07
Bill No. : AFDHC230000306
Receipt No. : AFDPR230005646

Service Details

S. No.	Investigation	Rooms	Remarks
1	MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS DR. PHC HEAD		
2	CBC-1(COMPLETE BLOOD COUNT)		
3	ESR		
4	URINE, ROUTINE EXAMINATION		
5	STOOL ROUTINE EXAMINATION		<i>refused</i>
6	* BLOOD GROUP (ABO & RH)		
7	GLUCOSE PLASMA (FASTING)		
8	GLUCOSE PLASMA (PP) POST PRANDIAL		<i>11:00</i>
9	GLYCATED HAEMOGLOBIN (HBA1C)		
10	THYROID PROFILE (FT3+FT4+TSH)		
11	LIPID PROFILE		
12	KFT/RFT-KIDNEY/RENAL PANEL 1		
13	LIVER FUNCTION TESTS (LFT)		
14	ECG		
15	2D ECHO DR. MITHILESH KUMAR		
16	USG-BREAST BOTH		
17	XRAY-CHEST P.A.		
18	PAP SMEAR		
19	USG-FOR WHOLE ABDOMEN		
20	OPD Consultation-Internal Medicine DR. MUKUND SINGH		
21	OPD Consultation-Gynae DR. CHANCHAL GUPTA / DR. MALA DIXIT		
22	OPD Consultation-Dental DR. RAVJOT AHUJA		<i>Refused by Pt.</i>
23	OPD Consultation-Ophthal DR. UPASANA		

Employee ID
Signature

Prepared By : MRS. PRIYA MOURYA

FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004188	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 10:05
		Reporting Date & Time	: 21-02-2023 12:40

HAEMATOLOGY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS
CBC -1 (COMPLETE BLOOD COUNT)

TOTAL LEUCOCYTE COUNT (Flow Cytometry)		9.2	thousand/cumm	4 - 11
RED BLOOD CELL COUNT (Hydro Dynamic Focussing)		4.2	million/cumm	3.8 - 4.8
HAEMOGLOBIN (SLS Hb Detection)		12.8	g/dL	12 - 15
PACK CELL VOLUME (Cumulative Pulse Height Detection)		38.5	%	36 - 46
MEAN CORPUSCULAR VOLUME		91.2	fL	83 - 101
MEAN CORPUSCULAR HAEMOGLOBIN		30.3	pg	27 - 32
MEAN CORPUSCULAR HAEMOGLOBIN CONCENTRATION		33.2	g/dL	31.5 - 34.5
PLATELET COUNT (Hydro Dynamic Focussing)		360	thousand/cumm	150 - 400
RED CELL DISTRIBUTION WIDTH (S.D - RDW) (Particle Size Distribution)	H	53.8	fL	39 - 46
RED CELL DISTRIBUTION WIDTH (C.V.)	H	16.1	%	11.6 - 14

DIFFERENTIAL LEUCOCYTE COUNT

NEUTROPHILS		65	%	40 - 80
LYMPHOCYTES		26	%	20 - 40
MONOCYTES		5	%	2 - 10
EOSINOPHILS		4	%	1 - 5
BASOPHILS		0	%	0 - 1
ESR (Westergren)	H	52	mm 1st hr	0 - 20

**** End of Report ****
IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low


DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST

FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004226	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 13:42
		Reporting Date & Time	: 21-02-2023 16:06

CLINICAL PATH REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Urine

MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS
URINE, ROUTINE EXAMINATION
PHYSICAL EXAMINATION

QUANTITY		40 mL		
COLOUR		Pale yellow		Pale Yellow
TURBIDITY		Slight turbid		

CHEMICAL EXAMINATION

PH (Double pH indicator method)		7.5		5.0 - 8.5
PROTEINS (Protein-error-of-indicators)		Negative		Negative
SUGAR (GOD POD Method)		Negative		Negative
SPECIFIC GRAVITY, URINE (Apparent pKa change)		1.010		1.005 - 1.030

MICROSCOPIC EXAMINATION

LEUCOCYTES		16-18	/HPF	0 - 5
RBC's		1-2		
EPITHELIAL CELLS		8-10		
CASTS		Nil		
CRYSTALS		Nil		

**** End of Report ****

IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low



DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST


FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: If PHC :
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004189	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 10:05
		Reporting Date & Time	: 21-02-2023 12:07

BLOOD BANK REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
<i>Sample Type: EDTA Whole Blood</i>				
MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS				
BLOOD GROUP (ABO & RH)				
ABO GROUP		"O"		
RH TYPE		POSITIVE		

Forward grouping done by slide method.

**** End of Report ****
IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low


DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST

FINAL REPORT

Bill No.	: AFDHC23000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: If PHC :
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004190	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 10:05
		Reporting Date & Time	: 21-02-2023 11:18

Sample Type: Serum


MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS
KFT/RFT- KIDNEY/RENAL PANEL 1

BLOOD UREA (Urea: S.U.N/Ketic)	21	mg/dL	15 - 45
CREATININE-SERUM (Modified Jaffe's Kinetic)	0.6	mg/dL	0.6 - 1.1
SODIUM-SERUM (Indirect Ion-Selective Electrode)	137	m.mol/L	135 - 145
POTASSIUM-SERUM (Indirect Ion-Selective Electrode)	4.4	m.mol/L	3.5 - 5.1
CHLORIDE-SERUM (Indirect Ion-Selective Electrode)	105	m.mol/L	98 - 107
GLUCOSE-PLASMA (FASTING) (UV Hexokinase)	97.8	mg/dL	70 - 100

Note: A diagnosis of diabetes mellitus is made if fasting blood glucose exceeds 126 mg/dL.
 (As per American Diabetes Association recommendation)

**** End of Report ****
IMPORTANT INSTRUCTIONS

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DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST

FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC : <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004225	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 13:42
		Reporting Date & Time	: 21-02-2023 16:09

BIOCHEMISTRY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Plasma

MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS

GLUCOSE-PLASMA (POST PRANDIAL) (UV Hexokinase)		106.3	mg/dL	70 - 140
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Note: A diagnosis of diabetes mellitus is made if 2 hour post load glucose exceeds 200 mg/dL.
 (As per American Diabetes Association recommendation)

**** End of Report ****

IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low



DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST



FINAL REPORT

Bill No.	: AFBCB230000632	Bill Date	: 21-02-2023 10:30
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFB23063128	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 11:42
		Reporting Date & Time	: 21-02-2023 14:08

HAEMATOLOGY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

GLYCATED HAEMOGLOBIN (HBA1C)

HBA1C (HPLC)		5.6	%	4.27 - 6.07
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INTERPRETATION:

HbA1c %	Degree of Glucose Control
>8%	Action suggested due to high risk of developing long term complications like Retinopathy, Nephropathy, Cardiopathy and Neuropathy
7.1 - 8.0	Fair Control
<7.0	Good Control

Note:

1. A three monthly monitoring is recommended in diabetics.
2. Since HbA1c concentration represents the integrated values for blood glucose over the preceding 6 - 10 weeks and is not affected by daily glucose fluctuation, exercise and recent food intake, it is a more useful tool for monitoring diabetics.

**** End of Report ****

IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low

DR. SHARMILA RAI
MD, PATHOLOGY
Consultant



FINAL REPORT

Bill No.	: AFBCB230000632	Bill Date	: 21-02-2023 10:30
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFB23063129	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 11:42
		Reporting Date & Time	: 21-02-2023 13:33

SEROLOGY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

THYROID PROFILE (FT3+FT4+TSH)

FREE-TRI IODO THYRONINE (FT3) (ECLIA)		2.40	pg/mL	2.0-4.4
FREE -THYROXINE (FT4) (ECLIA)		1.13	ng/dL	0.9-1.7
THYROID STIMULATING HORMONE (TSH) (ECLIA)		1.99	mIU/L	0.27-4.20

**** End of Report ****

IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low

Shilpa

DR. SHILPA G
MD, PATHOLOGY
Sr Consultant

FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004190	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 10:05
		Reporting Date & Time	: 21-02-2023 11:18

BIOCHEMISTRY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS

CHOLESTROL-TOTAL (CHO-POD)	H	187	mg/dL	0 - 160
HDL CHOLESTROL Enzymatic Inhibition		54	mg/dL	>45
CHOLESTROL-LDL DIRECT Enzymatic Selective Protection	H	125	mg/dL	0 - 100
S.TRYGLYCERIDES (GPO - POD)		112	mg/dL	0 - 160
NON-HDL CHOLESTROL	H	133.0	mg/dL	0 - 125
TOTAL CHOLESTROL / HDL CHOLESTROL		3.5		1/2 Average Risk <3.3 Average Risk 3.3 - 4.4 2 Times Average Risk 4.5 - 7.1 3 Times Average Risk 7.2-11.0
LDL CHOLESTROL / HDL CHOLESTROL		2.3		1/2 Average Risk <1.5 Average Risk 1.5-3.2 2 Times Average Risk 3.3-5.0 3 Times Average Risk 5.1-6.1
CHOLESTROL-VLDL		22	mg/dL	10 - 35

Comments:

- Disorders of Lipid metabolism play a major role in atherosclerosis and coronary heart disease.
- There is an established relationship between increased total cholesterol & LDL cholesterol and myocardial infarction.
- HDL cholesterol level is inversely related to the incidence of coronary artery disease.
- Major risk factors which adversely affect the lipid levels are:
 - Cigarette smoking.
 - Hypertension.
 - Family history of premature coronary heart disease.
 - Pre-existing coronary heart disease.

**** End of Report ****
IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low


DR. REETU JADHAV NAGE
 MBBS, DCP, DNB (PATHOLOGY)
 CONSULTANT PATHOLOGIST

GE MAC2000 11 128L V241 25 mm/s


FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: If PHC :
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23004190	Current Ward / Bed	: /
		Receiving Date & Time	: 21-02-2023 10:05
		Reporting Date & Time	: 21-02-2023 11:18

BIOCHEMISTRY REPORTING

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
--------------------	------	--------	-----	-------------------------------

Sample Type: Serum

MEDIWHEEL PKG FOR FEMALE ABOVE 40YRS
LIVER FUNCTION TESTS (LFT)

BILIRUBIN-TOTAL (DPO)		0.40	mg/dL	0.2 - 1.0
BILIRUBIN-DIRECT (DPO)		0.07	mg/dL	0 - 0.2
BILIRUBIN-INDIRECT		0.33	mg/dL	0.2 - 0.8
S.PROTEIN-TOTAL (Buret)		6.7	g/dL	6 - 8.1
ALBUMIN-SERUM (Dye Binding-Bromocresol Green)		3.8	g/dL	2.8-3.8
S.GLOBULIN		2.9	g/dL	1.5 - 2.5
A/G RATIO	L	1.31		
ALKALINE PHOSPHATASE (IFCC AMP BUFFER)		53.5	IU/L	42 - 98
ASPARTATE AMINO TRANSFERASE (IFCC)		11.3	IU/L	10 - 42
ALANINE AMINO TRANSFERASE (IFCC)		13.5	IU/L	10 - 40
GAMMA-GLUTAMYLTRANSFERASE (IFCC)		14.5	IU/L	7 - 35
LACTATE DEHYDROGENASE (IFCC; L-F)		181.2	IU/L	0 - 248

CHOLESTROL-TOTAL (CHO-PGD)	H	187	mg/dL	0 - 160
HDL CHOLESTROL (Enzymatic Inhibition)		54	mg/dL	>45
CHOLESTROL-LDL DIRECT (Enzymatic Selective Protection)	H	125	mg/dL	0 - 100
S.TRYGLYCERIDES (GPO - PGO)		112	mg/dL	0 - 160
NON-HDL CHOLESTROL	H	133.0	mg/dL	0 - 125
TOTAL CHOLESTROL / HDL CHOLESTROL		3.5		1/2 Average Risk <3.3 Average Risk 3.3 - 4.4 2 Times Average Risk 4.5 - 7.1 3 Times Average Risk 7.2-11.0
LDL CHOLESTROL / HDL CHOLESTROL		2.3		1/2 Average Risk <1.5 Average Risk 1.5-3.2 2 Times Average Risk 3.3-5.0 3 Times Average Risk 5.1-6.1
CHOLESTROL-VLDL		22	mg/dL	10 - 35

Comments:

- Disorders of Lipid metabolism play a major role in atherosclerosis and coronary heart disease.
- There is an established relationship between increased total cholesterol & LDL cholesterol and myocardial infarction.
- HDL cholesterol level is inversely related to the incidence of coronary artery disease.
- Major risk factors which adversely affect the lipid levels are:
 - Cigarette smoking.
 - Hypertension.
 - Family history of premature coronary heart disease.
 - Pre-existing coronary heart disease.

**** End of Report ****
IMPORTANT INSTRUCTIONS

CL - Critical Low, CH - Critical High, H - High, L - Low



FINAL REPORT

Bill No.	: AFDHC230000306	Bill Date	: 21-02-2023 09:28
Patient Name	: MRS. SUNITA	UHID	: AFD000012682
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Patient Type	: OPD
Ref. Consultant	: DR. PHC HEAD	Ward	:
Sample ID	: AFD23004211	Current Bed	:
	:	Reporting Date & Time	: 21-02-2023 13:08
	:	Receiving Date & Time	: 21/02/2023 11:54

CYTOPATHOLOGY REPORTING

Pap smear (Manual no. P -16/23)

Specimen type: Conventional Cervico-vaginal smear

Specimen adequacy: Satisfactory for evaluation, without endocervical or transformation zone component

Comment: Smears show mainly superficial and intermediate squamous epithelial cells. Many parabasal cells are also noted. Cells are having normal N:C Ratio. Along with this, there are sheets of polymorphonuclear cells are present. Normal bacterial flora seen. Reactive inflammatory changes seen.

No Candida or Trichomonas seen.

No atypical cells or granulomas seen.

INTERPRETATION / RESULT: Negative for intraepithelial lesion or malignancy (NILM), Reactive changes associated with inflammation

(Note: Report as per the 2014 Bethesda system for reporting cervical cytology).

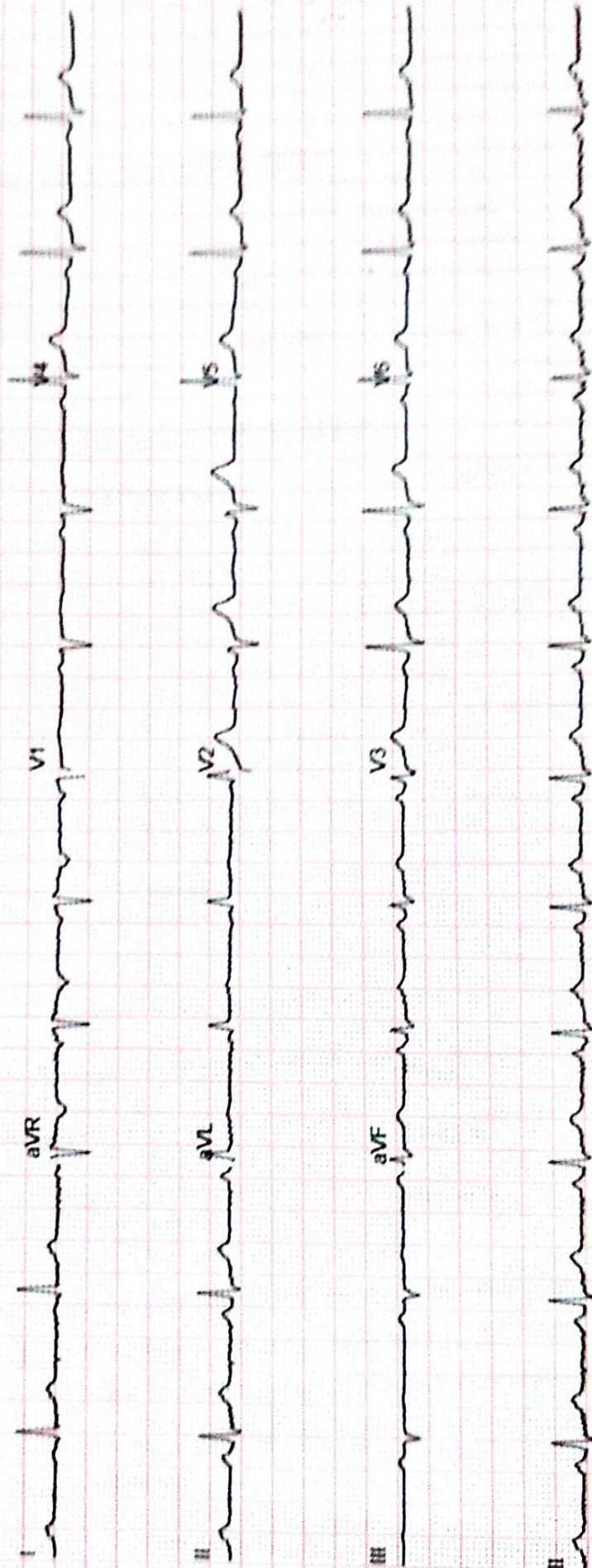
*** End of Report ***

DR. REETU JADHAV NAGE
MBBS, DCP, DNB
(PATHOLOGY)
CONSULTANT PATHOLOGIST

Normal sinus rhythm
Normal ECG

QRS : 88 ms
QT / QTcBaz : 404 / 439 ms
PR : 130 ms
P : 84 ms
RR / PP : 850 / 845 ms
P / QRS / T : 62 / 15 / 50 degrees

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:



NON INVASIVE CARDIOLOGY

Patient Name	: MRS. SUNITA	IPD No.	:
Ago	: 47 Yrs 2 Mth	UHID	: AFD000012682
Gender	: FEMALE	Bill No.	: AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 21-02-2023 09:28:07
Ward	:	Room No.	:
		Procedure Date	: 21-02-2023 14:19:03

ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

MEASUREMENTS	ABSOLUTE VALUE	NORMAL VALUE
Aortic Root Diameter	2.8	2.0-3.7cm < 2.2cm/M2
Aortic Valve Opening	N	1.5-2.6cm
Left Atrial Dimension	3.0	1.9-4.0cm < 2.2cm/M2
RV Dimensions	N	0.7-2.6cm
RV thickness	N	0.3-0.9cm
LV ED Dimension	4.9	3.7-5.6 cm < 3.2cm /M2
LV ES Dimension	3.0	2.2-4.0 cm
IVS thickness	ED - 0.8 ES-0.9	0.6-1.2cm
LVPW Thickness	ED - 0.7 ES-1.2	0.5-1.1cm
IVS/ LVPW Ratio	N	
Mitral Valve	DE-N EF -N	

<i>INDICES OF LV FUNCTION</i>		
EPSS		<9mm
FS%		24-42%
LV Ejection Fraction	62%	60+/-6%

IMAGING:

2D- imaging in PLAX.SAX and apical views revealed normal left ventricle. Movement of septum, posterior and lateral walls are normal. Global LVEF is 62%. Mitral valve opening is normal. No evidence of mitral valve prolapse is seen. Aortic valve has three cusps and its opening is not restricted. Tricuspid valve leaflets move normally, Pulmonary valve is normal. Interatrial and Interventricular septal are intact, No intracardiac mass or thrombus is seen. No pericardial pathology is observed.

NON INVASIVE CARDIOLOGY

Patient Name	: MRS. SUNITA	IPD No.	:
Age	: 47 Yrs 2 Mth	UHID	: AFD000012682
Gender	: FEMALE	Bill No.	: AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 21-02-2023 09:28:07
Ward	:	Room No.	:
		Procedure Date	: 21-02-2023 14:19:03

MORPHOLOGICAL DATA

Mitral Valve : AML PML	Normal	Interatrial Septum	Intact
Aortic Valve	Normal	Interventricular Septum	Intact
Tricuspid Valve	Normal	Pulmonary Artery	Normal
Pulmonary Valve	Normal	Aorta	Normal
Right Ventricle	Normal	Right Atrium	Normal
Left Ventricle	Normal	Left Atrium	Normal

DOPPLER STUDY

	m/s	m/s	
MITRAL VELOCITY	E-0.7	A-0.6	MR 0/4
TRICUSPID VELOCITY	2.34 m/s		TR 0/4
AORTIC VELOCITY	1.08 m/s		AR 0/4
PULMONARY VELOCITY	0.81 m/s		PR 0/4
PA Pressure	21 mmHg		



NON INVASIVE CARDIOLOGY

Patient Name	: MRS. SUNITA	IPD No.	:
Age	: 47 Yrs 2 Mth	UHID	: AFD000012682
Gender	: FEMALE	Bill No.	: AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 21-02-2023 09:28:07
Ward	:	Room No.	:
		Procedure Date	: 21-02-2023 14:19:03

COLOUR FLOW MAPPING

Trace TR.

FINAL IMPRESSION

1. No RWMA, LVEF-62%.
2. Normal RV systolic function.
3. Normal cardiac chamber dimension.
4. Trace TR.
5. Normal mitral inflow pattern.
6. No clot/mass/vegetation/PE.

DR. MITHUNESH KUMAR
MD(DNB (Cardiology)).
Consultant Cardiologist
HMC/HN19723



For The perusal of a medical professional only
The content of this report is only an opinion based on images and is therefore subject to inherent technical limitations.

It is not the diagnosis & must be correlated clinically.
NOT FOR MEDICOLEGAL PURPOSES

.....End of Report.....

Prepare By.
MADHVI.S

DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : XRAY

Patient Name	: MRS. SUNITA	IPD No.	:	
Age	: 47 Yrs 2 Mth	UHID	:	AFD000012682
Gender	: FEMALE	Bill No.	:	AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	:	21-02-2023 09:28:07
Ward	:	Room No.	:	
		Print Date	:	21-02-2023 12:47:22

CHEST PA VIEW:

Cardiac shadow appears normal.

Both lung fields appear clear.

Both domes of diaphragm and both CP angles are clear.

Both hila appear normal.

Soft tissues and bony cage appear normal.

Please correlate clinically.

.....End of Report.....



DR. BHANOO CHAUDHARY, MBBS, MD
CONSULTANT

Prepare By.
BHANOO

Note : The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : ULTRASOUND

Patient Name	: MRS. SUNITA	IPD No.	:
Age	: 47 Yrs 2 Mth	UHID	: AFD000012682
Gender	: FEMALE	Bill No.	: AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 21-02-2023 09:28:07
Ward	:	Room No.	:
		Print Date	: 21-02-2023 10:27:30

USG BOTH BREASTS

PROTOCOL: High resolution ultrasound examination of both breasts was performed with 10 to 12-MHz linear probe.

FINDINGS:

Mild ductal prominence is seen bilaterally.

Few prominent left sided axillary lymphnodes are seen.

Rest of the breasts parenchyma appears normal. No focal lesion or collection seen.

Both the nipples are normal in position with normal posterior shadowing.

Skin and subcutaneous tissues are unremarkable on both sides.

IMPRESSION: BIRADS – I.

Please correlate clinically.

.....End of Report.....



**DR. BHANOO CHAUDHARY, MBBS,MD
CONSULTANT**

Prepare By.
BHANOO

Note : The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : ULTRASOUND

Patient Name	: MRS. SUNITA	IPD No.	:
Age	: 47 Yrs 2 Mth	UHID	: AFD000012682
Gender	: FEMALE	Bill No.	: AFDHC230000306
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 21-02-2023 09:28:07
Ward	:	Room No.	:
		Print Date	: 21-02-2023 10:22:48

USG WHOLE ABDOMEN

FINDINGS:

- Liver is normal in size (longitudinal span 12.4 cm), contour and echotexture. No evidence of any focal lesion is seen. No dilated intrahepatic biliary radicles are seen. Common duct and portal vein are normal in course and caliber.
- The gall bladder is contracted (? Post-prandial status).
- *Visualized Pancreas is normal in size and parenchymal echogenicity. Rest of the pancreas and retroperitoneal structures are obscured by overlying bowel gas shadows.*
- Spleen is normal in size and echo pattern with no focal lesion.
- Both the kidneys are normal in size, shape and position. No evidence of any hydronephrosis is noted on either side. Normal corticomedullary differentiation is maintained bilaterally. The cortical thickness is within normal limits. The right kidney measures 10.0 x 3.5 cm. The left kidney measures 10.5 x 3.7 cm. No focal lesion/calculus noted in either kidney.
- The Urinary Bladder is minimally distended.
- Pelvis could not be assessed.
- No ascites/retroperitoneal lymphadenopathy/pleural effusion.

IMPRESSION:

- **No significant abnormality is detected in abdomen and pelvis.**

Please correlate clinically.

.....End of Report.....



Prepare By.
BHANO

DR. BHANO CHAUDHARY, MBBS, MD
CONSULTANT

Note : The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

OPD Assessment Form (First visit/Follow-up)



Name	: MRS. SUNITA	UHID No.	: AFD000012682
HUSBAND	: AMIT OHLAN	Date	: 21-02-2023 09:20:13
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Doctor / Unit	: DR. MUKUND SINGH /
CPG	: CORPORATE CASHAIMS2122_FD	Department	: INTERNAL MEDICINE_FD
Inst. Name	: Acrofemi Healthcare Ltd		
Address	: FLAT NO-1204 TOWER-B7 RPS SAVANA, SEC-88, FARIDABAD, HARYANA, INDIA, Zip No.-121014		

Present Complaints:

PHC

c/w fatigue

BP (mm Hg) *110/80 mm/Hg*
 Pulse *72 b/m*
 RR *SpO2-99%*
 Ht/Length *158cm*
 Wt- *66.4 kg*
 Pain Score (1-10)

Past/Family History:

None

History Given By : *Self*

Clinical Findings : *None*

Any known Allergies

None known

T. redman *9* *hypotension*
DR. MUKUND SINGH, MBBS, DNB, CONSULTANT-INTERNAL MEDICINE_FD, Reg. No: BMC-35607

Provisional Diagnosis:

Asian Fidelis Multispeciality Hospital OPD Timing: Mon - Sat : 10:00am-04:00pm.

Nature of illness, prognosis, potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.

WHEN TO OBTAIN URGENT CARE : In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom

Investigations Advised :

R_s


Plan Of Care :

- ① Atrol 60 K twice weekly
- ② Ryceal 500
0 ←————— x
- ③ Acti-Φ 10 500
0 ←————— x

Treatment Advice:

1 month

Nutritional Screening : Required (If required, please contact, the dietician)
 Not Required

Signature of Doctor / Consultant:  Date:..... Time:.....

Dr. Mukund Singh
 Consultant Internal Medicine
 Asian Fidelis Multi Speciality Hospital
 RPS Savana City, Sector-88
 Faridabad-121002, Haryana
 MBBS 2004, DNB (Medicine) 2010
 MCI-IMR/11/1008

OPD Assessment Form (First visit/Follow-up)



Name	: MRS. SUNITA	UHID No.	: AFD000012682
HUSBAND	: AMIT OHLAN	Date	: 21-02-2023 09:20:13
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Doctor / Unit	: DR. CHANCHAL GUPTA / DR. MALA DIXIT /
CPG	: CORPORATE CASHAIMS2122_FD	Department	: OBS / GYNAE
Inst. Name	: Acrofemi Healthcare Ltd		
Address	: FLAT NO-1204 TOWER-B7 RPS SAVANA, SEC-88, FARIDABAD, HARYANA, INDIA, Zip No.-121014		

Health checkup.

Present Complaints:

umb - 2d back

Past/Family History: RNF 3.400 year.

h/c - 15 yrs. use.

History Given By :

Clinical Findings :

No h/o HT/Di/Hypertens

h/h NS.

b/c breast soft.

h/a soft

b/s (6 H)

small erosion

(R) Vulvar skin tag

h/v ut n/c b/c fissure free.

BP (mm Hg) 110/80 mm/Hg
Pulse 72 b/M
RR SpO2 - 99%
Ht/Length 158 cm
Wt- 66.4 kg
Pain Score (1-10)

Any known Allergies

h/p's smear done

DR. CHANCHAL GUPTA / DR. MALA DIXIT, MBBS, DNB, FMAS, FICOG, Sr. Consultant & Head-OBS / GYNAE, Reg. No: HN

Provisional Diagnosis:

Note: Patient has been informed about the potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.
WHEN TO OBTAIN URGENT CARE : In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom



Renew & reports

Investigations Advised :

Pap's smear NILM
USG abd. (K)
USG Forecast breast 1
|

Plan Of Care :



Treatment Advice:

Nutritional Screening : Required (If required, please contact, the dietician)
Not Required

Signature of Doctor / Consultant:..... Date:..... Time:.....

OPD Assessment Form (First visit/Follow-up)



Name	: MRS. SUNITA	UHID No.	: AFD000012682
HUSBAND	: AMIT OHLAN	Date	: 21-02-2023 09:20:13
Age / Gender	: 47 Yrs 2 Mth / FEMALE	Doctor / Unit	: DR. RAVJOT AHUJA /
CPG	: CORPORATE CASHWAIMS2122_FD	Department	: DENTAL
Inst. Name	: Acrofemi Healthcare Ltd		
Address	: FLAT NO-1204 TOWER-B7 RPS SAVANA, SEC-88, FARIDABAD, HARYANA, INDIA, Zip No.-121014		

Present Complaints:

BP (mm Hg) 110/80 mmHg
Pulse 72 b/m
RR SpO2 - 99%
Ht/Length 158 CM
Wt- 66.4 kg
Pain Score (1-10)

Past/Family History:

History Given By :
Clinical Findings :

*dental consultant
not required
- parents*

Any known Allergies

DR. RAVJOT AHUJA, DENTAL,

Provisional Diagnosis: Asian Fidelis Multispeciality Hospital OPD Timings: Mon - Sat: 10:00am to 04:00pm.

Nature of illness, prognosis, potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.
WHEN TO OBTAIN URGENT CARE : In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom

OPD Assessment Form (First visit/Follow-up)



Name : MRS. SUNITA
 HUSBAND : AMIT OHLAN
 Age / Gender : 47 Yrs 2 Mth / FEMALE
 CPG : CORPORATE CASHVAIMS2122_FD
 Inst. Name : Acrofemi Healthcare Ltd
 Address : FLAT NO-1204 TOWER-B7 RPS SAVANA, SEC-88, FARIDABAD, HARYANA, INDIA, Zip No.-121014

UHID No. : AFD000012682
 Date : 21-02-2023 09:20:13
 Doctor / Unit : DR. UPASANA /
 Department : OPHTHALMOLOGY

Present Complaints: *for Routine Check up R*

BP (mm Hg) *110/80 mm/mg*
 Pulse *72 b/m*
 RR *SpO2 - 99%*
 Ht/Length *158 cm*
 Wt- *66.4 kg*
 Pain Score (1-10)

Past/Family History:

MIA

History Given By :

Clinical Findings :
UAC 6/6
6/6?

Any known Allergies

*ST (Remo + 0.25 * 10 6/6*
add + 1.75 (B) N/6

DR. UPASANA, MBBS, DOMS, FAEH, Consultant-OPHTHALMOLOGY, Reg. No: MCI 09/35142

Provisional Diagnosis:

Note: Nature of illness, prognosis, potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.
 WHEN TO OBTAIN URGENT CARE : In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom