

Place Label Here
 Pt. Name : _____
 UMR : _____
 Age : _____ Sex : _____
 IP : _____
 If label not available, write Pt. Name, IP No., Sex,
 Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Tejas Dhukase Date of Birth : _____ Age/Sex: 23 UMR No.: 22735

Assessment :

Height: 173 cms Weight: 45 kg. BMI: _____ Respiration: _____/min Pulse H/R: 71/min
 BP: 135/81 mmHG Temperature : _____ °F/°C SpO2 98 % BSL _____

Chief Complaints :

Health check up

Tick Appropriate :

- Interpreter Needed Yes No
- Nutritional Status: Weight Loss/Gain in Last 3 Months Yes No
- If Weight Loss / ain-Dietary Referral Yes No
- Psychological Assessment Agitated Anxious Yes No Normal
- (If Agitated, Inform Physician) Irritable

Any Allergies Known Including Drugs : NO

Past History: Any Surgeris Explain : NO

Any Other illness: Explain : NO

Pain Score: Numerical Scales (1-10) _____ Location _____ Characteristics _____

Need to be seen immediately by the Doctor _____ Yes No

Fall risk: Age 65Yrs. _____ Tremors _____ High Grade Fever _____ H/O Fall in last 3 months _____

Cardiac Medicines _____ Seizure Medications _____ Fall Prevention Education Done _____

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
<u>Sushma</u>	<u>029987</u>	<u>Sushma</u>	<u>13/5/24</u>

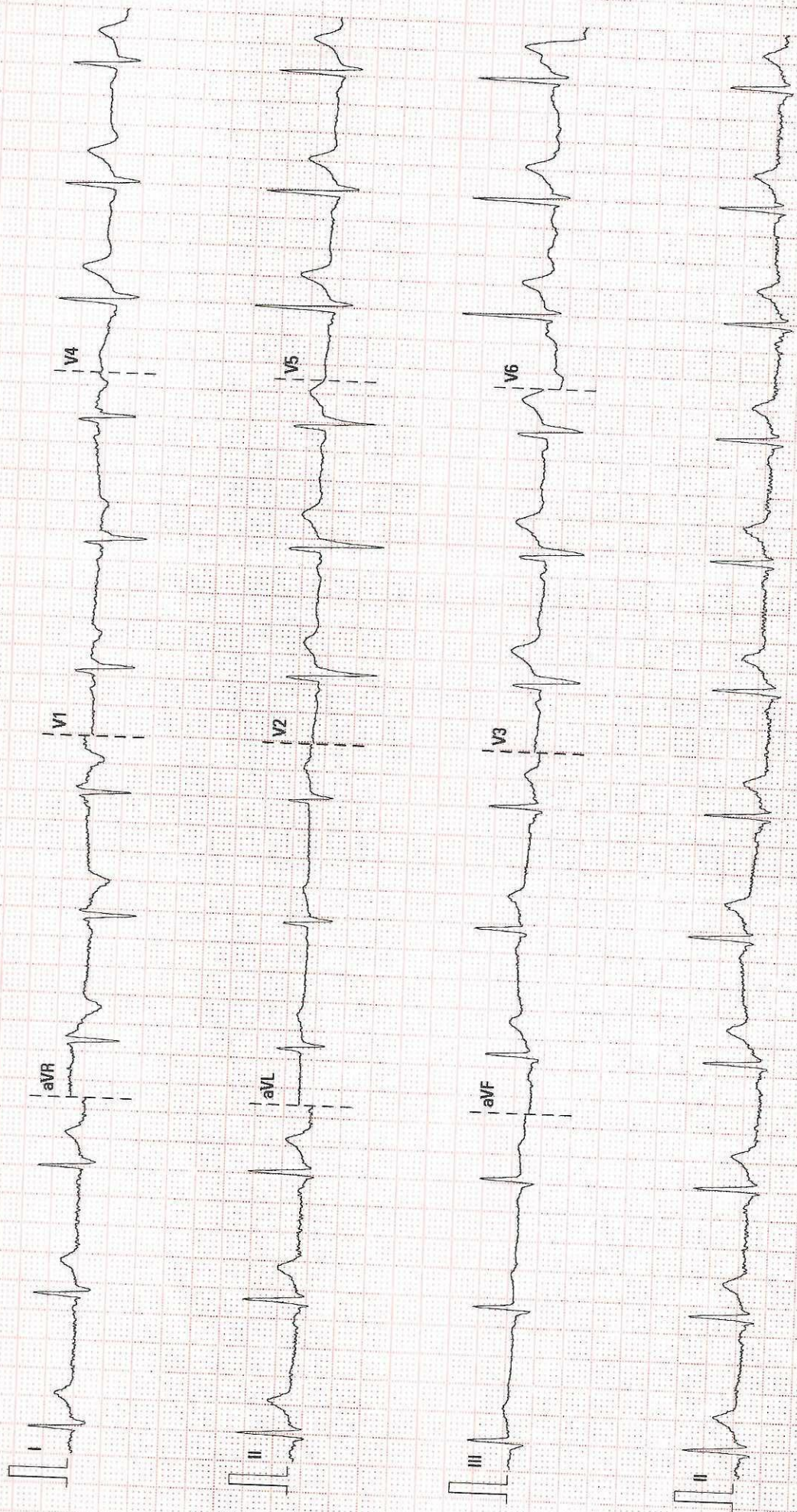
2024-05-13 11:37:12 AM

Name: tejas dhakare
Age: 23 Years
Gender: Male

Vent. Rate: 70 bpm
PR Interval: 138 ms
QRS Duration: 102 ms
QT/QTc Interval: 370/388 ms
P/QRS/T Axes: 72/67/48 deg
QTc: Hodges

Sinus rhythm
Normal ECG

Unconfirmed Diagnosis



25 mm/s
10 mm/mV
50 Hz
BUR 35 Hz

02.10.00/V28.4.1
SN:FN-26035810



DEPARTMENT OF LABORATORY

Patient Name : Mr. TEJAS MAHADEV DHAKARE	Age /Gender : 23 Y(s)/Male
Bill No/ UMR No : PUBC22789/PUU22735	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:30 pm	Report Date : 13-May-24 01:20 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
CUE(COMPLETE URINE EXAMINATION)			
<u>GENERAL EXAMINATION</u>			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.015	1.010 - 1.030
PH		5.0	4.5 - 8.0
<u>CHEMICAL EXAMINATION</u>			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
<u>MICROSCOPIC EXAMINATION</u>			
PUS CELLS	Urine	0-1	0 - 5 /hpf
RBC		NIL	0 - 2 /hpf
EPITHELIAL CELLS		0-1	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

*** End Of Report ***

System Name : M



DEPARTMENT OF LABORATORY

Patient Name : Mr. TEJAS MAHADEV DHAKARE	Age /Gender : 23 Y(s)/Male
Bill No/ UMR No : PUBC22789/PUU22735	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:30 pm	Report Date : 13-May-24 01:20 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	16.3	13.2 - 17.3 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		7,330	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		410000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		5.53	4.5 - 6 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		47.7	40 - 50 %	Analogical integration
MCV		86.3	82 - 95 fl	Calculated
MCH		29.4	27 - 32 pg	Calculated
MCHC		34.1	32 - 36 g/dL	Calculated
RDW(cv)		12.1	11.5 - 14.0 %	Calculated
MPV		8.2	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	62.3	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		27.6	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		2.3	00 - 06 %	DHSS/Microscopy
MONOCYTES		6.5	00 - 10 %	DHSS/Microscopy
BASOPHILS		1.3	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" AB "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		4	0 - 15 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

System Name : M



DEPARTMENT OF LABORATORY

Patient Name : Mr. TEJAS MAHADEV DHAKARE	Age /Gender : 23 Y(s)/Male
Bill No/ UMR No : PUBC22789/PUU22735	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:32 pm	Report Date : 13-May-24 03:09 pm

Parameters Specimen Result Biological Reference In Method

System Name : M



DEPARTMENT OF LABORATORY

Patient Name : Mr. TEJAS MAHADEV DHAKARE	Age /Gender : 23 Y(s)/Male
Bill No/ UMR No : PUBC22789/PUU22735	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:32 pm	Report Date : 13-May-24 03:53 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		82.5	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
SERUM CREATININE		0.81	0.8 - 1.3 mg/dL	Jaffe
SERUM BILIRUBIN TOTAL		1.10	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
DIRECT BILIRUBIN		0.31	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.79	<= 1.0 mg/dL	
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		9.3	7.0 - 21.0 mg/dL	Calculatead
SGPT (ALT)		32.8	<= 41 U/L	Enzymatic
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		89.7	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase

*** End Of Report ***

Lab Incharge

Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST

Test results related only to the item tested.

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

System Name : M



Mr. Tejas Dhakare

23/M

PEME

No +/o DM/HtM/BA/DA

No DOE chut pain

Rt. B.S. vesic

On. S.L. (N)

LINE - NAD



13/5/24

Dr. Aditya Vinod Sondankar
MBBS, DNB (Medicine)
Masterclass in Diabetes (PGDCED)
Consultant General Medicine
Reg No. 2009083017



Date:- 13/05/24

Name:- Mr Tejas Dhakare .

Age/Sex:- 23 , M .

S/B: Ophthalmologist: Dr Kirti Mane .

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	> 6/6	> no glasses	> 6/6	N ₆ C	WNL
Left	6/6	> no glasses	> 6/6	out glasses.	(16/16).

Oti findings:-

Sq, ir

Nystagmus

Nip it blindness:-

} no.

Impression:-

Eye exams within normal limits

for required fitness for work.

Dr. Kirti Mane
MBBS, DOMS, MMC
Reg. No. : 2005/05/2708



Patient ID:	PUU22734	Patient Name:	SHARON DIVE
Age:	22 Years	Sex:	M
Accession Number:	PUBC22788-PK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	13-May-2024		

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

The visualized lung fields are clear.

No obvious consolidation is seen.

There is no pleural effusion or pneumothorax seen.

No pneumoperitoneum is seen.

The cardiac silhouette appears within normal limits.

The diaphragmatic shadow and mediastinal structures are within normal limits.

Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

No radiographically evident acute cardiopulmonary process in the present study.

**Dr. Sunita Shewale (MBBS, DMRE)
Consulting Radiologist**

Dr. Sunita Shewale
Consulting Radiologist
MBBS, DMRE

Date: 13-May-2024 12:50:54



MEDICAL CERTIFICATE

I, Dr. Ravindra Kulkarni do hereby certify that I have carefully examined
Sri./Smt. (Whose signature is given below), son / daughter
of Tejas Dhokare is physically unfit to join school / organization / undergo
professional education.

Signature of Candidate / Guardian: Tejas Dhokare

Signature of Doctor: Registration No:

[Handwritten signature of Dr. Ravindra L. Kulkarni]

Dr. Ravindra L. Kulkarni
MD, DNB (FSCAI)
Cardiology Sr Consultant
Physician & Cardiologist
Reg No : 88810

Place: Medicover Hospital
KLE Pune

Date: 15/05/2024

Seal:

