



DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 13/05/24

PATIENT NAME: Mr Yuvraj Pawar

AGE / SEX: 38 / m

NAVI MUMBAI

UMR NO: NM00050781

	RE	LE
VA (DISTANCE)	<u>6/6 20/20</u>	<u>6/6 20/20</u>
VA (NEAR)	<u>Ng. 20/20</u>	<u>Ng. 20/20</u>
COLOUR VISION	<u>Normal</u>	<u>Normal</u>

		SPHERE	CYLINDER	AXIS	VA
MRx	<u>OD</u> <u>(R)</u>	<u>+</u>	<u>-1.25</u>	<u>60°</u>	<u>6/6, Ng.</u>
	<u>OS</u> <u>(L)</u>	<u>0.00</u>	<u>-2.00</u>	<u>140°</u>	<u>6/6, Ng.</u>

HISTORY :

- H/O using spectacles. (Distance)
- No. H/O Ocular trauma Allegies & sensations.
- No H/O systemic illness (DM, HTN, thyroid)

OCULAR FINDINGS :

(BE) - Ant seg WNL
 (undilated) Disc < 0.3
0.3, Tilted disc

ADVICE:

Refresh Tears e/d qid 17 77 X 1 month

AS
 CDR. ANUSHREE VANUARY



<i>Patient ID:</i>	<i>NMU0050731</i>	<i>Patient Name:</i>	<i>YUVRAJ SURESH PAWAR</i>
<i>Age:</i>	<i>38 Years</i>	<i>Sex:</i>	<i>M</i>
<i>Accession Number:</i>	<i>NMBC66223</i>	<i>Modality:</i>	<i>DX</i>
<i>Referring Physician:</i>	<i>DR.DMO</i>	<i>Study:</i>	<i>CHEST</i>
<i>Study Date:</i>	<i>13-Apr-2024</i>	<i>Study Time:</i>	<i>09:46:58</i>

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 Garima Sharma
MD, DNB, FRCR
Consultant Radiologist.

Rate 65 . Sinus rhythm.....normal P axis, V-rate 50- 99
Partial missing lead(s): V1

PR 146
QRS 85
QT 370
QTc 385

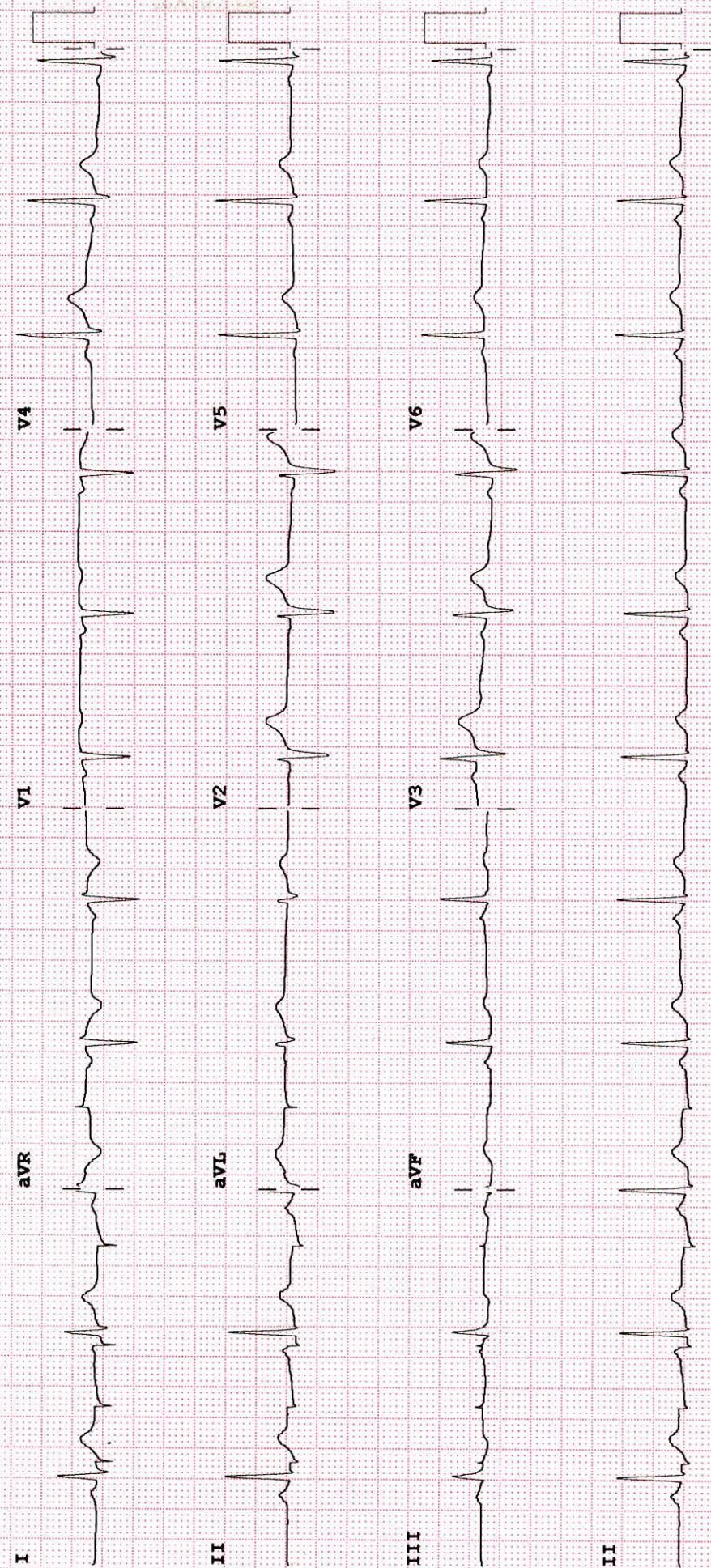
--AXIS--

P 70
QRS 64
T 21

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CU

P?



DEPARTMENT OF LABORATORY

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Bill No/ UMR No : NMBC66223/NMU0050731	Referred By : Dr. DMO
Received Dt : 13-Apr-24 09:15 am	Report Date : 13-Apr-24 04:04 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	20ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		CLEAR	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.025	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.
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	0-1	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION

NOTE

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

*** End Of Report ***





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<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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DEPARTMENT OF LABORATORY

NAVI MUMBAI

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Bill No/ UMR No : NMBC66223/NMU0050731	Referred By : Dr. DMO
Received Dt : 13-Apr-24 09:15 am	Report Date : 13-Apr-24 12:12 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
ESR	CITRATED BLOOD	01	0 - 10 mm/1st hour	WESTERGREN'S METHOD

COMPLETE BLOOD COUNT

RBC

R B C COUNT	EDTA Blood	6.60	4.5 - 5.5 $10^6/\mu\text{L}$
HEMOGLOBIN		13.4	13.0 - 17.0 g/dl
PCV/HCT		43.3	40 - 50 %
MCV		65.6	83 - 101 fl
MCH		20.3	27 - 32 pg
MCHC		30.9	31.5 - 34.5 g/dL
RDW(cv)		15.2	11.6 - 14.0 %

PLATELETS

PLATELET COUNT	EDTA Blood	312	150 - 400 $10^3/\mu\text{L}$
MPV		8.9	7.5 - 11.5 fl

WBC

TC (TOTAL LEUCOCYTE COUNT)	EDTA Blood	7.62	4.0 - 11.0 $10^3/\mu\text{l}$
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DIFFERENTIAL COUNT

NEUTROPHILS	EDTA Blood	61	40 - 80 %
LYMPHOCYTES		31	20 - 40 %
MONOCYTES		05	02 - 10 %
EOSINOPHILS		03	00 - 06 %
BASOPHILS		00	00 - 01 %

PERIPHERAL SMEAR EXAMINATION
RBC

Mild anisocytosis moderate poikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes, tear drop cells and some target cells.

WBC Normal morphology.
PLATELETS Adequate in smear.
ADVISED Haemoglobin electrophoresis/ HPLC assay.

BLOOD GROUPING AND RH

BLOOD GROUP	Blood	" O "	TUBE AGGLUTINATION
RH TYPE		POSITIVE	

*** End Of Report ***





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Bill No/ UMR No : NMBC66223/NMU0050731	Referred By : Dr. DMO
Received Dt : 13-Apr-24 09:15 am	Report Date : 13-Apr-24 03:32 pm

Parameters

Specimen **Result**

TUBE AGGLUTINATI





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Patient Name : Mr. YUVRAJ SURESH PAWAR	Age / Gender : 38 Y(s)/Male
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Received Dt : 13-Apr-24 09:15 am	Report Date : 13-Apr-24 12:12 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		88	Normal Range : 70 - 99 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.4	< 5.7 Normal Prediabetic 5.7 TINIA - 6.4 & >=6.5 Diabetic %	
MPG(Mean Plasma Glucose)		108	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
T3,T4 AND TSH				
T3		79.37	70 - 204 ng/dL	Method : ECLIA
T4		4.64	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		10.43	0.270 - 4.20 uIU/mL	Method : ECLIA
NOTE		Rechecked for TSH (Thyroid Stimulating Hormone) - serum.		
SERUM CREATININE				
CREATININE		1.03	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		1.03	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		11.65	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.7	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.5	<= 1.0 mg/dL	
SGPT (ALT)		32	<= 41 U/L	Method : UV without P5P
SGOT (AST)		21	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		80	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.4	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.6	2.5 - 3.5 g/dL	
A/G RATIO		1.22	1.2 - 2.5	





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Received Dt : 13-Apr-24 09:15 am	Report Date : 13-Apr-24 01:48 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
GAMMA GLUTAMYL TRANSFERASE(GGT)		27	10 - 71 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		198	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		37	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		148	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		16		
SERUM TRYGLYCERIDES		78	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		5.35	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		4.0		
SERUM URIC ACID		5.9	3.4 - 7.0 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		96	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Nil		Dipstick

*** End Of Report ***





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Bill No/ UMR No : NMBC66223/NMU0050731	Referred By : Dr. DMO
Received Dt : 13-Apr-24 11:49 am	Report Date : 13-Apr-24 03:28 pm

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Consultant Hematologist

Verified By : : 026979

Test results related only to the item tested.

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