



Saraj Deni  
Age - 57y 1F  
Ophthal

**Vitals :**

**Chief Complaints :**

Routine eye checkup

**H/O Present Illness :**

NU → 6/6 unaided  
— 6/6

MCT → 15  
— 12

**Past History :**

NU → MB  
— MB = glasses

**Investigation :**

**Drug Allergies : (if any)**

**Treatment :**

Colour vision - normal

Function - normal





Sarwaj Devi  
Age - 57y | F  
Gynaecologist

Vitals :

Chief Complaints :

Burnup in perineum for last 1yrs  
Hot flushes for last 12-13 yrs.

H/O Present Illness :

Menopausal 1yrs  
NO H/O bleed p/so.

Past History :

of H . 2 FTND . Last child 29yrs old.

Investigation :

Drug Allergies : (if any)

NO H/O DM, ~~HT~~  
H/O Thyroid & BP. on HT.  
Of - G.C. fan a/bnle pallor @ .  
P/A Soft

Treatment :

NS Cx (H) PAB Smear later  
P/P ut av as per fee.

✓ PAB Smear

- Esthadiol Valerate Vaginal  
Tab 2 mg. OD x 2wks

- Menopace 1 caps @ 11  
x 1wks



Saroj Devi  
Age - 57y/F  
ENT

Ear - B/C TM intact  
Noisy  
Throated } N/A.

Vitals :

Chief Complaints :

H/O Present Illness:

Ado  
- pure tone  
audiometry.

Past History :

Investigation :

Drug Allergies : (if any)

Treatment :







19/1

Saroj Devi  
Age - 57y 1f  
Dermatology

Vitals :

Chief Complaints :

1 Pw  
1 Y

H/O Present Illness :

Adv:

→ Jecel 6%  
Ointment

Past History :

N/S

(7A) ————— (N)  
x 10 days

Investigation :

Drug Allergies : (if any)

N/A

Treatment :

→ XERINA Cream

(7A) (M) —————  
x 10 days

- R/v after 10 days

Biopsy



Gurgaon

Q Block South City 11, Sohna Road, Main Sector-47, Gurgaon, Haryana Ph.: 0124-49000000 Fax : 0124-2218733  
E-mail : parkmedicenters@gmail.com

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**DEPARTMENT OF BIOCHEMISTRY**

**Patient Name** : Mrs. SAROJ DEVI  
**MR No** : 697054  
**Age/Sex** : 57 Years / Female  
**Type** : OPD  
**TPA/Corporate** : MEDIWHEEL PVT LTD

**Bill Date** : 19/03/2024  
**Reporting Date** : 19/03/2024  
**Sample ID** : 262127  
**Bill/Req. No.** : 25267430  
**Ref Doctor** : Dr.RMO

Test	Result	Blo. Ref. Interval	Units	Method
<b>LIPID PROFILE</b>				
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL	232	0 - 250	mg/dL	CHOD -Trinder
SERUM TRIGLYCERIDES	<b>271</b>	<i>H</i> 60 - 165	mg/dl	GPO-TRINDER
HDL-CHOLESTEROL	51	30 - 70	mg/dl	DIRECT
VLDL CHOLESTEROL	54.2	6 - 32	mg/dL	calculated
LDL	126.8	50 - 135	mg/dl	calculated
LDL CHOLESTEROL/HDL RATIO	2.49	1.0 - 3.0	mg/dL	calculated
TOTAL CHOLESTEROL/HDL RATIO	4.55	2.0 - 5.0	mg/dl	calculated

SAMPLE TYPE: SERUM

**Note** : ATP III Guidelines At-A-Glance Quick Desk Reference

Step 1 - Determine lipoprotein levels obtain complete lipoprotein profile after 9- to 12-hour fast.

ATP III Classification of LDL, Total, and HDL Cholesterol (mg/dL):-

LDL Cholesterol Primary Target of Therapy  
 <100 Optimal  
 130-159 Borderline high  
 >190 Very high.

Total Cholesterol  
 <200 Desirable  
 200-239 Borderline high  
 >240 High

HDL Cholesterol  
 <40 Low  
 >60 High

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



Sample no.

**Dr. JAY PRAKASH SINGH**  
MBBS, MD (PATHOLOGY)

**Dr. ISHA RASTOGI**  
MD, MBBS MICROBIOLOGY  
CONSULTANT CLINICAL MICROBIOLOGIST



USER NM AMIT1



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Test	Result	Bio. Ref. Interval	Units	Method
<b>KFT (RENAL PROFILE)</b>				
<b>KFT</b>				
SERUM UREA	19	10 - 45	mg/dL	
SERUM CREATININE	0.7	0.4 - 1.4	mg/dL	MODIFIED JAFFES
SERUM URIC ACID	6.8	2.5 - 7.0	mg/dL	URICASE
SERUM SODIUM	137	135 - 150	mmol/L	ISE
SERUM POTASSIUM	3.8	3.5 - 5.5	mmol/L	ISE
SERUM CALCIUM	9.1	8.5 - 10.5	mg/dL	ARSENazo III
SERUM PHOSPHORUS	3.3	2.5 - 4.5	mg/dL	AMMONIUM
<b>SAMPLE TYPE:</b>	<b>SERUM</b>			

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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**DEPARTMENT OF IMMUNOLOGY**

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**TPA/Corporate** : MEDIWHEEL PVT LTD

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Test	Result	Bio. Ref. Interval	Units	Method
<b>THYROID PROFILE</b>				
TRI-IODOTHYRONINE (T3)	1.26	0.60 - 1.81	ng/ml	Chemiluminescence
THYROXINE (T4)	8.3	5.01 - 12.45	µg/dL	Chemiluminescence
THYROID STIMULATING HORMONE	0.86	0.5-5.50 ,	µIU/ml	
SPECIMEN TYPE	SERUM			
<b>Method</b> : chemiluminescent immunoassay				

**Note** : Clinical Significance:

Thyroid function tests (TFTs) is a collective term for blood tests used to check the function of the thyroid. TFTs may be requested if a patient is thought to suffer from hyperthyroidism (overactive thyroid) or hypothyroidism (underactive thyroid), or to monitor the effectiveness of either thyroid-suppression or hormone replacement therapy. It is also requested routinely in conditions linked to thyroid disease, such as atrial fibrillation and anxiety disorder. A TFT panel typically includes thyroid hormones such as thyroid-stimulating hormone (TSH, thyrotropin) and thyroxine (T4), and triiodothyronine (T3) depending on local laboratory policy.

Note: Please correlate with clinical condition

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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MD, MBBS MICROBIOLOGY  
CONSULTANT CLINICAL MICROBIOLOGIST



USER NM PAWAN



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# Park Hospital

GROUP SUPER SPECIALITY HOSPITAL



Saroj Devi  
Age - 57y 1f  
Dental

Vitals :

Chief Complaints :

H/O Present Illness :

Past History :

Investigation :

Drug Allergies : (if any)

Treatment :



Gurgaon

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**DEPARTMENT OF BIOCHEMISTRY**

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Test	Result	Blo. Ref. Interval	Units	Method
<b>LFT (LIVER FUNCTION TEST)</b>				
<b>LFT</b>				
TOTAL BILIRUBIN	0.8	0 - 1.2	mg/dL	DIAZO
DIRECT BILIRUBIN	0.3	0 - 0.4	mg/dL	DIAZO
INDIRECT BILIRUBIN	0.5	0.10 - 0.6	mg/dL	CALCULATED
SGOT (AST)	30	0 - 45	U/L	IFCC WITHOUT
SGPT (ALT)	18	0 - 45	U/L	IFCC WITHOUT
ALKALINE PHOSPHATASE	99	30 - 170	IU/L	MODIFIED IFCC
TOTAL PROTEINS	7.7	6.4 - 8.0	g/dL	BIURET
ALBUMIN	4.4	3.3 - 5.5	g/dL	BCG DYE
GLOBULIN	3.3	2.3 - 4.5	g/dL	CALCULATED
A/G RATIO	1.33	1.1 - 2.2		CALCULATED
<b>SAMPLE TYPE:</b>	<b>SERUM</b>			

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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CONSULTANT CLINICAL MICROBIOLOGIST



USER NM

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## DEPARTMENT OF MICROBIOLOGY

Patient Name : Mrs. SAROJ DEVI  
 MR No : 697054  
 Age/Sex : 57 Years / Female  
 Type : OPD  
 TPA/Corporate : MEDIWHEEL PVT LTD

Bill Date : 19/03/2024  
 Reporting Date : 21/03/2024  
 Sample ID : 262127  
 Bill/Req. No. : 25267430  
 Ref Doctor : Dr.RMO

Test	Result	Bio. Ref. Interval	Units	Method
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### URINE C/S

NAME OF SPECIMEN	Urine (Uncentrifuged )			
ORGANISM IDENTIFIED	NO ORGANISM GROWN IN CULTURE AFTER 48HRS OF INCUBATION AT 37 C DEGREE.			Aerobic culture

Method :

**Note : URINE CULTURE :**

Presence of >105 cfu/ml (100000) in midstream urine sample is considered clinically significant. However in symptomatic, immune-compromised or diabetic patients & patients with indwelling catheters, even a smaller count of bacteria may signify infection (100-10000cfu/ml). Kindly correlate clinically.

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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 MBBS, MD (PATHOLOGY)



Dr. ISHA RASTOGI  
 MD, MBBS MICROBIOLOGY  
 CONSULTANT CLINICAL MICROBIOLOGIST

USER NM ADITYA



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**DEPARTMENT OF HAEMATOLOGY**

**Patient Name** : Mrs. SAROJ DEVI  
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Test	Result	Bio. Ref. Interval	Units	Method
<b>ESR (WESTERGREN)</b>				
E.S.R. 1ST HRS.	16	0 - 20	mm/Hr.	Westergren
<b>Method</b> : (Capillary photometry)				

- Note** :
1. C-Reactive Protein (CRP) is the recommended test in acute inflammatory conditions.
  2. Test conducted on EDTA whole blood at 37C.
  3. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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**DEPARTMENT OF BIOCHEMISTRY**

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Test	Result	Blo. Ref. Interval	Units	Method
<b>BLOOD SUGAR FASTING</b>				
PLASMA GLUCOSE FASTING	84	60 - 110	mg/dl	GOD TRINDERS

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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Test	Result	Bio. Ref. Interval	Units	Method
<b>BLOOD SUGAR 2 HR. PP</b>				
BLOOD SUGAR P.P.	124	80 - 150	mg/dl	

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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## DEPARTMENT OF PATHOLOGY

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**Ref Doctor** : Dr.RMO

Test	Result	Blo. Ref. Interval	Units	Method
<b>URINE ROUTINE AND MICROSCOPY</b>				
<b>PHYSICAL CHARACTERSTICS</b>				
QUANTITY	40ml	5 - 100	ml	
COLOUR	Pale Yellow	Pale Yellow		Manual Method
TURBIDITY	Clear	clear		
SPECIFIC GRAVITY	1.020	1.000-1.030		urinometer
PH - URINE	6.0	5.0 - 9.0		PH PAPER
<b>CHEMICAL EXAMINATION-1</b>				
UROBILINOGEN	Negative	NIL		Ehrlich
URINE PROTEIN	Absent	NIL	mg/dl	Protein error indicator
BLOOD	NIL	NIL		
URINE BILIRUBIN	NIL	NIL		
GLUCOSE	NIL	NIL	mg/dL	GOD-POD/Benedicts
URINE KETONE	NIL	NIL		SOD.
<b>MICRO.EXAMINATION</b>				
PUS CELL	2-4	0-5	cells/hpf	Microscopic
RED BLOOD CELLS	Nil	0-2	cells/hpf	
EPITHELIAL CELLS	1-3	0-5	cells/hpf	
CASTS	NIL	NIL	/lpf	
CRYSTALS	NIL	NIL	/Lpf	
OTHER	NIL			
AMORPHOUS URINE	Absent			MicroScopy

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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 CONSULTANT CLINICAL MICROBIOLOGIST



USER NM RAVINDRA



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**DEPARTMENT OF HAEMATOLOGY**

**Patient Name** : Mrs. SAROJ DEVI

**MR No** : 697054

**Age/Sex** : 57 Years / Female

**Type** : OPD

**TPA/Corporate** : MEDIWHEEL PVT LTD

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Test	Result	Blo. Ref. Interval	Units	Method
<b>BLOOD GROUPING AND RH FACTOR</b>				
BLOOD GROUP	" A " RH POSITIVE			ABO/Rh (D) SLIDE

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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Test	Result	Bio. Ref. Interval	Units	Method
<b>CBC</b>				
HAEMOGLOBIN	13.1	12 - 15	gm/dL	COLORIMETRY
TOTAL LEUCOCYTE COUNT	8210	4000-11000	/μL	LASER FLOW
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	64	40.0 - 70.0	%	FLOW CYTOMETRY
LYMPHOCYTES	26	20.0 - 40.0	%	FLOW CYTOMETRY
MONOCYTES	08	3.0 - 8.0	%	FLOW CYTOMETRY
EOSINOPHILS	02	0.5 - 5.0	%	FLOW CYTOMETRY
BASOPHILS	00	0.0 - 2.0	%	FLOW CYTOMETRY
RED BLOOD CELL COUNT	4.5	3.5 - 5.5	millions/μL	ELECTRICAL
PACKED CELL VOLUME	38.9	35.0 - 50.0	%	ELECTRICAL
MEAN CORPUSCULAR VOLUME	85.2	83 - 101	fL	ELECTRICAL
MEAN CORPUSCULAR HAEMOGLOBIN	28.7	27 - 31	Picogrames	CALCULATED
MEAN CORPUSCULAR HB CONC	33.7	33 - 37	g/dl	CALCULATED
PLATELET COUNT	343	150 - 450	thou/μL	ELECTRICAL
RDW	14.5	11.6 - 14.5	%	CALCULATED
SAMPLE TYPE FOR C.B.C	Whole Blood EDTA			

\*\*\*\*\* END OF THE REPORT \*\*\*\*\*



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Name : Mrs . SAROJ DEVI 25267430  
Age/Gender : 57 Y(s) /Female  
VID : 190324514  
KPID : KP0472640  
Referred By : PARK HOSPITAL  
Sample Id : 220400641

Location : KPL A43  
Registered On : 19-03-2024 16:29  
Release Date : 20-Mar-2024 16:26  
ClientId :  
Histo Id : A24/13957



### AW-CYTOLOGY

#### Test

#### ResultUnit

Pap Smear

**CYTOPATHOLOGY NO.: C- 604/24**

**SPECIMEN SUBMITTED:** 2 Conventional cervical smears (2 smears prepared).

**SPECIMEN ADEQUACY:** Satisfactory for evaluation; Endocervical /transformation zone component absent.

#### **MICROSCOPIC EXAMINATION:**

**Squamous cell population:**

**Superficial – Present.**

**Intermediate – Present.**

**Inflammation – Not significant.**

**Atypical cells – Not present.**

**Background bacterial flora – Maintained.**

#### **INTERPRETATION:**

**- Negative for squamous intraepithelial lesion or malignancy.**

#### **COMMENT:**

1. The smears are reported using the Bethesda system (2014) for reporting cervical cytology.
2. Cervical cytology is a screening test primarily for squamous cancer and its precursors and has associated false-negative and false-positive results. Technologies such as liquid-based preparations may decrease but will not eliminate all false negative results. Follow-up of unexplained clinical signs and symptoms is recommended to minimize false-negative results.
3. In patients with squamous or glandular intraepithelial abnormalities, further diagnostic follow-up procedures, such as HPV testing, colposcopy / biopsy with endocervical sampling are suggested, as clinically indicated.

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1. All reports are for interpretation by the treating doctor only and have to be viewed and correlated with clinical examination and other investigations. 2. All investigations have their limitation which is imposed by the limits to sensitivity and specificity of individual assay procedures as well as the quality of the specimen received by the laboratory. Isolated laboratory investigations never confirm the final diagnosis of the disease. 3. If the result (s) of tests are alarming or unexpected the doctor is advised to contact the lab immediately for useful and necessary action.

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CAP PROFICIENCY PARTICIPATING LAB  
ISO 9001 : 2008 CERTIFIED DIAGNOSTIC CENTRE

**LABORATORY REPORT**

Name : Mrs . SAROJ DEVI 25267430  
Age/Gender : 57 Y(s) /Female  
VID : 190324514  
KPID : KP0472640  
Referred By : PARK HOSPITAL  
Sample Id : 220400641

Location : KPL A43  
Registered On : 19-03-2024 16:29  
Release Date : 20-Mar-2024 16:26  
ClientId :  
Histo Id : A24/13957



*Magoon*  
\* PARK HOSPITAL \*  
**Dr.N.Magoon**  
**M.D. (Path)**  
Consulting Pathologist DMC Reg.No-  
97859

Print Date : 21-03-2024 16:18

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A-43, Hauz Khas (Near Hauz Khas Police Stn.), New Delhi - 16, C.S. Rana Complex, I block, Sector 22, Noida (UP)  
Email : info@pathcareindia.com Website : www.pathcareindia.com







NAME	: MRS. SAROJ DEVI	DATE	: 19 / 3 / 2024
Age Sex	: 57 Years / Female	Inpatient No	: 697054
PERFORMED BY	: Dr. SACHIN BANSAL	UHID	: 25267430

## TRANS THORACIC ECHO CARDIOGRAPHY REPORT

### MITRAL VALVE

**Morphology** AML: Normal / Thickening / Calcification / Flutter / Vegetation / Non significant Prolapse / SAM

PML: Normal / Thickening / Calcification / Prolapse / Paradoxical Motion / Fixed.  
Subvalvular deformity: Present / Absent

**Doppler** Normal / Abnormal

Mitral Stenosis Present / Absent

Mitral Regurgitation; Absent / Normal / Mild / Trace / Moderate / Severe / Trivial

### TRICUSPID VALVE

**Morphology** Normal / Atresia / Thickening / Calcification / Prolapse / Vegetation / Doming.

**Doppler** Normal / Abnormal

Tricuspid Stenosis : Present / Absent.

Tricuspid Regurgitation; Absent / Normal / Mild / Trace / Moderate / Severe.

### PULMONARY VALVE

**Morphology** Normal / Atresia / Thickening / Calcified / Doming / Vegetation.

**Doppler** Normal / Abnormal.

Pulmonary stenosis : Present / Absent

Pulmonary regurgitation : Present / Absent

### AORTIC VALVE

**Morphology** Normal / Thickened / Mildly / Calcified / Flutter / Vegetation / Restricted / Opening

No. of Cusps 1 / 2 / 3 / 4

**Doppler** Normal / Abnormal

Aortic Stenosis : Present / Absent

Aortic regurgitation : Present / Absent / Mild / Trace



Cert. No. H-2016-0369

(This is only professional opinion and not the diagnosis, please correlate clinically)

Q Block, South City -II, Sohna Road, Sector-47, Gurgaon, Haryana

Ph.: 0124-4900000 (100 Lines), Toll Free No. : 1800-102-6767, Mob.: 62 62 82 82 35, Email: [customercare@parkhospital.in](mailto:customercare@parkhospital.in)

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<u>Measurements</u>	<u>Normal Values</u>	<u>Measurements</u>	<u>Normal Value</u>
IVSD : 1.3cm	(0.6-1.1cm)	LA : 3.6cm	(1.9-4.0cm)
LVID : 4.6cm	(3.7-5.6cm)	LVOT : 1.4cm	
LVPW : 1.1cm	(0.6-1.1cm)	AORTA : 2.5cm	(2.0-3.7cm)
EF : 55-60%	(55% - 80%)	IVSmotion :	<b>Normal / Flat / Paradoxical</b>
Any Other			

### CHAMBERS:-

- LV** **Normal** / Enlarged / **Clear** / Thrombus /  
Contraction Normal LV shows concentric LVH, no gradient across LVOT / Inetic / Intra capillary  
Regional wall motion abnormality: **Absent**/ Present
- LA** **Normal** / Enlarged / Clear / Thrombus / Myxoma; **LAA: Clear** / Thrombus
- RA** **Normal** / **Clear** / Thrombus, Dilated.
- RV** **Normal** / Enlarged / **Clear** / Thrombus / Hypertrophied/ Dilated.
- PERICARDIUM** **Normal** / Thickening / Calcification / Effusion.

### COMMENTS & SUMMARY:-

- All cardiac chambers dimensions are with in normal limits.
- Global LVEF – 55-60%
- No RWMA
- NORMAL LV FUNCTION
- CONCENTRIC LVH
- LVDD GRADE – I
- NO MR / NO AR / NO TR
- GOOD RV FUNCTION
- No Flow seen across IAS/IVS.
- No Thrombus/Mass in any chamber.
- No Pericardial Effusion.

Please correlate clinically

Dr. SACHIN BANSAL  
M.D.(Medicine)  
D.M (Cardiology)



Cert. No. H-2016-0369

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## DEPARTMENT OF RADIOLOGY

Patient Name	Mrs. SAROJ DEVI	Billed Date	: 19/03/2024
Reg No	697054	Reported Date	: 19/03/2024
Age/Sex	57 Years / Female	Req. No.	: 25267430
Type	OPD	Consultant Doctor	: Dr. RMO

### USG WHOLE ABDOMEN

The real time, B mode, gray scale sonography of the abdominal organs was performed.

**LIVER** : The liver is normal in size (15.0cm) and **shows raised echotexture**. No evidence of any focal lesion. IHBR is not dilated.

**GALL BLADDER** : The gall bladder is well distended. No evidence any calculus or mass seen. GB wall thickness with in normal limits. No evidence of pericholecystic fluid is seen.

**BILE DUCT** :The common bile duct is normal in caliber. No evidence of calculus is noted in common bile duct.

**SPLEEN** :The spleen is normal in size (9.5cm) and shape.Its echotexture is homogeneous.No evidence of focal lesion is noted.

**PANCREAS** :The pancreas is normal in size, shape, contours and echotexture.No evidence of solid or cystic mass lesion is noted.MPD is not dilated. No evidence of peripancreatic collection.

**KIDNEYS** : Right kidney measures 9.5 x 3.6 cm. Left kidney measures 10.7 x 4.2 cm. The bilateral kidneys are normal in size and echotexture. Cortico-medullary differentiation is maintained.There is no evidence of obvious calculus or hydronephrosis.

**URINARY BLADDER** :The urinary bladder is well distended.It shows uniformly thin walls and sharp mucosa.No evidence of calculus is seen. No evidence of mass or diverticulum is noted.

**UTERUS**: The uterus is atrophied.

No evidence of ascites or interbowel free fluid is seen.

No evidence of obvious retroperitoneal or mesentric lymphadenopathy is seen.

**Bowel loop distended with gas.**

**IMPRESSION- Grade II fatty liver.**

To be correlated clinically.



Dr. ANSHU K. SHARMA  
MBBS, MD  
CONSULTANT RADIOLOGIST  
Cert. No. H-2016-0369

Dr. MANJEET SEHRAWAT  
MBBS, MD, PGCC  
CONSULTANT RADIOLOGIST

ALISHA KHAN

MEDICAL TRANSCRIPTIONIST

Dr. NEENA SIKKA  
MBBS, DNB  
CONSULTANT RADIOLOGIST

RAJNISH SHARMA  
MEDICAL  
TRANSCRIPTIONIST

Ph.: 0124-4900000 (100 Lines), Toll Free No. : 1800-102-6767, Mob.: 62 62 82 82 35, Email: customercare@parkhospital.in

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**DEPARTMENT OF RADIOLOGY**

<b>Patient Name</b>	Mrs. SAROJ DEVI	<b>Billed Date</b>	: 19/03/2024
<b>Reg No</b>	697054	<b>Reported Date</b>	: 19/03/2024
<b>Age/Sex</b>	57 Years / Female	<b>Req. No.</b>	: 25267430
<b>Type</b>	OPD	<b>Consultant Doctor</b>	: Dr. RMO

**X-RAY CHEST AP/PA**

Bilateral lungs appears normal.

No focal lung lesion seen.

No evidence of free fluid is seen.

Both hila are normal in size, have equal density and bear normal relationship.

The heart and trachea are central in position and no mediastinal abnormality is visible.

The cardiac size is normal for patient age and view.

The domes of the diaphragms are normal in position, and show smooth outline.

To be correlated clinically



*Dr. Anshu K. Sharma*  
Dr. ANSHU K. SHARMA  
MBBS, MD  
CONSULTANT RADIOLOGIST  
Cert. No. H-2018-0369

Dr. MANJEET SEHRAWAT  
MBBS, MD, DCC  
CONSULTANT RADIOLOGIST

ALISHA KHAN

MEDICAL TRANSCRIPTIONIST  
CONSULTANT RADIOLOGIST

Dr. NEENA SIKKA

MBBS, DNB  
CONSULTANT RADIOLOGIST

RAJNISH SHARMA

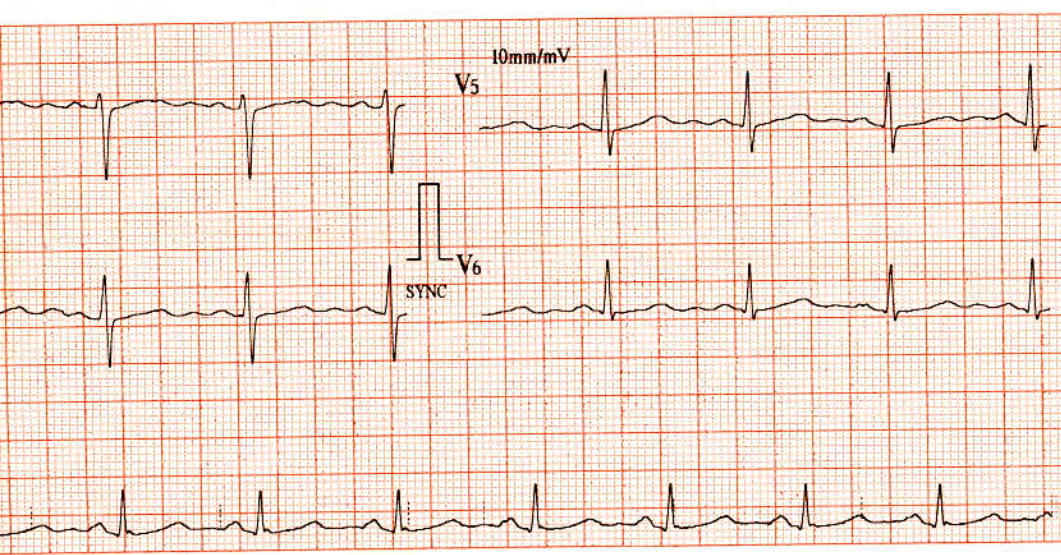
MEDICAL  
TRANSCRIPTIONIST

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ID : 0003

HR : 81 bpm

Name:

Saraj Devi

R-R : 737 ms

P-R : 157 ms

QRS : 89 ms

Sex :

Female

QT/QTc : 396/461 ms

R/QRS/T : 52/-1/36

Age :

57 years

R5/SV1 : 0.750/0.960 mV

SV5/SV1 : 1.710 mV



----- Sinus Rhythm

----- T Abnormality (Flat T)

----- Long QTc

----- Mild Left Axis Deviation

8:51 AM

Unconfirmed report Verified by:



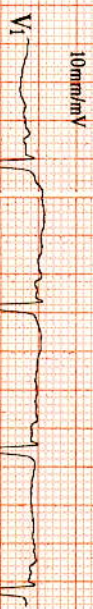
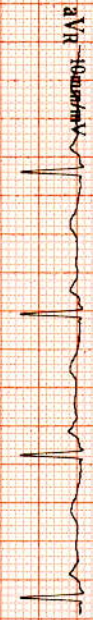
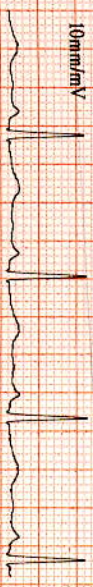
25mm/s 0.5~25Hz

I 10mm/mV

aVR 10mm/mV

V1 10mm/mV

V3 10mm/mV

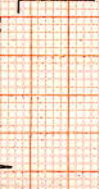
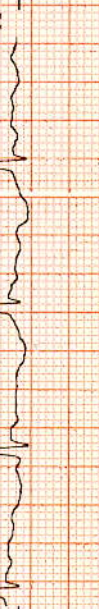
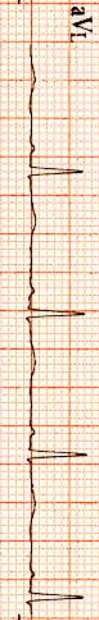


II

aVI

V2

V4



SYNC

SYNC

SYNC

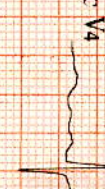
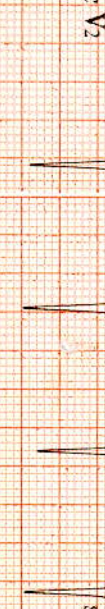
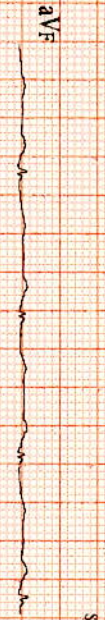
SYNC

III

aVF

V5

V6



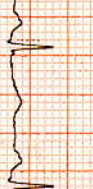
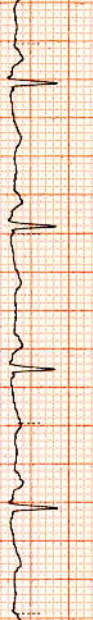
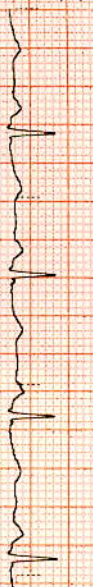
10mm/mV

II

II

II

II



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