DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

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Name Mr. Chetan D. Tuvi Age.Sex 55/M MR.No. S137021

Doctor Dr. Krunal Gajjar Date 18/05/23

Ht : 173/cm Wt. : 98.7kg Temp : 97.6F Pulse : 76 b/m BP : 167/80

SPO2 : 98 % Post of walk SPO2 :

Chief Complaints :

NOT - Any.

Drug / Food Allergy : Not taken today's medicine.

Prior Medication Reviewed : Yes ☑ No ☐

On examination :

HbA1c: 9.9

Rs
CVS } NAD

Past History :

K/C/O DM.

T. Gluconorm G1 1-0-0 ½.

T. UDP-AT (5/50) 1-0-0

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☑ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Investigation advised :

Rx

→ Stop T. Gluconorm G1.

→ Tab. Vysov-M (50/500) 1-0-1. BBF BD. × (01) month.

→ Tab. UDP-AT (5/50) 1-0-0.

Dr. Krunal Gajjar
M.B.B.S., MD (MEDICINE)
CONSULTANT PHYSICIAN
Reg. No. G-20422
SUNSHINE GLOBAL HOSPITAL
SURAT.

FBS, PPBS after (15) day

Follow Up : **Date :** _____ **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

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OPD ASSESSMENT FORM

Name Chetan Kuvi **Age.Sex** 55 / M **MR.No.** S 137021

Doctor Dr. Hardik Shroff **Date** 18/05/23

Ht : ____ **Wt. :** ____ **Temp :** ____ **Pulse :** ____ **BP :** ____

SPO2 : ____ **Post of walk SPO2 :** ____

Chief Complaints :

No complaint

Drug / Food Allergy : H/O DM

Prior Medication Reviewed : Yes ☐ No ☐

On examination : BE - GR-unt

Vn C 6/6 6/6 N/6 c el. sAdd.

Fundii clentral, BE - MAD

Past History :

Provisional Diagnosis :

Presbyopia.

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

℞

Gentel eye drops

0 — 0 — 0

Investigation advised :

Dr. Hardik Shroff
DOMS, DNB (Ophthalmology)
Regd. No. G-28902
SUNSHINE GLOBAL HOSPITAL
Piploa, SURAT.

Follow Up : **Date :** ____ **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

DOC. No.	SGHS/FMT/OPD002	DOI	14/06/2014	Rev. No.	0.1

OPD ASSESSMENT FORM

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Name Mr. Chetan D. Kavi Age.Sex 55 / M MR.No. S137021

Doctor Dr. Shailaja Desai Date 18/05/23

Ht : _____ Wt. : _____ Temp : _____ Pulse : _____ BP : _____

SPO2 : _____ Post of walk SPO2 : _____

Chief Complaints :

- Routine dental checkup

Drug / Food Allergy :

Prior Medication Reviewed : Yes ☐ No ☐

On examination :

- Stain deposits

Past History :

Provisional Diagnosis :

Nutritional Assessment :

- ☐ Obese
- ☐ Well nourished
- ☐ Mild- moderate nourished
- ☐ Severely mal-nourished

Treatment and further Advices :
(Write in Capital Letters)

Rx

1) Scaling

Investigation advised :

Dr. Shailaja Desai
B.D.S. (Dental Surgeon)
A-9793
Dental Surgeon
Sunshine Global Hospital, Surat

Follow Up : **Date :** _____ **Signature**

In case of emergency Please report to Emergency Department of Hospital OR
Call : 75748 49465, 0261-4111000

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18/5/23

℞

- Gentael eye drops — (1)

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Emergency No. : 7574849465

OPD

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2-D ECHO COLOUR DOPPLER STUDY

MR No.	**: S**	**Date**	**: 18/05/2023**
Patient Name	**: Chetan D. Kavi**	**Age**	**: 55yrs Sex : M**
Done By	**: Dr. Sarvendra Singh**		

FINDINGS : For health check up plan

- All cardiac chambers are normal. No LVH.
- No regional wall motion abnormality at rest.
- Good RV systolic function. LVEF > 60%.
- All valves are structurally & functionally normal.
- No clot / mass / vegetation / pericardial effusion.
- IAS/IVS are intact.
- No e/o diastolic dysfunction.
- PASP by TR Jet ~ 10mmHg.
- IVC - normal in size, collapsing >50% with inspiration.

MEASUREMENT			
LVIDd	48mm	LVPWd	10mm
LVIDs	28mm	LVPWs	15mm
IVSd	09mm	FS	42.00%
IVSs	15mm	LVEF	72.00%

MV E/A – 0.93/0.67m/s E' – 0.10m/s
Dec.T – 119ms LA – 3.5cm
Slop – 7.9m/s2 Ao – 3.0cm
E/e' – 9

Dr. Sarvendra Singh
MBBS , PGDCC (Hon.), FCR
Non – Invasive Cardiologist
Reg.No. MCI-52268

Transcripted By: Dimple Chavan
Date & Time of report: 18/05/2023 11:05 AM

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PAT. NAME : Chetan Kavi	**Date** : 18/05/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 55 Yrs / M
INV. : Radiograph of Chest PA	**MR NO.** : S137021

Clinical Details: HC.

Observation:

- Both the lung fields appears normal.
- Both costophrenic angles appear clear.
- Both the hila appears normal.
- Trachea appears in midline.
- Cardiac size and other mediastinal shadows appears normal.
- Both domes of diaphragm appear normal.
- Bony thorax appears normal.

Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 18/05/2023 – 11:25 AM

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PAT. NAME : Chetan Kavi	**Date** : 18/05/2023
REF. DOCTOR : Hosp. Dr.	**AGE** : 55 Yrs / M
INV. : USG Abdomen & Pelvis	**MR NO.** : S137021

Findings:

Liver is enlarge in size (16.5 cm), shape and shows moderate increase in parenchymal echopattern. No e/o any focal or diffuse lesion noted. Intrahepatic biliary radicals are normal.

Gall bladder is distended and appears normal. No e/o calculus, sludge or mass lesion is seen. CBD and Portal Vein appears normal is size and calibre.

Pancreas appears normal in size and shows normal echopattern to the extent assessed. Spleen appears normal in size, shape and homogenous echopattern.

Both kidneys appear normal in size, shape and echopattern. The corticomedullary differentiation is well maintained. No e/o any calculus or hydronephrosis is seen.

Aorta and para-aortic regions appears normal. No e/o any lymphadenopathy.
Urinary bladder appears well distended and normal.
Prostate appears enlarge in size (Vol: 26 cc), shape and echopattern.
No e/o free fluid in pelvis.

IMPRESSION:

- **Hepatomegaly with grade II fatty liver.**
- **Prostatomegaly.**

Dr. Sneha Dumaswala
MBBS, DNB-Radiodiagnosis
Consultant Radiologist
G-21796

Transcribed By: Asha

Date & Time of report: 18/05/2023 – 11:29 AM

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MR No.	**: S137021**	**Collection Date**	**: 18/05/2023 9:08AM**
Patient Name	**: Mr. Chetan D Kavi**	**Age**	**: 55 Y Sex : Male**
Ref By	**: Dr. Hospital A Doctor**	**Report Date**	**: 18/05/2023 10:40AM**

HAEMATOLOGY

Parameter	Result	Units	Normal Range
CBC with ESR			
HAEMOGLOBIN	14.2	gm/dl	13.0 - 17.0
PCV	42.0	%	40 - 50
RBC COUNT	5.22	mill/cmm	4.5 - 5.5
MCV	80.5	fl	76 - 96
MCH	27.2	pg	26 - 32
MCHC	33.8	%	32 - 36
RDW	12.2	%	11 - 15
PLATELET COUNT	2.20	lacs/cmm	1.5 - 4.5
WBC COUNT	7500	/cmm	4000 - 11000
ESR	08	mm/hr	0 - 10
DIFFERENTIAL WBC COUNT			
NEUTROPHIL	50	%	40 - 70
LYMPHOCYTES	**41**	%	20 - 40
EOSINOPHILS	03	%	1 - 6
MONOCYTES	06	%	2 - 11
BASOPHILS	00	%	0 - 2
PERIPHERAL SMEAR			
RBC MORPHOLOGY	Normochromic Normocytic		
WBC MORPHOLOGY	Within Normal Range		
PLATELET ON SMEAR	Adequate		
HEMOPARASITES	Not Seen		

SYSMEX XN-550

******* End Report *******

Dr. Amrish Pandya
MD, DCP (Pathology)
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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 10:36AM

HAEMATOLOGY

Parameter	Result		Normal Range
BLOOD GROUP & RH FACTOR			
BLOOD GROUP	"B"		
RH FACTOR	POSITIVE		

BIOCHEMISTRY

FASTING BLOOD SUGAR (FBS)			
FASTING BLOOD GLUCOSE (Hexokinase)	**160**	mg/dl	74 - 110
FASTING URINE GLUCOSE	SNR		
FASTING URINE KETONE	SNR		

CLINICAL CHEMISTRY

THYROID FUNCTION TEST [TFT]			
TOTAL T3 (CLIA)	1.09	ng/ml	0.846 - 2.02
TOTAL T4 (CLIA)	6.72	ug/dl	5.1 - 14.0
TSH (CLIA)	4.13	uIU/ml	0.2 - 4.5

Note:-

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechnism involving concentrations of FT3 (free T3) and FT4 (freeT4). Additionally the hypothalamic tripeptide. thyrotropin releasing hormone (TSH) directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy also stimulate the thyroid gland to synthesize and secrete T3 and T4.

Quantification of TSH significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism. TSH levels are significantly elevated whiled in secondary and tertiary hypothyroidism . TSH levels are low.

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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 10:37AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
HBA1C [GLYCOSYLATED HEAMOGLOBIN]			
HbA1C	9.9	%	Non-Diabetic level: <6 Good Control: 6 - 7 Poor Control: 7 - 8 Action Suggested > 8
MEAN BLOOD GLUCOSE	**237.43**	mg/dl	

The test is done on Cobas Integra 400plus-Turbidimetric Inhibition ImmunoAssay
Note:- Criteria for the diagnosis of diabetes HbA1c >/=6.5*
1. HbA1c is important test for the assessment of long term blood glucose control (also called glycemic control).
2. HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of long term glycemic control than blood glucose determination.
3. HbA1C is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefor remains unaffected by short term fluctuations in blood glucose levels.
4. Long term complications of diabetes such as retinopathy,nephropathy, and neuropathy are potentially serious and can lead to blindness kidney failure etc.
5. Genetic Variants (Hb-S trait,Hb-C trait) elevated fetal haemoglobin & chemically modified derivatives of haemoglobin (eg carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1C measurement.

******* End Report *******

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MR No.	**: S137021**	**Collection Date**	**: 18/05/2023 9:08AM**
Patient Name	**: Mr. Chetan D Kavi**	**Age**	**: 55 Y Sex : Male**
Ref By	: Dr. Hospital A Doctor	**Report Date**	**: 18/05/2023 10:37AM**

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIPID PROFILE			
SERUM CHOLESTEROL CHOD PAP	164	mg/dl	50 - 200
HDL CHOLESTEROL Direct	**34**	mg/dl	40 - 60
LDL CHOLESTEROL Direct	94.8	mg/dl	0 - 100
SERUM TRIGLYCERIDE GPO PAP	**178**	mg/dl	50 - 150
VLDL Calc	**35.6**	mg/dl	0 - 30
CHOLESTEROL / HDL RATIO	4.82		0 - 5
LDL / HDL RATIO	2.79		0 - 3

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment.
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Details on test interpretation available from the lab.

TEST	NEAR OPTIMAL (Moderate Risk)	BORDER LINE (Risk)	HIGH (Risk)	VERY HIGH
CHOLESTROL	160-199	200-239	240-279	280
HDL	50-59	40-49	< 40	
LDL	100-129	130-159	160-190	>190
TRIGLYCERIDES	150-169	170-199	240-499	>500
CHO/HDL RATIO	3.3-4.4	4.4-11.0	>11.0	
LDL/HDL RATIO	0.5-3.0	3.0-6.0	>6.0	

******* End Report *******

AP

Dr. Amrish Pandya
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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 10:39AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
LIVER FUNCTION TEST			
ALKALINE PHOSPHATASE (IFCC)	67	U/L	35 - 130
BILIRUBIN TOTAL Diazo	0.7	mg/dl	0.0 - 1.2
BILIRUBIN DIRECT Diazo	0.3	mg/dl	0.0 - 0.4
BILIRUBIN INDIRECT (Calc)	0.4	mg/dl	0.0 - 0.8
SGPT (IFCC)	24	U/L	5 - 41
SGOT (IFCC)	26	U/L	5 - 40
SERUM TOTAL PROTEIN Biuret	7.1	gm/dl	6.6 - 8.7
SERUM ALBUMIN BCG	4.7	gm/dl	3.5 - 5.2
SERUM GLOBULIN Calc	2.4	gm/dl	1.5 - 3.5
SERUM A/G RATIO Calc	1.96	gm/dl	1.5 - 2.5
SERUM CREATININE			
SERUM CREATININE (JAFFE)	1.0	mg/dl	0.5 - 1.2
SERUM URIC ACID			
SERUM URIC ACID (Uricase)	5.4	mg/dl	3.4 - 7.0
BUN [BLOOD UREA NITROGEN]			
BUN	10.8	mg/dl	8 - 23

******* End Report *******

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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 11:31AM

BIOCHEMISTRY

Parameter	Result	Units	Normal Range
ALBUMIN-CREATININE RATIO			
URINE ALBUMIN/MICROALBUMIN (Immunoturbidimetry)	**9.5**	mg/L	
URINE CREATININE (JAFFE)	**82.6**	mg/dl	
ALBUMIN-CREATININE RATIO (Calculated)	11.5	mg/gm	Normal: <30; Microalbuminuria: 30-299; Clinical Albuminuria: >300

******* End Report *******

Dr. Amrish Pandya
MD, DCP (Pathology)
Reg. No.: G-5966

18/05/2023 11:31AM

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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 10:36AM

CLINICAL CHEMISTRY

Parameter	Result	Units	Normal Range
PSA [PROSTATE SPECIFIC ANTIGEN]			
PSA (CLIA)	0.624	ng/ml	0 - 4.0

CHEMILUMINESCENCE
Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-8 ng/ml.
Percentage of Free PSA = Free PSA / Tota PSA x 100 = Percent free PSA.
Patient with prostate cancer generally have a lower percentage of free PSA compared to benigh prostatic hyoerplasia.
Percentage free PSA of less than 25% is a high likedlihood of prostatic cancer.

******* End Report *******

Dr. Amrish Pandya
MD, DCP (Pathology)
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MR No.	: **S137021**	**Collection Date**	: 18/05/2023 9:08AM
Patient Name	: **Mr. Chetan D Kavi**	**Age**	: 55 Y **Sex** : Male
Ref By	: Dr. Hospital A Doctor	**Report Date**	: 18/05/2023 11:30AM

CLINICAL PATHOLOGY

Parameter	Result	Normal Range
URINE ROUTINE & MICROSCOPIC EXAMINATION		
TYPE OF SPECIMEN - URINE	Random	
PHYSICAL EXAMINATION		
QUANTITY	**30** ml	
COLOUR	Pale Yellow	
APPEARANCE	Clear	
REACTION (pH)	6.0	
SPECIFIC GRAVITY	1.020	
CHEMICAL EXAMINATION		
PROTEIN	Absent	
GLUCOSE	Present(++)	
KETONE	Absent	
BILE SALT	Absent	
BILE PIGMENT	Absent	
OCCULT BLOOD	Absent	
MICROSCOPIC EXAMINATION		
PUS CELLS	2-3 /hpf	
EPITHELIAL CELLS	6-8 /hpf	
RBC	Absent /hpf	
CASTS	Absent	
CRYSTALS	Absent	
BACTERIA	Absent	
YEAST CELLS	Absent	

******* End Report *******

Dr. Amrish Pandya
MD, DCP (Pathology)
Reg. No.: G-5966

Surat:
Piplod
Besides Dumas Road, Surat - 395007
T : + 91 0261 4111000
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Vadodara :
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Nr. Shreyas Vidyalaya, Nalini House, Manjalpur, Vadodara - 390 011.
T : +91 265 3300400, 2633200, 2632044
F : +91 265 2632400

Vadodara :
Tilak Road
Anant Apartment, B/s. Aradhna Cinema, Tilak Road, Vadodara - 390 001.
T : +91 265 2429282, 2429262
F : +91 265 434073

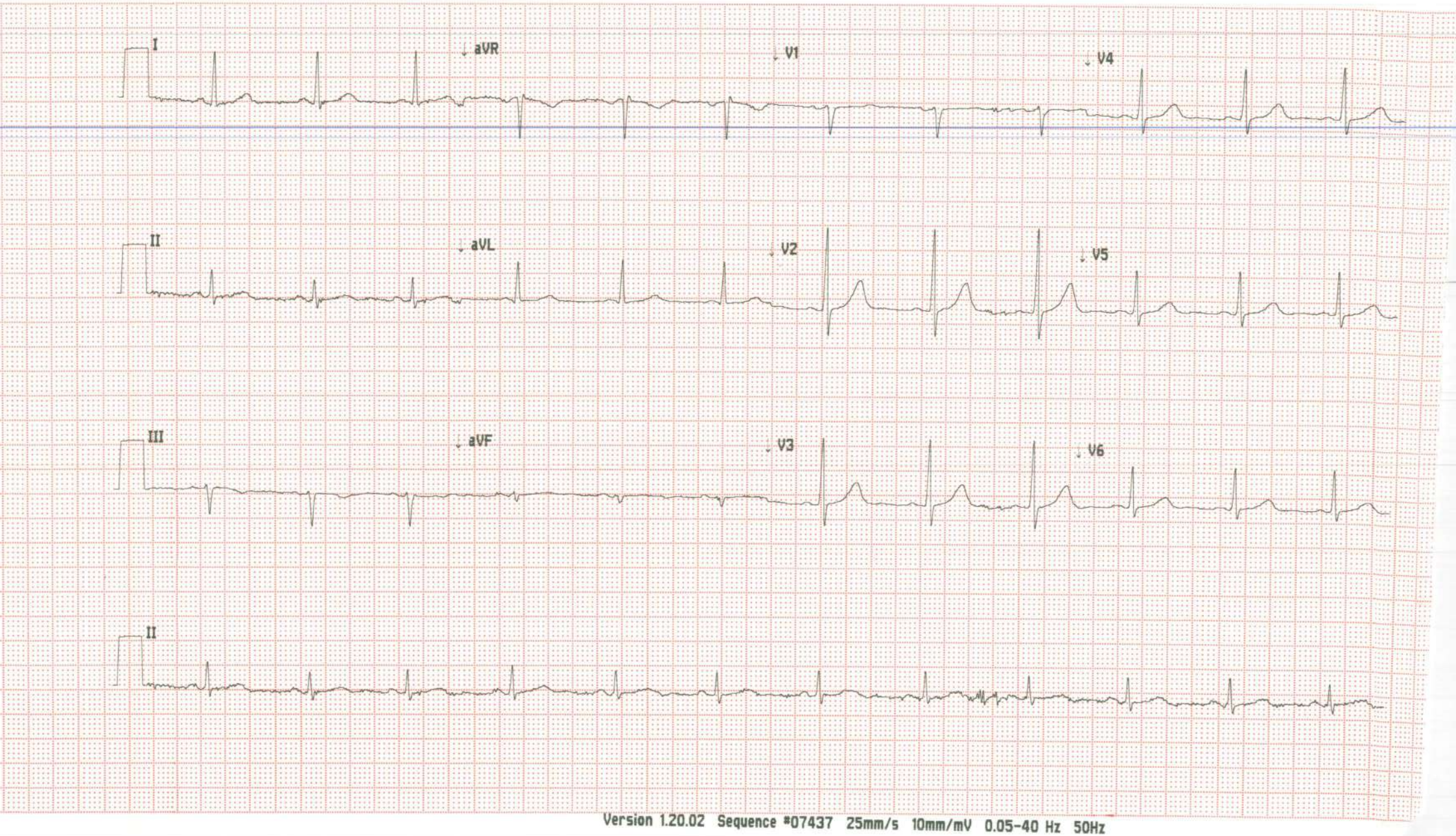
DOB:
yr, MALE

Vent rate:	73 BPM
PR int:	133 ms
QRS dur:	89 ms
QT/QTc:	390/415 ms
P-R-T axes:	36 -6 5

SINUS RHYTHM
NORMAL ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS

Reviewed by _____

Mr. Chetan D. Kaeji



Version 1.20.02 Sequence #07437 25mm/s 10mm/mV 0.05-40 Hz 50Hz

SPECTACLE CARD

sunshine GLOBAL HOSPITALS
health & happiness... always!

Ref. No. 513702 Name : Mr. Chetan Kavi Date : 18 / 5 / 2023

RIGHT			
Sph.	Cyl.	Axis	V.A.
			6/6
+1.5			N6

LEFT			
Sph.	Cyl.	Axis	V.A.
			6/6
+1.5			N6

Remarks : Reading glass.

INSTRUCTION :

- Verify your new glasses before using them.
- Bring this prescription on every visit.
- Get your glasses checked every six months to one year if necessary.
- **Donate Eyes, Help Blind.**
- **Request to optician. Please prepare the glasses according to this prescription only.**

Time : 09.00 am to 11.00 am, Monday to Saturday
Please obtain reporting time in advance & always bring OPD File

Consulting Eye Surgeon