



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Puja Nandy	Age / Gender : 32 Y(s)/Female
Bill No/ UMR No : NMBC60819/NMU0047203	Referred By : Dr. DMO
Received Dt : 09-Mar-24 09:54 am	Report Date : 09-Mar-24 06:36 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	20 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.020	1.000 - 1.030	Dipstick
PH		6.0	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	4-6	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		3-4	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		8-10	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
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION





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Parameters
NOTE

Specimen

Result

Biological Reference In Method

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

*** End Of Report ***





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Bill No/ UMR No : NMBC60819/NMU0047203	Referred By : Dr. DMO
Received Dt : 09-Mar-24 09:54 am	Report Date : 09-Mar-24 01:59 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.83	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		11.2	12.0 - 15.0 g/dl	
PCV/HCT		34.4	40 - 50 % 36 - 46 %	
MCV		71	83 - 101 fl 83 - 101 fl	
MCH		23.2	27 - 32 pg	
MCHC		32.5	31.5 - 34.5 g/dL	
RDW(cv)		15.3	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	130	150 - 400 $10^3/\mu\text{L}$	
MPV		12.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.1	4.0 - 11.0 $10^3/\mu\text{L}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	63	40 - 80 %	
LYMPHOCYTES		30	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC			Mild anisopoikilocytosis. Microcytic hypochromic with ovalocytes and some target cells.	
WBC			Normal morphology.	
PLATELETS			Mildly reduced in smear. Macroplatelets are also seen.	
ADVISED			1. Serum iron studies. 2. Haemoglobin electrophoresis/ HPLC assay.	
ESR	CITRATED BLOOD	45	0 - 20 mm/1st hour	WESTERGREN'S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

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Bill No/ UMR No : NMBC60819/NMU0047203	Referred By : Dr. DMO
Received Dt : 09-Mar-24 09:54 am	Report Date : 09-Mar-24 05:13 pm

Parameters

Specimen Result

TUBE AGGLUTINATI





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Puja Nandy **Age / Gender** : 32 Y(s)/Female
Bill No/ UMR No : NMBC60819/NMU0047203 **Referred By** : Dr. DMO
Received Dt : 09-Mar-24 09:55 am **Report Date** : 09-Mar-24 05:03 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		81	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.2	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
T3, T4 AND TSH				
T3		110.0	70 - 204 ng/dL	Method : ECLIA
T4		7.30	5.1 - 14.1 ug/dL	Method : ECLIA
TSH (THYROID STIMULATING HORMONE)		2.13	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.57	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.57	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		12.2	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)		20	<= 33 U/L	Method : UV without P5P
SGOT (AST)		20	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		103	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.8	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.66	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE (GGT)		14	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.





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Received Dt : 09-Mar-24 09:54 am	Report Date : 09-Mar-24 04:12 pm

Specimen

BUN(BLOOD UREA NITROGEN)

BUN (Blood Urea Nitrogen.) 7 7.0 - 21.0 mg/dL Calculated

TOTAL PROTEIN

TOTAL PROTEINS 7.7 6.0 - 8.0 g/dL Method : Biuret method

LIPID PROFILE

TOTAL CHOLESTEROL 151
 Desirable : : ≤ 200 mg/dL
 Borderline High : : 200 - 239 mg/dL
 High risk : : > 240 mg/dL
 METHOD : Enzymatic colorimetric

HDL CHOLESTEROL 46
 Low : : < 40 mg/dL
 High : : > 60 mg/dL
 Homogeneous enzymatic colorimetric

LDL CHOLESTEROL 96
 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 15
 SERUM TRYGLYCERIDES 75
 < 150 mg/dL
 Borderline High : : 150 - 199 mg/dL
 High : : 200 - 499 mg/dL
 METHOD: Enzymatic colorimetric

CHO/HDL RATIO 3.28
 Normal : : < 3.5
 High Risk : : ≥ 5.0

LDL/HDL RATIO 2.09
 SERUM URIC ACID 5.3
 2.4 - 5.7 mg/dL uricase

HBA1C (GLYCOSYLATED HAEMOGLOBIN)

HBA1C 5.4
 < 5.7 Normal
 Prediabetic 5.7 - 6.4
 & ≥ 6.5 Diabetic %
 MPG(Mean Plasma Glucose) 108
 Excellent Control : : 90 - 120 mg/dL
 Good Control : : 121 - 150 mg/dL

PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)

PLBS (POST LUNCH BLOOD GLUCOSE) 117 110 - 180 mg/dL Hexokinase

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Puja Nandy	Age / Gender : 32 Y(s)/Female
Bill No/ UMR No : NMBC60819/NMU0047203	Referred By : Dr. DMO
Received Dt : 09-Mar-24 02:37 pm	Report Date : 11-Mar-24 08:35 am

<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 Pathologist

Verified By : : 022633

Test results related only to the item tested.

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





MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mrs. Puja Nandy

Date:-09/03/2024

Age / Sex : 32 Yrs /Female

UMR No. 0047203

Referred By : Health check up

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- Mild mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Mild tricuspid regurgitation. No pulmonary hypertension.
PASP – 30 mmHg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal left atrium and left ventricle dimensions.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- No RWMA.
- Mild MR and TR. No PH.
- Normal LV and RV systolic function.

DR. SAMEER VANKAR
MD DM CARDIOLOGY





MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	09	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Mild
AORTIC	5			Nil
TRICUSPID	30			Mild
PULMONERY	4.4			Nil



Rate 79 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . RSR' in V1 or V2, probably normal variant.....small R' only

PR 138
 QRSD 105
 QT 362
 QTc 416

MIR
 MBBB

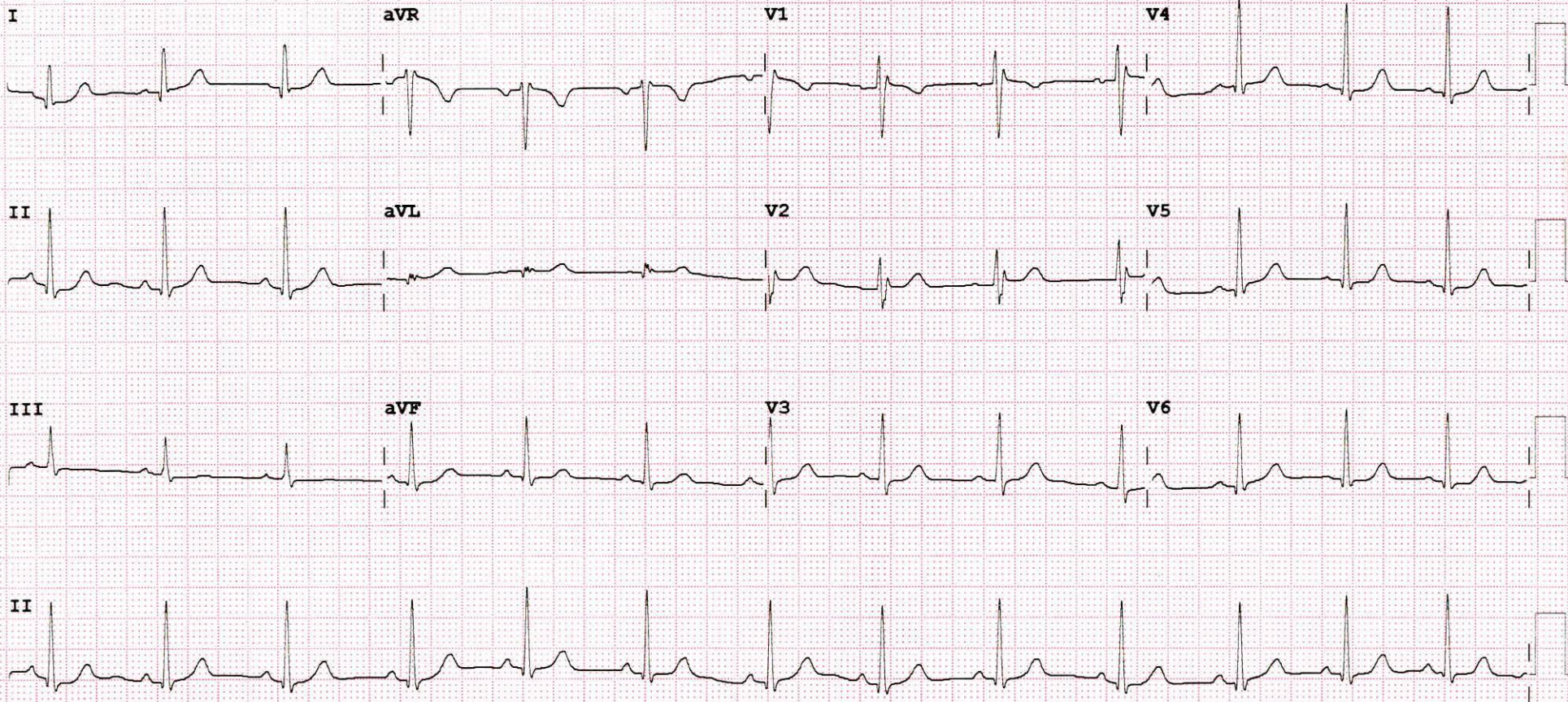

--AXIS--

P 59
 QRS 55
 T 32

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



<i>Patient ID:</i>	<i>NMU0047203</i>	<i>Patient Name:</i>	<i>Puja Nandy</i>
<i>Age:</i>	<i>32 Years</i>	<i>Sex:</i>	<i>F</i>
<i>Accession Number:</i>	<i>NMBC60819</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>09-Mar-2024</i>		

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

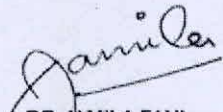
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

- **No significant abnormality is seen.**



DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 10-Mar-2024 14:04:12

Patient ID:	NMU0047203	Patient Name:	Puja Nandy
Age:	32 Years	Sex:	F
Accession Number:	NMBC60819	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	10:44:55

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

GALL BLADDER appears partially distended with normal wall thickness. There is no obvious calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

URINARY BLADDER is adequately distended; no e/o wall thickening or mass or calculi seen. Post-void residue is not significant.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 8 - 9 mm.

Both ovaries are normal in size, shape and position.

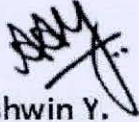
Visualised bowel loops appear normal. There is no free fluid seen.

NB:- This scan does not rule out all pathologies related to bowel and appendix.

IMPRESSION –

- **No significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE. THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



Dr. Ashwin Y.
M.D. (Radio-Diagnosis)



MEDICOVER
HOSPITALS
NAVI MUMBAI

Puja

o/e: pericoronitis \bar{e} $\frac{+}{8}$


Stains⁺⁺⁺

Calculus⁺⁺

Adv: Complete Oral prophylaxis

Extⁿ \bar{e} $\frac{+}{8}$




Dr. Sayali Vasant Mandekar
MDS In Conservative Dentistry
And Endodontics
Reg. No. A-32634.





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 9/3/24

PATIENT NAME: Mrs Puja Nandy.

AGE / SEX 32/F NAVI MUMBAI

UMR NO: NM00047203.

	RE	LE
VA (DISTANCE)	6/6	6/6
VA (NEAR)	N6	N6
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	Plano	_____		6/6
	O S	Plano	_____		6/6

HISTORY :

'NH/O systemic illness (DM, HTN, Thyroid), NH/O spectacles.
 'NH/O ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Ant-seq WNL
 (undilated) Disc ≤ 0.5
 0.4

ADVICE:

Refresh Tears eld qid 1777 x / month

AI
 (DR-ANUSHREE VANAPR)



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Puja Nandy-----

DATE: 9/3/24

AGE : 32 yrs

SEX: Male/ Female
 Female

NMU: NMU000 47203

DOCTOR'S NAME:
Health Package

TEMP :	<u>97.6</u>	° f	BP :	<u>110/66</u>	mmHg
PULSE :	<u>76</u>	b/m	HEIGHT :	<u>153</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>61.4</u>	kg
SPO2 :	<u>98</u>	%	HGT:	<u>—</u>	

REMARK: