MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. HEMANT V KOLAPPAN	**Age /Gender**	: 45 Y(s)/Male
Bill No/ UMR No	: NMBC61703/NMU0047802	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:12 am	**Report Date**	: 13-Mar-24 12:46 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.46	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		12.5	13.0 - 17.0 g/dl	
PCV/HCT		37.1	40 - 50 % 36 - 46 %	
MCV		83	83 - 101 fl 83 - 101 fl	
MCH		28.0	27 - 32 pg	
MCHC		33.6	31.5 - 34.5 g/dL	
RDW(cv)		13.3	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	304	150 - 400 10^3/µL	
MPV		7.2	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	9.0	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	54	40 - 80 %	
LYMPHOCYTES		37	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	30	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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Bill No/ UMR No	: NMBC61703/NMU0047802	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:12 am	**Report Date**	: 13-Mar-24 11:32 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		102	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		169.2	70 - 204 ng/dL	Method : ECLIA
T4		9.24	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		4.39	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		6.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		145	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.87	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		10.34	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		43	<= 41 U/L	Method : UV without P5P
SGOT (AST)		22	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		55	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.5	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.6	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.59	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		28	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. HEMANT V KOLAPPAN	**Age /Gender**	: 45 Y(s)/Male
Bill No/ UMR No	: NMBC61703/NMU0047802	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:12 am	**Report Date**	: 13-Mar-24 03:13 pm

Specimen

BUN (Blood Urea Nitrogen.)	9	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN			
TOTAL PROTEINS	7.5	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE			
TOTAL CHOLESTEROL	225	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL	34	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL	174	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	24		
SERUM TRYGLYCERIDES	119	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO	6.62	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO	5.12		
SERUM URIC ACID	6.4	3.4 - 7.0 mg/dL	uricase
PSA (PROSTATE SPECIFIC ANTIGEN).			
PROSTATE SPECIFIC ANTIGEN (PSA)	0.314	0 - 4.0 ng/mL	Method : ECLIA
SERUM ELECTROLYTES			
SERUM SODIUM	139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM	4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES	103	98 - 107 mmol/L	ISE INDIRECT
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)	126	110 - 180 mg/dL	Hexokinase
URINE SUGAR	Nil		Dipstick

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. HEMANT V KOLAPPAN	**Age /Gender**	: 45 Y(s)/Male
Bill No/ UMR No	: NMBC61703/NMU0047802	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 02:00 pm	**Report Date**	: 14-Mar-24 08:32 am

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head - Laboratory Services
Consultant Hematopathologist

Verified By : : 022633

Test results related only to the item tested.

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MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mr. Hemant Kolappan**	**Date:-13/03/2024**
Age / Sex	: **45 Yrs / Male**	**UMR No. 0047802**
Referred By	: **Health Checkup**	

FINDINGS:

- Mild concentric left ventricle hypertrophy.
- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 20 mm of Hg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

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

DR. KESHAV KALE
DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist

M-MODE MEASURMENTS:

LA	34	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	32	mm
LVID(d)	41	mm
IVS(d)	13	mm
LVPW(d)	12	mm
RVID(d)	29	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	14			Nil
TRICUSPID	20			Trivial
PULMONERY	5.1			Nil

MEDICOVER HOSPITALS

Patient ID:	*NMU0047802*	*Patient Name:*	*HEMANT V KOLAPPAN*
Age:	*45 Years*	*Sex:*	*M*
Accession Number:	*NMBC61703*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*13-Mar-2024*	*Study Time:*	*11:23:48*

USG WHOLE ABDOMEN

LIVER is normal in size, normal in shape and shows bright echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepatopetal 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 or free fluid noted. CBD appears normal.

Visualised parts of head & body of pancreas appear normal. PD is not dilated.

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

PROSTATE is normal in size, shape & echotexture.

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 –

- **Grade I fatty liver.**
- **No other significant abnormality detected.**

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

MEDICOVER HOSPITALS

Patient ID:	*NMU0047802*	*Patient Name:*	*HEMANT V KOLAPPAN*
Age:	*45 Years*	*Sex:*	*M*
Accession Number:	*NMBC61703*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*13-Mar-2024*	*Study Time:*	*10:28:40*

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. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 13-Mar-2024 14:35:10

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 19/03/24

PATIENT NAME: Mrs Heeramani v. Kolappan AGE / SEX 45/F

UMR NO : NMU0047802.

	RE	LE
VA (DISTANCE)	6/9p	6/6.
VA(NEAR)	N8	N10
COLOUR VISION	Normal	Normal.

			SPHERE	CYLINDER	AXIS	VA	Aeon
MRx	O (R)	D	−0.50	———		6/6	+1.50 N6
	O (L)	S	plano	———		6/6.	+1.50 N6.

HISTORY :

NO H/O Systemic Illness (DM, HTN, thyroid) - H/O using spectacle (previously)
NO H/O Ocular trauma Allegis & surgeries. ——— (for Distance).
- H/O chickenpox 15 days back & took Rx for the same

OCULAR FINDINGS :

(BE)- Ant seg WNL
Lens-clear

ADVICE:

Refresh Tears eld qid 1777 X 1month.

AS
(DR-ANUSHREE VANKAR).

47802 HEMANT KOLAPPAN 3/13/2024 12:13:59 PM
45 Years Male

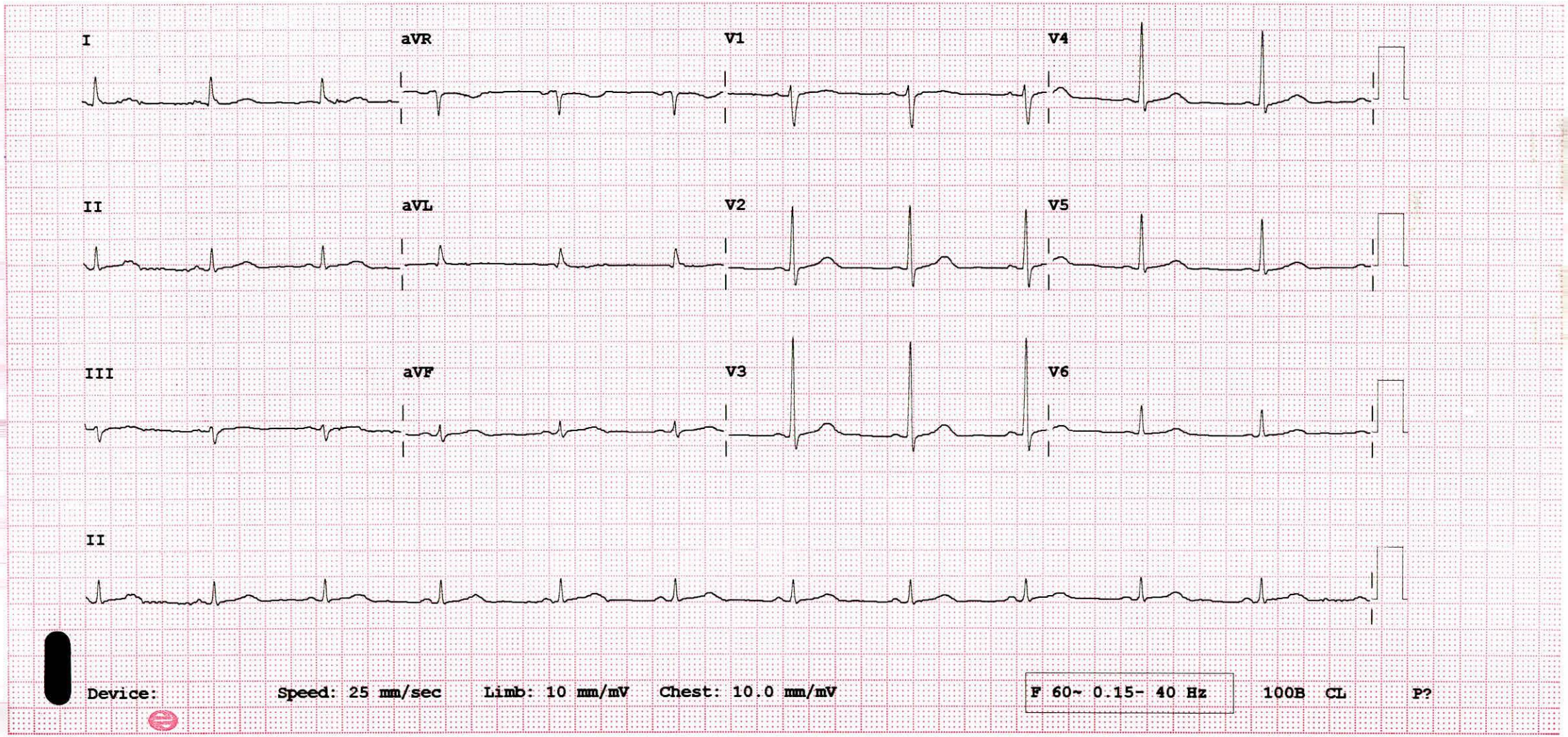
Rate	67	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline low voltage, extremity leads.....all extremity leads <0.6mV
PR	141	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	81	
QT	401	
QTc	424	

--AXIS--
P 24
QRS 9
T 59

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15- 40 Hz 100B CL P?