



Name : Mrs. ASMITA BARVEKAR (A) Collected On : 23/3/2024 12:17 pm
Lab ID. : 187559 Received On : 23/3/2024 12:27 pm
Age/Sex : 40 Years / Female Reported On : 23/3/2024 8:00 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	198.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	45.0	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	143.4	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	29	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	124	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.76		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	4.40		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





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COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	10.0	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	30.0	%	36 - 46
RBC COUNT	3.96	x10 ⁶ /uL	4.5 - 5.5
MCV	76	fl	80 - 96
MCH	25.3	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	16.2	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	4520	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	40	%	40 - 80
LYMPHOCYTES	55	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	03	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	388000	/cumm	150000 - 450000
MPV	9.9	fl	6.5 - 11.5
PDW	15.8	%	9.0 - 17.0
PCT	0.380	%	0.200 - 0.500
RBC MORPHOLOGY	Hypochromia(mild),anisocytosis(mild),reduced red blood cells count		
WBC MORPHOLOGY	Lymphocytosis		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	4-6	/ HPF	0 - 5
CASTS	Absent		

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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TFT (THYROID FUNCTION TEST)

SPECIMEN	Serum		
T3	84.90	ng/dl	84.63 - 201.8
T4	6.94	µg/dl	5.13 - 14.06
TSH	1.63	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER COBAS e411.

INTERPRETATION T3 (Triiodo Thyronine) T4 (Thyroxine)

AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

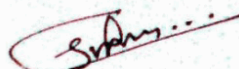
TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'B'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
----- END OF REPORT -----			

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***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	13.2	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	6.17	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.62	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	3.6	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	139.4	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.0	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	102.0	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.53	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	9.3	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.02	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.87	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.15	g/dl	1.9 - 3.5
A/G RATIO calculated	1.23		0 - 2

NOTE BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole blood EDTA
RBC	Normocytic, Normochromic
WBC	Total leukocyte count is normal on smear. Lymphocytes are increased on smear.
	NEUTROPHILS:40% LYMPHOCYTES:55% EOSINOPHILS:02% MONOCYTES:03% BASOPHILS:00%
PLATELET	Adequate on smear
HEMOPARASITE	No parasites seen
Result relates to sample tested, Kindly correlate with clinical findings.	
----- END OF REPORT -----	

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LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.23	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.15	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.08	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	17.0	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	7.7	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	62.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.02	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.87	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.15	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.23		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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* 1 8 7 5 5 9 *

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	36	mm/1hr.	0 - 20

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	8.1	U/L	5 - 55
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	97.8	mg/dL	70 - 110
URINE GLUCOSE FASTING			
BLOOD GLUCOSE PP	93.3	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

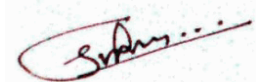
- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms +Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.6	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	114.0	mg/dL	65.1 - 136.3
METHOD	Particle Enhanced Immunoturbidimetry		

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BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
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Consultant Histocytopathologist



Asmita Barvelkar
40 yrs / female

23/03/2024

No fresh complaints.
No comorbidities.

No PIH.

No SH.

LMP - 13/03/2024, regular

OH - G₂P₁, A, L, D₀.

G₁ - Male, 17 yrs, FTND, healthy.

G₂ - MTP.

⊗ F/m - Mother - HTN.


father - DM, HTN.

BP - 100/60 mmHg

P - 90/min

SpO₂ = 98%.

PT is fit and can resume
her normal duties


DR. VISHAL DALVI
MBBS, MD (Medicine),
Consultant Physician
Reg. No. 2011/09/3272

ID: 1181

23-03-2024

10:04:48 AM

Banerjee Asmita
Female
Years 40 y/f
Req. No.

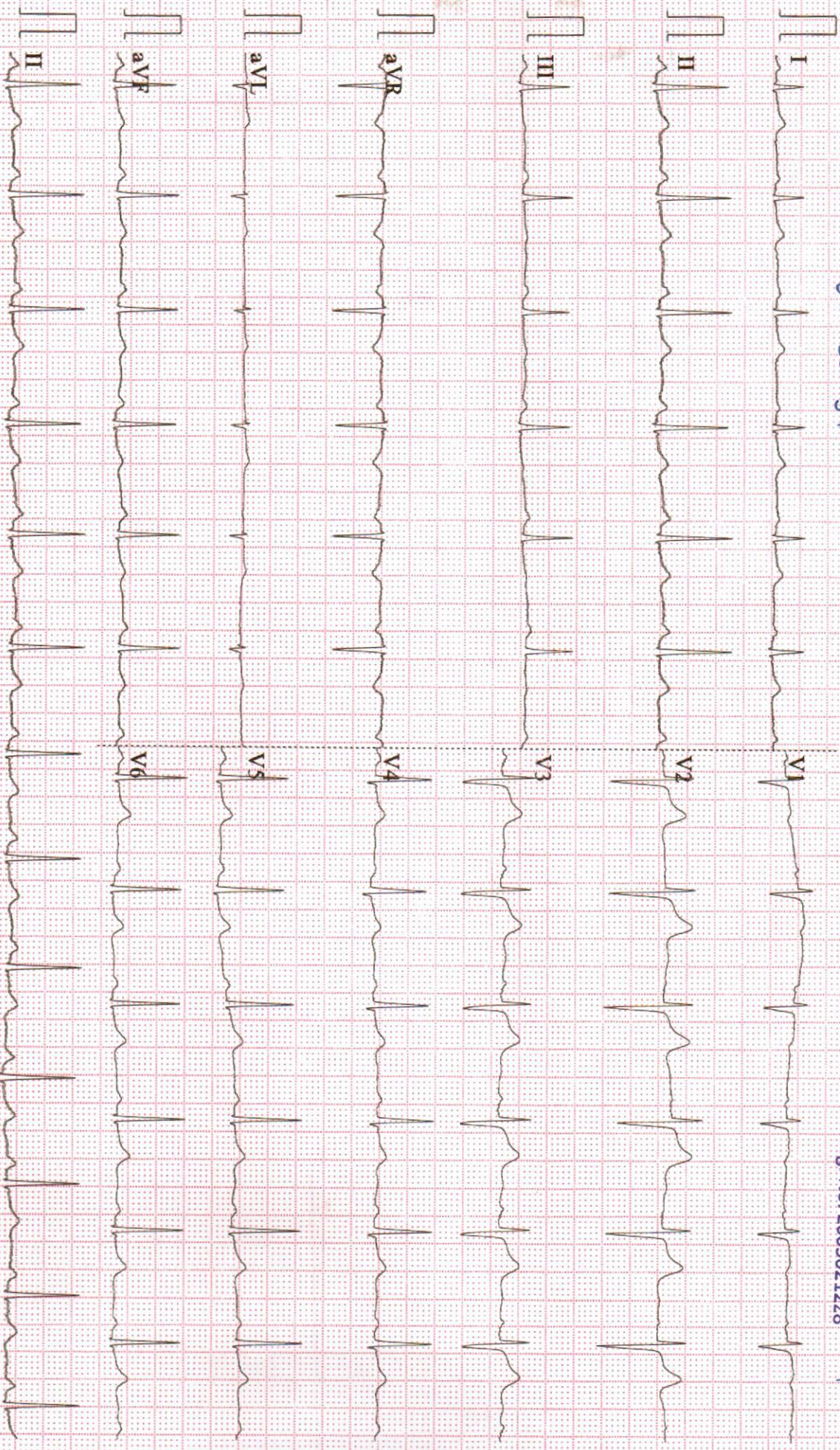
BP - 100/60
SPo2 - 99%
PR - 90m
HR - 75
WT - 62.50 kg

HR : 75 bpm
P : 107 ms
PR : 165 ms
QRS : 77 ms
QT/QTcBz : 387/434 ms
P/QRST : 64/71/45
RV5/SV1 : 1.173/0.501 mV

Diagnosis Information:
Sinus Rhythm
Normal ECG

Report Confirmed by:

NSK
No significant ST-T
Changes seen.
No Immediate Intervention
Required for now.
Dr. Anant R. M. Kishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228



0.15-45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital



2D ECHOCARDIOGRAM & COLOUR DOPPLER REPORT

NAME	: MRS. ASMITA BARVEKAR
AGE	: 40 YR/F
DATE OF EXAMINATION	: 23/03/2024
REF BY	: SIDDHIVINAYAK HOSPITAL
ECHOCARDIOGRAM DONE BY	: DR.SANDIP FULPAGARE

Mitral Valve	:	Normal.	
Aortic Valve	:	Normal.	
Pulmonary Valve	:	Normal.	
Tricuspid Valve	:	Normal.	
Interatrial septum	:	Intact.	
Interventricular septum	:	Intact.	
RA	:	Normal	
RV	:	Normal	
LA	:	3.7cm	
LV	:	Normal, No RWMA.	
LV Dimensions			
LVID (d): 4.6 cm		LVID (s):2.4 cm	LVEF: 60%
IVS (d): 1.0 cm		LVPW (d):1.0cm	
Aorta		2.7cm	
Pericardium	:	Normal.	
IVC / Other findings			

DOPPLER MEASUREMENTS:-

MV: E = 0.4, A = 0.7, DT = 160 ms.
Aortic flow velocity = 1.2 m/s.
Pulmonary flow velocity = 0.7 m/s.
MR: Nil, AR: Nil, TR: Nil, PR: Nil

IMPRESSION:-

Normal Sized cardiac chambers.
No RWMA, Good LV Systolic Function. (LVEF- 60 %)
Normal Valves.
RA/ RV Normal, Good RV systolic function.
No pericardial effusion/ Clot.

DR. SANDIP FULPAGARE,
MD (MEDICINE), DNB (CARDIOLOGY).FESC.

Dr. Sandip Fulpagare
MD (Medicine), DNB (Cardiology)
Reg. No.- 75794





Name - MRS . ASMITA BARVEKAR	Age - 40 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 23 /03/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE

MBBS; DMRE

CONSULTANT RADIOLOGIST

DR. AMOL BENDRE

MBBS DMRE

Reg. No. 2015/08/4412

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





Name - Mrs. Asmita Barvekar	Age - 40 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 23/03/2024

USG ABDOMEN & PELVIS

FINDINGS:

The liver dimension is normal in size. It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally with no stones within.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (9.9 cm) and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 9.9 x 4.5 cm.

The left kidney measures 9.9 x 5.6 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus : is bulky in size: 9.6 x 6.2 x 5.8 cm. Evidence of two Subserosal fibroids of sizes 34 x 24 mm & 26 x 13 mm are seen along anterior & fundal region respectively

Endometrium: 6.4 mm, it appears normal in morphology.

Both ovaries are normal in size.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Fatty liver (Grade I)
- Bulky uterus with Subserosal fibroids

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Dr. AMOL BENDRE
MBBS DMRE
Reg. No. 2015/08/4412





Name - Mrs. Asmita Barvekar	Age - 40 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 23/03/2024

USG - BOTH BREASTS

Real time sonography of both breasts was performed with high frequency probe.

Both breast show normal, medium level, homogeneous echotexture. No evidence of any solid or cystic focal mass lesion.

No evidence of calcification noted.

The pectorallis major muscles appear normal.

No evidence of axillary lymphadenopathy seen.

IMPRESSION:

- No significant abnormality is noted.

Thanks for the referral.....

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Dr. AMOL BENDRE
MBBS DMRE
Reg. No. 2015/08/4412



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE Asmita Barvekar

AGE 40

DATE - 23.03.2024

Specks : With Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/6	6/6
Color Blind Test	Normal	



SIDDHIVINAYAK HOSPITALS

Name : Mrs. ASMITA BARVEKAR (A) Collected On : 23/3/2024 12:17 pm
Lab ID. : 187559 Received On : 23/3/2024 12:27 pm
Age/Sex : 40 Years / Female Reported On : 25/3/2024 7:54 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 7 5 5 9 *

PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/117/24		
CLINICAL HISTORY	Routine check up		
NO. OF SMEARS RECEIVED	One		
SPECIMEN ADEQUACY	Adequate		
CELL TYPE	Superficial, intermediate, squamous metaplastic cells		
ORGANISM	Absent		
EPITHELIAL CELL ABNORMALITY	Nil		
OTHER NON-NEOPLASTIC FINDINGS	Few neutrophils		
FINAL IMPRESSION	Negative for intraepithelial lesion or malignancy.		
NOTE	Cervical cytology is a screening test and has associated false negative and false positive results. Regular sampling and follow up is recommended.		

----- END OF REPORT -----

Checked By
Dr_smita.ranveer

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

