



Vasavi Hospitals

LABORATORY

WE CURE WITH CARE

(A Unit of Sree Vasavi Trust)

Patient Name	Mr. SANDEEP	Lab No	48379
UHID	200850	Sample Date	21/01/2023 8:43AM
Age/Gender	31 Yrs/Male	Receiving Date	21/01/2023 9:28AM
Bed No/Ward	OPD	Report Date	21/01/2023 1:19PM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/23/6451	Manual No.	

BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD UREA NITROGEN	8.5	mg/dl	Upto 14 years : 5 - 18 mg/dl Male (above 14 years): 8 - 24 mg/dl Female (above 14 years): 6 - 21 mg/dl Pregnant women : 5 - 12 mg/dl	
SERUM CREATININE	0.95	mg/dl	0.60 - 1.40	
FASTING BLOOD SUGAR	109.8 H	mg/dl	74.00 - 100.00	
GLYCOSYLATED HAEMOGLOBIN (HbA1c)				
HbA1c (GLYCOSYLATED Hb)	5.0	%	4.00 - 6.00	Immunoturbidimetric
MEAN BLOOD GLUCOSE	96.80	mg/dl	70.00 - 140.00	
LIPID PROFILE				
TOTAL CHOLESTEROL	176	mg/dl	0.00 - 200.00	
TRIGLYCERIDES	327.3 H	mg/dl	0.00 - 200.00	
HDL CHOLESTEROL - DIRECT	41.3	mg/dl	35.00 - 55.00	
LDL CHOLESTEROL - DIRECT	114.6	mg/dl	0.00 - 130.00	
TC/HDL	4.26			
LDL/HDL	2.77			

Sample: Serum

LIVER FUNCTION TEST (LFT)

Ravi Shankar

Verified By

Ravi Shankar K

Shashi Kumar G

Bio Chemist

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#15, 70th Cross, 14th Main, 1st Stage, Kumaraswamy Layout (Opp. to 15 E Bus Stop), Bengaluru - 560 078

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TOTAL BILIRUBIN 0.51 mg/dl Adult - 0.2 - 1.3 mg/ dL

Special condition:
 Premature - <2.0 mg/ dL
 Full term - <2.0 mg/ dL
 0-1 day - Premature- 1.0 - 8.0 mg/ dL
 0-1 day - Full term - 2.0 - 6.0 mg/ dL
 1 - 2 days Premature - 6.0 - 12.0 mg/ dL
 1 - 2 days Full term - 6.0 - 10.0 mg/ dL
 3 - 5 days Premature - 10.0 - 14.0 mg/ dL
 3 - 5 days Full term - 4.0 - 8.0 mg/ dL

DIRECT BILIRUBIN	0.21	mg/dl	0.00 - 0.30
INDIRECT BILIRUBIN.	0.30	mg/dl	
ASPARATE AMINOTRANSFERASE (SGOT/AST)	25.1	U/L	0.00 - 40.00
ALANINE AMINOTRANSFERASE (SGPT/ALT)	29.1	U/L	0.00 - 40.00
ALKALINE PHOSPHATASE (ALP)	128	IU/L	53.00 - 128.00
TOTAL PROTEIN	6.82	g/dl	6.00 - 8.50
SERUM ALBUMIN	4.70	g/dl	3.50 - 5.20
SERUM GLOBULIN	2.12 L	g/dl	2.30 - 3.50
A/G RATIO	2.22 H	%	1.00 - 1.50
POST PRANDIAL BLOOD GLUCOSE	101	mg/dl	70.00 - 140.00
URIC ACID	8.6 H	mg/dl	4.50 - 8.10

--End Of Report--

Ravi Shankar

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LABORATORY

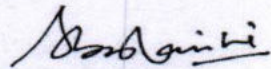
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Patient Name	Mr. SANDEEP	Lab No	48379
UHID	200850	Sample Date	21/01/2023 8:43AM
Age/Gender	31 Yrs/Male	Receiving Date	21/01/2023 9:24AM
Bed No/Ward	OPD	Report Date	21/01/2023 1:19PM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/23/6451	Manual No.	

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
STOOL ANALYSIS				
PHYSICAL EXAMINATION				
COLOUR	Yellow			
CONSISTANCY	SEMI SOLID			
PH	6.0			
MUCUS	ABEST			
MICROSCOPIC EXAMINATION				
OVA	NOT SEEN			
CYST	NOT SEEN			
TROPHOZOITES	NOT SEEN			
PUS CELLS	2-3/HPF			
R.B.C	Nil			
BACTERIA	PRESENT 2+			
OTHERS	NIL			
MISCELLANEOUS	NIL			
URINE GLUCOSE FASTING				
URINE SUGAR	NIL		NEGATIVE	Sample: Urine
PHYSICAL CHARACTERS				
COLOUR	Pale Yellow			
APPEARANCE	Clear		Clear	
SPECIFIC GRAVITY	1.015			
PH	6.0			
CHEMICAL CONSTITUENTS				
ALBUMIN	Nil			
SUGAR	Nil			
BILE SALTS	Absent			

Verified By
Shashi Kumar G


BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name Mr. SANDEEP
UHID 200850
Age/Gender 31 Yrs/Male
Bed No/Ward OPD
Referred By Dr. CMO
Bill No. OPCR/23/6451

Lab No 48379
Sample Date 21/01/2023 8:43AM
Receiving Date 21/01/2023 9:24AM
Report Date 21/01/2023 1:19PM
Report Status Final
Manual No.

BILE PIGMENTS Absent
KETONE BODIES NEGATIVE
BLOOD Absent
MICROSCOPY
PUS CELLS 1-2 /HPF
R.B.C Nil
EPITHELIAL CELLS 0-1 / HPF
CASTS Nil
CRYSTALS Nil
BACTERIA Absent

--End Of Report--

Verified By
Shashi Kumar G

BADARINATH S
MD (PGI) KMC No 19014

HEMATOPATHOLOGIST / PATHOLOGIST

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Patient Name	Mr. SANDEEP	Lab No	48379	WE CURE WITH CARE
UHID	200850	Sample Date	21/01/2023 8:43AM	(A Unit of Sree Vasavi Trust)
Age/Gender	31 Yrs/Male	Receiving Date	21/01/2023 12:36PM	
Bed No/Ward	OPD	Report Date	21/01/2023 1:19PM	
Referred By	Dr. CMO	Report Status	Final	
Bill No.	OPCR/23/6451	Manual No.		

CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
URINE GLUCOSE-POST PRANDIAL				
URINE SUGAR	NIL		NEGATIVE	

--End Of Report--

Verified By
Shashi Kumar G

Ravi Shankar K
Ravi Shankar K
Bio Chemist

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Patient Name	Mr. SANDEEP	Lab No	48379
UHID	200850	Sample Date	21/01/2023 8:43AM
Age/Gender	31 Yrs/Male	Receiving Date	21/01/2023 9:28AM
Bed No/Ward	OPD	Report Date	21/01/2023 11:06AM
Referred By	Dr. CMO	Report Status	Final
Bill No.	OPCR/23/6451	Manual No.	

HAEMATOTOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
BLOOD GROUP	O			
RH TYPE	POSITIVE			
			Sample: Blood	
HAEMOGLOBIN	16.8	gm/dl	14.00 - 18.00	
TOTAL COUNT	11820 H	cells/cumm	4500.00 - 11000.00	
DLC				
NEUTROPHILS	56	%	35.00 - 66.00	
LYMPHOCYTES	36	%	24.00 - 44.00	
MONOCYTES	06	%	4.00 - 10.00	
EOSINOPHILS	02	%	1.00 - 6.00	
BASOPHILS	00	%	0.00 - 1.00	
R.B.C COUNT	5.74	mill/cumm	4.50 - 5.90	
PACKED CELL VOLUME (PCV)	50.2 H	%	40.00 - 50.00	
PLATELET COUNT	3.49	lakh/cumm	1.50 - 4.50	
M.C.V	87.5	fL	80.00 - 100.00	
M.C.H	29.3	pg	26.00 - 34.00	
M.C.H.C	33.5	%	32.00 - 36.00	
ESR (ERYTHROCYTE SEDIMENTATION RATE)	05	mm/hr	0.00 - 10.00	

--End Of Report--

Verified By
Shashi Kumar G

Badarinath S
BADARINATH S
MD (PGI) KMC No 19014
HEMATOPATHOLOGIST / PATHOLOGIST

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Age/Gender	31 Yrs/Male	Receiving Date	21/01/2023 9:28AM	
Bed No/Ward	OPD	Report Date	21/01/2023 11:02AM	
Referred By	Dr. CMO	Report Status	Final	
Bill No.	OPCR/23/6451	Manual No.		

HORMONES

Test Name	Result	Unit	Biological Ref. Range	Method
THYROID PROFILE (T3, T4, TSH)				
TOTAL TRIIODOTHYRONINE (T3)	2.11	nmol/L	0.93 - 3.72	
TOTAL THYROXINE (T4)	168.2 H	nmol/L	41.00 - 163.00	
TSH (THYROID STIMULATING HORMONE)	2.87	uIU/ml	0.40 - 5.00	

--End Of Report--

Verified By
Shashi Kumar G

Ravi Shankar
Ravi Shankar K
Bio Chemist

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PATIENT NAME	SANDEEP	AGE & SEX	31 YRS / MALE
UHID	200850	DATE	21/01/2023
REF. BY DR.	CMO	MANUAL NO.	24747

ULTRASOUND SCAN OF ABDOMEN AND PELVIS

LIVER: Liver is 13.9 cm in size, both lobes of liver are normal in size with increased echotexture. No evidence of any focal lesion / intrahepatic biliary dilatation noted. CBD and Portal vein normal in size and echotexture.

GALL BLADDER: Well distended, gall bladder wall thickness is normal. Contents are clear. No evidence of gall stones / cholecystitis.

PANCREAS: Obscured by bowel shadows.

SPLEEN: Normal in size measuring 8.4 cms with normal echotexture.

KIDNEYS: Both kidneys are normal in size, shape, contour & position. Cortico medullary differentiation is well maintained. No evidence of any hydronephrosis / hydroureter. Right Kidney measures : 10.0 x 4.1 cms. Parenchymal thickness 1.4 cms. Left Kidney measures : 9.8 x 4.8 cms. Parenchymal thickness 1.4 cms.


URINARY BLADDER: Well distended with clear contents. Wall thickness is normal.

PROSTATE: Normal in size and echotexture. Vol: 16.8 cc. No focal lesion seen. Both seminal vesicles appear normal.

No obvious free fluid in the peritoneal cavity.

IMPRESSION: FATTY LIVER.

**** Note: All abnormalities cannot be detected by Ultrasound scan due to technical limitation, obesity and other factors. Scan findings to be correlated with old reports or other investigations.**



Dr. KIRUTHIKA SELVARAJ MBBS, DMRD.
Consultant Radiologist
KMC Reg. No. 101138

MR Sanaeep 32 yrs
Male

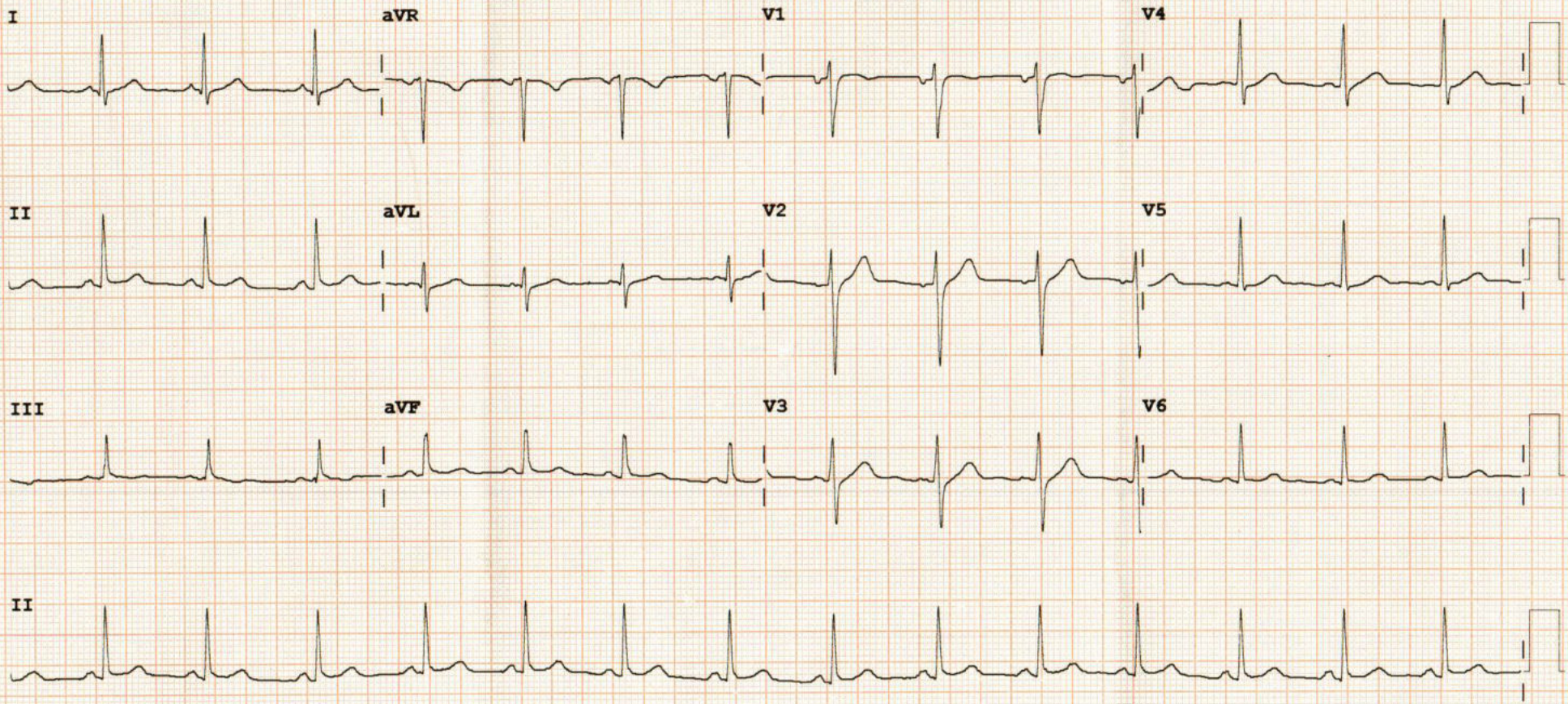
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Rate 89
PR 116
QRSD 77
QT 335
QTc 408

--AXIS--

P 47
QRS 64
T 29

12 Lead; Standard Placement



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.15-100 Hz 100B CL P?

Name: Sandeep

Age / Sex: 31/M Ph. No.:

UHID No: 200850

OUT PATIENT HISTORY, FINDINGS & ADVISE

BP - 120/70 mmHg

As/B & Sridhar

SpO₂ - 97%

PR - 105 bpm

Case reviewed

wt - 68 kg

no weakness.

Ht - 166 cm

T - (N)

IBW - 66 kg

uric acid levels - 8.4%

As & Sridhar

Rs occasional wheezing

Advice

① 3-4 lts of water/day

② Tab. Pulmodear 1-0-1 x 10 days

③ tab Levocet-M 001 x 5 days

Recheck - lipid profile & uric acid after 2 months.

[Signature]
Sridhar
9800601

PLEASE SIGN AFTER EACH ENTRY

Name :

Age / Sex :

Ph. No. :

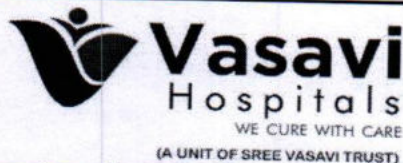
UHID No :

OUT PATIENT HISTORY, FINDINGS & ADVISE

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PLEASE SIGN AFTER EACH ENTRY

OPD Prescription



Reg. No 200850 Issue Date 20/01/23
 Name Mr Sandeep Age/Sex 31/M
 Doctor Swathi Department
 Patient Mob. 9701562156 Category

BP: 120/70 Height: 166 Weight: 68.3 Pain: Pulse: 105 Temperature: 37.1 SpO2: 97%
 many cm kg bpm

Allergies: [] YES [] NO Details: COVID 19 Positive: [] YES [] NO

Previous Drug Reactions: [] YES [] NO Details: routine check up

History and complaints: eyeglasses. changed last year. (around -20) no visual complaints.

Past History: VA (6/6) 2/12 (6/6) Top (12/10) mm Hg.

colour vision (partial red green colour blind).

Examination: Anterior segment (wnc) Drug orders:

Investigations: Fundus (indie) (Disc & macula normal).

Provisional/Final Diagnosis: Both eyes myopic astigmatism.

Advice: (Lifestyle / Rehab / Diet) - Continue same glasses.

Nutritional Screening: [] Poor [] Moderate [x] Well - Review at Kaveri Nithulaya

Fall Risk: [x] No Risk [] Low [] high if planning reproductive sex.

Follow up: Date: 20/1/24 Time: _____

Name & Signature of the Consultant with Stamp: Swathi.
 #15, 70th Cross, 14th Main, 1st Stage, Kumaraswamy Layout (Opp.to 15E Bus Stop), Bangalore-560078.
 Appointment: 080 71 500 500 | Emergency: 080 71 500 555

UHID / IP NO	200850 (3391)	RISNo./Study :	48379
Patient Name :	Mr. SANDEEP	Age/Gender :	31 Y/M
Referred By :	Dr. CMO	Ward/Bed No :	OPD
Bill Date/No :	21/01/2023 8:43AM/ OPCR/23/6451	Scan Date :	
Report Date :	21/01/2023 11:54AM	Company Name:	Final

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M- MODE MEASUREMENTS

AO	3.13	cm	RVIDD	1.20	cm
LA	2.90	cm	IVSD	0.98	cm
AO/LA RATIO	0.75	cm	LVIDD	3.89	cm
AV CUP	1.46	cm	LVPWD	1.23	cm
EPSS	0.9	cm	IVSS	1.31	cm
DE	1.83	cm	LVIDS	2.42	cm
EF SLOPE	0.7	cm	LVPWS	1.23	cm
SV	57.41		EDV	65.52	ml
CO			ESV	33.34	ml
HR			EF	68.53	%
LVMI			FS	37.80	%
OTHERS			LV MASS	178.32	grams

DESCRIPTIVE FINDINGS: Technically Adequate Study. Normal Sinus rhythm during Study.

LEFT VENTRICLE	Normal in size
LEFT ATRIUM	Normal in size
RIGHT VENTRICLE	Normal in size
RIGHT ATRIUM	Normal in size
WALL MOTION ANALYSIS	No RWMA
TRICUSPID VALVE	Normal
MITRAL VALVE	Normal
PULMONIC VALVE	Normal
AORTIC VALVE	Normal
IAS & IVS	Intact
AORTA & PA	Normal In Size
SYSTEMIC & PULMONARY VENIS	Normally Draining
PERICARDIUM	Normal
OTHERS	No Intra Cardiac Thrombus, Tumour or Vegetation

CARDIOLOGY

UHID / IP NO	200850 (3391)	RISNo./Status :	48379/
Patient Name :	Mr. SANDEEP	Age/Gender :	31 Y/M
Referred By :	Dr. CMO	Ward/Bed No :	OPD
Bill Date/No :	21/01/2023 8:43AM/ OPCR/23/6451	Scan Date :	
Report Date :	21/01/2023 11:54AM	Company Name:	Final

DOPPLER STUDY

VALVES	VELOCITY	GRADIENT	REGURGITATION	OTHERS
P V	0.71m/s		NO PR	
MV	E: 0.93 m/s A: 0.66 m/s		NO MR	
AV	1.13 m/s		NO AR	
TV	E: 0.60m/s A: 0.40m/s		NO TR	
OTHERS				

SUMMARY FINDINGS:

NORMAL CARDIAC CHAMBERS & VOLUMES

NO REGIONAL WALL MOTION ABNORMALITY AT REST

NORMAL LV SYSTOLIC FUNCTION (EF-68 %)

NO CLOT / EFFUSION / VEGETATION/PAH


Dr. PRANEETHS
CONSULTANT
CARDIOLOGIST

Mr. Deva Sagayam C