

**Patient Details**

UHID : AFD000018165  
Patient Name : MR. SINGH ALOK  
Age / Gender : 32 Yrs 4 Mth / MALE / 14-09-1990  
Company : Acrofemi Healthcare Ltd  
Address : H.NO-36, GROUND FLOOR, SEC-15A, FARIDABAD, HARYANA, INDIA

Bill Date : 14-01-2023 09:08:45  
Bill No. : AFDHC230000124  
Receipt No. : AFDPRT230001328

**Service Details**

S. No.	Investigation	Rooms	Remarks
1	MEDIWHEEL PKG FOR MALE BELOW 40YRS DR. PHC HEAD		
2	CBC-1( COMPLETE BLOOD COUNT )•		
3	ESR•		
4	URINE, ROUTINE EXAMINATION•		
5	STOOL ROUTINE EXAMINATION		
6	• BLOOD GROUP (ABO & RH) •		
7	GLUCOSE PLASMA (FASTING)•		
8	GLUCOSE PLASMA (PP) POST PRANDIAL• 10' 47		
9	GLYCATED HAEMOGLOBIN (HBA1C)•		
10	THYROID PROFILE (FT3+FT4+TSH)•		
11	LIPID PROFILE•		
12	KFT/RFT-KIDNEY/RENAL PANEL 1•		
13	LIVER FUNCTION TESTS (LFT)•		
14	ECG•		
15	2D ECHO DR. MITHILESH KUMAR•		
16	XRAY-CHEST P.A•		
17	USG-FOR WHOLE ABDOMEN•		
18	OPD Consultation-Internal Medicine DR. MUKUND SINGH		
19	OPD Consultation-Ophthal DR. UPASANA		

  
Employee ID  
Signature

Prepared By : MS. PRIYANKA MOURYA

**FINAL REPORT**

Bill No.	: AFDHC230000124	Bill Date	: 14-01-2023 09:06
Patient Name	: MR. SINGH ALOK	UHID	: AFD000018165
Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23001094	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 10:21
		Reporting Date & Time	: 14-01-2023 11:30

**HAEMATOLOGY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**
**CBC -1 (COMPLETE BLOOD COUNT)**

TOTAL LEUCOCYTE COUNT (Flow Cytometry)		8.0	thousand/cumm	4 - 11
RED BLOOD CELL COUNT (Hydro Dynamic Focussing)		5.0	million/cumm	4.5 - 5.5
HAEMOGLOBIN (SLS Hb Detection)		14.1	g/dL	13 - 17
PACK CELL VOLUME (Cumulative Pulse Height Detection)		42.0	%	40 - 50
MEAN CORPUSCULAR VOLUME		83.2	fL	83 - 101
MEAN CORPUSCULAR HAEMOGLOBIN		27.9	pg	27 - 32
MEAN CORPUSCULAR HAEMOGLOBIN CONCENTRATION		33.5	g/dL	31.5 - 34.5
PLATELET COUNT (Hydro Dynamic Focussing)		261	thousand/cumm	150 - 400
RED CELL DISTRIBUTION WIDTH (S.D - RDW) (Particle Size Distribution)	H	50.6	fL	39 - 46
RED CELL DISTRIBUTION WIDTH (C.V.)	H	16.6	%	11.6 - 14

**DIFFERENTIAL LEUCOCYTE COUNT**

NEUTROPHILS		57	%	40 - 80
LYMPHOCYTES		36	%	20 - 40
MONOCYTES		5	%	2 - 10
EOSINOPHILS		2	%	1 - 5
BASOPHILS		0	%	0 - 1

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



**DR. REETU JADHAV NAGE**  
 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST

**FINAL REPORT**

Bill No.	: AFDHC230000124	Bill Date	: 14-01-2023 09:06
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**BIOCHEMISTRY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**

GLUCOSE-PLASMA (FASTING) (UV Hexokinase)	H	108.0	mg/dL	70 - 100
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Note: A diagnosis of diabetes mellitus is made if fasting blood glucose exceeds 126 mg/dL.  
 (As per American Diabetes Association recommendation)

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

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**BIOCHEMISTRY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**

CHOLESTROL-TOTAL (CHO-POC)	H	268	mg/dL	0 - 160
HDL CHOLESTROL <small>Enzymatic Immunoinhibition</small>		55	mg/dL	>40
CHOLESTROL-LDL DIRECT <small>Enzymatic Selective Protection</small>	H	188	mg/dL	0 - 100
S.TRYGLYCERIDES (GPO - POC)	H	213	mg/dL	0 - 160
NON-HDL CHOLESTROL	H	213.0	mg/dL	0 - 125
TOTAL CHOLESTROL / HDL CHOLESTROL		4.9		½Average Risk <3.3 Average Risk 3.3-4.4 2 Times Average Risk 4.5-7.1 3 Times Average Risk 7.2-11.0
LDL CHOLESTROL / HDL CHOLESTROL		3.4		½Average Risk <1.0 Average Risk 1.0-3.6 2 Times Average Risk 3.7-6.3 3 Times Average Risk 6.4-8.0
CHOLESTROL-VLDL	H	43	mg/dL	10 - 35

**Comments:**

- Disorders of Lipid metabolism play a major role in atherosclerosis and coronary heart disease.
- There is an established relationship between increased total cholesterol & LDL cholesterol and myocardial infarction.
- HDL cholesterol level is inversely related to the incidence of coronary artery disease.
- Major risk factors which adversely affect the lipid levels are:
  - Cigarette smoking.
  - Hypertension.
  - Family history of premature coronary heart disease.
  - Pre-existing coronary heart disease.

**\*\* End of Report \*\***
**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



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 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST

**FINAL REPORT**

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**BIOCHEMISTRY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**
**KFT/RFT- KIDNEY/RENAL PANEL 1**

BLOOD UREA <small>Urease-GLDH,Kinetic</small>		37	mg/dL	15 - 45
CREATININE-SERUM <small>(Modified Jaffe s Kinetic)</small>		0.9	mg/dL	0.9 - 1.3
SODIUM-SERUM <small>(Indirect Ion-Selective Electrode)</small>	L	134	m.mol/L	135 - 145
POTASSIUM-SERUM <small>(Indirect Ion-Selective Electrode)</small>		4.7	m.mol/L	3.5 - 5.1
CHLORIDE-SERUM <small>(Indirect Ion-Selective Electrode)</small>		98	m.mol/L	98 - 107

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

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**BIOCHEMISTRY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**
**LIVER FUNCTION TESTS (LFT)**

BILIRUBIN-TOTAL (DPO)		0.77	mg/dL	0.2 - 1.0
BILIRUBIN-DIRECT (DPO)		0.12	mg/dL	0 - 0.2
BILIRUBIN-INDIRECT		0.65	mg/dL	0.2 - 0.8
S.PROTEIN-TOTAL (Buret)	H	8.2	g/dL	6 - 8.1
ALBUMIN-SERUM (Dye Binding-Bromocresol Green)		4.8	g/dL	
S.GLOBULIN		3.4	g/dL	2.8-3.8
A/G RATIO	L	1.41		1.5 - 2.5
ALKALINE PHOSPHATASE (IFCC AMP BUFFER)	L	49.0	IU/L	53 - 128
ASPARTATE AMINO TRANSFERASE (IFCC)		27.4	IU/L	10 - 42
ALANINE AMINO TRANSFERASE (IFCC)	H	53.8	IU/L	10 - 40
GAMMA-GLUTAMYLTRANSFERASE (IFCC)		25.4	IU/L	11 - 50
LACTATE DEHYDROGENASE (IFCC; L-F)		209.1	IU/L	0 - 248

CHOLESTROL-TOTAL (CHOD-PAP)	H	268	mg/dL	0 - 160
HDL CHOLESTROL (Enzymatic Inhibition)		55	mg/dL	>40
CHOLESTROL-LDL DIRECT (Enzymatic Selective Protection)	H	188	mg/dL	0 - 100
S.TRYGLYCERIDES (GPO - POC)	H	213	mg/dL	0 - 160
NON-HDL CHOLESTROL	H	213.0	mg/dL	0 - 125
TOTAL CHOLESTROL / HDL CHOLESTROL		4.9		1/2 Average Risk <3.3 Average Risk 3.3-4.4 2 Times Average Risk 4.5-7.1 3 Times Average Risk 7.2-11.0
LDL CHOLESTROL / HDL CHOLESTROL		3.4		1/2 Average Risk <1.0 Average Risk 1.0-3.6 2 Times Average Risk 3.7-6.3 3 Times Average Risk 6.4-8.0
CHOLESTROL-VLDL	H	43	mg/dL	10 - 35

**Comments:**

- Disorders of Lipid metabolism play a major role in atherosclerosis and coronary heart disease.
- There is an established relationship between increased total cholesterol & LDL cholesterol and myocardial infarction.
- HDL cholesterol level is inversely related to the incidence of coronary artery disease.
- Major risk factors which adversely affect the lipid levels are:
  - Cigarette smoking.
  - Hypertension.
  - Family history of premature coronary heart disease.
  - Pre-existing coronary heart disease.

**\*\* End of Report \*\***

FINAL REPORT

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**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



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MBBS, DCP, DNB (PATHOLOGY)  
CONSULTANT PATHOLOGIST

**FINAL REPORT**

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Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23001095	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 10:21
		Reporting Date & Time	: 14-01-2023 13:24

**BLOOD BANK REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**
**BLOOD GROUP (ABO & RH)**

ABO GROUP	"A"
RH TYPE	POSITIVE

Forward grouping done by Slide method.

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



**DR. REETU JADHAV NAGE**  
 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST



**FINAL REPORT**

Bill No.	: AFDHC230000124	Bill Date	: 14-01-2023 09:06
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Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23001094	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 10:21
		Reporting Date & Time	: 14-01-2023 15:36

**HAEMATOLOGY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**

ESR (Westergren)	H	55	mm 1st hr	0 - 10
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**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



**DR. REETU JADHAV NAGE**  
 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST

**FINAL REPORT**

Bill No.	: AFDHC230000124	Bill Date	: 14-01-2023 09:06
Patient Name	: MR. SINGH ALOK	UHID	: AFD000018165
Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23001137	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 13:17
		Reporting Date & Time	: 14-01-2023 15:12

**BIOCHEMISTRY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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*Sample Type: Plasma*
**MEDIWHEEL PKG FOR MALE BELOW 40YRS**

GLUCOSE-PLASMA (POST PRANDIAL) (UV Hexokinase)		118.6	mg/dL	70 - 140
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Note: A diagnosis of diabetes mellitus is made if 2 hour post load glucose exceeds 200 mg/dL.  
 (As per American Diabetes Association recommendation)

**\*\* End of Report \*\***
**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



**DR. REETU JADHAV NAGE**  
 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST



**FINAL REPORT**

Bill No.	: AFBCB230000156	Bill Date	: 14-01-2023 11:42
Patient Name	: MR. SINGH ALOK	UHID	: AFD000018165
Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: If PHC :
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFB23016253	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 12:52
		Reporting Date & Time	: 14-01-2023 13:55

**HAEMATOLOGY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

**\*GLYCATED HAEMOGLOBIN (HBA1C)**

HBA1C (HPLC)		5.8	%	4.27 - 6.07
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**INTERPRETATION:**

HbA1c %	Degree of Glucose Control
>8%	Action suggested due to high risk of developing long term complications like Retinopathy, Nephropathy, Cardiopathy and Neuropathy
7.1 - 8.0	Fair Control
<7.0	Good Control

- Note:
- 1.A three monthly monitoring is recommended in diabetics.
  - 2.Since HbA1c concentration represents the integrated values for blood glucose over the preceding 6 - 10 weeks and is not affected by daily glucose fluctuation, exercise and recent food intake, it is a more useful tool for monitoring diabetics.

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low

DR. SHARMILA RAI  
MD, PATHOLOGY  
Consultant



**FINAL REPORT**

Bill No.	: AFBCB230000156	Bill Date	: 14-01-2023 11:42
Patient Name	: MR. SINGH ALOK	UHID	: AFD000018165
Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFB23016254	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 12:52
		Reporting Date & Time	: 14-01-2023 14:53

**SEROLOGY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: Serum

**\*THYROID PROFILE (FT3+FT4+TSH)**

FREE-TRI IODO THYRONINE (FT3) (ECLIA)		3.03	pg/mL	2.0-4.4
FREE -THYROXINE (FT4) (ECLIA)		1.12	ng/dL	0.9-1.7
THYROID STIMULATING HORMONE (TSH) (ECLIA)		1.89	mIU/L	0.27-4.20

**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low

**DR. SHILPA G**  
MD, PATHOLOGY  
Sr Consultant


**FINAL REPORT**

Bill No.	: AFDHC230000124	Bill Date	: 14-01-2023 09:06
Patient Name	: MR. SINGH ALOK	UHID	: AFD000018165
Age / Gender	: 32 Yrs 4 Mth / MALE	Patient Type	: <input type="checkbox"/> If PHC <input type="checkbox"/>
Ref. Consultant	: DR. PHC HEAD	Ward / Bed	: /
Sample ID	: AFD23001102	Current Ward / Bed	: /
		Receiving Date & Time	: 14-01-2023 10:37
		Reporting Date & Time	: 14-01-2023 15:32

**CLINICAL PATH REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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*Sample Type: Urine*
**MEDIWHEEL PKG FOR MALE BELOW 40YRS**
**URINE, ROUTINE EXAMINATION**
**PHYSICAL EXAMINATION**

QUANTITY		40 mL		
COLOUR		Pale yellow		Pale Yellow
TURBIDITY		Clear		

**CHEMICAL EXAMINATION**

PH (Double pH indicator method)		5.0		5.0 - 8.5
PROTEINS (Protein-error-of-indicators)		Negative		Negative
SUGAR (GOD POD Method)		Negative		Negative
SPECIFIC GRAVITY, URINE (Apparent pKa change)		1.010		1.005 - 1.030

**MICROSCOPIC EXAMINATION**

LEUCOCYTES		0-1	/HPF	0 - 5
RBC's		Nil		
EPITHELIAL CELLS		2-4		
CASTS		Nil		
CRYSTALS		Nil		

**\*\* End of Report \*\***
**IMPORTANT INSTRUCTIONS**

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 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST

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**HAEMATOLOGY REPORTING**

Test (Methodology)	Flag	Result	UOM	Biological Reference Interval
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Sample Type: EDTA Whole Blood

**MEDIWHEEL PKG FOR MALE BELOW 40YRS**

ESR (Westergren)	H	55	mm 1st hr	0 - 10
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**\*\* End of Report \*\***

**IMPORTANT INSTRUCTIONS**

CL - Critical Low, CH - Critical High, H - High, L - Low



**DR. REETU JADHAV NAGE**  
 MBBS, DCP, DNB (PATHOLOGY)  
 CONSULTANT PATHOLOGIST

12.01.2023 10.30.17  
ASIAN FIDELIS HOSPITAL  
SEC- 88 FARIDABAD HARYANA  
RPS CITY

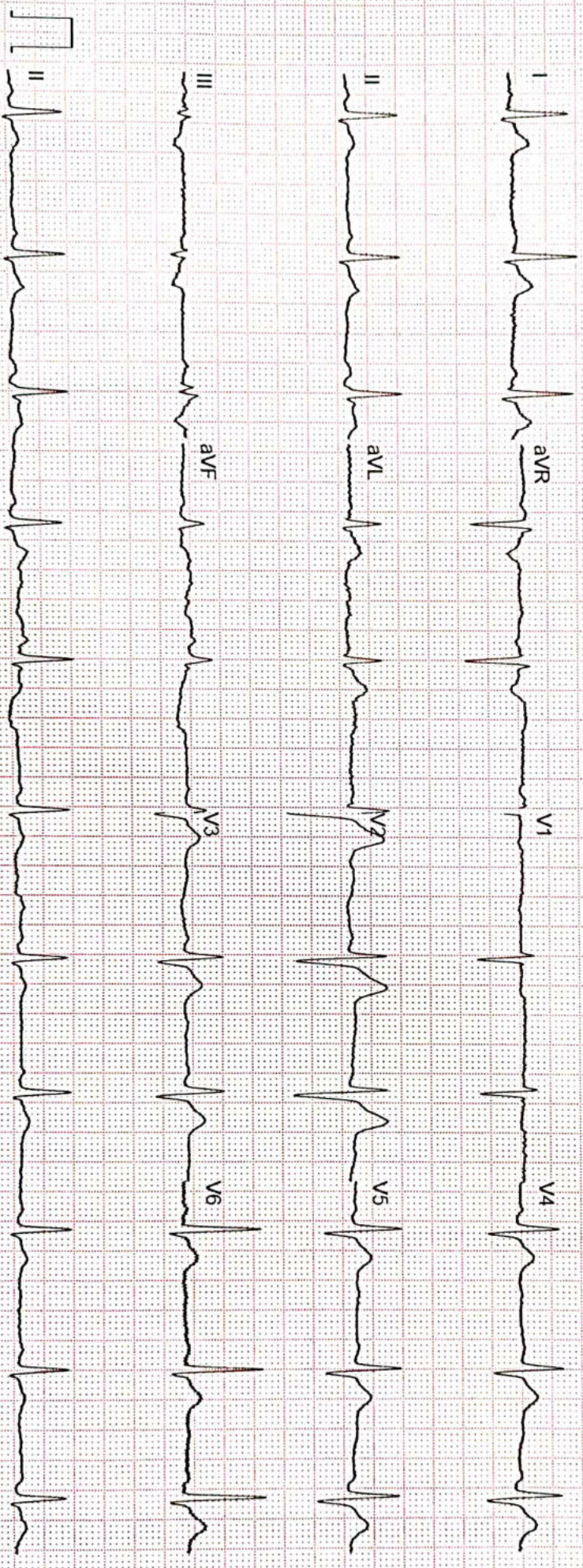
Location:  
Room:  
Order Number:  
Indication:  
Medication 1:  
Medication 2:  
Medication 3:

Technician:  
Ordering Ph:  
Referring Ph:  
Attending Ph:

QRS : 92 ms  
QT / QTcBaz : 346 / 356 ms  
PR : 144 ms  
P : 40 ms  
RR / PP : 934 / 937 ms  
P / QRS / T : 22 / 23 / -4 degrees

Normal sinus rhythm  
Normal ECG

64 bpm  
-- / -- mmHg



## NON INVASIVE CARDIOLOGY

Patient Name	: MR. SINGH ALOK	IPD No.	:
Age	: 32 Yrs 4 Mth	UHID	: AFD000018165
Gender	: MALE	Bill No.	: AFDHC230000124
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 14-01-2023 09:06:45
Ward	:	Room No.	:
		Procedure Date	: 14-01-2023 11:15:03

### ECHOCARDIOGRAPHY & COLOR DOPPLER REPORT

MEASUREMENTS	ABSOLUTE VALUE	NORMAL VALUE
Aortic Root Diameter	2.9	2.0-3.7cm < 2.2cm/M2
Aortic Valve Opening	N	1.5-2.6cm
Left Atrial Dimension	3.2	1.9-4.0cm < 2.2cm/M2
RV Dimensions	N	0.7-2.6cm
RV thickness	N	0.3-0.9cm
LV ED Dimension	5.6	3.7-5.6 cm < 3.2cm /M2
LV ES Dimension	3.5	2.2-4.0 cm
IVS thickness	ED - 1.1      ES-1.3	0.6-1.2cm
LVPW Thickness	ED - 1.0      ES-1.2	0.5-1.1cm
IVS/ LVPW Ratio	N	
Mitral Valve	DE-N      EF -N	

<i>INDICES OF LV FUNCTION</i>		
EPSS		<9mm
FS%		24-42%
LV Ejection Fraction	60%	60+/-6%

#### IMAGING:

2D- imaging in PLAX.SAX and apical views revealed normal left ventricle. Movement of septum, posterior and lateral walls are normal. Global LVEF is 60%. Mitral valve opening is normal. No evidence of mitral valve prolapse is seen. Aortic valve has three cusps and its opening is not restricted. Tricuspid valve leaflets move normally, Pulmonary valve is normal. Interatrial and Interventricular septal are intact, No intracardiac mass or thrombus is seen. No pericardial pathology is observed.



### NON INVASIVE CARDIOLOGY

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Gender	: MALE	Bill No.	:	AFDHC230000124
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	:	14-01-2023 09:06:45
Ward	:	Room No.	:	
		Procedure Date	:	14-01-2023 11:15:03

#### MORPHOLOGICAL DATA

Mitral Valve : AML PML	Normal	Interatrial Septum	Intact
Aortic Valve	Normal	Interventricular Septum	Intact
Tricuspid Valve	Normal	Pulmonary Artery	Normal
Pulmonary Valve	Normal	Aorta	Normal
Right Ventricle	Normal	Right Atrium	Normal
Left Ventricle	Normal	Left Atrium	Normal

#### DOPPLER STUDY

	m/s	m/s		
MITRAL VELOCITY	E-0.7	A-0.4	MR	0/4
TRICUSPID VELOCITY	1.3 m/s		TR	0/4
AORTIC VELOCITY	1.0 m/s		AR	0/4
PULMONARY VELOCITY	0.7 m/s		PR	0/4
PA Pressure				

## NON INVASIVE CARDIOLOGY

Patient Name	: MR. SINGH ALOK	IPD No.	:
Age	: 32 Yrs 4 Mth	UHID	: AFD000018165
Gender	: MALE	Bill No.	: AFDHC230000124
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	: 14-01-2023 09:06:45
Ward	:	Room No.	:
		Procedure Date	: 14-01-2023 11:15:03

### COLOUR FLOW MAPPING

No valvular regurgitation.

### FINAL IMPRESSION

1. No RWMA, LVEF-60%.
2. Normal cardiac chamber dimension.
3. Normal cardiac valves.
4. Normal mitral inflow pattern.
5. No clot/mass/vegetation/PE.

DR. MITHULESH KUMAR  
MD, DNB (Cardiology).  
Consultant Cardiologist  
HMC HN19723

For The perusal of a medical professional only

The content of this report is only an opinion based on images and is therefore subject to inherent technical limitations.

It is not the diagnosis & must be correlated clinically.  
**NOT FOR MEDICOLEGAL PURPOSES**

.....End of Report.....

Prepare By.  
MADHVI.S

## DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : ULTRASOUND

Patient Name	: MR. SINGH ALOK	IPD No.	:	
Age	: 32 Yrs 4 Mth	UHID	:	AFD000018165
Gender	: MALE	Bill No.	:	AFDHC230000124
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	:	14-01-2023 09:06:45
Ward	:	Room No.	:	
		Print Date	:	14-01-2023 10:14:04

### USG WHOLE ABDOMEN

#### FINDINGS:

- Liver is normal in size (longitudinal span 14.2 cm) and shows mild to moderate fatty infiltration (s/o grade I/II fatty liver). No evidence of any focal lesion is seen. No dilated intrahepatic biliary radicles are seen. Common duct and portal vein are normal in course and caliber.
- The gall bladder is well distended with normal wall thickness. No intraluminal calculi focal lesion seen. No pericholecystic pathology seen.
- *Visualized Pancreas is normal in size and parenchymal echogenicity. Rest of the pancreas and retroperitoneal structures are obscured by overlying bowel gas shadows.*
- Spleen is normal in size and echo pattern with no focal lesion.
- Both the kidneys are normal in size, shape and position. No evidence of any hydronephrosis is noted on either side. Normal corticomedullary differentiation is maintained bilaterally. The cortical thickness is within normal limits. The right kidney measures 11.3 x 4.9 cm. The left kidney measures 10.3 x 5.3 cm. No focal lesion/calculus noted in either kidney.
- The Urinary Bladder is well distended and shows anechoic contents. No focal lesion/calculus seen. There is no evidence of any obvious intraluminal or perivesical pathology.
- Prostate is normal in size and echotexture.
- No ascites/retroperitoneal lymphadenopathy/pleural effusion.

#### IMPRESSION:

- Grade I/II fatty liver changes.

*Please correlate clinically.*

.....End of Report.....

Prepare By.  
BHANO

  
DR. BHANO CHAUDHARY, MBBS, MD  
CONSULTANT

**Note :** The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

## DEPARTMENT OF RADIO-DIAGNOSIS & IMAGING

Report : XRAY

Patient Name	: MR. SINGH ALOK	IPD No.	:	
Age	: 32 Yrs 4 Mth	UHID	:	AFD000018165
Gender	: MALE	Bill No.	:	AFDHC230000124
Ref. Doctor	: DR. PHC HEADAsian Fidelis	Bill Date	:	14-01-2023 09:06:45
Ward	:	Room No.	:	
		Print Date	:	14-01-2023 13:22:35

### CHEST PA VIEW:

Rotation +.

Both lung fields show prominent bronchovascular markings.

Cardiac shadow appears normal.

Both domes of diaphragm and both CP angles are clear.

Both hila appear normal.

Soft tissues and bony cage appear normal.

*Please correlate clinically.*

.....End of Report.....



Prepare By.  
BHANOO

DR. BHANOO CHAUDHARY, MBBS, MD  
CONSULTANT

**Note :** The information in this report is based on interpretation of images. This report is not the diagnosis and should be correlated with clinical details and other investigation.

OPD Assessment Form (First visit/Follow-up)



Name : MR. SINGH ALOK UHID No. : AFD000018165  
FATHER : ANIL KUMAR SINGH Date : 14-01-2023 09:02:59  
Age / Gender : 32 Yrs 4 Mth / MALE Doctor / Unit : DR. UPASANA /  
CPG : CORPORATE CASHVAIMS2122\_FD Department : OPHTHALMOLOGY  
Inst. Name : Acrofemi Healthcare Ltd  
Address : H.NO-36, GROUND FLOOR, SEC-15A, FARIDABAD, HARYANA, INDIA

Present Complaints: c/o Routine Check-up.

Past/Family History: Screen time 7-8 hours.

History Given By :

Clinical Findings :  
VA  $\angle$   $\begin{matrix} 6/6 \\ 6/6 \end{matrix}$

Als  $\left( \begin{matrix} \odot \\ \odot \end{matrix} \right)$  OS  $\left( \begin{matrix} \odot \\ \odot \end{matrix} \right)$   
NOY  $\left( \begin{matrix} \odot \\ \odot \end{matrix} \right)$

BP (mm Hg) 140/90 mm/Hg  
Pulse 73 b/M  
RR SpO2 - 99%  
Ht/Length 175cm  
Wt- 98kg  
Pain Score (1-10)

Any known Allergies

None.

Provisional Diagnosis : C.V.S.

DR. UPASANA, MBBS, DOMS, FAEH, Consultant-OPHTHALMOLOGY, Reg. No: MCI 09/35142

Note :

Nature of illness, prognosis, potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.

**WHEN TO OBTAIN URGENT CARE :** In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash, breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom

Investigations Advised :

Plan Of Care :

Treatment Advice:

20/20/20 rule / frequent  
blinking  
Wick n Blink  
(PST) Year drop old 4 to 6 Y/D  
month  
(wetter)

Continue blue lens glasses

RA 6/12

Nutritional Screening : Required  (If required, please contact, the dietician)  
Not Required

Signature of Doctor / Consultant: ..... Date: 14/1/23 Time: 11:45:



OPD Assessment Form (First visit/Follow-up)

Name : MR. SINGH ALOK UHID No. : AFD000018165  
FATHER : ANIL KUMAR SINGH Date : 14-01-2023 09:02:59  
Age / Gender : 32 Yrs 4 Mth / MALE Doctor / Unit : DR. MUKUND SINGH /  
CPG : CORPORATE CASHAIMS2122\_FD Department : INTERNAL MEDICINE\_FD  
Inst. Name : Acrofemi Healthcare Ltd  
Address : H.NO-36, GROUND FLOOR, SEC-15A, FARIDABAD, HARYANA, INDIA

Present Complaints:

PHC

BP (mm Hg) 140/90 mm/Hg  
Pulse 73 b/m  
RR SpO2-99%  
Ht/Length 175 CM  
Wt- 98 kg  
Pain Score (1-10)

Past/Family History:

None

History Given By : Self

Clinical Findings : None

Any known Allergies

Not known

Provisional Diagnosis :

mixed dyslipidemia

DR. MUKUND SINGH, MBBS, DNB, CONSULTANT-INTERNAL MEDICINE\_FD, Reg. No: BMC-35607

Asian Fidelis Multispeciality Hospital OPD Timing: Mon - Sat : 10:00am-04:00pm.

**Note :**  
Nature of illness, prognosis, potential side effects of medication used, risk of allergic reaction, need for follow-up & monitoring has been explained to the Patient/attendants in their own language.  
**WHEN TO OBTAIN URGENT CARE :** In case high grade fever, recurrent vomiting, profuse diarrhea, severe oral ulcers, skin rash breathlessness, dizziness, loss of consciousness, bleeding from any site or new relevant/ alarming symptom

Investigations Advised :

Total cholesterol	=	268
HDL	=	55
LDL	=	188
Triglycerides	=	213
HbA1c	=	5.8

Grade I/II Fatty liver

Ad - Life style modification

Plan Of Care :

- Diet - low carb
- low fat
- High fiber
- High protein

Treatment Advice:

- Exercise - 40 minute brisk walk

Ad - HbA1c  
- Lipid profile } After 3 months.

Nutritional Screening : Required  (If required, please contact, the dietician)  
 Not Required

Signature of Doctor / Consultant: ..... Date: ..... Time: .....

**Dr. Mukund Singh**  
 Consultant Internal Medicine  
 Asian Fidelis Multi speciality Hospital  
 Faridabad, Sector-88  
 MBBS (1994), MD (1997) (Kishanpur)  
 MCh (1998/11/1000)