

Patient Name : MRS. NEMILA VASAVA

Age / Gender : 33 years / Female

Patient ID : 21496

Source : Sardar Patel Hospital (OPD)

Referral : Dr Mediwheel Full body Health Checkup

Collection Time : 30/03/2023, 08:46 AM

Reporting Time : 30/03/2023, 01:40 PM

Sample ID :



001708923

Test Description	Value(s)	Unit(s)	Reference Range
<b>CBC</b>			
<b>Complete Blood Count (CBC)</b>			
Hemoglobin (Hb)* Method : Cymeth Photometric Measurement	12.4	gm/dL	12.0 - 15.0
Erythrocyte (RBC) Count* Method : Electrical Impedance	5.54	mil/cu.mm	3.8 - 4.8
Packed Cell Volume(Hematocrit) Method : Calculated	39.1	%	36 - 46
<b>Red cell indices</b>			
Method - Calculated/Electrical Impedance			
MCV	70.58	fL	83 - 101
MCH	22.38	pg	27 - 32
MCHC	31.71	gm/dL	31.5 - 34.5
RDW - CV	13.2	%	11.6 - 14.0
<b>Total and Differential count</b>			
Method - Electrical Impedance and VCSN Technology			
Total Leucocytes (WBC) Count*	5250	cell/cu.mm	4000-10000
Neutrophils	50	%	40 - 80
Lymphocytes	40	%	20 - 40
Monocytes	08	%	2 - 10
Eosinophils*	02	%	1 - 6
Basophils	00	%	0 - 2
<b>Platelet Count</b> Method : Electrical Impedance	235	10 <sup>3</sup> /ul	150 - 450
Sample Type : EDTA Whole Blood.			

**E.S.R**

Erythrocyte Sedimentation Rate  
Method : EDTA Whole blood, modified westerngren  
16 mm/hr <20

**Interpretation:**

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

\*\*END OF REPORT\*\*

*Bholiya*

Dr. Bhavika Dholiya  
M. D. Pathology  
Registration No: G-32571

can to Validate



**Fidelity Diagnostics Pvt. Ltd.**, Chikwadi, Opp. Railway Yard, Ankleshwar - 393001  
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Test Description	Value(s)	Unit(s)	Reference Range
<b>BLOOD GROUP &amp; RH (D) FACTOR, EDTA WHOLE BLOOD</b>			
Blood Group Method : Forward and Reverse By Tube Method	"B"		
RH Factor	Positive		
<b>Methodology</b>			
This is done by forward and reverse grouping by tube Agglutination method.			
<b>Interpretation</b>			
Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2-4 years).			
<b>BUN CREATININE RATIO</b>			
Urea	22.2	mg/dL	17 - 43
Blood urea nitrogen	10.37	mg/dL	7 - 25
Creatinine	0.58	mg/dL	0.6 - 1.2
BUN/Creatinine ratio	17.88	Ratio	6 - 22
<b>BLOOD UREA NITROGEN</b>			
Urea *	22.2	mg/dL	17- 43
Method : Serum, Urease			
Blood Urea Nitrogen-BUN*	10.37	mg/dL	7 - 25 mg/dL
Method : Calculated			
<b>CREATININE</b>			
Creatinine	0.58	mg/dL	0.6 - 1.2 mg/dl
Method : Enzymatic			
<b>URIC ACID</b>			
Uric Acid*	4.1	mg/dL	2.5 - 6.8 mg/dL
Method : Uricase, POD			

\*\*END OF REPORT\*\*

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Test Description	Value(s)	Unit(s)	Reference Range
<b>BLOOD GLUCOSE FASTING (FBS)</b>			
Glucose fasting Method : GOD-POD	105.3	mg/dL	Normal: 70 - 99 Impaired Tolerance: 100-125 Diabetes mellitus: >= 126 (on more than one occasion) (American diabetes association guidelines 2018)
Urine Fasting	Absent		
<b>BLOOD GLUCOSE POST PRANDIAL (PP2BS)</b>			
Blood Glucose-Post Prandial Method : GOD-POD	100.9	mg/dL	70 - 140
Urine Post Prandial	Absent		
<b>GLYCOSYLATED HB (HBA1C)</b>			
Glyco Hb (HbA1C)	5.1	%	Non-Diabetic: <=5.6 Pre Diabetic:5.7-6.4 Diabetic: >=6.5
Estimated Average Glucose :	99.67		mg/dL

Interpretations

- HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
- Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
- In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.
  - Excellent control-6-7 %
  - Fair to Good control - 7-8 %
  - Unsatisfactory control - 8 to 10 %
  - Poor Control - More than 10 %

**\*\*END OF REPORT\*\***

*Bholya*

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Test Description	Value(s)	Unit(s)	Reference Range
<b>LIVER FUNCTION TEST-1</b>			
Bilirubin - Total Method : Diazotization	0.71	mg/dL	0.3 - 1.2
Bilirubin - Direct Method : Serum, Diazotization	0.37	mg/dL	Adults and Children: 0.0 - 0.4
Bilirubin - Indirect Method : Calculated	0.34		
SGOT Method : Serum, UV without P5P	20.0	U/L	< 50
SGPT Method : Serum, UV without P5P	28.3	U/L	< 50
Alkaline Phosphatase-ALPI Method : Serum, PNPP, AMP Buffer, IFCC 37 degree	71.0	U/L	30-120
Total Protein Method : Serum, Buret, reagent blank end point	7.66	g/dL	6.6 - 8.3
Albumin Method : Serum, Bromocresol green	4.21	g/dL	Adults: 3.5 - 5.2
Globulin Method : Calculated	3.45	g/dL	1.8 - 3.6
A/G Ratio Method : Calculated	1.22	ratio	1.2 - 2.2

**\*\*END OF REPORT\*\***

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Test Description	Value(s)	Unit(s)	Reference Range
<b>LIPID PROFILE (D)</b>			
Cholesterol-Total Method : Serum, Cholesterol oxidase esterase, peroxidase	165.0	mg/dL	Desirable: <= 200 Borderline High: 201-239 High: > 239
Triglycerides Method : Serum, Enzymatic, endpoint	52.1	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499
Cholesterol-HDL Direct Method : Serum, Direct measure-PEG	62.2	mg/dL	Very High: >= 500 Normal: > 40
LDL Cholesterol Method : Calculated	92.38	mg/dL	Major Heart Risk: < 40 Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189
Non - HDL Cholesterol, Serum Method : calculated	102.80	mg/dL	Very High: >= 190 Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL
VLDL Cholesterol Method : calculated	10.42	mg/dL	Very High: > or = 190 mg/dL 6 - 38
CHOL/HDL RATIO Method : calculated	2.65	ratio	3.5 - 5.0
LDL/HDL RATIO Method : calculated	1.49	ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0
HDL/LDL RATIO Method : calculated	0.67	ratio	Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

Note: 8-10 hours fasting sample is required. Test results may show interferences due to pregnancy, certain drugs such as estrogens and other drugs (such as androgenic and related steroids), and insulin therapy etc. 12 hours fast is recommended prior to the test as non fasting status may result in falsely elevated test values. Alcohol should not be consumed for atleast 24 hours before the test. Values may be increased in acute illness, colds or flu. Obesity, stress, physical inactivity, cigarette smoking may lead to increase test values. If possible all medications should be withheld for atleast 24 hours before testing (On Doctors Advice). Intraindividual variations, seasonal as well as positional variations (levels lower when sitting compared to standing etc.) have been observed. Cholesterol and HDL-C should not be measured immediately after MI, and 3 months wait is suggested.

\*\*END OF REPORT\*\*

*B. Sholiya*

Dr. Shavika Dholiya  
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Sample ID :

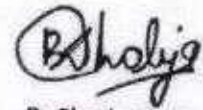


001708923

Test Description	Value(s)	Unit(s)	Reference Range
<b>THYROID FUNCTION TEST 1</b>			
T3-Total Method : Serum, CLIA	1.31	ng/mL	0.69 - 2.15 ng/mL
T4-Total Method : Serum, CLIA	10.7	ug/dL	5.2 - 12.7 ug/dL
TSH Method : Serum, CLIA	1.05	uIU/mL	0.3 - 4.5 uIU/mL

Interpretation

\*\*END OF REPORT\*\*



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Test Description	Value(s)	Unit(s)	Reference Range
<b>URINE ROUTINE</b>			
Volume*	20	ml	ml -
Colour*	Pale Yellow		Pale Yellow
Transparency (Appearance)*	Clear		Clear
Deposit*	Absent		Absent
Reaction (pH)*	5.5		4.5 - 8
Specific Gravity*	1.030		1.010 - 1.030
<b>Chemical Examination (Automated Dipstick Method) Urine</b>			
Urine Glucose (sugar)*	Absent		Absent
Urine Protein (Albumin)*	Absent		Absent
Urine Ketones (Acetone)*	Absent		Absent
Blood*	Absent		Absent
Bile pigments*	Absent		Absent
Nitrite*	Absent		Absent
<b>Microscopic Examination Urine</b>			
Pus Cells (WBCs)*	Absent	/hpf	0 - 5
Epithelial Cells*	1-3	/hpf	0 - 4
Red blood Cells*	Absent	/hpf	Absent
Crystals*	Absent		Absent
Cast*	Absent		Absent
Trichomonas Vaginalis*	Absent		Absent
Yeast Cells*	Absent		Absent
Amorphous deposits*	Absent		Absent
Bacteria*	Absent		Absent

\*\*END OF REPORT\*\*

*Bholiya*

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Patient Name :-	NEMILA VASAVA		Date :-	30/03/2023
Age & Sex :-	32Y	F		
Referred By :-	HEALTH CHECK UP			

**RADIOGRAPH CHEST PA**

**Report:**

Inspiratory film.

Trachea is central.

Bilateral hila appear unremarkable.

Bilateral lung field appears normal.

Costo-phrenic angle appear normal.

Mediastinal, thymic and diaphragmatic outlines appear normal.

Cardiac silhouette appear normal.

Visualized bony thoracic cage and soft tissues are normal.

**IMPRESSION: X ray chest PA reveals no significant abnormality.**

Please correlate with clinical findings and relevant investigations.



**Dr. Shashank S. Durshetwar**

**MD Radiology**

**Consultant Radiologist**

# SHRIMATI JAYABEN MODY HOSPITAL

REGD. No. F/106/BHARUCH

**MANAGED BY :**

*Ankleshwar Industrial Development Society, Ankleshwar*

**VALIA ROAD, GIDC, ANKLESHWAR - 393 002. PHONE : 222220, 224550**

**NAME OF PATIENT : NEMILABEN VASAVA**  
**DATE : 31/03/2023**

## USG OF ABDOMEN AND PELVIS

**Liver** appears normal in size, shape and shows normal echotexture.

No evidence of focal SOL or dilation of IHBR seen.

**Porta hepatis** is appears normal.

**Gallbladder** appears normal. No evidence of calculi.

**Pancreas** appears normal in size and echotexture.

**Spleen** appears normal in size and echotexture.

**Aorta** appears normal. No para aortic lymphnodes seen.

**Right kidney** appears normal in size, location and echotexture.

Cortex and collecting system of right kidney appears normal.

No calculi or obstructive uropathy.

**Left kidney** appears normal in size, location and echotexture.

Cortex and collecting system of left kidney appears normal.

No calculi or obstructive uropathy.

**Bladder** appears minimally distended.

**Uterus** is antverted, appears normal in size.

Uterus is filled with homogeneous myometrial echoes

Cavity echo appears normal. No evidence of G sac seen.

Approx 8 x 6 mm sized subserosal fibroid is seen along fundus.

Approx 3 x 2 mm size intramural anterior wall fibroid noted.

**Both ovaries** appears normal. No evidence of adnexal pathology.

Terminal ileum and caecum appears normal.

Appendix not seen due to bowel gas. no evidence of probe tenderness.

No evidence of free fluid or collection is seen in peritoneal spaces.

### COMMENTS:

- Uterine fibroids.

THANKS FOR THE REFERENCE

DR. JANAKI RAJ (M.D)  
CONSULTANT RADIOLOGIST

30.03.2023 12:18:23  
SARDI STATE HOSPITAL  
CHIKI, DISTRICT  
ANKLESHWAR

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

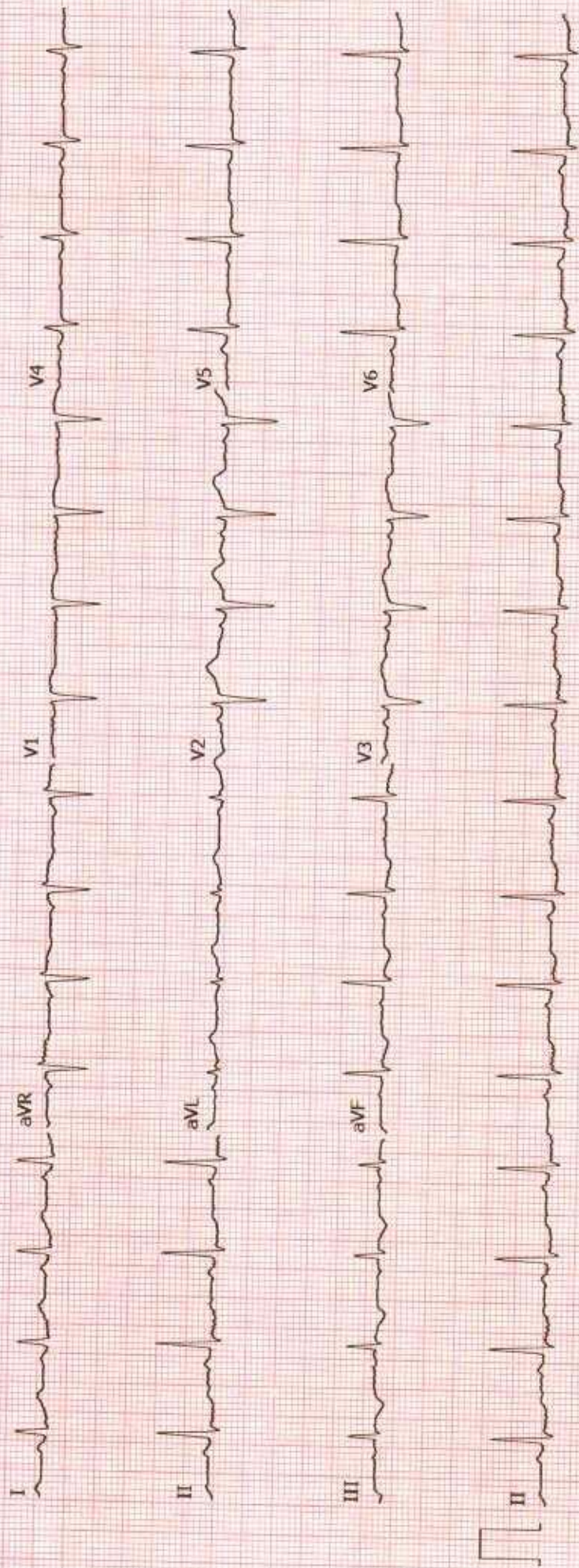
97 bpm  
--/-- mmHg

~~NEERAJ K...~~  
Nirmalaben  
UASGAV

Technician:  
Ordering Ph:  
Referring Ph:  
Attending Ph:

QRS : 80 ms  
QT / QTcBaz : 358 / 454 ms  
PR : 120 ms  
P : 80 ms  
RR / PP : 618 / 618 ms  
P / QRS / T : 27 / 57 / -38 degrees

Normal sinus rhythm  
Cannot rule out Anterior infarct, age undetermined  
T wave abnormality, consider inferior ischemia  
Abnormal ECG





Routine check-up.

Name: Nemilaben Vasava

Date: 30/9/23

Age: 33 Sex: F

V<sub>n</sub> < 6/6  
6/6.

BE ASWXL  
RRLR  
Clear lens

Fundus: DSB  
PR+nt

Adv  
Nil intervention  
needed

**Dr. Shreya Shah**  
Consultant Ophthalmologist &  
Phaco Surgeon  
REG NO:-G 26895



**OPD INITIAL ASSESSMENT FORM**

(To be filled by Nursing Staff)

Patient Name: - Nemilaben vadara UHID Number: - 4468

Consultant Name: Dr. Kalpesh Vadodariya Date: 31/3/22 Start Time: - \_\_\_\_\_ Age: - 33 (Years)

Sex: - ♀ (M/F)

Height:- \_\_\_\_\_ cms, Weight: - \_\_\_\_\_ kgs. Temp. \_\_\_\_\_, Pulse: - \_\_\_\_\_ (Per minute), SPO2 \_\_\_\_\_

B.P. :- \_\_\_\_\_ (mm of Hg), RBS:- \_\_\_\_\_ First Visit / Follow Up

Visit: First visit

(PRK)

Nursing Staff Name & Signature:- \_\_\_\_\_

Sushma

End Time:- \_\_\_\_\_

**Past History: - (TICK MARK)**

Diabetes, Hypertension, IHD, COPD, Asthma, TB, Smoker, Alcoholic, Hypothyroidism

Other:- \_\_\_\_\_

AKO

Family History:- \_\_\_\_\_

Nutritional Screening:- \_\_\_\_\_

Psychosocial Assessment:- \_\_\_\_\_

Immunization Status:- \_\_\_\_\_

To be filled by Clinician) Start Time:- \_\_\_\_\_

Clinical Findings:-

came for health-check up

no do abdominal pain

QA P/A - soft non-tender RFE

Diagnosis:-

Investigations and Advice:-

USG abdomen noted



SARDAR  
PATEL HOSPITAL  
& HEART INSTITUTE

Name : \_\_\_\_\_

Date : \_\_\_\_\_

Age : \_\_\_\_\_ Sex : \_\_\_\_\_

31/3/23

Dr Rizwan

gen skin

Acw

oral prophylaxis  
(800/-)



(14.15.16)



SARDAR PATEL HOSPITAL & HEART INSTITUTE

Chikwadi, Opp. Railway Yard, Ankleshwar - 393 001 ☎ : 247882 / 247883

**OPD INITIAL ASSESSMENT FORM**

(To be filled by Nursing Staff)

Patient Name: - Nemita Vasava UHID Number: - 4468

Consultant Name: - Dr. Kaulali Kakadiya Date: - 20/9/23 Start Time: - 4:15 Age: - 23 (Years)

Sex: - F (M/F)

Height: - \_\_\_\_\_ cms, Weight: - \_\_\_\_\_ kgs. Temp. \_\_\_\_\_, Pulse: - \_\_\_\_\_ (Per minute), SPO2 \_\_\_\_\_

B.P. :- \_\_\_\_\_ (mm of Hg), RBS:- \_\_\_\_\_ First Visit / Follow Up

Visit: First Visit

Nursing Staff Name & Signature: - Vasava Savita

End Time:-

Past History: - (TICK MARK)

Diabetes, Hypertension, IHD, COPD, Asthma, TB, Smoker, Alcoholic, Hypothyroidism

plcld hypothyroidism

Other:-

Family History:-

Nutritional Screening:-

Psychosocial Assessment:-

Immunization Status:-

To be filled by Clinician) Start Time:- \_\_\_\_\_

Clinical Findings:-

cl0 Recurrent pregnancy (as).

plmlh - 3-5 cmp = 24-30 AMPL

olh - Do A2 Lo

2 Spont abortion / nat flb D2 SPH/OPD/03

Diagnosis:-

Investigations and Advice:-