



ভারত সরকার

Government of India



তমালিকা ঘোষ

Tamalika Ghosh

পিতা : স্বপন কুমার ঘোষ

Father : Swapan Kr. Ghosh

জন্মতারিখ/DOB: 29/09/1989

মহিলা / Female

8185 4204 1928



আধার - সাধারণ মানুষের অধিকার

FITNESS CERTIFICATE

Name : TAMALIKA GHOSH

Medical Date - 23/9/23

Gender : Female

AGE : 34

PHYSICAL EXMINATION	Cardiovascular System	Respiratory System	Alimentary System	
Height 157	Puls 70	Trachea : Normal	Liver	NORMAL
Weight 77			Spleen	NORMAL
BMI 31.2	BP 120/80	RR	Kidney	NORMAL
SKIN NAD			Hernia	NO
NOSE NAD	Heart Sound:Normal	RS NAD	Hydrocele	NO
EAR & Tonsils: NAD				

Central Nervous System
X-Ray :- Normal

ECG :- WNL

PFT :- NA

	<u>Spects</u>	Without Glasses / With Glasses	
	<u>VISION</u>	RIGHT	LEFT
	NEAR -	N/8	N/6
	DISTANT-	6/6	6/8
	Colour Vision	NORMAL	

Employee Present History
 11/10 - Viral Fever now recovered well
 11/10 - Hypothyroidism on Tab Euthyron 150mcg
 chole, uric acid, Sugar in HbA1c. consult physician

Employee Family History :-
 mother of Kilo-Dm
 father of Kilo-Dm

ADVICE : wt. loss, Diet, Refⁿ, maintain consult a Dietist.

REMARK :- Employee is free from any infectious contagious & communicable diseases and join his/her normal duties



Name : Mrs. TAMALIKA GHOSH
Lab ID. : 168434
Age/Sex : 34 Years / Female
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS

Collected On : 23/9/2023 11:51 am
Received On : 23/9/2023 12:01 pm
Reported On : 24/9/2023 2:13 pm
Report Status : FINAL




PAP SMEAR REPORT 1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/160/23		
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.		

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

Checked By
Dr. Smita Ranveer


DR. SMITA RANVEER,
M.B.B.S.M.D. Pathology(Mum)
Consultant Histo-cytopathologist



ECHOCARDIOGRAM

NAME	MRS. TAMALIKA GHOSH
AGE/SEX	34 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DOCTOR	DR. ANANT MUNDE, DNB, DM (CARDIOLOGY)
DATE OF EXAMINATION	23/ 09/2023

2D/M-MODE ECHOCARDIOGRAPHY

VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal	CHAMBERS: LEFT ATRIUM: Normal LEFT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal	VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	32 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	40.2 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	24.1 mm	RVEF	%
Ascending aorta	mm	IVSd	8.0 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.0 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	70 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	15 mm





Name - Mrs. Tamalika Ghosh	Age - 34 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 23/09/2023

USG ABDOMEN & PELVIS

Clinical details:- Routine

The Liver is moderately enlarged in size (RLS -19.5 cm)and shows normal echogenicity. There is no obvious abnormal focal lesion seen. There is no IHBR dilatation seen in both the lobes of the liver.

The CBD and the Portal vein appear normal.

The Gall bladder is well distended & appears normal. No calculi or filling defects are seen. No evidence of Pericholecystic collection. The wall thickness is normal.

Right Kidney measures 11.0 x 4.4 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

Left Kidney measures 10.9 x 4.8 cm & appears normal in shape and position. There is no evidence of hydronephrosis or any calculi seen. Cortico-medullary differentiation is maintained.

The Pancreas is normal in size & shows homogenous echopattern. It shows no focal lesion.

The Spleen is normal in size (10.7cm) with homogenous echotexture.

The urinary bladder is adequately distended and appears normal. There is no evidence of any obvious calculi or any mass lesion seen. Both Uretero-vesical junctions appear clear. No abnormal intraluminal lesion noted.

The Uterus is anteverted & measures approximately 8.6 x 4.4 x 5.3 cms with normal homogenous echotexture. The uterine outline is smooth and normal. No abnormal focal lesion noted. Endometrial thickness is normal

Both ovaries are normal in size and echotexture.

Bilateral adnexae appear normal. No focal lesion noted.

No free fluid or obvious lymphadenopathy is seen in abdomen and pelvis.

IMPRESSION:

- **Moderate Hepatomegaly.**
- **Mildly Bulky uterus.**

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

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. Second opinion is always advisable.



ID: 1903

Terranilika Ghosh
Male
Years 34 1F
Req. No. :

BP - 120/80 mm/hg
SpO2 - 99%
PR - 70 m.

23-09-2023 09:09:04 AM

HR : 81 bpm
P : 77 ms
PR : 133 ms
QRS : 95 ms
QT/QTcBz : 391/454 ms
PQRST : 41/51/53 °
RV5/SV1 : 0.685/0.452 mV

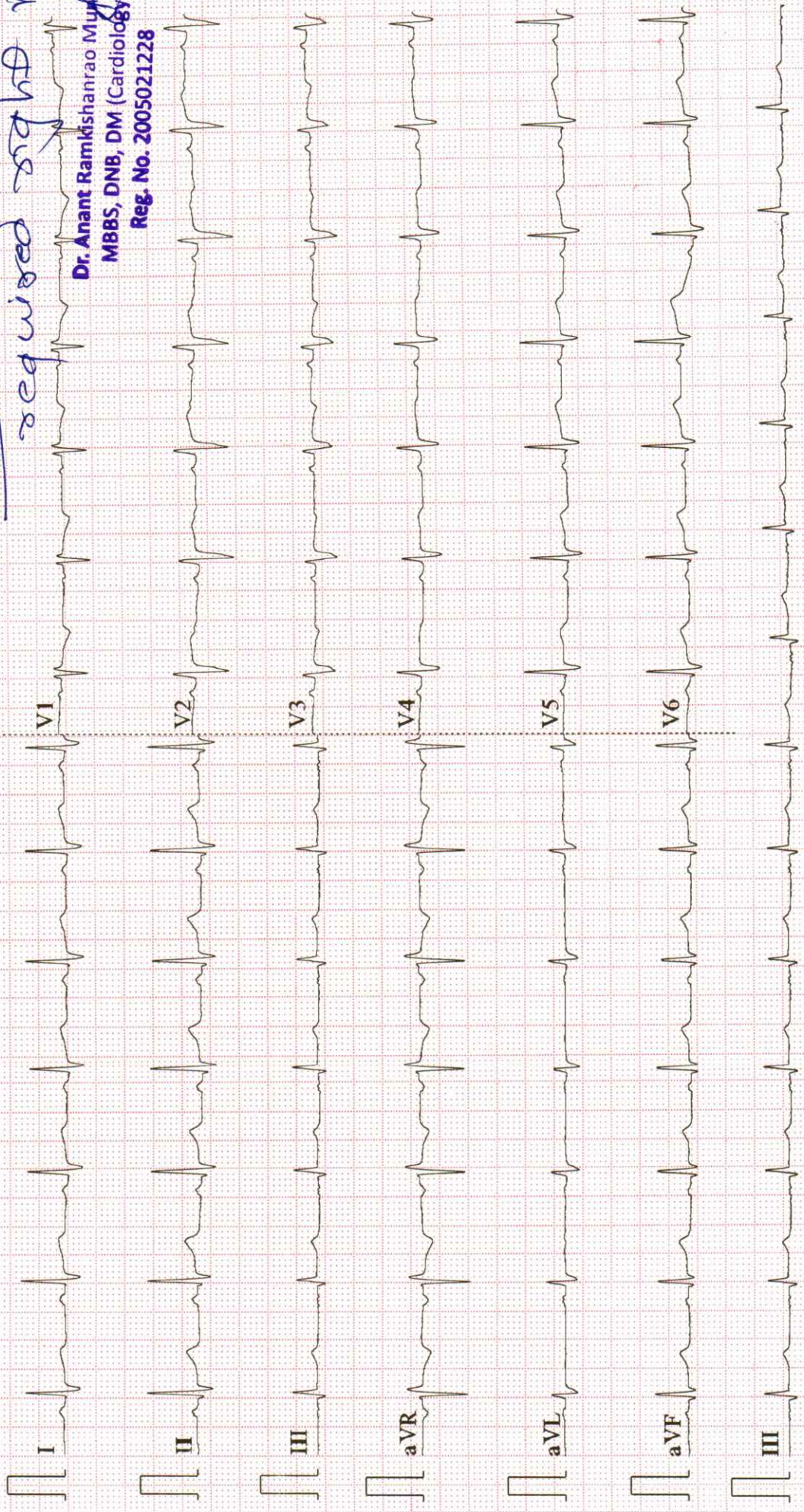
Diagnosis Information:
Sinus Rhythm
Inverted T Wave(V3)
Low Voltage(Chest Leads)

NSR

Incomplete RBBB
No sign ST-T changes
Adv: No averse intervention
sequenced sig HD now

Report Confirmed by:

Dr. Anant Ramkishanrao Munde
MBBS, DNB, DM (Cardiology)
Reg. No. 2005021228





Name - MRS. Tamalika Ghosh	Age - 34 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 23/09/2023

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. MOHAMMAD SOHAIB
MBBS; DMRE
CONSULTANT RADIOLOGIST

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Name	: Mrs. TAMALIKA GHOSH	Collected On	: 23-Sep-2023 11:51 AM
Lab ID.	: 168434	Received On	: 23-Sep-2023 12:01 PM
Age/Sex	: 34 Years /Female	Reported On	: 23-Sep-2023 7:58 PM
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: INTERIM



***LIPID PROFILE**

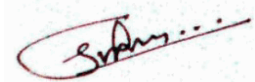
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	227.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	44.5	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	260.4	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)	52	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	130	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)	2.92		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	5.10		<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
SHAISTA Q



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Consultant Histocytopathologist



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COMPLETE BLOOD COUNT

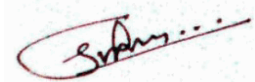
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	12.5	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	37.5	%	36 - 46
RBC COUNT	4.32	x10 ⁶ /uL	4.5 - 5.5
MCV	87	fl	80 - 96
MCH	28.9	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	13.8	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	7250	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	56	%	40 - 80
LYMPHOCYTES	32	%	20 - 40
EOSINOPHILS	06	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	251000	/ cumm	150000 - 450000
MPV	13.5	fl	6.5 - 11.5
PDW	16.4	%	9.0 - 17.0
PCT	0.340	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
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.

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HEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	40	mm/1hr.	0 - 20

METHOD - WESTERGREN

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

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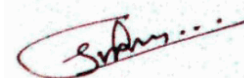
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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	30 ml		
COLOUR	Pale yellow	Text	Pale Yellow
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION	Acidic		Acidic
(methyl red and Bromothymol blue indicator)			
SP. GRAVITY	1.010		1.005 - 1.022
(Bromothymol blue indicator)			
PROTEIN	Absent		Absent
(Protein error of PH indicator)			
BLOOD	Absent		Absent
(Peroxidase Method)			
SUGAR	Absent		Absent
(GOD/POD)			
KETONES	Absent		Absent
(Acetoacetic acid)			
BILE SALT & PIGMENT	Absent		Absent
(Diazonium Salt)			
UROBILINOGEN	Absent		Normal
(Red azodye)			
LEUKOCYTES	Absent	Text	Absent
(pyrrole amino acid ester diazonium salt)			
NITRITE	Absent		Negative
(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)			
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent		
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	1-3	/ 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
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	105.7	ng/dl	84.63 - 201.8
T4	12.24	µg/dl	5.13 - 14.06
TSH	1.46	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
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 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

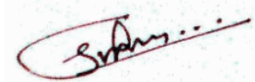
INTERPRETATION :

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.

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

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

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HAEMATOLOGY

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

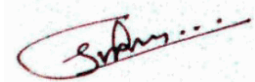
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	22.6	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	10.56	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.62	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	6.6	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	140.7	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.82	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	103.2	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	4.16	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	10.1	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.91	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.32	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.59	g/dl	1.9 - 3.5
A/G RATIO calculated	1.67		0 - 2

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

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

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Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA
RBC	Normocytic Normochromic
WBC	Total leucocyte count is normal on smear.
	Neutrophils:58 % Lymphocytes:30 % Monocytes:07 % Eosinophils:05 % Basophils:00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No parasite seen.

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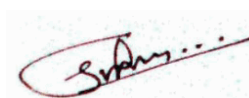
LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.85	mg/dL	0.0 - 2.0
DIRECT BILLIRUBIN (Method-Diazo)	0.31	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.54	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	21.4	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	22.7	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	54.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.91	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.32	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.59	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.67		0 - 2

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

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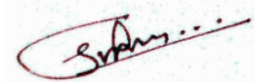
BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	7.3	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	162.8	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
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.			
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	127.5	mg/dL	70 - 110
BLOOD GLUCOSE PP	180.6	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

Checked By
SHAISTA Q



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



Name	: Mrs. TAMALIKA GHOSH	Collected On	: 23-Sep-2023 11:51 AM
Lab ID.	: 168434	Received On	: 23-Sep-2023 12:01 PM
Age/Sex	: 34 Years /Female	Reported On	: 23-Sep-2023 7:58 PM
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: INTERIM



BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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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 $> 6.5\%$

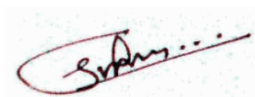
***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT	45.0	U/L	5 - 55
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Result relates to sample tested, Kindly correlate with clinical findings.

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

Checked By
SHAISTA Q



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Consultant Histocytopathologist



Name : Mrs. TAMALIKA GHOSH Collected On : 23/9/2023 11:51 am
Lab ID. : 168434 Received On : 23/9/2023 12:01 pm
Age/Sex : 34 Years / Female Reported On : 24/9/2023 2:13 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



PAP SMEAR REPORT1

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CYTO NUMBER	F/160/23		
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.		

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

Checked By
Dr_smita.ranveer

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