

NABH ACCREDITED

PRAKASH

EYE HOSPITAL & LASER CENTRE

Dr. AMIT GARG

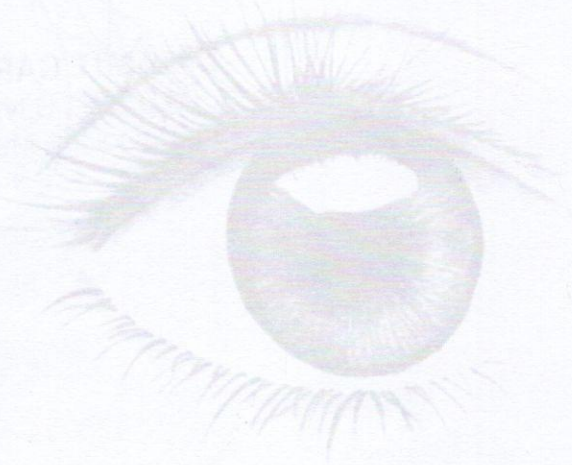
M.B.B.S., D.N.B. (Oph.)

I-Lasik (Femto) Bladefree Topical Micro Phaco
& Medical Retina Specialist

Ex. Micro Phaco Surgeon

Venu Eye Institute & Research Centre, New Delhi

Name Juhi Rastogi Age/Sex 32 / F C/o Date 23/Apr/22



Accredited Eye Hospital Western U.P.

First NABH ECO

प्रकाश आँखों का अस्पताल एवं लेजर सेंटर



Website: www.prakasheyehospital.in
Facebook: <http://www.prakasheyehospital.in>

Counsellor 9837066186
7535832832
Manager 7895517715
OT 730222373
TPA 9837897788

Timings Morning : 10:00 am to 2:00 pm.
Evening : 5:00 pm to 8:00 pm.
Sunday : 10:00 am to 2:00 pm.
Near Nai Sarak, Garh Road, Meerut
E-mail : prakasheyehosp@gmail.com


भारत सरकार
Government of India



जुही रस्तोगी
Juhi Rastogi
जन्म तिथि/ DOB: 24/07/1990
महिला / FEMALE



2432 9807 0016

मेरा आधार, मेरी पहचान



Dr. MONIKA GARG
M.B.B.S. M.D. (Path.)
GARG PATHOLOGY


आधार
राष्ट्रीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:
आत्मजा: सुरेन्द्र कुमार रस्तोगी,
जेमीनी क्लानिक, मोहल्ला झण्डा,
किरतपुर, बिजनौर,
उत्तर प्रदेश - 246731

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D/O: Surendra Kumar Rastogi,
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Kiratpur, Bijnor,
Uttar Pradesh - 246731

2432 9807 0016

1947  help@uidai.gov.in  www.uidai.gov.in

Vn $\left\{ \begin{array}{l} R 2/60 \\ L 2/60 \end{array} \right.$

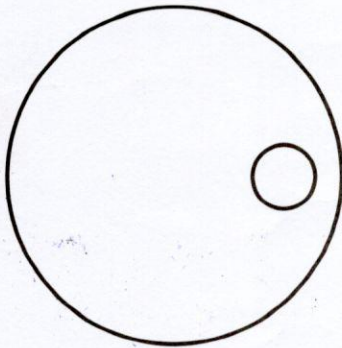
PH $\left\{ \begin{array}{l} R 6/12 \\ L 6/12 \end{array} \right.$

IOP $\left\{ \begin{array}{l} R 15 \\ L 15 \end{array} \right.$

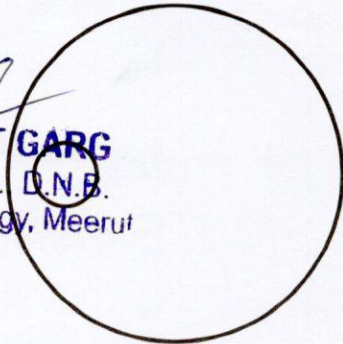
Jmay

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance	11.00	—	—	6/9	11.00	—	—	6/9
Near	—	—	—	N6	—	—	—	N6

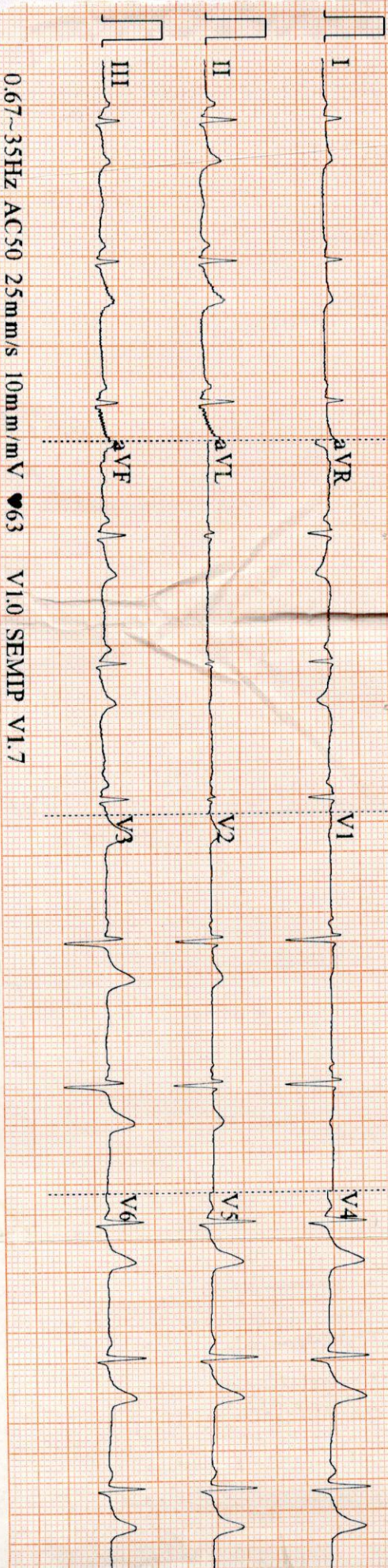
BE - (Color vision Normal)



Dr. AMIT GARG
M.B.B.S. D.N.B.
Garg Pathology, Meerut



ID: 345 23-04-2022 10:17:34



0.67~35Hz AC50 25mm/s 10mm/mV 63 V1.0 SEMIP V1.7

ID: 345	Female	32Years	cm	kg	KPa	Diagnosis Information: Sinus Rhythm Low Voltage(Chest Leads)
HR	: 66	bpm				
P	: 103	ms				
PR	: 130	ms				
QRS	: 84	ms				
QT/QTc	: 380/398	ms				
P/ORS/T	: 77/54/67	ms				
RV5/SV1	: 0.71/70.730	mV				Report Confirmed by:

DR MONIKA GARG
 M.B.B.S. M.D. (Pathology)
 GARG PATHOLOGY



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ISO 9001:2008
Garden House Colony, Near Nai Sarak, Garh Road, Meerut
Ph.: 0121-2600454, 8979608687, 9837772828

DR. MONIKA GARG

M.D. (Path) Gold Medalist

Former Pathologist :

St. Stephan's Hospital, Delhi

PUID : 220423/603 **C. NO:** 603 **Collection Time** : 23-Apr-2022 8:58AM
Patient Name : Mrs. JUHI RASTOGI 32Y / Female **Receiving Time** : 23-Apr-2022 9:15AM
Referred By : Dr. BANK OF BARODA **Reporting Time** : 23-Apr-2022 12:40PM
Sample By : **Centre Name** : Garg Pathology Lab - TPA
Organization :



Investigation	Results	Units	Biological Ref-Interval
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HAEMATOLOGY (EDTA WHOLE BLOOD)

COMPLETE BLOOD COUNT

HAEMOGLOBIN (Colorimetry)	7.7	gm/dl	12.0-15.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	5920	*10 ⁶ /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	44	%.	40-80
Lymphocytes	50	%.	20-40
Eosinophils	04	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	2.60	x 10 ⁹ /L	2.0-7.0(40-80%)
Absolute lymphocyte count	2.96	x 10 ⁹ /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.24	x 10 ⁹ /L	0.02-0.5(1-6%)

Method:- (EDTA Whole blood, Automated /

ESR (Automated Westergren's) **42** mm/1st hr 0.0 - 15.0

RBC Indices

TOTAL R.B.C. COUNT (Electric Impedence)	4.28	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	26.9	%	26-50
MCV (Calculated)	62.9	fL	80-94
MCH (Calculated)	18.0	pg	27-32
MCHC (Calculated)	28.6	g/dl	30-35
RDW-SD	43.3	fL	37-54



*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

Dr. Monika Garg
MBBS, MD(Path)
(Consultant Pathologist)

२१ घंटे सुविधा उपलब्ध है।





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(Calculated)			
RDW-CV	16.7	%	11.5 - 14.5
(Calculated)			
Platelet Count	3.36	/Cumm	1.50-4.50
(Electric Impedence)			
MPV	8.9	%	7.5-11.5
(Calculated)			
GENERAL BLOOD PICTURE			
NLR	0.88		1-3
6-9 Mild stres			
7-9 Pathological cause			

-NLR is a reflection of physiologic stress,perhaps tied most directly to cortisol and catecholamine levels.
 -NLR can be a useful tool to sort out patients who are sicker, compared to those who are less sick (its not specific to infection).
 -NLR has proven more useful than white blood cell count (WBC) when the two are directly compared. Ultimately, NLR may be a logical replacement for the WBC. In some situations, NLR is competitive with more expensive biomarkers (e.g. procalcitonin,lactate).
 -With specific clinical contexts (e.g. pancreatitis, pulmonary embolism), NLR may have surprisingly good prognostic value.

BLOOD GROUP * "O" POSITIVE \$ \$



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GLYCATED HAEMOGLOBIN (HbA1c)*	5.1	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	99.7	mg/dl	

EXPECTED RESULTS :

Non diabetic patients & Stabilized diabetics	: 4.3% to 6.30%
Good Control of diabetes	: 6.4% to 7.5%
Fair Control of diabetes	: 7.5% to 9.0%
Poor Control of diabetes	: 9.0 % and above

-Next due date for HBA1C test : After 3 months

-High HbF & Trig.level, iron def.anaemia result in high GHb

-Haemolytic anemia, presence of HbS, HbC and other Haemoglobinopathies may produce low values. three months.

INTERPRETATION: HbA1c is an indicator of glycemic control.HbA1c represents average glycemia over the past six to eight weeks.Glycation of hemoglobin occurs over the entire 120 day life span of the red blood cell, but with in this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months two to four. Mean Plasma Glucose mg/dl = (HbA1c x 35.6) - 77.3 Correlation between HbA1c and Mean Plasma Glucose (MPG) is not "perfect" but rather only this means that to predict or estimate average glucose from Hb-A1c or vice-versa is not "perfect" but gives a good working ballpark estimate. Afternoon and evening results correlate more closely to HbA1c than morning results, perhaps because morning fasting glucose levels vary much more than daytime glucose levels, which are easier to predict and control.

As per IFCC recommendations 2007, HbA1c being reported as above maintaining traceability to both IFCC (mmol/mol) & NGSP (%) units.

BIOCHEMISTRY (FLORIDE)

PLASMA SUGAR FASTING	92.0	mg/dl	70 - 110
(GOD/POD method)			

BIOCHEMISTRY (SERUM)

SERUM CREATININE	0.8	mg/dl	0.6-1.4
(Enzymatic)			
BLOOD UREA NITROGEN	9.90	mg/dL.	8-23



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Page 3 of 7

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Investigation	Results	Units	Biological Ref-Interval
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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL 0.8 mg/dl 0.1-1.2
(Diazo)

DIRECT 0.3 mg/dl <0.3
(Diazo)

INDIRECT 0.5 mg/dl 0.1-1.0
(Calculated)

S.G.P.T. 16.0 U/L 8-40
(IFCC method)

S.G.O.T. 29.0 U/L 6-37
(IFCC method)

SERUM ALKALINE PHOSPHATASE 98.0 IU/L 37-103
(IFCC KINETIC)

SERUM PROTEINS

TOTAL PROTEINS 6.8 Gm/dL 6-8
(Biuret)

ALBUMIN 3.9 Gm/dL 3.5-5.0
(Bromocresol green Dye)

GLOBULIN 2.90 Gm/dL 2.5-3.5
(Calculated)

A : G RATIO **1.34** 1.5-2.5
(Calculated)



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LIPID PROFILE

SERUM CHOLESTEROL (CHOD - PAP)	169.0	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	77.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	41.8	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	15.4	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	111.8	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	02.7	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	4.0	ratio	3.8-5.9

Interpretation :

Patient Should be Fast overnight For Minimum 12 hours and normal diet for one week

NOTE :

Lipid Profile Ranges As PER NCEP-ATP III :

SERUM CHOESTEROL : Desirable : < 200 Borderline : 200 - 239 Elevated : > 240 mg/dl
HDLCHOLESTEROL : Desirable : > 60 Borderline : 40- 60 Decreased : < 40 mg/dl
LDL CHOLESTEROL : Desirable : 100 mg/dl, Borderline : 100- 159 Elevated : >160 mg/dl
Triglycerides : Desirable : 150 Borderline : 150- 199 High : 200 - 499 Very High : >500

Friedwald Equation, VLDL & LDL values are not applicable for triglyceride > 400 mg/dl.

SERUM SODIUM (Na) * 139.0 mEq/litre 135 - 155
(ISE method)
(ISE)



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THYROID PROFILE*

Triiodothyronine (T3) * (ECLIA)	1.265	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	8.565	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) * (ECLIA)	4.748	uIU/ml	0.38-5.30

Hyperthyroid patient have suppressed TSH values, with the exception of those few individuals whos have hyperthyroidism caused by TSH producing pituitary tumor or other rare disorders such as pituitary resistance to thyroid hormones. Subclinical hyperthyroidism is defined as low TSH with levels of T4 and T3 within the reference interval. In most patients with hypothyroidism,serum TSH results are markedly elevated, but results are low in individuals with hypothyroidism caused by pituitary or hypothalamic disorders. An important cause of both incresed and decreased TSH results is NTI. Patients with NTI tend to have low TSH results during their acute illness ,then TSH rises to within or above the reference range with resolution of the underlying illness,and finally returns to within the reference range. The situation is complicated because drugs,including glucagon and dopamine,suppress TSH . Sensitive TSH assays are helpful in evaluation of treatment with thyroid hormone both for replacement therapy and suppressive doses for malignant thyroid disease.

SERUM POTASSIUM (K) * (ISE method)	4.0	mEq/litre.	3.5 - 5.5
SERUM CALCIUM (Arsenazo)	8.9	mg/dl	9.2-11.0

BIOCHEMICAL EXAMINATION

URIC ACID	4.1	mg/dL.	2.5-6.8
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URINE

PHYSICAL EXAMINATION

Volume	20	ml	
Colour	Pale Yellow		
Appearance	Clear		Clear
Specific Gravity	1.020		1.000-1.030
PH (Reaction)	Acidic		

BIOCHEMICAL EXAMINATION

Protein	Nil		Nil
Sugar	Nil		Nil

MICROSCOPIC EXAMINATION

Red Blood Cells	Nil	/HPF	Nil
Pus cells	1-2	/HPF	0-2
Epithelial Cells	2-3	/HPF	1-3
Crystals	Nil		
Casts	Nil		
@ Special Examination			
Bile Pigments	Absent		
Blood	Nil		
Bile Salts	Absent		

-----{END OF REPORT }-----



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24 घंटे सुविधा उपलब्ध है।



DATE	23.04.2022	REF. NO.	467		
PATIENT NAME	JUHI RASTOGI	AGE	32 YRS	SEX:	F
INVESTIGATION	USG WHOLE ABDOMEN	REF. BY	GARG (PATHOLOGY)		

REPORT

Liver - appears normal in size and echotexture. No mass lesion seen. Portal vein is normal.

Gall bladder - Wall thickness is normal. No calculus / mass lesion seen. CBD is normal.

Pancreas- appears normal in size and echotexture. No mass lesion seen.

Spleen- is normal in size and echotexture.

Right Kidney - Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Left Kidney - Normal in size and echotexture. Show well maintained corticomedullary differentiation. No calculus / hydronephrosis is noted.

Urinary bladder - appears distended. Wall thickness is normal. No calculus / mass seen

Uterus - Normal in size shape & normal in echotexture. Endometrium appears normal. Myometrium appears normal.

Ovaries and adnexa are unremarkable.

IMPRESSION

Normal study

Dr. P.D. Sharma
 M.B.B.S., D.M.R.D. (VIMS & RC)
 Consultant Radiologist and Head

1. Impression is a professional opinion & not a diagnosis
2. All modern machines & procedures have their limitations. if there is variance clinically this examination may be repeated or reevaluated by other investigations
 Ps. All congenital anomalies are not picked upon ultrasounds.
3. Suspected typing errors should be informed back for correction immediately.
4. Not for medico-legal purpose. Identity of the patient cannot be verified.

• 1.5 Tesla MRI • 64 Slice CT • Ultrasound
 • Doppler • Dexa Scan / BMD • Digital X-ray

**PRENATAL DETERMINATION OF SEX IS BANNED,
 PREVENT FEMALE FOETICIDE**

Helpline Numbers : 0121-2792500, 2601901

DATE	23.04.2022	REF. NO.	888		
PATIENT NAME	JUHI RASTOGI	AGE	32 YRS	SEX	F
INVESTIGATION	X-RAY CHEST PA VIEW	REF. BY	GARG (PATHOLOGY)		

REPORT

- Trachea is central in position.
- Both lung show mildly prominent broncho vascular marking.
- Cardiac size is within normal limits.
- Both costophrenic angles are clear.
- Both domes of diaphragm are normal in contour and position.

IMPRESSION

Both lung show mildly prominent broncho vascular marking.

Dr. P.D. Sharma
M.B.B.S., D.M.R.D. (VIMS & RC)
Consultant Radiologist and Head

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