



To,
The Coordinator,
Mediwheel (Arcofemi Healthcare Limited)
Helpline number: 011- 41195959

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following spouse of our employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS OF HEALTH CHECK UP BENEFICIARY	
NAME	MONICA GUPTA
DATE OF BIRTH	27-10-1988
PROPOSED DATE OF HEALTH CHECKUP FOR EMPLOYEE SPOUSE	09-03-2024
BOOKING REFERENCE NO.	23M161967100095478S
SPOUSE DETAILS	
EMPLOYEE NAME	MR. PRASAD ROHIT KUMAR
EMPLOYEE EC NO.	161967
EMPLOYEE DESIGNATION	RELATIONSHIP MANAGER (NTB)
EMPLOYEE PLACE OF WORK	HIMMATNAGAR,MOTIPURA
EMPLOYEE BIRTHDATE	27-03-1987

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from 02-03-2024 till 31-03-2024. The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a cashless facility as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee's spouse and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

**Chief General Manager
HRM Department
Bank of Baroda**

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact Mediwheel (Arcofemi Healthcare Limited))



Aashka Hospitals Ltd.
Between Sergasan and Reliance Cross Roads,
Sergasan, Gandhinagar - 382421, Gujarat, India
Phone: 079-29750750, +91-7575006000 / 9000
Emergency No.: +91-7575007707 / 9879752777
www.aashkahospitals.in
CIN: L85110GJ2012PLC072647

 **aashka**
H O S P I T A L



DR. TAPAS RAVAL
MBBS . D.O
(FELLOW IN PHACO & MEDICAL
RATINA)
REG.NO.G-21350

UHID:	Date:	Time:
Patient Name: <i>Monica Gupta</i>	Age / Sex: <i>36</i>	Height: <i>162</i>
History: <i>Compt Hctbn dnt. ft bn gves - 6-7 yem.</i>	Weight: <i>53</i>	
Allergy History:		
Nutritional Screening: <i>Well-Nourished / Malnourished / Obese</i>		
Examination:	<i>VN x 6/6od L/6od</i>	<i>Colours vision - Normal</i>
	<i>VN C-2mmtm</i>	
	<i>6/6</i>	
	<i>6/6</i>	
	<i>nil</i>	
Diagnosis:		<i>Refractive error</i>

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Eye examination:

	RIGHT			LEFT		
	S	C	A	S	C	A
D						
N						

Other Advice:

Follow-up:

Consultant's Sign:

Dr. MAULIK VYAS

M.B.B.S., D.T.C.D., T.D.D.

Reg.no: G-0749

CHEST PHYSICIAN, ALLERGY SPECIALIST and INTERVENTIONAL PULMONOLOGIST

NAME: MONICA GUPTA

AGE: 36y+ **SEX:** F

Height: **Weight:**

Chief Complaints:

PC = 192 mg/dl.

VADs ~ 12.7. + WENT = 20.3 mg/dl.

Body built / Nutritional status: GA.

Any known allergies: None.

K/C/O: - DM-II, HTN, Thyroid, Hyperlipidemia, Asthma, COPD, TB, Cancer, ILLD, etc.

None

Provisional Diagnosis: "FIT FOR DUTY".

***General Examination:-**

- Lymph node enlargement: None

***On Examination:-**

- Breath sounds: Normal Breath sound / Wheezing / Crackles / Stridor / Rhonch / Plural friction rub.

- Chest movements: (N)

- Air entry: AE = BE.

Rx,

Tab. Sildenafil 0-0-1 x 10 months.

Amv = (1) Inform LOS.

(2). Inform LOS.

M.A. MAHAR

Date: 23/9/2024
Pulse: 86/mv.
B.P.: 100/70 mm Hg
R.R.: 18/mv
Spo2: 99.1.
Temp: (N).
R.B.S.: 103 mg/dl.
Sleep cycle: (N).
E.C.G.: (N).

SD

Coughing: (N)
Cyanosis: (N)
Edema: (N)

Advice:

- 1) Chest X-ray (CXR)
- 2) CBC - Anemia
- 3) Sputum Grams (Papanicolaou) Contain's
- 4) Skin Prick test for allergy / Allergy Screening Tests (by IMUNO-EIA)
- 5) Pulmonary Function Test (PFT) with Airflow Spirometry
- 6) Spirometry (Flow-volume / PFT)
- 7) Pulmonary examination (physical / biochemical / hematological / radiological / EP-fungal culture / cytology)
- 8) Sputum Examination (Positive / Microscopic / Microbiological)
- 9) Blood investigations:
 - CBC, ESR, TBN, CRP, ESR, SGA, V, Transferrin, Serum electrolytes, BUN, HBAAg, Dequene AST, Uric acid, ANP, VitD, Iron, YUK test, liver Function test, kidney Function test, lipid profile, thyroid profile (T3, T4, TSH).
- 10) Urinary investigations:
 - Alpha anti-pyruvic level.
 - Total anti-specific IgG level.
 - Antigenic screening enzyme.
- 11) Urea analysis:
 - CO2 (urinary excretion antigen).
 - Serum specific antibodies (ASG) (Serum and membrane).
 - CO2 (urinary and excretion antigen).
- 12) Urinary CO2:
 - Urinary CO2.
- 13) Adrenaline:

Dr. Zeinab Yousef



aashka
HOSPITAL



Cytological examination- Pap smear
request form

Name: Honi Co. Gupta. Age: 23/3/24

Complaints:
none

No of deliveries: 1 LSC/O/3ju.

Last Delivery: 60:3ju

History of abortion: non

Last abortions:

H/O medical conditions associated;

DM	<input type="checkbox"/>
HTN	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>

MH: 45 Reg: 20ju.
25-30 2/3/24

LMP: 2/3/24

P/A:

P/S: [Signature]
P/N: Pap smear

Sample:-

Vagina	<input type="checkbox"/>
Cervix	<input checked="" type="checkbox"/>

Doctors Sign:- [Signature]

PATIENT NAME: MONICA GUPTA

GENDER/AGE: Female / 35 Years

DOCTOR:

OPDNO: OSP23635

DATE: 23/03/24

SONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: Liver appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen. No evidence of dilated IHBR is seen. Intrahepatic portal radicles appear normal. No evidence of solid or cystic mass lesion is seen.

GALL BLADDER: Gall bladder is physiologically distended and appears normal. No evidence of calculus or changes of cholecystitis are seen. No evidence of pericholecystic fluid collection is seen. CBD appears normal.

PANCREAS: Pancreas appears normal in size and shows normal parenchymal echoes. No evidence of pancreatitis or pancreatic mass lesion is seen.

SPLEEN: Spleen appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen.

KIDNEYS: Both kidneys are normal in size, shape and position. Both renal contours are smooth. Cortical and central echoes appear normal. Bilateral cortical thickness appears normal. No evidence of renal calculus, hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 10.1 x 4.6 cms in size.

Left kidney measures about 10.6 x 4.8 cms in size.

No evidence of suprarenal mass lesion is seen on either side.

Aorta, IVC and para aortic region appears normal.

No evidence of ascites is seen.

BLADDER: Bladder is normally distended and appears normal. No evidence of bladder calculus, diverticulum or mass lesion is seen. Prevoid bladder volume measures about 190 cc.

UTERUS: Uterus is anteverted and appears normal in size, shape and position. Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 6 mm. No evidence of uterine mass lesion is seen.

COMMENT: Normal sonographic appearance of liver, GB, pancreas, spleen, kidneys, para aortic region, bladder and uterus.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

monika. GUPTA.

23.03.2024 12:01:34 PM
AASHKA HOSPITAL LTD.
SARGASAN
GANDHENAGAR

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

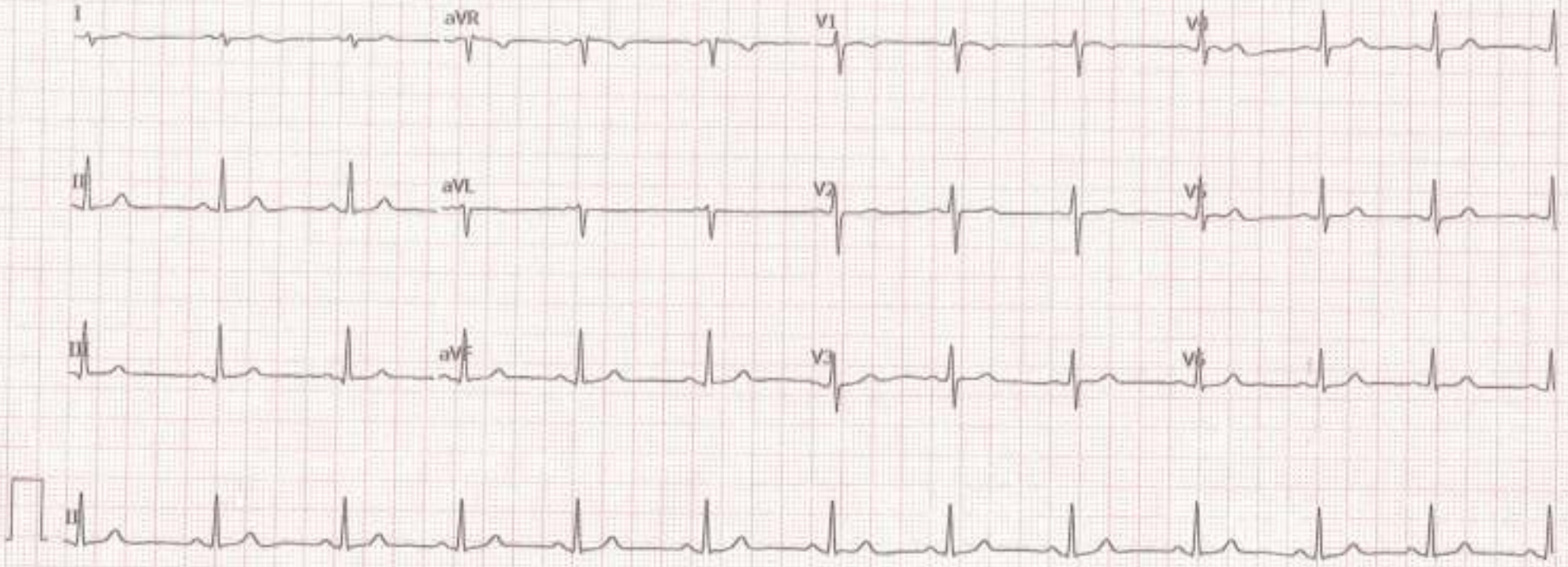
Room:

73 bpm
-/- mmHg

Technician:
Ordering Pt:
Referring Pt:
Attending Pt:

QRS : 76 ms
QT / QTcBaz : 356 / 392 ms
PR : 130 ms
P : 96 ms
RR / PP : 824 / 821 ms
P / QRS / T : 56 / 93 / 79 degrees

Normal sinus rhythm
Rightward axis
Borderline ECG



Aashka Hospitals Ltd.

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Sargasan, Gandhinagar - 382421, Gujarat, India
Phone: 079-29750750, +91-7575006000 / 9000
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www.aashkahospitals.in
CIN: L85110GJ2012PLC072647

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H O S P I T A L



PATIENT NAME: MONICA GUPTA

GENDER/AGE: Female / 35 Years

DOCTOR:

OPDNO: OSP23635

DATE: 23/03/24

X-RAY CHEST PA

Both lung fields show increased broncho-vascular markings.
No evidence of collapse, consolidation, mediastinal lymph adenopathy, soft tissue infiltration or pleural effusion is seen.
Both hilar shadows and C.P. angles are normal.
Heart shadow appears normal in size. Aorta appears normal.
Bony thorax and both domes of diaphragm appear normal.
No evidence of cervical rib is seen on either side.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

PATIENT NAME: MONICA GUPTA

GENDER/AGE: Female / 35 Years

DOCTOR: DR. HASIT JOSHI

OPDNO: OSP23635

DATE: 23/03/24

2D-ECHO

MITRAL VALVE	: MILD MVP	
AORTIC VALVE	: NORMAL	
TRICUSPID VALVE	: NORMAL	
PULMONARY VALVE	: NORMAL	
AORTA	: 28mm	
LEFT ATRIUM	: 27mm	
LV Dd / Ds	: 40/28mm	EF 55%
IVS / LVPW / D	: 10/9mm	
IVS	: INTACT	
IAS	: FLOPPY	
RA	: NORMAL	
RV	: NORMAL	
PA	: NORMAL	
PERICARDIUM	: NORMAL	
VEL	: PEAK	MEAN
M/S	: Gradient mm Hg	Gradient mm Hg
MITRAL	: 0.9/0.7m/s	
AORTIC	: 1.15m/s	
PULMONARY	: 1.0m/s	
COLOUR DOPPLER	: MILD MR/TR	
RVSP	: 29mmHg	
CONCLUSION	: <u>NORMAL LV SIZE / SYSTOLIC FUNCTION.</u>	

CARDIOLOGIST

DR. HASIT JOSHI (9825012235)





LABORATORY REPORT

Name : **MONICA GUPTA**
 Ref.By : **HOSPITAL**
 Bill. Loc. : **Aashka hospital**

Sex/Age : **Female/ 36 Years**
 Dis. At :
 Case ID : **40302200637**
 Pt. ID : **3455156**
 Pt. Loc :

Reg Date and Time : **23-Mar-2024 09:17** Sample Type :
 Sample Date end Time : **23-Mar-2024 09:18** Sample Coll. By :
 Report Date and Time : Acc. Remarks : **Normal**

Mobile No :
 Ref Id1 : **OSP23635**
 Ref Id2 : **O232411332**

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Blood Glucose Fasting & Postprandial			
Plasma Glucose - F	103.11	mg/dL	70.0 - 100
Blood Urea Nitrogen (BUN)	20.3	mg/dL	7.00 - 16.70
Lipid Profile			
HDL Cholesterol	38.9	mg/dL	48 - 77
Triglyceride	192.39	mg/dL	<150
Chol/HDL	4.39		0 - 4.1
Liver Function Test			
S.G.P.T.	12.31	U/L	14 - 59
S.G.O.T.	14.22	U/L	16 - 37
25 OH Cholecalciferol (D2+D3)	12.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 160 Toxicity

Abnormal Result(s) Summary End

Note: (L)-VeryLow, (L)-Low, (H)-High, (HH)-VeryHigh, (A)-Abnormal

Printed On : 23-Mar-2024 13:13



1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities related to the business. It emphasizes the need for transparency and accountability, particularly in the context of tax reporting and financial statements. The text highlights that proper record-keeping is essential for identifying potential areas of improvement and for ensuring compliance with relevant regulations.

2. The second part of the document focuses on the role of technology in streamlining business operations. It explores various digital tools and software solutions that can help automate repetitive tasks, reduce errors, and improve overall efficiency. The text suggests that investing in technology is a strategic move that can lead to significant cost savings and enhanced productivity over the long term.

3. The third part of the document addresses the importance of regular communication and collaboration within the organization. It stresses that effective teamwork and clear communication channels are crucial for achieving common goals and resolving any issues that may arise. The text encourages a culture of open dialogue and mutual support, where team members feel empowered to share their ideas and concerns.

4. The fourth part of the document discusses the need for ongoing professional development and training. It highlights that the business landscape is constantly evolving, and employees must stay updated with the latest industry trends and skills. The text suggests that providing training opportunities and encouraging continuous learning can help build a more skilled and adaptable workforce, which is essential for long-term success.

5. The fifth part of the document concludes by summarizing the key points discussed and reiterating the importance of a proactive and strategic approach to business management. It emphasizes that success is not achieved overnight but through consistent effort, innovation, and a commitment to excellence. The text ends with a call to action, encouraging the reader to implement the strategies discussed and to stay focused on their long-term vision.



LABORATORY REPORT

Name : **MONICA GUPTA**
 Ref.By : **HOSPITAL**
 Bill. Loc. : **Aashka hospital**

Sex/Age : **Female/ 36 Years**
 Dis. At :
 PL Loc :

Case ID : **40302200637**

PL ID : **3456156**

PL Loc :

Reg Date and Time : **23-Mar-2024 08:17** Sample Type : **Whole Blood EDTA**

Mobile No :

Sample Date and Time : **23-Mar-2024 08:16** Sample Coll. By :

Ref Id1 : **OSP23635**

Report Date and Time : **23-Mar-2024 09:34** Acc. Remarks : **Normal**

Ref Id2 : **0232411332**

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin	12.3	G%	12.0 - 15.0	
RBC (Electrical Impedance)	4.03	millions/cumm	3.80 - 4.80	
PCV(Calc)	38.00	%	36.00 - 46.00	
MCV (RBC histogram)	94.3	fL	83.00 - 101.00	
MCH (Calc)	30.6	pg	27.00 - 32.00	
MCHC (Calc)	32.4	gm/dL	31.50 - 34.50	
RDW (RBC histogram)	14.30	%	11.00 - 16.00	

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
Total WBC Count	6300	/uL	4000.00 - 10000.00	
Neutrophil	63.0	%	40.00 - 70.00	EXPECTED VALUES /uL 2000.00 - 7500.00
Lymphocyte	28.0	%	20.00 - 40.00	1764
Eosinophil	5.0	%	1.00 - 6.00	315
Monocytes	4.0	%	2.00 - 10.00	252
Basophil	0.0	%	0.00 - 2.00	0

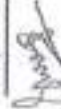
PLATELET COUNT (Optical)

Platelet Count	194000	/uL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	2.25		0.76 - 3.53

SMEAR STUDY

RBC Morphology	Normocytic Normochromic RBCs.
WBC Morphology	Total WBC count within normal limits.
Platelet	Platelets are adequate in number.
Parasite	Malarial Parasite not seen on smear.

Note (L-Very Low, L-Low, H-High, HH-Very High, A-Abnormal)



Dr. Shreya Shah
 M.D. (Pathologist)

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1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that proper record-keeping is essential for transparency and accountability, particularly in the context of public administration and financial management.

2. The second part of the document outlines the various methods and tools used to collect, store, and analyze data. It highlights the need for robust systems that can handle large volumes of information while ensuring data integrity and security.

3. The third part of the document focuses on the role of technology in modern record-keeping. It discusses the benefits of digitalization, such as improved efficiency, reduced risk of loss, and enhanced accessibility for authorized users.

4. The fourth part of the document addresses the challenges associated with maintaining records over time. It discusses the importance of regular audits, updates, and the implementation of retention policies to ensure that records remain relevant and usable.

5. The fifth part of the document concludes by emphasizing the ongoing nature of record-keeping and the need for continuous improvement. It calls for a commitment to best practices and the adoption of new technologies to stay ahead of the curve.



LABORATORY REPORT

Name : MONICA GUPTA
Ref.By : HOSPITAL
Bill. Loc. : Ashoka hospital

Sex/Age : Female/ 35 Years
Dis. At :
Case ID : 40302200637
PL ID : 3455156
PL Loc :

Reg Date and Time : 23-Mar-2024 09:17 Sample Type : Whole Blood EDTA
Sample Date and Time : 23-Mar-2024 09:18 Sample Coll. By :
Report Date and Time : 23-Mar-2024 10:20 Acc. Remarks : Normal
Mobile No :
Ref Id1 : OSP23835
Ref Id2 : O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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ESR Westgren Method	08		mm after 1hr 3 - 20	
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Note (LL-Very Low, L-Low, H-High, HH-High, A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT

Name : **MONICA GUPTA**

Ref.By : **HOSPITAL**

Bill. Loc. : **Aashka hospital**

Sex/Age : **Female/ 36 Years**

Dis. At :

Case ID : **40302200637**

PL ID : **3455156**

PL Loc :

Reg Date and Time : **23-Mar-2024 09:17**

Sample Type : **Plasma Fluoride F, Plasma Fluoride PP**

Mobile No :

Sample Date and Time : **23-Mar-2024 09:19**

Sample Coll. By :

Ref Id1 : **OSP23635**

Report Date and Time : **23-Mar-2024 13:04**

Acc. Remarks : **Normal**

Ref Id2 : **C232411332**

TEST RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

BIOCHEMICAL INVESTIGATIONS

Blood Glucose Level (Fasting & Post Prandial)

Plasma Glucose - F	H	103.11	mg/dL	70.0 - 100
Plasma Glucose - PP		100.63	mg/dL	70.0 - 140.0

Reference range has been changed as per recent guidelines of ISPAD 2018.

<100 mg/dL : Normal level

100-<126 mg/dL: Impaired fasting glucose guidelines

>=126 mg/dL: Probability of Diabetes, Confirm as per guidelines.

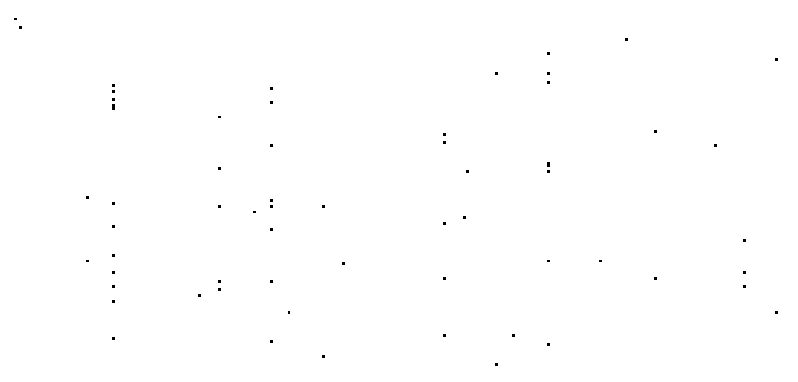
Note: (L-VeryLow, L-Low, H-High, HH-VeryHigh, A-Abnormal)

Dr. Shreya Shah
M.D. (Pathology)

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LABORATORY REPORT

Name : MONICA GUPTA

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Female/ 35 Years

Case ID : 40302200637

Dis. At :

Pl. ID : 3455158

Pl. Loc :

Reg Date and Time : 23-Mar-2024 09:17

Sample Type : Whole Blood EDTA

Mobile No :

Sample Date and Time : 23-Mar-2024 09:18

Sample Coll. By :

Ref Id1 : OSP23635

Report Date and Time : 23-Mar-2024 09:43

Acc. Remarks : Normal

Ref Id2 : O232411332

TEST

RESULTS

UNIT

BIOLOGICAL REF RANGE

REMARKS

Glycated Haemoglobin Estimation

HbA1C 5.03

% of total Hb <5.7: Normal

5.7-6.4: Prediabetes

>=6.5: Diabetes

Estimated Avg Glucose (3 Mths) 97.66

mg/dL

Not evaluable

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycaemic control. Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Hemoglobin forms of rare variant Hb(C, S, E, F, G) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycaemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Note (L-L-Very Low, L-Low, H-High, MH-Very High ,A-Absnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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Neuberg Diagnostics Private Limited

laboratory : "KEDAM" Opposite Kalyan Petrol Pump, Near Fernand Garden,
Ahmedabad - 380006 ☎ 079-40408181 / 61618181 |
☘ contact@neubergsupratech.com

Regd. Office : Plot No. 7, Industrial Estate, Rajiv Gandhi Satal, Perungudi,
Chennai - 600096, Tamil Nadu, India | CIN - U63300TN2017PTC114099
☘ www.neubergsupratech.com



Figure 1: The number of people in the workforce from 1980 to 2000. The graph shows a steady increase in the workforce over the 20-year period, starting at 60 million in 1980 and reaching 100 million by 2000.

The graph illustrates the growth of the workforce over time. The x-axis represents the year, and the y-axis represents the number of people in the workforce in millions. The data points are as follows:

Year	Number of people in the workforce (Millions)
1980	60
1985	65
1990	70
1995	75
2000	100

The workforce grew by 5 million people every 5 years from 1980 to 1995, and then by 25 million people between 1995 and 2000.

The total increase in the workforce from 1980 to 2000 is 40 million people.

The average annual increase in the workforce is 2 million people per year.

The workforce in 2000 is 100 million people.

The workforce in 1980 is 60 million people.

The workforce in 1985 is 65 million people.

The workforce in 1990 is 70 million people.

The workforce in 1995 is 75 million people.

The workforce in 2000 is 100 million people.

The workforce in 1980 is 60 million people.

The workforce in 1985 is 65 million people.

The workforce in 1990 is 70 million people.



LABORATORY REPORT

Name : **MONICA GUPTA**
 Ref.By : **HOSPITAL**
 Bill. Loc. : **Aashka hospital**

Sex/Age : **Female/ 36 Years** Case ID : **40302200637**
 Dis. At : Pl. ID : **3455156**
 Pl. Loc :

Reg Date and Time : **23-Mar-2024 08:17** Sample Type : **Serum**
 Sample Date and Time : **23-Mar-2024 08:18** Sample Coll. By :
 Report Date and Time : **23-Mar-2024 11:28** Acc. Remarks : **Normal**

Mobile No :
 Ref Id1 : **OSP23635**
 Ref Id2 : **O232411332**

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol Colorimetric, CHOD-PGD	170.89	mg/dL	110 - 200	
HDL Cholesterol	L 38.9	mg/dL	48 - 77	
Triglyceride Glycerol Phosphate Oxidase	H 192.39	mg/dL	<150	
VLDL Calculated	38.48	mg/dL	10 - 40	
Chol/HDL Calculated	H 4.39		0 - 4.1	
LDL Cholesterol Calculated	93.51	mg/dL	0.00 - 100.00	

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal <100	Desirable <200	Low <40	Normal <150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240		High 200-499
High 160-189			

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment
- For LDL Cholesterol level Please consider direct LDL value
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed
- Detail test interpretation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment

Note (L-Very Low, L-Low, H-High, HH-Very High, A-Abnormal)



Dr. Shreya Shah
 M.D. (Pathologist)

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1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that proper record-keeping is essential for transparency and accountability, particularly in the context of public administration and government operations. The text highlights how detailed records can help identify inefficiencies, prevent fraud, and ensure that resources are used effectively.

2. The second part of the document focuses on the role of technology in modern record-keeping. It explores how digital systems and software solutions can streamline the process of data collection, storage, and retrieval. The author notes that while technology offers significant advantages, it also presents challenges such as data security, system integration, and the need for staff training. The document suggests that a balanced approach, combining traditional methods with modern technology, is often the most effective solution.

3. The third part of the document addresses the legal and regulatory requirements surrounding record-keeping. It discusses various laws and standards that govern how records must be maintained, including retention periods, access protocols, and data protection regulations. The text stresses that organizations must stay up-to-date with these requirements to avoid legal penalties and ensure compliance. It also mentions the importance of having clear policies and procedures in place to guide staff in their record-keeping duties.

4. The final part of the document provides practical advice and best practices for implementing a robust record-keeping system. It suggests starting with a thorough audit of existing records to understand the current state of affairs. From there, organizations should develop a clear strategy, choose appropriate tools, and ensure that all staff are properly trained and aware of their responsibilities. The document concludes by emphasizing that record-keeping is not just a technical task but a fundamental aspect of good governance and organizational management.



LABORATORY REPORT

Name : MONICA GUPTA
Ref By : HOSPITAL
Bill. Loc. : Aashka hospital

Sex/Age : Female/ 36 Years
Dis. At :
Case ID : 40302200637
Pt. ID : 3455158
Pl. Loc. :

Reg Date and Time : 23-Mar-2024 09:17 Sample Type : Serum
Sample Date and Time : 23-Mar-2024 09:15 Sample Coll. By :
Report Date and Time : 23-Mar-2024 11:30 Acc. Remarks : Normal

Mobile No :
Ref Id1 : OSP23635
Ref Id2 : O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T. UV with Psp	L	12.31	U/L	14 - 59
S.G.O.T UV with Psp	L	14.22	U/L	15 - 37
Alkaline Phosphatase Enzymatic, P ₁₀₀ /AMP		78.57	U/L	46 - 116
Gamma Glutamyl Transferase L-Gamma-glutamyl-3-carboxy-4-nitroantile Substrate		10.98	U/L	0 - 38
Proteins (Total) Colorimetric, Biuret		8.30	gm/dL	6.40 - 8.30
Albumin Bromocresol purple		5.00	gm/dL	3.4 - 5
Globulin Calculated		3.30	gm/dL	2 - 4.1
A/G Ratio Calculated		1.5		1.0 - 2.1
Bilirubin Total Photometry		0.74	mg/dL	0.3 - 1.2
Bilirubin Conjugated Diazotization reaction ¹		0.21	mg/dL	0 - 0.50
Bilirubin Unconjugated Calculated		0.53	mg/dL	0 - 0.8

Note (L,VeryLow,L,Low,H-High,HH-VeryHigh ,A-Abnormal)

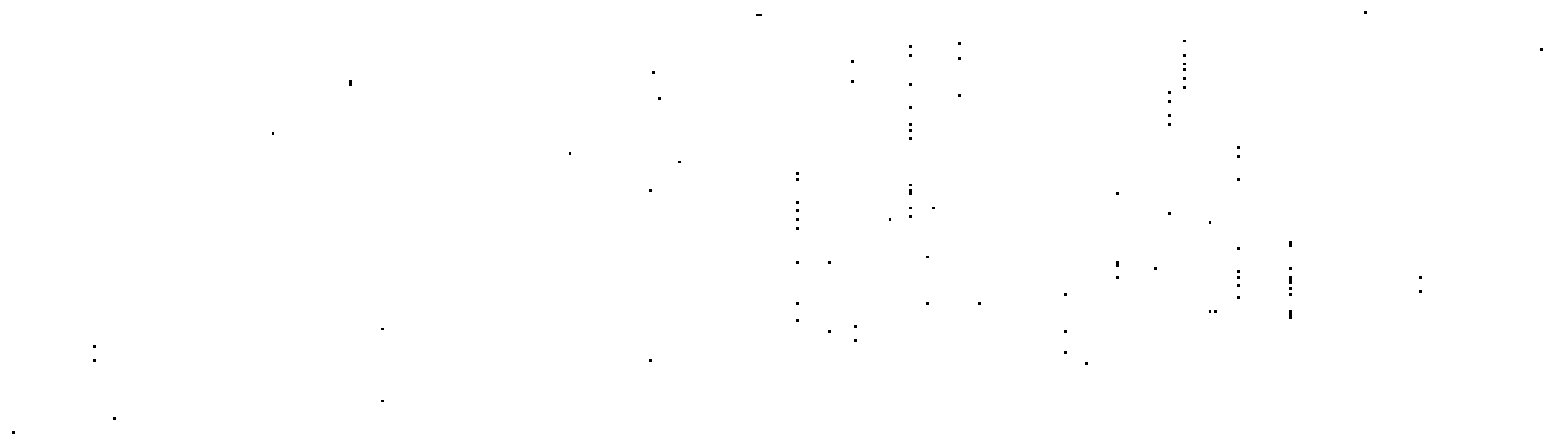


Dr. Shreya Shah
M.D. (Pathologist)

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Printed On : 25-Mar-2024 13:15







LABORATORY REPORT

Name : MONICA GUPTA

Ref By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Female/ 36 Years

Case ID : 40302200637

Dis. At. :

Pt. ID : 3455156

Pt. Loc :

Reg Date and Time : 23-Mar-2024 08:17

Sample Type : Serum

Sample Date and Time : 23-Mar-2024 08:18

Sample Coll. By :

Report Date and Time : 23-Mar-2024 13:09

Acc. Remarks : Normal

Mobile No :

Ref Id1 : OSP23635

Ref Id2 : O232411332


TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BUN (Blood Urea Nitrogen) GLDH	H 20.3	mg/dL	7.00 - 18.70	
Uric Acid uricase	3.62	mg/dL	2.6 - 6.2	
Creatinine	0.74	mg/dL	0.50 - 1.50	
25 OH Cholecalciferol (D3+D3)	L 12.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 160 Toxicity	

25-OH-VITD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VITD deficiency is common. In institutionalized elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VITD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VITD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcaemia and hyperphosphatemia.

INTERPRETATION

- Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings of bone biopsy/histomorphometry.
- Patients who present with hypercalcaemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VITD to 1,25 (OH)₂-VITD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)₂-VITD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VITD concentrations of >80 ng/mL.
- Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH-VITD into the active form, 1,25 (OH)₂-VITD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.
- Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VITD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)₂-VITD) levels are also overly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients. CAUTIONS: Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh, A-Abnormal)



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M.D. (Pathology)

Printed On : 23-Mar-2024 13:18

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LABORATORY REPORT

Name : **MONICA GUPTA**
Ref.By : **HOSPITAL**
Bill. Loc. : **Aashka hospital**

Sex/Age : **Female/ 35 Years** Case ID : **40302200637**
Dis. At : PL ID : **3455156**
 PL Loc :

Reg Date and Time : **23-Mar-2024 09:17** Sample Type : **Serum**
Sample Date and Time : **23-Mar-2024 09:18** Sample Coll. By :
Report Date and Time : **23-Mar-2024 13:09** Acc. Remarks : **Normal**

Mobile No :
Ref Id1 : **QSP23535**
Ref Id2 : **Q232411932**

VITAMIN B - 12

Vitamin B - 12 Level **352.0** **pg/mL** **180 - 914**

Introduction:

Vitamin B12, a member of the cobin family, is a cofactor for the formation of myelin, and along with folates. It is required for DNA synthesis. Levels above 300 or 400 are rarely associated with B12 deficiency induced hematological or neurological disease.

Clinical Significance:

Causes of Vitamin B12 deficiency can be divided into three classes: Nutritional, malabsorption syndromes and gastrointestinal causes. B12 deficiency can cause Megaloblastic anemia (MA), nerve damage and degeneration of the spinal cord. Lack of B12 even mild deficiencies damages the myelin sheath. The nerve damage caused by a lack of B12 may become permanently debilitating.

The relationship between B12 and MA is not always clear that some patients with MA will have normal B12 levels; conversely, many individuals with B12 deficiency are not affected with MA.

Decreased in:

Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraceptives, parabolic competition, pancreatic deficiency, treated epilepsy and advancing age.

Increased in:

Renal failure, liver disease and myeloproliferative diseases.

Variations due to age: Increases with age.

Temporarily increased after drug.

Falsely high in Deteriorated sample.

Note: (L-Very Low, L-Low, H-High, HH-Very High, A-Abnormal)

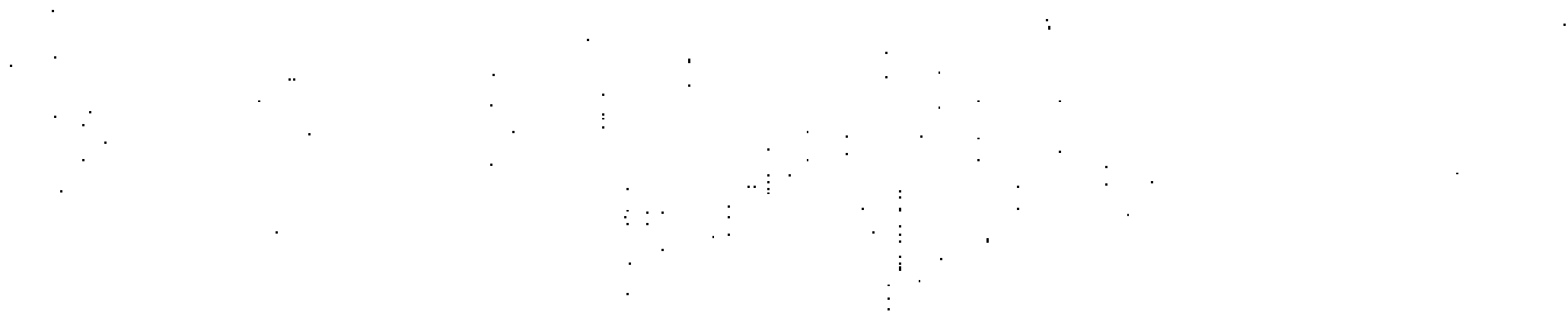

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LABORATORY REPORT

Name : **MONICA GUPTA**

Ref.By : **HOSPITAL**

Bill Loc. : **Aashka hospital**

Sex/Age : **Female/ 36 Years**

Case ID : **40302200637**

Dis. At :

Pl. ID : **3455156**

Pl. Loc :

Reg Date and Time : **23-Mar-2024 09:17** Sample Type : **Serum**

Sample Date and Time : **23-Mar-2024 09:18** Sample Coll. By :

Report Date and Time : **23-Mar-2024 10:20** Acc. Remarks : **Normal**

Mobile No :

Ref Id1 : **OSP23636**

Ref Id2 : **O232411332**

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
------	---------	------	----------------------	---------

Thyroid Function Test

Triiodothyronine (T3)	81.94	ng/dL	70 - 204	
Thyroxine (T4) CMA	5.86	ng/dL	4.67 - 11.72	
TSH CMA	3.22	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentrations (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism). PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipient hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a suppressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone. Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating anti-animal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy

First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

Reference range (microIU/ml)

Note (LL-VeryLow L-Low H-High, HH-VeryHigh A-Abnormal)



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2

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LABORATORY REPORT

Name : MONICA GUPTA

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Female/ 36 Years

Case ID : 40302200607

Dis. At :

Pl. ID : 3465156

Pl. Loc :

Reg Date and Time : 23-Mar-2024 09:17 Sample Type : Serum

Mobilia No :

Sample Date and Time : 23-Mar-2024 09:18 Sample Coll. By :

Ref Id1 : OSP23635

Report Date and Time : 23-Mar-2024 10:20 Acc. Remarks : Normal

Ref Id2 : Q232411332

Interpretation/Notes:

Ultra sensitive-thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an onset primary-thyroid abs. p-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased p-TSH indicates inadequate thyroid hormone, and suppressed p-TSH indicates excess thyroid hormone. Transient p-TSH abnormalities may be found in severely ill hospitalized patients, so this is not the ideal test to assess thyroid function. However, even in these patients, p-TSH works better than total thyroxine (an abnormal/elevating test), when the p-TSH result is abnormal. Appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0, free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks. If TSH is > 10, free T4 & free T3 level are normal then it is considered as overt hypothyroidism.

Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hospitalized patients, hypothyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed p-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormones vary according trimester in pregnancy:

TSH ref range in Pregnancy

First trimester

Second trimester

Third trimester

Reference range (microIU/ml)

0.28 - 2.00

0.43-3.7

0.5-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hypothyroidism	↑	↑	↓
Secondary Hypothyroidism	↑	↑	↑
Grave's Thyrotoxicosis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

Note (LL-VeryLow, L-Low, H-High, HH-VeryHigh, A-Abnormal)

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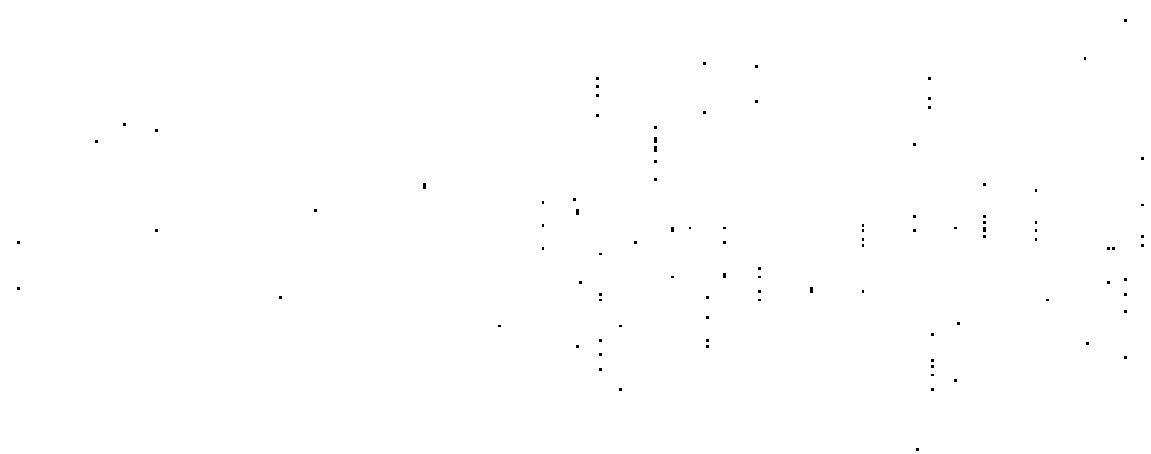


Figure 1: Schematic diagram of a multi-stage amplifier circuit.

The circuit is a multi-stage amplifier consisting of four common-emitter stages. The input stage is a common-emitter amplifier with a base bias network. The second stage is a common-emitter amplifier with a base bias network. The third stage is a common-emitter amplifier with a base bias network. The output stage is a common-emitter amplifier with a base bias network. The output is taken from the collector of the final stage.

The circuit is powered by a DC supply. The input signal is applied to the base of the first stage. The output signal is taken from the collector of the final stage. The circuit is designed to provide a high gain and a wide bandwidth.

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LABORATORY REPORT

Name : MONICA GUPTA

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Female/ 35 Years

Case ID : 40302200637

Dis. AI :

PL ID : 3455156

PL Loc :

Reg Date and Time : 23-Mar-2024 09:17 Sample Type : Spot Urine

Sample Date and Time : 23-Mar-2024 09:18 Sample Coll. By :

Mobile No :

Report Date and Time : 23-Mar-2024 09:41 Acc. Remarks : Normal

Ref Id1 : OSP23636

Ref Id2 : O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
------	---------	------	----------------------	---------

URINE EXAMINATION (STRIP METHOD AND FLOWCYTOMETRY)

Physical examination

Colour

Pale yellow

Transparency

Clear

Chemical Examination By Sysmex UC-3500

Sp.Gravity

>1.025

pH

6.00

Leucocytes (ESTERASE)

Negative

Protein

Negative

Glucose

Negative

Ketone Bodies Urine

Negative

Urobilinogen

Negative

Bilirubin

Negative

Blood

Negative

Nitrite

Negative

Flowcytometric Examination By Sysmex UF-5000

Leucocyte

Nil

/HPF

Nil

Red Blood Cell

Nil

/HPF

Nil

Epithelial Cell

Present +

/HPF

Present(+)

Bacteria

Nil

/uL

Nil

Yeast

Nil

/uL

Nil

Cast

Nil

/HPF

Nil

Crystals

Nil

/HPF

Nil

Note (L-Low, LL-Low, H-High, HH-High, V-Very High, A-Abnormal)



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LABORATORY REPORT

Name : **MONICA GUPTA**

Ref.By : **HOSPITAL**

Bill. Loc. : **Asstka hospital**

Sex/Age : **Female/ 36 Years**

Dis. At :

Case ID : **40302200637**

Pl. ID : **3455156**

Pl. Loc :

Reg Date and Time : **23-Mar-2024 09:17** Sample Type : **Spot Urine**

Sample Date and Time : **23-Mar-2024 09:18** Sample Coll. By :

Mobile No :

Report Date and Time : **23-Mar-2024 09:41** Acc. Remarks : **Normal**

Ref Id1 : **OSP23635**

Ref Id2 : **O232411332**

Parameter	Unit	Expected value	Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Plus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

----- End Of Report -----

For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

Note: [LL-VeryLow, L-Low, H-High, Hst-VeryHigh, A-Anomaly]



Dr. Shreya Shah
M.D. (Pathology)

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