

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

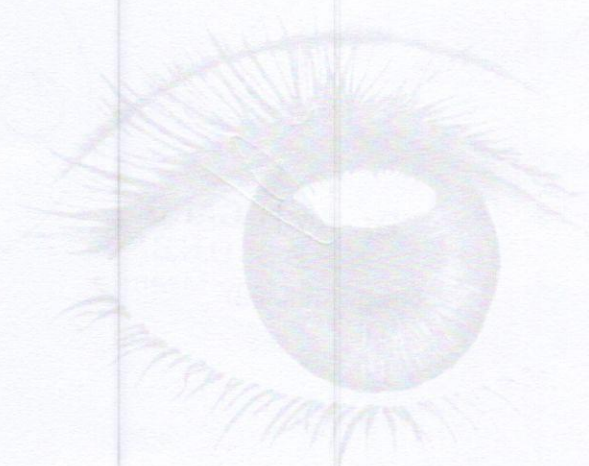
Name Munish Age/Sex 51 / m C/o VIP Date 23/Jul/22

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



Accredited Eye Hospital Western U.P.

First NABH ECO



Dr. AMIT GARG
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प्रकाश आँखों का अस्पताल एवं लेजर सैन्टर



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

Counsellor 9837066186
7535832832
Manager 7895517715
OT 7302222373
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

(एच आर वि एच आर वि)

भारत सरकार
Government of India

आधार

Issue Date: 27/05/2014



मुनीश
Munish
जन्म तिथि / DOB : 07/04/1971
पुरुष / MALE

8596 0996 6234

मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता: C/O आनंद प्रकाश, बी-10 राजबला भवन,
भगत मार्ग, राधे एन्क्लेव, गोविन्द पुरी, मोदीनगर,
गाजियाबाद, उत्तर प्रदेश, 201204
Address: C/O, Anand Prakash, B-10 Rajbala
Bhawan, Bhagat Road, Radhe Enclave,
Govind Puri, Modinagar, Ghaziabad, Uttar
Pradesh, 201204

Print Date: 19/04/2021



8596 0996 6234

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

4/9/10

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

Vn
 R 6/18p
 L 6/18p

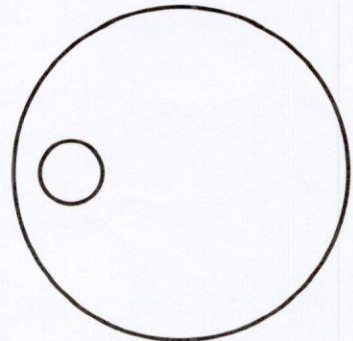
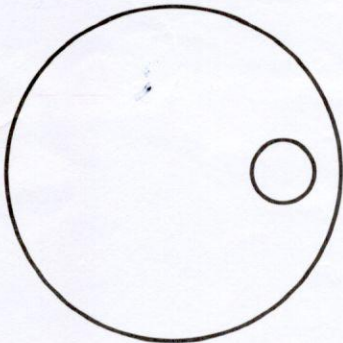
PH
 R 6/9
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 R 8
 L 10
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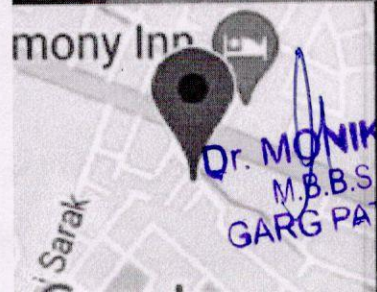
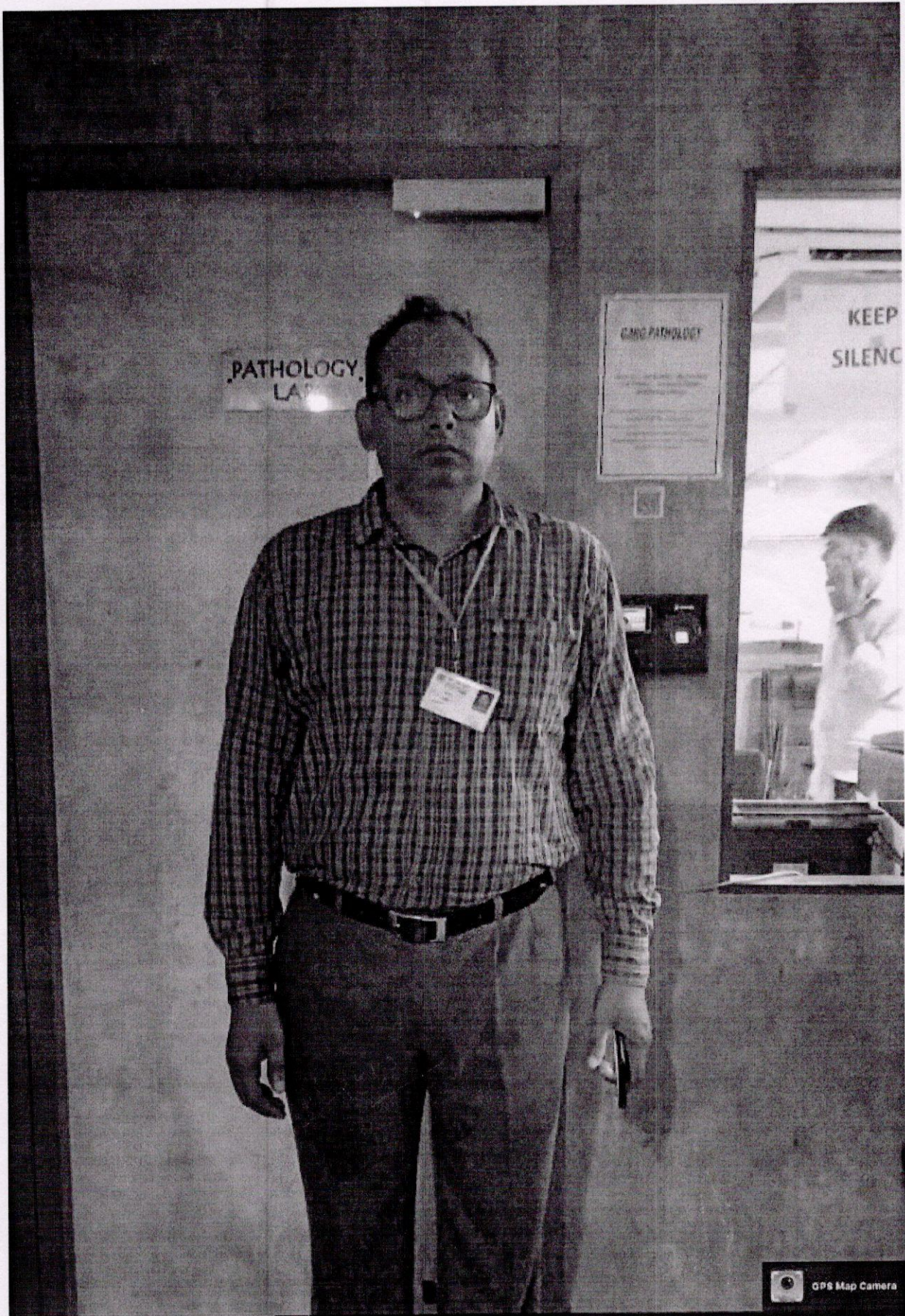
Colour vision
 NORMAL
 NORMAL

	RIGHT EYE				LEFT EYE			
	Sph.	Cyl.	Axis	Vision	Sph.	Cyl.	Axis	Vision
Distance	+1.50	+1.00	175	6/6	+1.75	+0.50	20	6/6
Near				N/6				N/6
Add Bk	+2.00				+2.00			

POH
 +1.25 / +0.80 X 180
 +1.25 / +0.75 X 180
 Add +2.00 Bk



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Meerut, Uttar Pradesh, India

XP8J+FHH, Sector 3, Tejgarhi, Meerut, Uttar

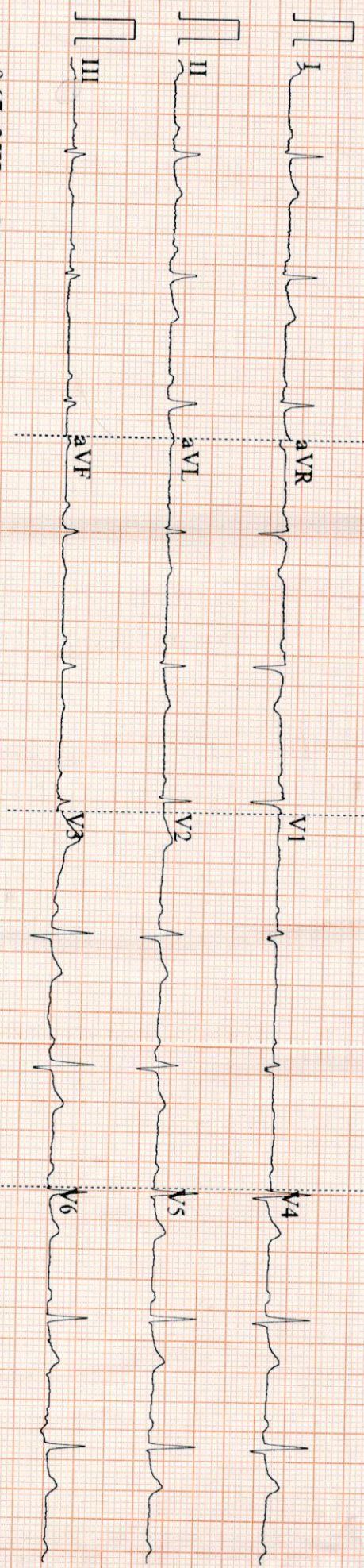
Pradesh 250001, India

Lat 28.966183°

Long 77.731423°

ID: 683 23-07-2022 09:47:17

0.67~35Hz AC50 25mm/s 10mm/mV ♣70 V10 SEMIP V1.7



ID: 683

Male
51 Years
cm

/ kg
kPa

Diagnosis Information:
Sinus Rhythm
Normal ECG

HR	: 69	bpm
P	: 103	ms
PR	: 166	ms
QRS	: 87	ms
QT/QTc	: 382/411	ms
P/ORS/T	: 38/32/14	°
RV5/SV1	: 0.856/0.181	mV

Handwritten signature

Report Confirmed by:

MONIK GARG
M.B.S., D. (Path.)
GARG PATHOLOGY



Garg Pathology

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National Accreditation Board For Testing & Calibration Laboratories
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 : 220723/605 **C. NO:** 605 **Collection Time** : 23-Jul-2022 9:33AM
Patient Name : Mr. MUNISH 51Y / Male **Receiving Time** : 23-Jul-2022 9:56AM
Referred By : Dr. BANK OF BARODA **Reporting Time** : 23-Jul-2022 3:31PM
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)	12.1	gm/dl	13.0-17.0
TOTAL LEUCOCYTE COUNT (Electric Impedence)	7090	*10 ⁶ /L	4000 - 11000
DIFFERENTIAL LEUCOCYTE COUNT (Microscopy)			
Neutrophils	50	%.	40-80
Lymphocytes	44	%.	20-40
Eosinophils	04	%.	1-6
Monocytes	02	%.	2-10
Absolute neutrophil count	3.55	x 10 ⁹ /L	2.0-7.0(40-80%)
Absolute lymphocyte count	3.12	x 10 ⁹ /L	1.0-3.0(20-40%)
Absolute eosinophil count	0.28	x 10 ⁹ /L	0.02-0.5(1-6%)

Method:- (EDTA Whole blood, Automated /

RBC Indices

TOTAL R.B.C. COUNT (Electric Impedence)	4.08	Million/Cumm	4.5 - 6.5
Haematocrit Value (P.C.V.)	37.8	%	26-50
MCV (Calculated)	92.6	fL	80-94
MCH (Calculated)	29.7	pg	27-32
MCHC (Calculated)	32.0	g/dl	30-35
RDW-SD (Calculated)	49.3	fL	37-54



*THIS TEST IS NOT UNDER NABL SCOPE

Checked By Technician:

Page 1 of 8

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MBBS, MD(Path)
(Consultant Pathologist)

२१ घंटे सुविधा उपलब्ध है।






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RDW-CV (Calculated)	12.8	%	11.5 - 14.5
Platelet Count (Electric Impedence)	1.74	/Cumm	1.50-4.50
MPV (Calculated)	12.3	%	7.5-11.5
GENERAL BLOOD PICTURE			
NLR 6-9 Mild stres 7-9 Pathological cause	1.14		1-3

-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.

Erythrocyte Sedimentation Rate end of 1st **22** mm 0-10
BLOOD GROUP * "B" POSITIVE \$ \$



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GLYCATED HAEMOGLOBIN (HbA1c)*	5.6	%	4.3-6.3
ESTIMATED AVERAGE GLUCOSE	114.0	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 106.0 mg/dl 70 - 110
(GOD/POD method)

PLASMASUGAR P.P. 130.0 mg/dl 80-140
(GOD/POD method)

BIOCHEMISTRY (SERUM)

BLOOD UREA NITROGEN 10.30 mg/dL. 8-23



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LIVER FUNCTION TEST

SERUM BILIRUBIN

TOTAL 0.9 mg/dl 0.1-1.2
(Diazo)

DIRECT 0.3 mg/dl <0.3
(Diazo)

INDIRECT 0.6 mg/dl 0.1-1.0
(Calculated)

S.G.P.T. **45.0** U/L 8-40
(IFCC method)

S.G.O.T. 36.0 U/L 6-37
(IFCC method)

SERUM ALKALINE PHOSPHATASE 108.0 IU/L 50-126
(IFCC KINETIC)

SERUM PROTEINS

TOTAL PROTEINS 6.4 Gm/dL 6-8
(Biuret)

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

GLOBULIN 2.5 Gm/dL 2.5-3.5
(Calculated)

A : G RATIO 1.6 1.5-2.5
(Calculated)



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PSA* 0.084 ng/ml

ECLIA
NORMAL VALUE

Age (years)	Median (ng/ml)
<49	<2.0
50-59	<3.5
60-69	<4.5
70-79	<6.5

KIDNEY FUNCTION TEST

UREA (Urease-GLDH)	33.9	mg / dl	10 - 50
CREATININE (Enzymatic)	1.1	mg/dl	0.6 - 1.4
S.CALCIUM Method:-Arsenazo	9.3	mg/dl	9.2-11.0
SODIUM (NA)* (ISE)	141.7	m Eq/litre.	135 - 155
POTASSIUM (K)* (ISE)	4.0	m Eq/litre.	3.5 - 5.5



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LIPID PROFILE

SERUM CHOLESTEROL (CHOD - PAP)	199.0	mg/dl	150-250
SERUM TRIGYCERIDE (GPO-PAP)	147.0	mg/dl	70-150
HDL CHOLESTEROL * (PRECIPITATION METHOD)	41.8	mg/dl	30-60
VLDL CHOLESTEROL * (Calculated)	29.4	mg/dl	10-30
LDL CHOLESTEROL * (Calculated)	127.8	mg/dL.	0-100
LDL/HDL RATIO * (Calculated)	03.1	ratio	<3.55
CHOL/HDL CHOLESTROL RATIO* (Calculated)	4.8	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.



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THYROID PROFILE*

Triiodothyronine (T3) * (ECLIA)	1.471	ng/dl	0.79-1.58
Thyroxine (T4) * (ECLIA)	9.658	ug/dl	4.9-11.0
THYROID STIMULATING HORMONE (TSH) * (ECLIA)	3.311	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 CALCIUM (Arsenazo)	9.4	mg/dl	9.2-11.0
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BIOCHEMICAL EXAMINATION

URIC ACID	6.3	mg/dL.	3.6-7.7
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Investigation	Results	Units	Biological Ref-Interval
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URINE

PHYSICAL EXAMINATION

Volume	30	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	23.07.2022	REF. NO.	6648		
PATIENT NAME	MUNISH	AGE	51 YRS	SEX	M
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

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**

DATE	23.07.2022	REF. NO.	1158		
PATIENT NAME	MUNISH	AGE	51YRS	SEX:	M
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. Show small (1.5) mm concretion.

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

Prostate – Normal in size (19g) & echotexture.

IMPRESSION

Essentially normal study

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

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

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



सर्वे सन्तु निरामयाः
Freedom from all Sickness

LOKPRIYA HOSPITAL

SAMRAT PALACE, GARH ROAD, MEERUT - 250003



DEPARTMENT OF NON-INVASIVE CARDIOLOGY

DATE : 23/07/2022 REFERENCE NO. : 5010
 PATIENT NAME : MUNISH AGE/SEX : 51 YRS/M
 REFERRED BY : DR. MONIKA GARG ECHOGENECITY : NORMAL
 REFERRING DIAGNOSIS : To rule out structural heart disease.

ECHOCARDIOGRAPHY REPORT

DIMENSIONS	NORMAL	NORMAL
AO (ed) 2.4 cm	(2.1 - 3.7 cm)	IVS (ed) 1.0 cm (0.6 - 1.2 cm)
LA (es) 3.1 cm	(2.1 - 3.7 cm)	LVPW (ed) 1.0 cm (0.6 - 1.2 cm)
RVID (ed) 1.5 cm	(1.1 - 2.5 cm)	EF 55% (62% - 85%)
LVID (ed) 4.3 cm	(3.6 - 5.2 cm)	FS 27% (28% - 42%)
LVID (es) 2.9 cm	(2.3 - 3.9 cm)	

MORPHOLOGICAL DATA :

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

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2-D ECHOCARDIOGRAPHY FINDINGS :

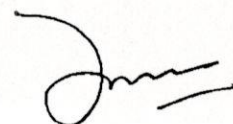
LV normal in size with normal contractions. No LV regional wall motion abnormality seen. RV normal in size with adequate contractions. LA and RA normal. Aortic valve is thickened and rest other cardiac valves are structurally normal. No intracardiac mass. Estimated LV ejection fraction is 55%.

DOPPLER STUDIES :

Valve	Regurgitation	Velocity m/sec	Gradient mmHg
Mitral Valve	Mild	0.93	3.4
Tricuspid Valve	Mild	2.1	20.0
Pulmonary Valve	No	0.79	2.6
Aortic Valve	No	1.1	4.8

IMPRESSION :

- No RWMA.
- LV Diastolic Dysfunction Grade I.
- Normal LV Systolic Function (LVEF = 55%).
- Mild MR, Mild TR, No PAH.



DR. HARIOM TYAGI
MD, DM (CARDIOLOGY)
(Interventional Cardiologist)
for Director, Lokpriya Heart Centre

NOTE: Echocardiography report given is that of the procedure done on that day and needs to be correlated clinically. This is not for medico legal purpose, as patient's identity is not confirmed. No record of this report is kept in the Hospital