

Place Label Here
Pt. Name : _____
UMR : _____
Age : _____ Sex : _____
IP : _____
If label not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Dipak Acharya Date of Birth : _____ Age/Sex: 24 UMR No.: 22726

Assessment :

Height: 173 cms Weight: 72 kg. BMI: _____ Respiration: _____ /min Pulse H/R : 74 /min
BP: 118/62 mmHG Temperature : _____ °F/°C SpO2 96 % BSL _____

Chief Complaints :

Health checkup

Tick Appropriate :

Interpreter Needed

Yes No

Nutritional Status: Weight Loss/Gain in Last 3 Months

Yes No

If Weight Loss / Gain-Dietary Referral

Yes No

Psychological Assessment Agitated Anxious

Yes No Normal

(If Agitated, Inform Physician)

Irritable

Any Allergies Known Including Drugs : No

Past History: Any Surgeries Explain : No

Any Other illness: Explain : No

Pain Score: Numerical Scales (1-10) _____ Location _____ Characteristics _____

Need to be seen immediately by the Doctor Yes No

Fall risk: Age 65Yrs. _____ Tremors _____ High Grade Fever _____ H/O Fall in last 3 months _____

Cardiac Medicines _____ Seizure Medications _____ Fall Prevention Education Done _____

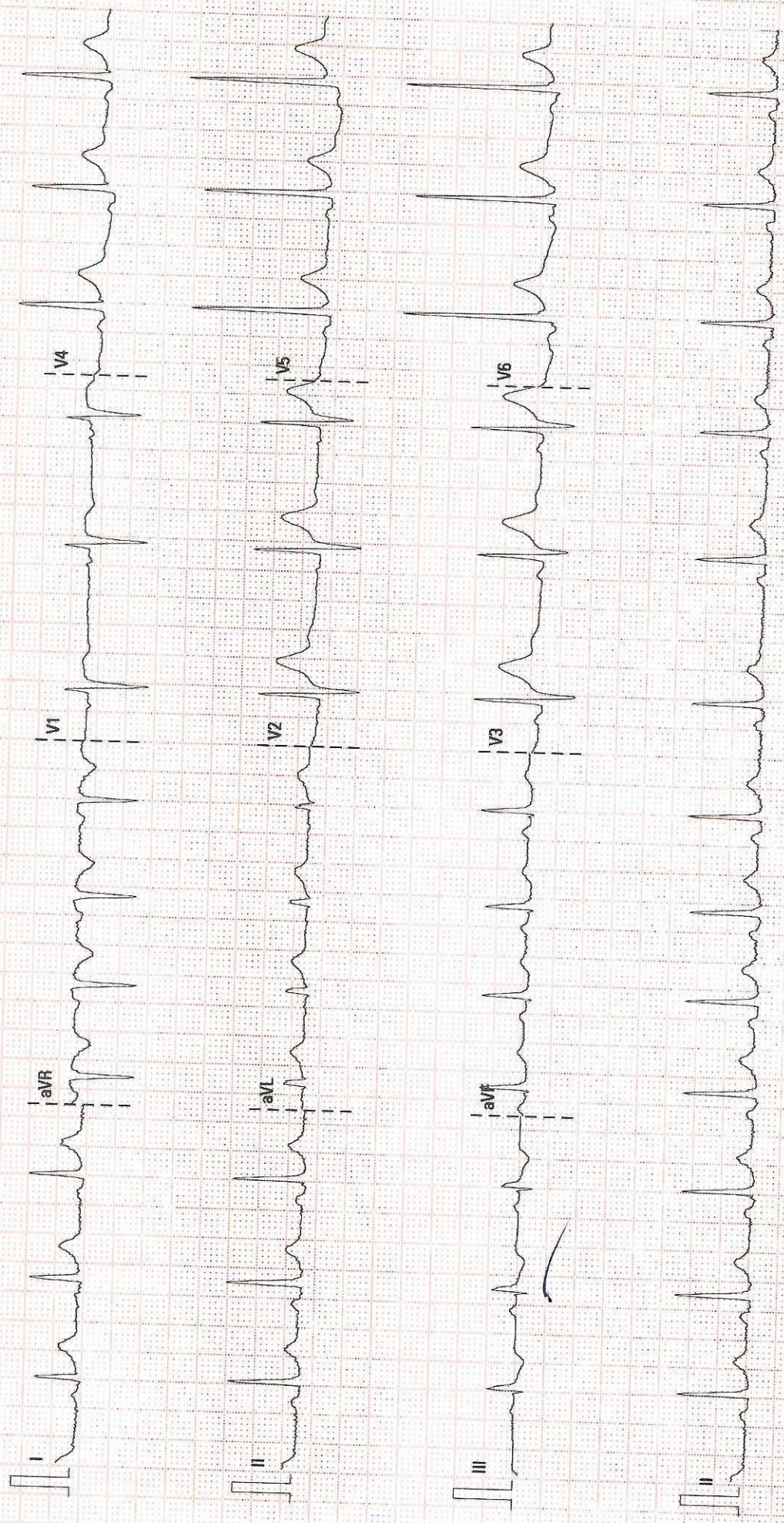
Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
<u>Sreshma</u>	<u>029987</u>	<u>Alinda</u>	

2024-05-13 11:54:55 AM

Name: dipak rahak
Age: 24 Years
Gender: Male

Vent. Rate	80 bpm
PR Interval	136 ms
QRS Duration	98 ms
QT/QTc Interval	360/395 ms
P/QRST Axes	59/45/13 deg
QTc:Hodges	

Unconfirmed Diagnosis



25 mm/s 10 mm/mV 50 Hz BDR 35 Hz

02.10.00/V28.4.1 SN-FN-26035810



DEPARTMENT OF LABORATORY

Patient Name : Mr. DEEPAK KUMAR NAHAK	Age / Gender : 24 Y(s)/Male
Bill No/ UMR No : PUBC22781/PUU22726	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 11:38 am	Report Date : 13-May-24 01:19 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>
CUE (COMPLETE URINE EXAMINATION)			
<u>GENERAL EXAMINATION</u>			
VOLUME	Urine	25	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		CLEAR	CLEAR
SPECIFIC GRAVITY		1.010	1.010 - 1.030
PH		5.0	4.5 - 8.0
<u>CHEMICAL EXAMINATION</u>			
PROTEIN	Urine	ABSENT	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		ABSENT	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
<u>MICROSCOPIC EXAMINATION</u>			
PUS CELLS	Urine	0-1	0 - 5 /hpf
RBC		NIL	0 - 2 /hpf
EPITHELIAL CELLS		0-1	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		ABSENT	ABSENT

*** End Of Report ***

System Name : M



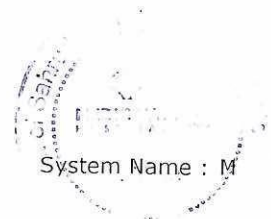
DEPARTMENT OF LABORATORY

Patient Name : Mr. DEEPAK KUMAR NAHAK	Age / Gender : 24 Y(s)/Male
Bill No/ UMR No : PUBC22781/PUU22726	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 11:38 am	Report Date : 13-May-24 01:19 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	14.3	13.2 - 17.3 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		5,810	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		153000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.57	4.5 - 6 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		42.3	40 - 50 %	Analogical integration
MCV		92.5	82 - 95 fl	Calculated
MCH		31.3	27 - 32 pg	Calculated
MCHC		33.9	32 - 36 g/dL	Calculated
RDW(cv)		12.0	11.5 - 14.0 %	Calculated
MPV		13.6	6 - 9.5 fl	Calculated
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	54.9	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		30.7	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		3.7	00 - 06 %	DHSS/Microscopy
MONOCYTES		9.7	00 - 10 %	DHSS/Microscopy
BASOPHILS		1.0	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" O "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		8	0 - 15 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***





DEPARTMENT OF LABORATORY

Patient Name : Mr. DEEPAK KUMAR NAHAK	Age / Gender : 24 Y(s)/Male
Bill No/ UMR No : PUBC22781/PUU22726	Referred By : Dr. GENERAL MEDICINE CONSUL
Received Dt : 13-May-24 12:24 pm	Report Date : 13-May-24 03:07 pm

Parameters Specimen Result Biological Reference In Method





DEPARTMENT OF LABORATORY

Patient Name : Mr. DEEPAK KUMAR NAHAK **Age /Gender** : 24 Y(s)/Male
Bill No/ UMR No : PUBC22781/PUU22726 **Referred By** : Dr. GENERAL MEDICINE CONSULTANT
Received Dt : 13-May-24 12:25 pm **Report Date** : 13-May-24 03:07 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM CREATININE		0.84	0.8 - 1.3 mg/dL	Jaffe
SGPT (ALT)		10.0	<= 41 U/L	Enzymatic
SERUM BILIRUBIN TOTAL		0.53	0.1 - 1.2 mg/dL	Colorimetric Diazo Method
DIRECT BILIRUBIN		0.17	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.36	<= 1.0 mg/dL	
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		91.8	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		9.1	7.0 - 21.0 mg/dL	Calculatead
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		108.0	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase

*** End Of Report ***

Lab Incharge


Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.

System Name : M...



Patient ID:	PUU22726	Patient Name:	DEEPAK NAHAK
Age:	24 Years	Sex:	M
Accession Number:	PUBC22781-PK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	13-May-2024		

X RAY CHEST PA VIEW


FINDINGS : Chest PA view with no comparison study shows.

The visualized lung fields are clear.
No obvious consolidation is seen.
There is no pleural effusion or pneumothorax seen.
No pneumoperitoneum is seen.
The cardiac silhouette appears within normal limits.
The diaphragmatic shadow and mediastinal structures are within normal limits.
Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

No radiographically evident acute cardiopulmonary process in the present study.

Dr. Sunita Shewale (MBBS, DMRE)
Consulting Radiologist

 Dr. Sunita Shewale Consulting Radiologist MBBS, DMRE Date: 13-May-2024 12:54:44
--





Mr. Deepak
24/M
Deme

Nahak


MEDICOVER
HOSPITALS



13/5/24

No H/O DM / HTN / BAI DA.

No DOE chest pain

No addictions

Rf - BS-vesi.

Am - GH(N)

Am - NAD

Dr. Aditya Vinod Sondankar
MBBS, DNB (Medicine)
Masterclass in Diabetes (PGDCED)
Consultant General Medicine
Reg No. 2009083017



Date:- 13/05/24.

Name:- Mr. Deepak Nahak.

Age/Sex:- 24 / M.

S/B: Ophthalmologist: Dr. Kirti Mane

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	6/6	> no	> 6/6	N ₆	WNL
Left	6/6	glasses	> 6/6	out	(16/16)

glasses

Other findings:-

Squint

Nystagmus

Night blindness:-

} no

Impression:-

Eye exam is within normal limits

for desired fitness for work.


Dr. Kirti Mane
MBBS, DOMS, MMC
Reg. No. : 2005/05/2708



MEDICAL CERTIFICATE

I, Dr. Ravindra Kulkarni do hereby certify that I have carefully examined
 the son (Whose signature is given below, son / daughter
 of Deepak Neshik is physically fit to join school / organization / undergo
 professional education.

Signature of Candidate / Guardian: Deepak Neshik

Signature of Doctor: Dr. Ravindra C. Kulkarni

Registration No. _____

Dr. Ravindra C. Kulkarni
 M.D. (General Medicine)
 Consultant in Internal
 Medicine & Gastroenterology

Place: Medicover Hospital KLE

Date: 15/01/2014

Seal:

