Nurse Assessment Time:

उपचार कक्ष [11 A]

Blood Pressure: 120/70 mm of Hg	Weight: 79 cm
Height: 168 [illegible] cm	Body Mass Index:: 28.01
PULSE 60	SPO2 97.

WHL/NAG/CC/HCU/03

radip rehpade 28-Sep-24 12:07:09 PM

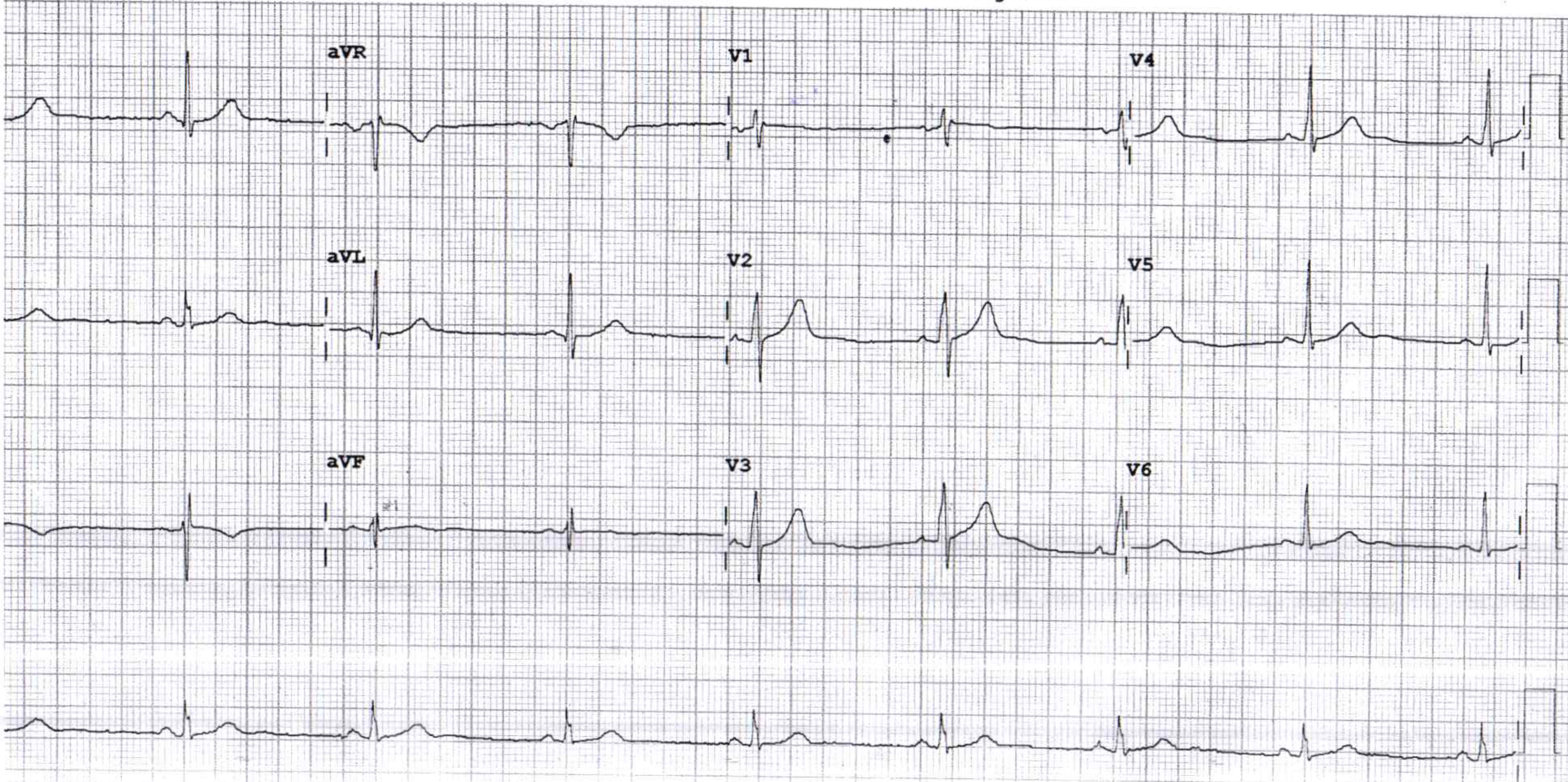
52 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
. Sinus rhythm....................................normal P axis, V-rate 50- 99
136 . RSR' in V1 or V2, right VCD or RVH...................QRS area positive & R' V1/V2
89
423
394

;--
.24
10
4

- OTHERWISE NORMAL ECG -

d; Standard Placement

Unconfirmed Diagnosis



Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15-100 Hz

DEPARTMENT OF LABORATORY MEDICINE

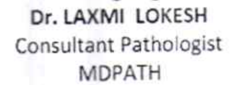
Patient Name	: Mr. PRADIP SUDAM REHPADE	Bill No.	: OCR3/25/0004134
Age/Sex	: 36 Years/Male	Sample Collection	: 28/09/2024 10:59 AM
UHID	: WHN2.0000348706	Receiving Date Time	: 28/09/2024 11:00 AM
Primary Consultant	: DR. WOCKHARDT DOCTOR	Report Date	: 28/09/2024 03:09 PM
Order Date	: 28/09/2024 10:48 AM	Approval Date Time	: 28/09/2024 03:12 PM
Order No.	: 32066	Specimen	: Serum
Visit Code	: OP3.0088269	Bed No.	:

HEMATOLOGY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Complete Blood Count (With ESR)- EDTA Blood				
Haemoglobin	SLS Method	15.4	g%	13 - 17
Haematocrit	RBC Pulse Height Detection	46.7	%	40 - 50
MCV	Calculated	93.4	fl	83-101
MCH	Calculated	30.8	pg	27-32
MCHC	Calculated	33.0	g/dl	32-35
RBC Count	DC Detection	5.00	Million/ul	4.5-5.5
RDW-CV	Calculated	12.3	%	12-14
WBC Total Count (TLC)	Electrical Impedance	6020	Cells/cumm	4000 - 10000
Neutrophils		49	%	40-80
Lymphocytes		40	%	20-40
Monocytes		08	%	2-10
Eosinophils		03	%	0-6
Basophils		00	%	0-2
Platelet Count	Hydrodynamic Focussing DC	198	Thou/Cumm	150-450
PDW	Calculated	12.0	fL	9.0-17
P-LCR	Calculated	25.7	%	13.0-43.0
MPV	Calculated	10.1	fl	9.4-12.3
PCT	Calculated	0.20	%	0.17-0.35
Blood ESR	Westergren Method	2	mm/hr	0-15

--- END OF REPORT ---



Dr. LAXMI LOKESH
Consultant Pathologist
MDPATH

SONAL SINGH
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Visit Code	: OP3.0088269	**Bed No.**	:

BIOCHEMISTRY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Serum Urea	Urease-GLDH	18.3	mg/dL	1-50
Blood Urea Nitrogen	Calculated	8.55	mg/dL	6-20
Creatinine- Serum				
Creatinine	Enzymatic colorimetric	0.69	mg/dL	0.67-1.17
Plasma Glucose				
Random Sugar		90.27	mg/dl	70-150
Uric Acid- Serum				
Uric Acid	Enzymatic colorimetric	5.5	mg/dL	3.4-7
Lipid Profile				
Cholesterol	Colorimetric - Cholesterol Oxidase	**152.33**	mg/dL	0-200
Triglycerides	Enzymatic colorimetric	107.3	mg/dL	0-150
HDL Cholesterol - Direct	Direct Homogenous Enzymatic Colorimetric	33.4		1. No Risk: >65 2. Moderate Risk: 45-65 3. High Risk: <45
LDL-Cholesterol -Direct	Direct Homogenous Enzymatic Colorimetric	97.47	mg/dL	0-100
VLDL Cholesterol	Calculated	21.46	mg/dL	10-35
Chol/HDL Ratio		**4.56**		1.Low Risk: 3.3-4.4 2.Average Risk: 4.4-7.1 3.Moderate Risk: 7.1-11.0 4.High Risk: >11.0
Liver Function Test (L.F.T.)				
Alkaline Phosphatase	Colorimetric IFCC	56.2	U/L	40-129
S.G.O.T (AST)	IFCC Without Pyridoxal 5 Phosphate	23.4	U/L	0-40
S.G.P.T (ALT)	IFCC Without Pyridoxal 5 Phosphate	13.5	U/L	0-50
Total Protein (Serum)	Colorimetric - Biuret Method	6.97	g/dL	6.4-8.3
Albumin, BCG	Colorimetric - Bromo-Cresol Green	4.83	g/dL	3.5-5.2
Globulin	Calculated	2.14	g/dL	1.9-3.5
Albumin/Globulin Ratio	Calculated	**2.25**		0.9-2
Serum Total Bilirubin	Colorimetric Diazo	0.78	mg/dL	0-1.2
Serum Direct Bilirubin	Colorimetric Diazo	0.3	mg/dL	0-0.4

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BIOCHEMISTRY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Liver Function Test (L.F.T.)				
Serum Indirect Bilirubin	Calculated	0.48	mg/dL	0-1

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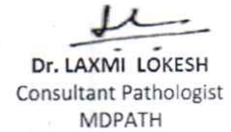
Visit Code	: OP3.0088269	Bed No.	:

IMMUNOLOGY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
T3 T4 TSH- Serum				
TOTAL T3	ECLIA	160.9	ng/dl	80-200
TOTAL T4	ECLIA	7.60	ug/dl	4.5-11.7
TSH	ECLIA	2.63	µIU/mL	0.27-4.2

--- END OF REPORT ---



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Visit Code	: OP3.0088269	**Bed No.**	:

CLINICAL PATHOLOGY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Urine Routine				
Physical Examination				
Colour		p.yel		
Appearance		Clear		
Urinalyser (Roche UriSys 1100)				
Specific Gravity		1.015		1.003 - 1.035
Reaction (pH)		5		
Leukocytes, microscopy		neg	/hpf	
Erythrocytes, microscopy		neg	/hpf	
Nitrite, urinalyser		neg		
Protein, urinalyser		neg		
Glucose, urinalyzer		neg		
Ketone, urinalyser		neg		
Urobilinogen urinalyser		neg		
Billirubin uirnalyser		neg		

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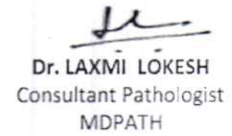
BIOCHEMISTRY

Final Report

PARAMETER	METHOD	RESULT	UNIT	B.R.I
Glycosylated Haemoglobin- EDTA Blood				
Glycosylated Haemoglobin	HPLC	5.4	%	Action required: 7.0-8.0% Good control: 6.5-7.0% Normal control: 4.8-6.4% Poor control: >8.0%
Estimated Mean glucose	Calculated	114.94	mg/dL	

--- END OF REPORT ---



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DEPARTMENT OF RADIODIAGNOSTICS

Patient Name	: Mr. PRADIP SUDAM REHPADE		
Age/Sex	: 36 Yrs / Male	Order Date	: 28/09/2024 10:48 AM
UHID	: WHN2.0000348706	Referred by	:
Reporting Date	: 28/09/2024 03:05 PM	Order No.	: 12670
Bill No.	: OCR3/25/0004134		

USG ABDOMEN WITH PELVIS :

Real time sonography of the abdomen and pelvis was performed using the 3.5 MHz transducer.

The liver is normal in size and shows bright echotexture suggesting fatty infiltration. No focal parenchymal lesion noted.
Intrahepatic biliary tree and venous radicles are normal.
The portal vein and CBD appear normal in course and calibre.
The gall bladder is normal in size with a normal wall thickness and there are no calculi noted within.
The pancreas is normal in size and echotexture. No evidence of focal lesion or calcification or duct dilatation seen.
The spleen is normal in size and echotexture.
Both kidneys are normal in size, position and echogenecity.
Cortical thickness and corticomedullary differentiation are normal.
No hydronephrosis or calculi noted.
The urinary bladder is normal in contour, capacity and wall thickness. No vesical calculi noted.
The prostate is normal in size and homogenous in echotexture.
There is no evidence of ascites.

Impression :
Grade I Fatty infiltration of liver.

DR. PREETI CHOUDHARY JAIN
M.B.B.S., D.M.R.E.
RADIOLOGIST

DEPARTMENT OF RADIODIAGNOSTICS

Patient Name	: Mr. PRADIP SUDAM REHPADE		
Age/Sex	: 36 Yrs / Male	**Order Date**	: 28/09/2024 10:48 AM
UHID	: WHN2.0000348706	**Referred by**	:
Reporting Date	: 28/09/2024 02:01 PM	**Order No.**	: 12670
Bill No.	: OCR3/25/0004134		

CHEST X-RAY PA VIEW :

Both lung fields are clear.

The costophrenic angles and domes of diaphragm appear normal.

No hilar or mediastinal lesion seen.

Cardiac silhouette is within normal limits.

Visualised bony thorax and soft tissues appear normal.

Impression:
Normal Chest X-Ray.

DR. VISHAL GAJBHIYE
M.B.B.S., M.D.
CONSULTANT - RADIOLOGIST