

Sarilee Sawalkar  
26 yrs / female

10/02/2024

No fresh complaints

No comorbidities

No PH.

No SH.

M/H - CMP - 6/2/2024, regular

G/H - G<sub>1</sub>, P<sub>1</sub>, A<sub>0</sub>, L<sub>1</sub> D<sub>0</sub>

G<sub>1</sub> - Male, 1½ yrs, healthy, FTND.

Height - 169 cm

Weight - 85 kg

BMI - 29.8 kg/m<sup>2</sup>  
(overweight)

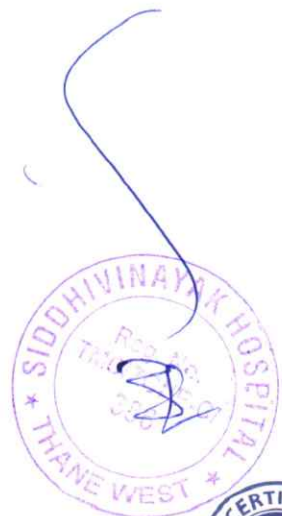
FIH - Mother <sup>BA</sup> healthy  
father healthy

BP - 120/70 mmHg

P - 72/min

SpO<sub>2</sub> - 98%

PT is fit and can resume her normal duties



**HELPLINE**

022 - 2588 3531

S-1, Vedant Complex,  
Vartak Nagar, Thane (W) 400 606

[www.siddhivinayakhospitals.org](http://www.siddhivinayakhospitals.org)





Name - Mrs. Sailee Sawalkar	Age - 26 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 10/02/2024

### USG ABDOMEN & PELVIS

#### FINDINGS:

The **liver** dimension is normal in size 15.8 cm . It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally with no stones within.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size ( 8.9cm ) and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 11.6 x 4.8 cm.

The left kidney measures 9.8 x 4.5 cm.

**Urinary bladder**: normally distended. Wall thickness - normal.

**Uterus** : normal in size and morphology. Size: 7.7 x 4.7 x 5.4 cm.

**Endometrium**: 9.5mm, it appears normal in morphology.

Both ovaries are normal.

**Adnexa** appear normal

No free fluid is seen.

Excessive gaseous distension of bowel loops. Visualized loops show normal forward peristalsis

#### IMPRESSION:

- Fatty liver ( Grade I )

**DR. AMOL BENDRE**  
MBBS; DMRE  
CONSULTANT RADIOLOGIST





Name - Mrs . Sailee Sawalkar	Age - 26Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 10/02/2024

### X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

#### **IMPRESSION:**

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

**DR. AMOL BENDRE**  
MBBS; DMRE  
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.



ID: 887 Satee Gowalkar 10-02-2024 10:36:55 AM

Female  
Years 26  
Req. No. : 891-120170

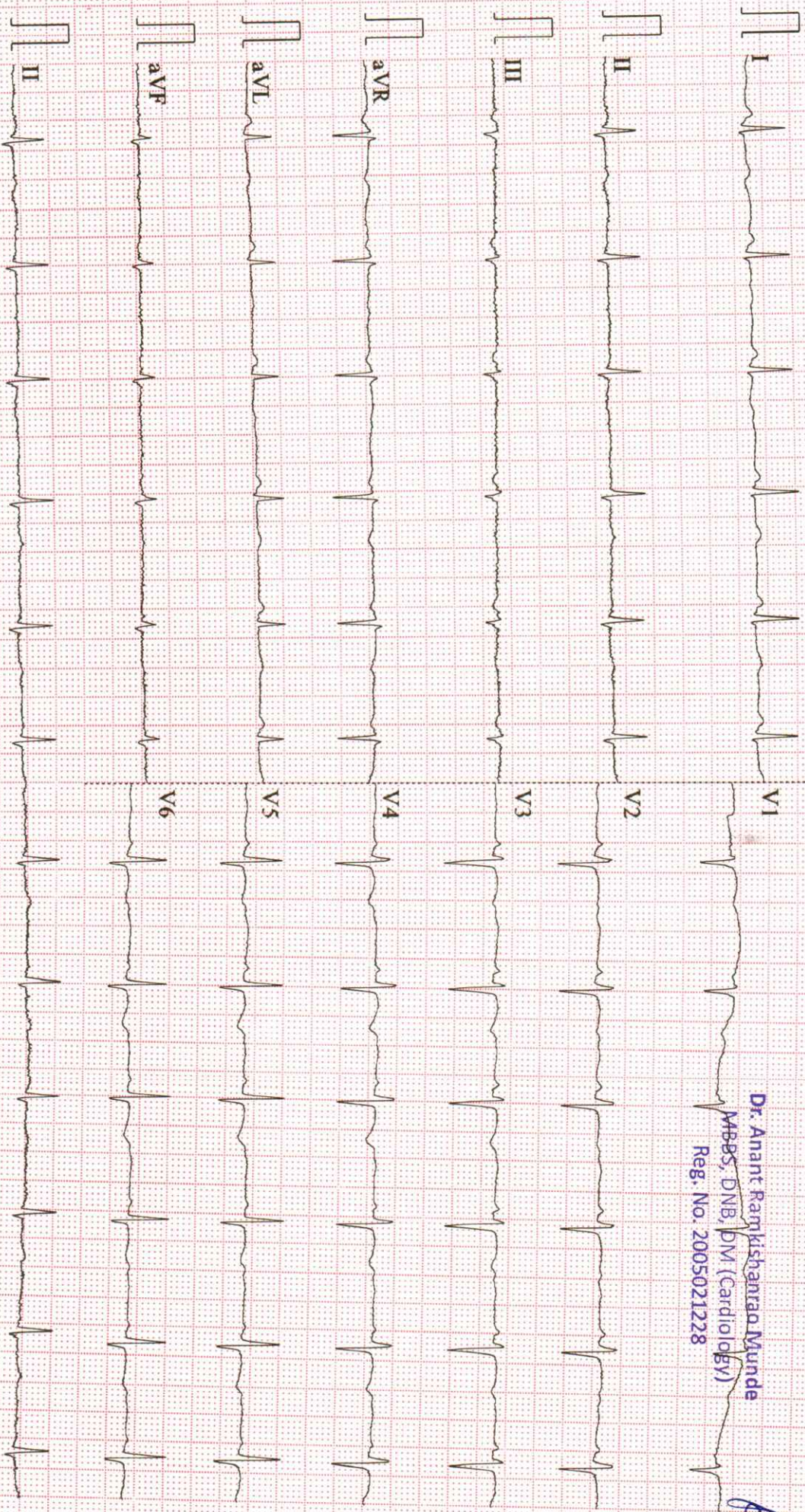
HR : 72 bpm  
P : 79 ms  
PR : 121 ms  
QRS : 88 ms  
QT/QTcBz : 397/435 ms  
P/QRST : -22/17/-8 °  
RV5/SV1 : 0.695/0.504 mV

Diagnosis Information:  
Sinus Rhythm  
T Wave Abnormality(V4,V5,V6)

Report Confirmed by:

Dr. Anant Ramkishanrao Munde  
MBBS, DNB, DM (Cardiology)  
Reg. No. 2005021228

NSR  
+ V3-V6  
Adv: - 2D ECG



0.15-45Hz AC50 25mm/s 10mm/mV 2\*5.0s+1r V2.21 SEMIP V1.92 Siddhivinayak Hospital

## OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE                      SAWALKAR SAILEE

AGE                      26                                              DATE -                      10.02.2024

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/6	6/6
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



### ECHOCARDIOGRAM

NAME	MRS. SAILEE SAWALKAR
AGE/SEX	26 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	10/02/2024

### 2D/M-MODE ECHOCARDIOGRAPHY

<b>VALVES:</b> <b>MITRAL VALVE:</b> <ul style="list-style-type: none"> <li>• AML: Normal</li> <li>• PML: Normal</li> <li>• Sub-valvular deformity: Absent</li> </ul> <b>AORTIC VALVE:</b> Normal <ul style="list-style-type: none"> <li>• No. of cusps: 3</li> </ul> <b>PULMONARY VALVE:</b> Normal <b>TRICUSPID VALVE:</b> Normal	<b>CHAMBERS:</b> <b>LEFT ATRIUM:</b> Normal <ul style="list-style-type: none"> <li>• Left atrial appendage: Normal</li> </ul> <b>LEFT VENTRICLE:</b> Normal <ul style="list-style-type: none"> <li>• RWMA: No</li> <li>• Contraction: Normal</li> </ul> <b>RIGHT ATRIUM:</b> Normal <b>RIGHT VENTRICLE:</b> Normal <ul style="list-style-type: none"> <li>• RWMA: No</li> <li>• Contraction: Normal</li> </ul>
<b>GREAT VESSELS:</b> <ul style="list-style-type: none"> <li>• AORTA: Normal</li> <li>• PULMONARY ARTERY: Normal</li> </ul>	<b>SEPTAE:</b> <ul style="list-style-type: none"> <li>• IAS: Intact</li> <li>• IVS: Intact</li> </ul>
<b>CORONARIES:</b> Proximal coronaries normal <b>CORONARY SINUS:</b> Normal	<b>VENACAVAE:</b> <ul style="list-style-type: none"> <li>• SVC: Normal</li> <li>• IVC: Normal and collapsing &gt;20% with respiration</li> </ul>
<b>PULMONARY VEINS:</b> Normal	<b>PERICARDIUM:</b> Normal

### MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	34 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	48.2 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	31.0 mm	RVEF	%
Ascending aorta	mm	IVSd	8.4 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.4 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	65 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	mm





MC-6135

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 Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



\* 1 8 3 3 0 5 \*

**\*LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)</b>	186.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
<b>S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)</b>	43.1	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
<b>S. TRIGLYCERIDE (ENZYMATIC, END POINT)</b>	115.2	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
<b>VLDL CHOLESTEROL (CALCULATED VALUE)</b>	23	mg/dL	UPTO 40
<b>S.LDL CHOLESTEROL (CALCULATED VALUE)</b>	120	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
<b>LDL CHOL/HDL RATIO (CALCULATED VALUE)</b>	2.78		UPTO 3.5
<b>CHOL/HDL CHOL RATIO (CALCULATED VALUE)</b>	4.32		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By  
Priyanka\_Deshmukh



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## COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>HEMOGLOBIN</b>	<b>11.5</b>	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	37.1	%	36 - 46
RBC COUNT	4.50	x10 <sup>6</sup> /uL	4.5 - 5.5
MCV	82	fl	80 - 96
MCH	<b>25.6</b>	pg	27 - 33
MCHC	<b>31</b>	g/dl	33 - 36
RDW-CV	<b>15.1</b>	%	11.5 - 14.5
<b>TOTAL LEUCOCYTE COUNT</b>	6670	/cumm	4000 - 11000
<b>DIFFERENTIAL COUNT</b>			
NEUTROPHILS	59	%	40 - 80
LYMPHOCYTES	32	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	07	%	2 - 10
BASOPHILS	00	%	0 - 1
<b>PLATELET COUNT</b>	310000	/cumm	150000 - 450000
MPV	<b>11.8</b>	fl	6.5 - 11.5
PDW	15.8	%	9.0 - 17.0
PCT	0.370	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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\* 1 8 3 3 0 5 \*

## URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>URINE ROUTINE EXAMINATION</b>			
<b>PHYSICAL EXAMINATION</b>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
<b>CHEMICAL EXAMINATION</b>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<b>MICROSCOPIC EXAMINATION</b>			
RED BLOOD CELLS	Absent		Absent
PUS CELLS	1-3	/ HPF	0 - 5

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URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
EPITHELIAL	0-2	/ HPF	0 - 5
CASTS	Absent		
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TFT (THYROID FUNCTION TEST )</b>			
SPACE		Space	-
SPECIMEN	Serum		
T3	116.8	ng/dl	84.63 - 201.8
T4	7.69	µg/dl	5.13 - 14.06
TSH	2.61	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine) hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

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HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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**BLOOD GROUP**

SPECIMEN	WHOLE BLOOD EDTA & SERUM
* ABO GROUP	'A'
RH FACTOR	POSITIVE

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

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\* 1 8 3 3 0 5 \*

## \*RENAL FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>BLOOD UREA</b> (Urease UV GLDH Kinetic)	22.3	mg/dL	13 - 40
<b>BLOOD UREA NITROGEN</b> (Calculated)	10.42	mg/dL	5 - 20
<b>S. CREATININE</b> (Enzymatic)	0.62	mg/dL	0.6 - 1.4
<b>S. URIC ACID</b> (Uricase)	6.0	mg/dL	2.6 - 6.0
<b>S. SODIUM</b> (ISE Direct Method)	139.3	mEq/L	137 - 145
<b>S. POTASSIUM</b> (ISE Direct Method)	4.32	mEq/L	3.5 - 5.1
<b>S. CHLORIDE</b> (ISE Direct Method)	105.2	mEq/L	98 - 110
<b>S. PHOSPHORUS</b> (Ammonium Molybdate)	3.81	mg/dL	2.5 - 4.5
<b>S. CALCIUM</b> (Arsenazo III)	9.7	mg/dL	8.6 - 10.2
<b>PROTEIN</b> (Biuret)	6.9	g/dl	6.4 - 8.3
<b>S. ALBUMIN</b> (BGC)	3.75	g/dl	3.2 - 4.6
<b>S.GLOBULIN</b> (Calculated)	3.15	g/dl	1.9 - 3.5
<b>A/G RATIO</b> calculated	1.19		0 - 2

## NOTE

 BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED ( EM 200 )  
 ANALYZER.

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### Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic, Normochromic
WBC	Total differential count is normal on smear.
	NEUTROPHILS - 59%
	LYMPHOCYTES - 32%
	EOSINOPHILS - 02%
	MONOCYTES - 07%
	BASOPHILS - 00%
PLATELET	Adequate on smear
HEMOPARASITE	No parasite seen
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MC-6135

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Lab ID. : 183305 Received On : 10/2/2024 10:47 am  
Age/Sex : 26 Years / Female Reported On : 12/2/2024 6:27 pm  
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TOTAL BILLIRUBIN</b> (Method-Diazo)	0.35	mg/dL	0.0 - 2.0
<b>DIRECT BILLIRUBIN</b> (Method-Diazo)	0.17	mg/dL	0.0 - 0.4
<b>INDIRECT BILLIRUBIN</b> Calculated	0.18	mg/dL	0 - 0.8
<b>SGOT(AST)</b> (UV without PSP)	14.1	U/L	0 - 37
<b>SGPT(ALT)</b> UV Kinetic Without PLP (P-L-P)	12.4	U/L	UP to 40
<b>ALKALINE PHOSPHATASE</b> (Method-ALP-AMP)	79.0	U/L	42 - 98
<b>S. PROTIEN</b> (Method-Biuret)	6.9	g/dl	6.4 - 8.3
<b>S. ALBUMIN</b> (Method-BCG)	3.75	g/dl	3.5 - 5.2
<b>S. GLOBULIN</b> Calculated	3.15	g/dl	1.90 - 3.50
<b>A/G RATIO</b> Calculated	1.19		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By  
Priyanka\_Deshmukh

DR. SMITA RANVEER.  
M.B.B.S.M.D. Pathology(Mum)  
Consultant Histocytopathologist



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Main Center :- 2-3, 'Silver Plaza' E.S.I.S. Hospital Road, Opp. Suryadarshan Tower, Thane (W)-400 604. ☎ +91 91363 56284

Collection Center 1 :- Dr. Ajay Vijay Singh, Clinic : Shop No. 19, Jupiter 3, Cosmos Regency CHS Ltd. Waghbil Road, G. B. Road, Thane (W)-400 615.

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E-mail : radiancediagnosticcentre@gmail.com ● Web : www.radianceclinicaldiagnostic.com



Dr. Smita Ranveer's  
**Radiance**<sup>TM</sup>

CLINICAL DIAGNOSTIC CENTRE  
COMPLETE PATHOLOGICAL SOLUTION

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**HAEMATOLOGY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>ESR</b>			
ESR	29	mm/1hr.	0 - 20

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

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**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u></b>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.9	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G. )	122.6	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<b><u>BLOOD GLUCOSE FASTING &amp; PP</u></b>			
BLOOD GLUCOSE FASTING	107.8	mg/dL	70 - 110
BLOOD GLUCOSE PP	126.5	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water ) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

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### BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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#### INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus :  $\geq 126$  mg/dl

#### POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus :  $\geq 200$  mg/dl

#### CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose  $\geq 126$  mg/dl
- Classical symptoms +Random plasma glucose  $\geq 200$  mg/dl
- Plasma glucose  $\geq 200$  mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin  $> 6.5\%$

\*\*\*Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT	14.6	U/L	5 - 55
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Result relates to sample tested, Kindly correlate with clinical findings.

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