

LETTER OF APPROVAL / RECOMMENDATION

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 employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS	EMPLOYEE DETAILS
NAME	MR. PRASAD ROHIT KUMAR
EC NO.	161967
DESIGNATION	RELATIONSHIP MANAGER (NTB)
PLACE OF WORK	HIMMATNAGAR, MOTIPURA
BIRTHDATE	27-03-1987
PROPOSED DATE OF HEALTH CHECKUP	09-03-2024
BOOKING REFERENCE NO.	23M161967100095472E

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 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))



ಹೆಸರು
Name

Rohit Kumar Prasad

ಉದ್ಯೋಗ ಕೋಡ್ ನಂ.
Employee Code No.

161967

ಉದ್ದೇಶಪಾಲಕರ ಸಹಿ
Issuing Authority



ಹಿರಿಯರ ಸಹಿ
Signature

ಹಿರಿಯರ ಸಹಿ
Signature of Holder

23.03.2024 11:53:44 AM
AASHKA HOSPITAL LTD.
SARGASAN
GANDHINAGAR

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

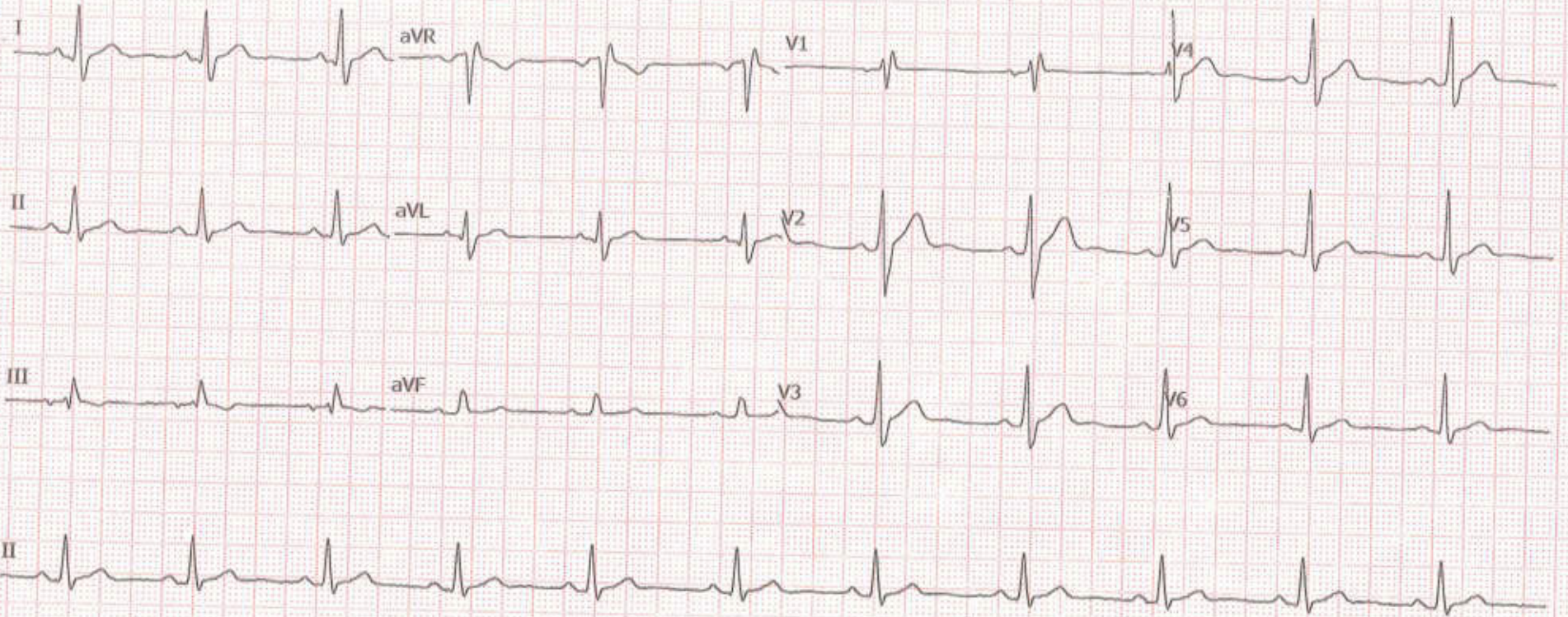
Room:

67 bpm
- / - mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 108 ms
QT / QTcBaz : 372 / 393 ms
PR : 146 ms
P : 102 ms
RR / PP : 890 / 895 ms
P / QRS / T : 33 / 49 / 26 degrees

Normal sinus rhythm
Incomplete right bundle branch block
Borderline ECG



Aashka Hospitals Ltd.

Between Sargasan and Reliance Cross Roads
Sargasan, 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>Robit Kumar</i>	<i>05/08/2024</i>	Age / Sex: <i>37</i> Height: Weight:
History:	<i>Common Heber deaf.</i>	
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination:	<i>VS 6/12 6/12 VVC Coarctation S16 S16 M16</i>	
Diagnosis:	<i>Colic & Vision - Normal 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:

Use glasses

Follow-up:

Consultant's Sign:



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CIN: L85110GJ2012PLC072647



aashka
H O S P I T A L



PATIENT NAME: ROHIT KUMAR PRASAD

GENDER/AGE: Male / 37 Years

DOCTOR:

OPDNO: OSP28284

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: ROHIT KUMAR PRASAD

GENDER/AGE: Male / 37 Years

DOCTOR: DR. HASIT JOSHI

OPDNO: OSP28284

DATE: 23/03/24

2D-ECHO

MITRAL VALVE	: NORMAL	
AORTIC VALVE	: NORMAL	
TRICUSPID VALVE	: NORMAL	
PULMONARY VALVE	: NORMAL	
AORTA	: 35mm	
LEFT ATRIUM	: 32mm	
LV Dd / Ds	: 38/26mm	EF 60%
IVS / LVPW / D	: 11/10mm	
IVS	: INTACT	
IAS	: INTACT	
RA	: NORMAL	
RV	: NORMAL	
PA	: NORMAL	
PERICARDIUM	: NORMAL	
VEL	: PEAK	MEAN
M/S	: Gradient mm Hg	Gradient mm Hg
MITRAL	: 1/0.7m/s	
AORTIC	: 1.2m/s	
PULMONARY	: 1.0m/s	
COLOUR DOPPLER	: MILD MR/TR	
RVSP	: 28mmHg	
CONCLUSION	: NORMAL LV SIZE / SYSTOLIC FUNCTION.	

CARDIOLOGIST

DR. HASIT JOSHI (9825012235)



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H O S P I T A L



PATIENT NAME: ROHIT KUMAR PRASAD

GENDER/AGE: Male / 37 Years

DOCTOR:

OPDNO: OSP28284

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.

PROSTATE: Prostate appears normal in size and shows normal parenchymal echoes. No evidence of pathological calcification or solid or cystic mass lesion is seen. Prostate volume measures about 14 cc.

COMMENT: Normal sonographic appearance of liver, GB; Pancreas, spleen, kidneys, para-aortic region, bladder and prostate.

RADIOLOGIST
DR.SNEHAL PRAJAPATI



LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

Pt. Loc. :

Case ID : 40302200636

Pt. ID : 3455149

Pt. Loc. :

Reg Date and Time : 23-Mar-2024 09:16

Sample Type :

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16

Sample Coll. By :

Ref Id1 : OSP28284

Report Date and Time :

Acc. Remarks : Normal

Ref Id2 : O232411331

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Blood Glucose Fasting & Postprandial			
Plasma Glucose - F	103.53	mg/dL	70.0 - 100
Haemogram (CBC)			
Haemoglobin	12.6	G%	13.00 - 17.00
RBC (Electrical Impedance)	4.31	millions/cu mm	4.50 - 5.50
PCV(Calc)	38.49	%	40.00 - 50.00
Lipid Profile			
HDL Cholesterol	41.8	mg/dL	48 - 77
Chol/HDL	4.51	0 - 4.1	
LDL Cholesterol	117.44	mg/dL	0.00 - 100.00
Liver Function Test			
Alkaline Phosphatase	122.71	U/L	46 - 116
Uric Acid	7.40	mg/dL	3.5 - 7.2
25 OH Cholecalciferol (D2+D3)	6.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 160 Toxicity
Vitamin B - 12 Level	146.0	pg/mL	180 - 914

Abnormal Result(s) Summary End

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



LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

Pl. Loc :

Case ID : 40302200636

Pt. ID : 3455149

Pl. Loc :

Reg Date and Time : 23-Mar-2024 09:16

Sample Type : Whole Blood EDTA

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16

Sample Coll. By :

Ref Id1 : OSP28284

Report Date and Time : 23-Mar-2024 09:33

Acc. Remarks : Normal

Ref Id2 : O232411331

TEST

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES	L	L	G%	13.00 - 17.00
Haemoglobin	L	12.6	G%	13.00 - 17.00
RBC (Electrical Impedance)	L	4.31	millions/cumm	4.50 - 5.50
PCV(Calc)	L	38.49	%	40.00 - 50.00
MCV (RBC histogram)		89.3	fL	83.00 - 101.00
MCH (Calc)		29.3	pg	27.00 - 32.00
MCHC (Calc)		32.8	gm/dL	31.50 - 34.50
RDW (RBC histogram)		16.00	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

Total WBC Count	6020	/µL	4000.00 - 10000.00
Neutrophil	53.0	%	40.00 - 70.00
Lymphocyte	38.0	%	20.00 - 40.00
Eosinophil	4.0	%	1.00 - 6.00
Monocytes	5.0	%	2.00 - 10.00
Basophil	0.0	%	0.00 - 2.00

PLATELET COUNT (Optical)

Platelet Count	166000	/µL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	1.39		0.78 - 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)





LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

Pt. Loc :

Case ID : 40302200636

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16

Sample Date and Time : 23-Mar-2024 09:16

Report Date and Time : 23-Mar-2024 11:20

Sample Type : Whole Blood EDTA

Sample Coll. By :

Acc. Remarks : Normal

Mobile No :

Ref Id1 : OSP28284

Ref Id2 : O232411331

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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ESR
Westergren Method

04	mm after 1hr 3 - 15
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Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh, A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. This is essential for ensuring the integrity of the financial statements and for providing a clear audit trail. The records should be kept up-to-date and should be easily accessible to all relevant parties.

2. The second part of the document outlines the various methods used to collect and analyze data. These methods include interviews, surveys, and focus groups. Each method has its own strengths and weaknesses, and it is important to choose the most appropriate method for the specific research objectives.

3. The third part of the document describes the process of data analysis. This involves identifying patterns and trends in the data, and then interpreting these findings in the context of the research objectives. It is important to be transparent about the methods used for data analysis, and to provide a clear explanation of how the findings were derived.

4. The fourth part of the document discusses the importance of reporting the results of the research. This involves presenting the findings in a clear and concise manner, and providing a detailed explanation of the implications of the findings. It is important to be honest and objective in the reporting of results, and to avoid making any unsupported claims.

5. The fifth part of the document concludes the report and provides a summary of the key findings. It also discusses the limitations of the study and suggests areas for further research. This is an important part of the research process, as it helps to identify the strengths and weaknesses of the study, and to provide a clear direction for future research.



LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Case ID : 40302200636

Dis. At :

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16 | Sample Type : Whole Blood EDTA

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16 | Sample Coll. By :

Ref Id1 : OSP26284

Report Date and Time : 23-Mar-2024 09:33 | Acc. Remarks : Normal

Ref Id2 : O232411331

TEST

RESULTS

UNIT BIOLOGICAL REF RANGE

REMARKS

HAEMATOTOLOGY INVESTIGATIONS

BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology) (Both Forward and Reverse Group)

ABO Type

O

Rh Type

POSITIVE

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

Dr. Shreya Shah

M.D. (Pathologist)

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Printed On: 23-Mar-2024 13:24

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that this is crucial for ensuring transparency and accountability in the organization's operations.

2. The second part of the document outlines the various methods and tools used to collect and analyze data. It highlights the need for consistent data collection procedures and the use of advanced analytical techniques to derive meaningful insights from the data.

3. The third part of the document focuses on the role of technology in data management and analysis. It discusses how modern software solutions can streamline data collection, storage, and analysis processes, thereby improving efficiency and accuracy.

4. The fourth part of the document addresses the challenges associated with data management, such as data quality, security, and privacy. It provides strategies to mitigate these risks and ensure that the data remains reliable and secure throughout its lifecycle.

5. The fifth part of the document concludes by summarizing the key findings and recommendations. It stresses the importance of ongoing monitoring and evaluation to ensure that the data management processes remain effective and aligned with the organization's goals.



LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

PL Loc :

Case ID : 40302200636

Pt. ID : 3455149

PL Loc :

Reg Date and Time : 23-Mar-2024 09:16

Sample Type : Plasma Fluoride F, Plasma Fluoride PP

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16

Sample Coll. By :

Ref Id1 : OSP28284

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

Acc. Remarks : Normal

Ref Id2 : O232411331

REMARKS

RESULTS

UNIT BIOLOGICAL REF RANGE

BIOCHEMICAL INVESTIGATIONS

Blood Glucose Level (Fasting & Post Prandial)

Plasma Glucose - F	H	103.53	mg/dL	70.0 - 100
Plasma Glucose - PP		85.88	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 glucoseeer guidelines

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

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

Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Case ID : 40302200636

Dis. At :

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Whole Blood EDTA

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

Ref Id1 : OSP28284

Report Date and Time : 23-Mar-2024 09:52 Acc. Remarks : Normal

Ref Id2 : O232411331

TEST

RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

Glycated Haemoglobin Estimation

HbA1C	5.40	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes
Estimated Avg Glucose (3 Mths) <small>Calculated</small>	108.28	mg/dL	Not available

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

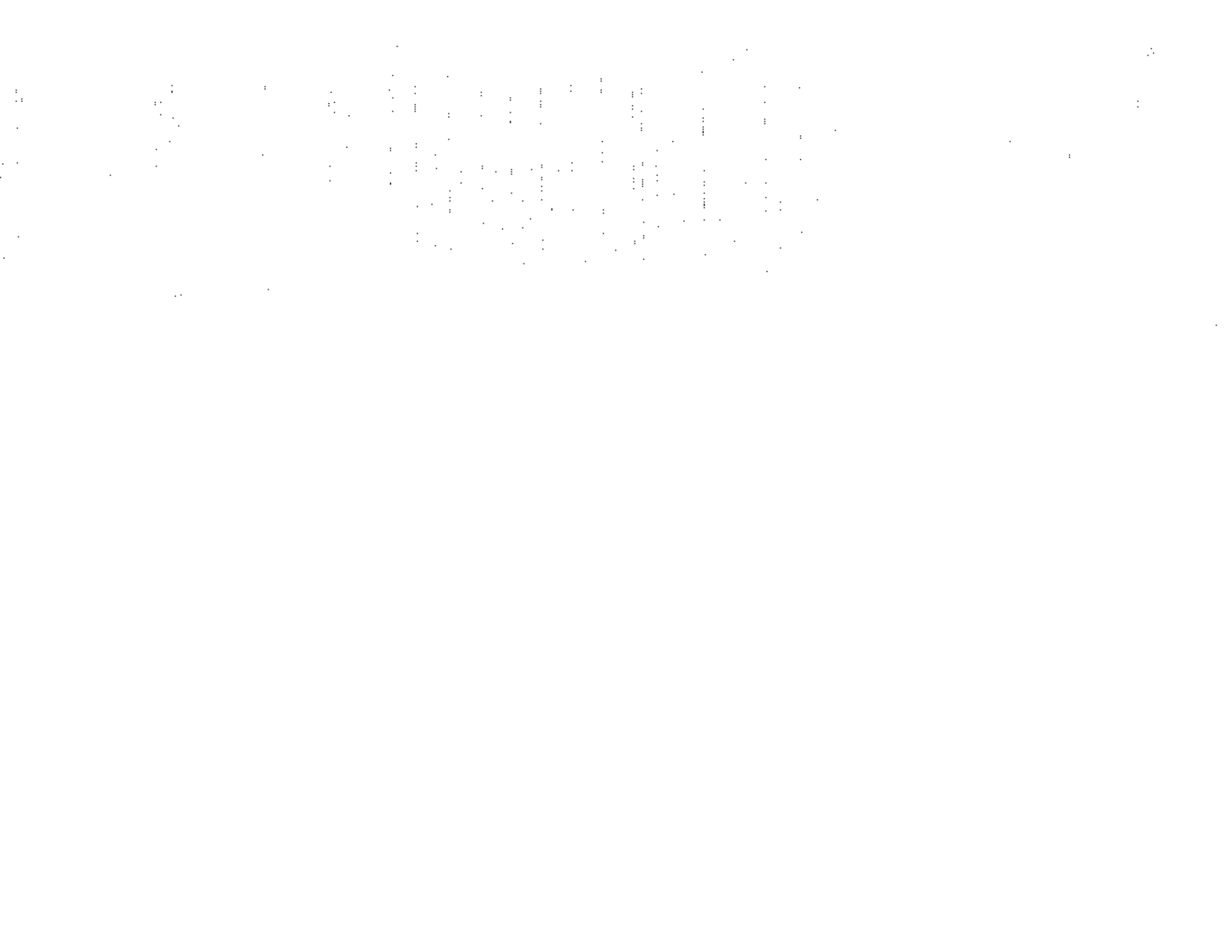
Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic 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 Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA. In such circumstances glycemic 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: (LL-VeryLow, L-Low, H-High, HH-VeryHigh, A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Sex/Age : Male / 37 Years Case ID : 40302200636

Ref.By : HOSPITAL

Dis. At :

Pt. ID : 3455149

Bill. Loc. : Aashka hospital

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16

Mobile No :

Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16

Sample Coll. By :

Ref Id1 : OSP28284

Report Date and Time : 23-Mar-2024 11:56

Acc. Remarks : Normal

Ref Id2 : O232411331

TEST

RESULTS

UNIT BIOLOGICAL REF RANGE

REMARKS

BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol Colorimetric, CHOD-POD	188.68	mg/dL	110 - 200
HDL Cholesterol	L 41.3	mg/dL	48 - 77
Triglyceride Glycerol Phosphate Oxidase	147.22	mg/dL	<150
VLDL Calculated	29.44	mg/dL	10 - 40
Chol/HDL Calculated	H 4.51		0 - 4.1
LDL Cholesterol Calculated	H 117.44	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
Bornemine 130-159	High >240		High 200-499

- 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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LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

PL. Loc :

Case ID : 40302200536

Pl. ID : 3455149

PL. Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

Report Date and Time : 23-Mar-2024 11:56 Acc. Remarks : Normal

Mobile No :

Ref Id1 : OSP28284

Ref Id2 : O232411331

TEST

RESULTS UNIT BIOLOGICAL REF RANGE REMARKS

BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T. <i>UV with P5P</i>	47.11	U/L	16 - 63
S.G.O.T. <i>UV with P5P</i>	25.39	U/L	15 - 37
Alkaline Phosphatase <i>Enzymatic, PNPP-AMP</i>	H 122.71	U/L	46 - 116
Gamma Glutamyl Transferase <i>L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate</i>	22.86	U/L	0 - 55
Proteins (Total) <i>Colorimetric, Biuret</i>	7.35	gm/dL	6.40 - 8.30
Albumin <i>Bromocresol purple</i>	4.58	gm/dL	3.4 - 5
Globulin <i>Calculated</i>	2.77	gm/dL	2 - 4.1
A/G Ratio <i>Calculated</i>	1.7		1.0 - 2.1
Bilirubin Total <i>Photometry</i>	0.56	mg/dL	0.3 - 1.2
Bilirubin Conjugated <i>Diazotization reaction</i>	0.21	mg/dL	0 - 0.50
Bilirubin Unconjugated <i>Calculated</i>	0.35	mg/dL	0 - 0.8

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



Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

Pt. Loc :

Case ID : 40302200636

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

Report Date and Time : 23-Mar-2024 13:13 Acc. Remarks : Normal

Mobile No :

Ref Id1 : OSP28284

Ref Id2 : O232411331

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BUN (Blood Urea Nitrogen)
GLDH 11.0 mg/dL 8.90 - 20.60

Uric Acid
Uricase H 7.40 mg/dL 3.5 - 7.2

Creatinine 1.01 mg/dL 0.50 - 1.50

25 OH Cholecalciferol (D2+D3) L 6.7 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 institutionalised 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 or bone biopsychistomorphometry.
- 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, typically >150 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-Very Low, L-Low, H-High, HH-Very High ,A-Abnormal)



Dr. Shreya Shah

M.D. (Pathologist)





LABORATORY REPORT



Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Case ID : 40302200636

Dis. At :

Pt. ID : 3455149

Pl. Loc :

Reg Date and Time : 23-Mar-2024 09:16

Mobile No :

Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16

Sample Coll. By :

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

Ref Id1 : OSP28284

Ref Id2 : O232411331

Acc. Remarks : Normal

VITAMIN B - 12

Vitamin B - 12 Level L 146.0 pg/mL 180 - 914

Introduction:

Vitamin B12, a member of the corrin family, a cofactor for the formation of myelin, and along with folate, 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 afflicted with MA.

Decreased In:

Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraception, parasitic 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:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah

M.D. (Pathologist)

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Printed On : 23-Mar-2024 13:24





LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years Case ID : 40302200636

Dis. At :

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

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

Mobile No :

Ref Id1 : OSP28284

Ref Id2 : O232411331

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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Thyroid Function Test

Triiodothyronine (T3)	107.34	ng/dL	70 - 204	
Thyroxine (T4) <small>CMA</small>	7.81	ng/dL	4.87 - 11.72	
TSH <small>CMA</small>	1.51	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 antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy

First trimester
Second trimester
Third trimester

Reference range (microIU/ml)

0.24 - 2.00
0.43-2.2
0.8-2.5

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



Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Ref By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Case ID : 40302200636

Dis. At :

Pt. ID : 3455149

Pt. Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Serum

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

Mobile No :

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

Ref Id1 : OSP28284

Ref Id2 : O232411331

Investigation Note:

Ultra sensitive-thyroid-stimulating hormones (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, suppressed s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test), when the s-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 hypothyroid 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 s-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)

0.24 - 2.00

0.43-2.7

0.8-2.5

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

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



Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT

Name : ROHIT KUMAR PRASHAD

Sex/Age : Male / 37 Years Case ID : 40302200636

Ref.By : HOSPITAL

Dis. At : PL ID : 3455149

Bill. Loc. : Aashka hospital

PL Loc :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Spot Urine

Mobile No :

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

Ref Id1 : OSP28284

Report Date and Time : 23-Mar-2024 09:40 Acc. Remarks : Normal

Ref Id2 : O232411331

TEST

RESULTS

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

1.005 - 1.030

pH 5.50

5 - 8

Leucocytes (ESTERASE)

Negative

Negative

Protein

Negative

Negative

Glucose

Negative

Negative

Ketone Bodies Urine

Negative

Negative

Urobilinogen

Negative

Negative

Bilirubin

Negative

Negative

Blood

Negative

Negative

Nitrite

Negative

Negative

Flowcytometric Examination By Sysmex UF-5000

Leucocyte Nil /HPF Nil

Red Blood Cell Nil /HPF Nil

Epithelial Cell Present + /HPF Present(+)

Bacteria Nil /µL Nil

Yeast Nil /µL Nil

Cast Nil /HPF Nil

Crystals Nil /HPF Nil

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

Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT

Name : **ROHIT KUMAR PRASHAD**

Ref.By : HOSPITAL

Bill. Loc. : Aashka hospital

Sex/Age : Male / 37 Years

Dis. At :

Pt. Loc. :

Case ID : 40302200536

Pt. ID : 3455149

Mobile No :

Reg Date and Time : 23-Mar-2024 09:16 Sample Type : Spot Urine

Sample Date and Time : 23-Mar-2024 09:16 Sample Coll. By :

RefId1 : OSP28284

Report Date and Time : 23-Mar-2024 09:40 Acc. Remarks : Normal

RefId2 : O232411331

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
Pus 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-Very Low, L-Low, H-High, HH-Very High ,A-Abnormal)



Dr. Shreya Shah
M.D. (Pathologist)

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Printed On : 23-Mar-2024 19:24

Handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly illegible due to fading and bleed-through, but appears to be organized into several lines or paragraphs. Some words like "The" and "and" are faintly visible.



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: **ROHIT KUMAR PRASHAD.**

Date: **23/3/2024.**

AGE: **37yrs.** SEX: **M**

Pulse= **74/min**

Height: _____ Weight: _____

B.P.= _____

Chief Complaints:

R.R.= **18/min**

No Complaints.

SpO2= **99%.**

Temp.= **(N)**

R.B.S.= **105 mg/dl**

Body built / Nutritional status: **OK**

Sleep cycle: **(N)**

Any known allergies: **None**

E.C.G: **(N)**

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

None

Provisional Diagnosis: **"FIT FOR DUTY"**

*General Examination: -

- Lymph node enlargement: **(N)**

*On Examination:-

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

- Chest movements: **(N)** - Air entry: **AE = BF.**

Rx,

Tab. MISONIL SL

Tab. METAPLUS

Tab. Sildenafil D

Adv: 1. Life style modification.

2. Inform...

Clubbing: **(N)**
Cyanosis: _____
Edema: _____

1-1-1
1-1-1
0-1-1

20 months

Advices:

- 1) Chest X ray (PA),
- 2) USG Abdomen ,
- 3) HRCT thorax (P)/ Contrast,
- 4) Skin Prick test for allergy / Allergy Screening Tests (By IMMUNO-VIA)
- 5) Pulmonary Function Test (PFT) with /without DLCO,
- 6) Bronchoscopy (Flexible / Rigid),
- 7) Pleural fluid examination (Biochemical / Hematological / Bacteriological/ TB-fungal culture/ Cytological),
- 8) Sputum Examination (Routine / Microscopic / Microbiological),
- 9) Blood investigations:-
 - CBC, PS For WBC, CPE, ESR, SGPT, S. Creatinine, Selectrolytes, HIV, HbsAg, Dengue NSI,
 - Urine(E, M), Widal test, VDRL test, Liver Function test, Kidney Function test, Lipid profile,
 - Thyroid profile (T3, T4, TSH).
- ABG (Arterial blood gas),
- D-Dimer level,
- Procalcitonin level,
- *tumor markers:-
 - CEA (carcinoembryonic antigen),
 - Neuron specific enolase (NSE) (Small cell carcinoma),
 - SCC(Squamous cell carcinoma antigen) ,
 - Mesothelin (Malignant mesothelioma),
 - CTHRA 21-1(Non-small cell carcinoma),
- 10) Follow up after days/months,
- 11) Inform SOS,
- 12) Admission.

Dr. Manvik Vyas