MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHITAL RAVAL	**Age /Gender**	: 41 Y(s)/Female
Bill No/ UMR No	: NMBC63425/NMU0048894	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:44 am	**Report Date**	: 23-Mar-24 06:17 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.005	1.000 - 1.030	Dipstick
PH		6.0	5.0 - 8.0	Dipstick
PROTEIN		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
GLUCOSE		ABSENT	ABSENT	Dipstick/Benedict's test
UROBILINOGEN		NORMAL	NORMAL	Dipstick
KETONE		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
BILIRUBIN		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
BILE SALT		NEGATIVE	NEGATIVE	Hay's sulpher powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION				
PUS CELLS	Urine	3-4	0 - 5 /hpf	
RBC		6-8	0 - 5 /hpf	
EPITHELIAL CELLS		12-15	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

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Parameters	Specimen	Result	Biological Reference In	Method

*** End Of Report ***

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Bill No/ UMR No	: NMBC63425/NMU0048894	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:44 am	**Report Date**	: 23-Mar-24 02:34 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.32	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.8	12.0 - 15.0 g/dl	
PCV/HCT		37.5	40 - 50 % 36 - 46 %	
MCV		87	83 - 101 fl 83 - 101 fl	
MCH		29.7	27 - 32 pg	
MCHC		34.2	31.5 - 34.5 g/dL	
RDW(cv)		11.6	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	357	150 - 400 10^3/µL	
MPV		6.9	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.0	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	61	40 - 80 %	
LYMPHOCYTES		29	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		04	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	39	0 - 20 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHITAL RAVAL	**Age /Gender**	: 41 Y(s)/Female
Bill No/ UMR No	: NMBC63425/NMU0048894	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:44 am	**Report Date**	: 23-Mar-24 02:34 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		87	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		139	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.1	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		104	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		97.67	70 - 204 ng/dL	Method : ECLIA
T4		5.82	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		7.65	0.270 - 4.20 uIU/mL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		68	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
SERUM CREATININE				
CREATININE		0.83	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.83	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		9.63	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		10	<= 33 U/L	Method : UV without P5P
SGOT (AST)		10	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		51	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.2	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)

DEPARTMENT OF LABORATORY

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Bill No/ UMR No	: NMBC63425/NMU0048894	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:44 am	**Report Date**	: 25-Mar-24 10:29 am

Parameters	Specimen	Result	Biological Reference In	Method
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.67	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		16	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.2	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		212	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		52	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		150	Optimal : - < 100 mg/dL Near Optimal : 100 - 129 mg/dL Borderline High : 130 - 159 mg/dL High : 160 - 189 mg/dL Very High : - > 190 mg/dL	Direct-Enzymatic colorimetric
VLDL		23		
SERUM TRYGLYCERIDES		117	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.08	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.88		
SERUM URIC ACID		5.4	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.5	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		111	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. SHITAL RAVAL	**Age /Gender**	: 41 Y(s)/Female
Bill No/ UMR No	: NMBC63425/NMU0048894	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:45 am	**Report Date**	: 25-Mar-24 10:29 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head, Laboratory Services
Consultant Hematopathologist

Verified By : : 026560

Test results related only to the item tested.

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NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOR DOPPLER

Name	: Mrs. Shital Raval	Date:- 23/03/2024
Age / Sex	: 41 Yrs / Female	UMR No. 0048894
Referred By	: Health Checkup	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
  PASP - 22 mmHg.
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Trivial TR. No PH.**
- **Normal LV and RV systolic function.**

DR. KESHAV KALE
DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist

M-MODE MEASURMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	44	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	11			Nil
TRICUSPID	22			Trivial
PULMONERY	5.3			Nil

HC48894 SITAL RAVAL 3/23/2024 2:18:53 PM
41 Years Female

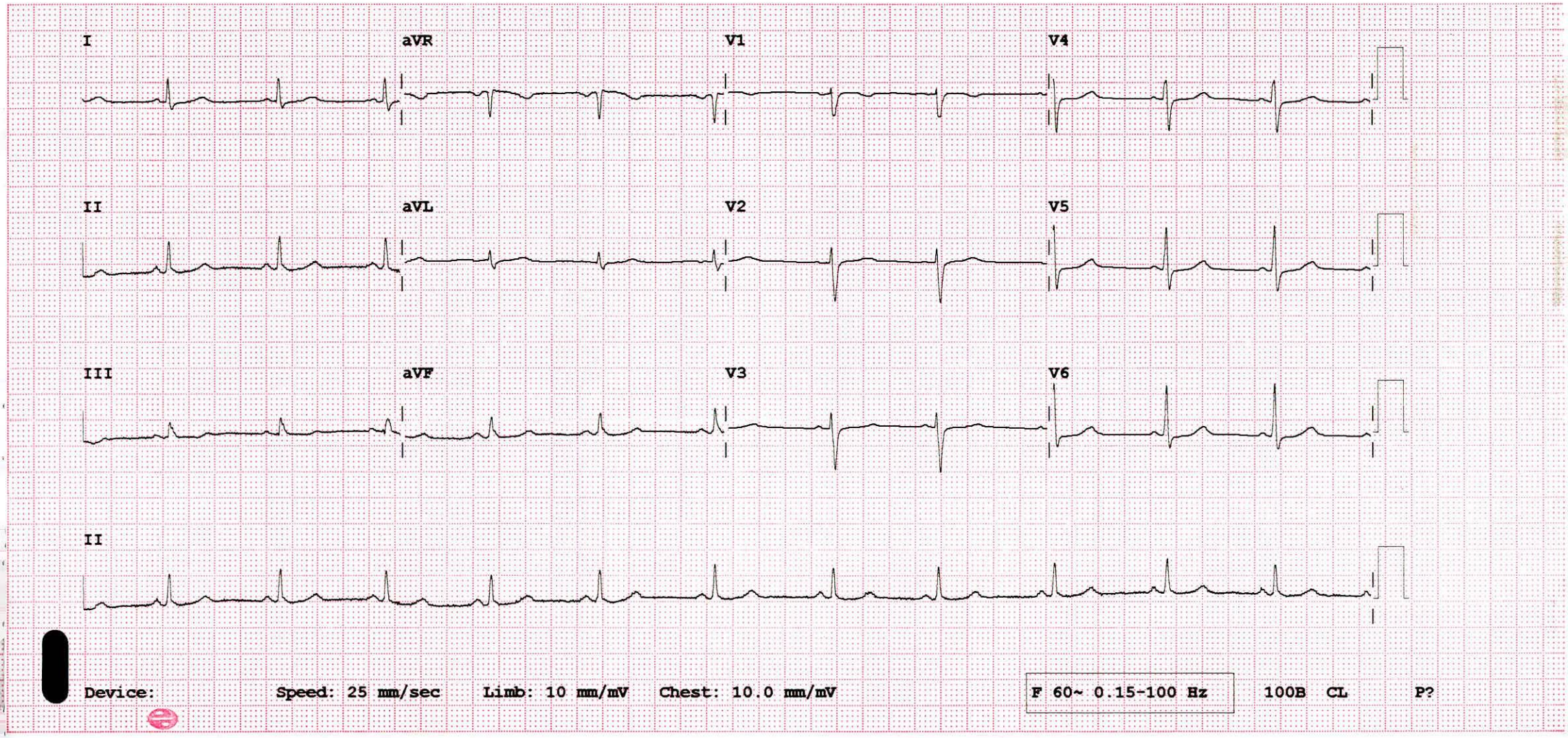
Rate 70 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 123
QRSD 92
QT 387
QTc 418

--AXIS--
P 63
QRS 66
T 33

- NORMAL ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15-100 Hz 100B CL P?

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 23/03/24

PATIENT NAME: Miss Shital Raval AGE / SEX: 41/F

UMR NO: NMU 0048894

	RE	LE
VA (DISTANCE)	6/9 c̄ (C.L)	6/6 c̄ (C.L)
VA(NEAR)	N8 c̄ (C.L)	N6 c̄ (C.L)
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D				
	O	S				

HISTORY :

- No h/o DM/HT.
h/o Thyroid on Rx : 5yrs, No h/o ocular Trauma(BE)
h/o using contact lenses & spectacles.

OCULAR FINDINGS :

(BE) - Ant seg WNL

(undilated) Disc $\frac{0.4}{0.4}$

ADVICE:

Refresh Tears eld qid 1777 x 1 month
F/u for Refraction & Fundoscopy (BE)

AS
(DR. ANUSHREE VANKAR)

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Shital Rawal.

S/B:- Dr. Mandira Kamble.

O/E:- Stain+ Calculus+

Advice oral prophylaxis.

Dr Mandira Sushil Kamble
MDS In Conservative Dentistry And Endodontics
Reg. No. A-43282

MEDICOVER
HOSPITALS

Patient ID:	*NMU0048894*	*Patient Name:*	*SHITAL RAVAL*
Age:	*41 Years*	*Sex:*	*F*
Accession Number:	*NMBC63425*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*	*Study Time:*	*13:33:39*

USG ABDOMEN & PELVIS

The Liver is normal in size (15 cm) and shows normal echotexture. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is physiologically distended with normal wall thickness. There is no evidence of gallstones. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size (7.6 cm). No focal lesion is seen.

Both kidneys are normal in size, shape and echotexture. They shows normal cortical echogenicity with maintained cortico-medullary distinction.
The Right Kidney measures 9.7 x 3.2 cm.
The Left Kidney measures 9.3 x 3.8 cm.
There is no evidence of a calculus, hydronephrosis, or hydroureter.

The Urinary bladder is partially distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

The uterus is normal in size and echotexture. It measures 8.3 x 3.6 x 3.3 cm.
No focal lesion is seen. The Endometrial thickness is 9.6 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 3.4 x 1.8 cm
The Left ovary measures 2.7 x 1.8 cm
There is no evidence of any ovarian or adnexal mass lesion.

Visualised bowel loops are unremarkable.
There is no evidence of significant lymphadenopathy.
No ascitis is seen.

IMPRESSION:

No significant abnormality is seen.

DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

MEDICOVER HOSPITALS

Patient ID:	*NMU0048894*	*Patient Name:*	*SITAL RAVAL 471YRS/F*
Age:		*Sex:*	*O*
Accession Number:		*Modality:*	*CR*
Referring Physician:		*Study:*	*BREAST*
Study Date:	*23-Mar-2024*		

X-RAY MAMMOGRAPHY

INDICATION: Routine screening.

MAMMOGRAPHY

Bilateral mammograms were obtained in the oblique mediolateral and craniocaudad projections.
The film markers are placed on the axillary / lateral part of the breast.
Both breasts display heterogenously dense glandular parenchyma, which may obscure small masses (ACR category C).
There is no focal spiculated mass lesion seen.
There are no clusters of microcalcification, distortion of the lobular architecture or nipple retraction.
Skin and subcutaneous tissues are normal.
Small lymphndoes are seen in both axilla.

IMPRESSION :-

Dense breasts limits mammographic evaluation.
BIRADS O - Suggest sonomammography for further evaluation.
BIRADS CATEGORY : *BIRADS O - Requires additional evaluation, I - Negative, II - Benign findings, III - Probably benign findings, IV - Suspicious abnormality, V - Highly suggestive of malignancy, VI - Known biopsy proven malignancy.)*

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 16:13:34

MEDICOVER HOSPITALS
NAVI MUMBAI

Patient ID:	*NMU0048894*	*Patient Name:*	*SHITAL RAVAL*
Age:	*41 Years*	*Sex:*	*F*
Accession Number:	*NMBC63425*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*23-Mar-2024*		

X RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

Impression:

- **No significant abnormality is seen.**

Jamila

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 25-Mar-2024 17:55:26