

RAJENDRA B DARWAI 45Y/M

Pat. Id. CH-2024-0054574

CHARUSAT HOSPITAL, CHANGA.

CHEST PA

Ref. By. DR. H/C

23/03/2024 10:51:17

TECH ID : VD

Body Profile

તારીખ / Date

23/3/24

રજીસ્ટ્રેશન નંબર / Registration Number

CH-2024-0054574

દર્દીનું નામ / Patient's Name

Rajendra Dorwai

સંપર્ક નંબર / Contact Number

હેલ્થ લાઇન

એપોઇન્ટમેન્ટ માટે સંપર્ક

+91-2697-265502/504

+91-95379 27873

૨૪ કલાક ઈમરજન્સી સંપર્ક

+91-2697-265500

+91-75748 38111

નોંધ : ફટી જતાવવા આવો ત્યારે આ ફાઇલ અચૂક સાથે લાવવી.



DATE	PATIENT NAME	AGE IN YEARS	SEX
23-03-2024	RAJENDRA DARWAI	45	M

USG ABD

Liver: show evidence of normal size, part solid or cystic mass lesion seen. Normal of intrahepatic biliary dilatation seen.

Gall bladder is contracted with evidence, possibility of calculus, no sludge. Thick evidence of pericholecystic fluid collectic CBD, portal vein & splenic vein size are

Spleen size & parenchymel echotexture Pancreas difficult to visualize due to over Aorta show normal caliber & no evidence

Right kidney show evidence of normal size parenchymel echotexture. No evidence seen.

No evidence of focal solid or cystic mass

Left kidney show evidence of normal size parenchymel echotexture. No evidence seen.

No evidence of focal solid or cystic mass

Bladder walls are normal & no evidence Prostate show evidence of normal size No evidence of ascitis or abnormal bowel

Size cm app

Right	Left
Kidney	Kidney
8.65x4.23	9.0x4.41

COMMENTS:

POSSIBILITY OF GALL BLADDER CALCULI

No other obvious abnormality detected.

Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S, D.M.R.D



DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR
23-03-2024	RAJENDRA DARWAI	45	M	BODY PROFILE

USG ABDOMEN report.

Liver: show evidence of normal size, parenchymel echotexture & no evidence of focal solid or cystic mass lesion seen. Normal hepatic vasculature seen with no evidence of intrahepatic biliary dilatation seen.

Gall bladder is contracted with evidence of echogenic shadow of app 0.27 cm size, possibility of calculus, no sludge. Thickness of gall bladder wall is normal with no evidence of pericholecystic fluid collection. CBD, portal vein & splenic vein size are normal.

Spleen size & parenchymel echotexture is normal with no focal mass lesion seen.

Pancreas difficult to visualize due to overlying bowels.

Aorta show normal caliber & no evidence of paraaortic mass lesion seen.

Right kidney show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Left kidney show evidence of normal size, position, corticomedullary differentiation & parenchymel echotexture. No evidence of obvious calcification or hydronephrosis seen.

No evidence of focal solid or cystic mass lesion seen.

Bladder walls are normal & no evidence of stone or mass seen.

Prostate show evidence of normal size & parenchymel echotexture.

No evidence of ascitis or abnormal bowel loops seen.

Size cm app

Right	Left
Kidney	Kidney
8.65x4.23	9.0x4.41

COMMENTS:

POSSIBILITY OF GALL BLADDER CALCULUS.

No other obvious abnormality detected.

Thanks for reference
 DR KIRTI C THAKKAR
 M.B.B.S,D.M.R.D



CHARUSAT HOSPITAL



DATE	PATIENT NAME	AGE IN YEARS	SEX	REFERRED BY DR
23-03-2024	RAJENDRA DARWAI	45	M	BODY PROFILE

X-ray CHEST PA view.

No evidence of abnormality seen involving both lungs. Costophrenic sinuses are clear.


Hilar shadows show evidence of normal size, position & opacity.

Aortic shadow show evidence of normal position & Size. Cardiac size & position is normal.

Domes of diaphragm & bony cage show no evidence of abnormality.

COMMENTS:


NO ABNORMALITY DETECTED


Thanks for reference
DR KIRTI C THAKKAR
M.B.B.S.D.M.R.D



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DARWAI	Sample No. :	SAMPLE-0108151 
Patient ID :	CH-2024-0054574	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 14:28
Ward :	-	Report Date :	23-Mar-2024 14:43

PP2BS

Investigation	Result	Normal Value
Post Prandial Blood Sugar (2Hrs) :	109.8 mg/dl [NORMAL]	100 - 140

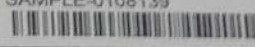
DR. NAIK Bhatia
CONSULTANT PATHOLOGIST
(M.B.B.S., D.C.P)

DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
(M.B.B.S., M.D)



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DARWAI	Sample No. :	SAMPLE-0108139 
Patient ID :	CH-2024-0054574	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :	-	Report Date :	23-Mar-2024 14:23

Hemoglobin (HB)

Investigation	Result	Normal Value
Hemoglobin	14.4 gm/dl [NORMAL]	[M : 14-18, F : 12-16]

WBC

Investigation	Result	Normal Value
R.B.C Count :	4.64 mill./c.mm [NORMAL]	[M : 4.5 - 5.5 , F : 3.8 - 5.2]

WBC :	8060 /c.mm [NORMAL]	4000 - 10000
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Platelet count

Investigation	Result	Normal Value
Platelets	2.82 Lakh/cmm [NORMAL]	1.5 - 4.5

WBC count - Differential

Investigation	Result	Normal Value
Polymorphs	52 % [NORMAL]	40 - 70
Lymphocytes	40 % [NORMAL]	20 - 40
Eosinophils	02 % [NORMAL]	1 - 6
Monocytes	06 % [NORMAL]	2 - 10
Basophils	00 % [NORMAL]	0 - 1

BLOOD UREA

Investigation	Result	Normal Value
Blood Urea	22.4 mg/dl [NORMAL]	15 - 40

S.Creatinine



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DARWAI	Sample No. :	CSAMPLE-0108139
Patient ID :	CH-2024-0064874	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :		Report Date :	23-Mar-2024 14:23

Investigation
Serum Creatinine
Result 1.03 mg/dl [NORMAL]
Normal Value
Male : 0.9 to 1.5 mg/dl
Female : 0.8 to 1.2 mg/dl

BUN
Investigation
BUN :
Result 10 [NORMAL]
Normal Value
8.0 to 23.0 (mg/dl)

URIC ACID
Investigation
Serum Uric Acid
Result 5.85 mg/dl [NORMAL]
Normal Value
Male : 2.5 to 7.0
Female : 1.5 to 6.0

ESR
Investigation
ESR - After One Hour
Result 04 mm [NORMAL]
Normal Value
[M : 3 - 5, F : 4 - 7]

Blood Group
Investigation
ABO : B
Rh : Positive
Result
Normal Value

FASTING BLOOD GLUCOSE
Investigation
Fasting Blood Sugar :
Result 104.6 mg/dl [NORMAL]
Normal Value
70 - 110

Fasting Urine Sugar : Absent
HBA1C
Investigation
Mean Blood Glucose
Result 142.7 mg/dl
Normal Value



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DARWAI	Sample No. :	SAMPLE-0108139
Patient ID :	CH-2024-0054574	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :		Report Date :	23-Mar-2024 14:23

Hb A 1c 6.6 %

- > 8 : Action Suggested
- 7-8 : Good Control
- < 7 : Goal
- 6-7 : Near Normal Glycemia
- < 6 : Non-diabetic Level

Comments

Hb A1C also known as Glycosylated Haemoglobin is the most important test for the assessment of longterm Blood glucose control (also called glycemic control).

Hb A1C reflects mean glucose concentration over past 65-90 week and provides a much better indication of longterm glycemic control than blood glucose determination.

This Reaction is irreversible & therefore remains unaffected glucose & Haemoglobin. Long term complications of diabetes such as Retinopathy (Eye-complications),

neuropathy(kidney-complications) & neuropathy(never complications) are potentially serious and can lead to blindness, kidney failure etc. Glycemic control as monitored by Hb A1C measurement is considered most important.

TSH

Investigation

TSH :

Investigation	Result	Normal Value
TSH :	6.29 uIU/ml [HIGH]	0.34 to 4.5 (uIU/ml)

T3

Investigation

T3-Triiodothyronine :

Investigation	Result	Normal Value
T3-Triiodothyronine :	1.58 ng/ml [NORMAL]	0.69 to 2.15 (ng/ml)

T4

Investigation

T4-Thyroxine :

Investigation	Result	Normal Value
T4-Thyroxine :	63.7 ng/ml [NORMAL]	52.0 to 127.0 (ng/mL)

LIPID PROFILE

Investigation

Result Normal Value



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DIXITWAL	Sample No. :	CS00PL1E-51109139
Patient ID :	CH/2524-0554574	Visit No. :	CS0020240519051272
Age/Sex :	45y/Male	Coll. Date :	23-Mar-2024 19:22
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :	-	Report Date :	23-Mar-2024 14:23

Serum Cholesterol (Chol) :	176.6 mg/dl	<200 mg/dl Desirable 200-239 mg/dl Borderline High > 240 mg/dl High
Serum Triglyceride :	78.8 mg/dl	<150 mg/dl Normal 150-199 mg/dl Borderline high 200-499 mg/dl High
S HDL Cholesterol :	45.0 mg/dl	Men : >55, Ws : >65 Standard Risk Level Men : 35-55, Ws : 45-65 Risk Men : <35, Ws : <45
LDLC :	91.48 mg/dl	
VLDL :	36.12 mg/dl [HIGH]	10.0 to 30.0 (mg/dl)
LDL/HDL Ratio :	2.03 - [NORMAL]	< 3.5
TC / HDL Ratio :	3.79 - [LOW]	4.0 to 8.0
LDL (DIRECT) :	125.3 mg/dl	< 100.0 (Optimal), 100.0 to 129.9 (Near Optimal), 130.0 to 159.9 (Border line high), 160.0 to 189.9 (High), > 190.0 (Very high)

LIVER FUNCTION TEST

Investigation	Result	Normal Value
Total Bilirubin :	1.02 mg/dl [NORMAL]	0.0 to 1.2
Direct Bilirubin (DBIL) :	0.30 mg/dl [NORMAL]	0.0 to 0.30
ALT (SGPT) :	28.1 IU/L [NORMAL]	[0.0 - 40]
AST (SGOT) :	18.1 IU/L [NORMAL]	≤ 45.0
Alkaline Phosphatase (ALP) :	144.8 IU/L [NORMAL]	15 - 80 - : 37.0 to 147.0



CHARUSAT HOSPITAL



Patient Name :	RAJENDRA BANDHARINATH DAIKAWI	Sample No. :	SAMPLE-0108159
Patient ID :	CH-2024-0054574	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :		Report Date :	23-Mar-2024 14:23

Total Protein (TP) :	7.7 gm/dl [NORMAL]	(Adult 6.0 to 7.8)
Albumin (ALB) :	4.6 gm/dl [NORMAL]	3.5 to 5.0 (gm/dl)
Indirect Bilirubin (IBIL) :	0.72 [NORMAL]	0.0 to 0.75 (mg/dl)
Globulins :	3.1 gm/dl [NORMAL]	2.4 to 3.5 (gm/dl)
A/G Ratio :	1.5	

URINE R & M

Investigation

Physical Examination :

Quantity :	15 ml	Normal Value
Colour :	Pale Yellow -	
Appearance :	Clear -	
Odour :	URINIOD -	
Reaction :	Acidic -	
Specific Gravity :	1.030 -	

Chemical Examination :

Albumin :	Absent -
Sugar :	Absent -
Bile Salts :	Absent -
Bile Pigments :	Absent -
Acetone :	Absent -
Urobilinogen :	Absent -

Microscopic Examination :

Pus Cells :	1-2 -
RBCs :	Absent -
Epithelial cells :	1-2 -

Patient Name :	RAJENDRA BANDHARINATH DARWAI	Sample No. :	SAMPLE-0108139
Patient ID :	CH-2024-0054574	Visit No. :	OPD/2024/03/0001272
Age/Sex :	45y/Male	Call. Date :	23-Mar-2024 09:32
Referred By :	RIPAL PATEL	S. Coll. Date :	23-Mar-2024 11:42
Ward :	-	Report Date :	23-Mar-2024 14:23

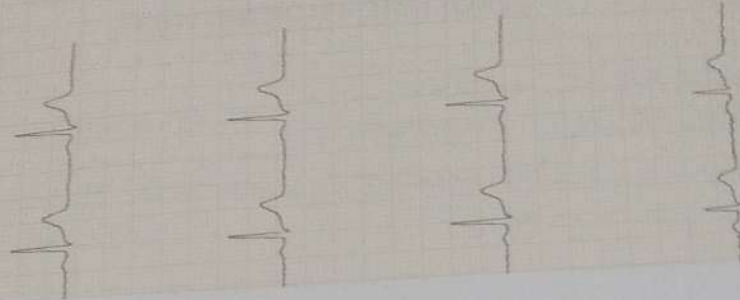
Casts : Absent -
Crystals : Absent -

Investigation	Result	Normal Value
PSA	0.30	0.0 - 4.0 ng/ml
FREE PSA	-	4.0 - 10.0 ng/ml Gray Z 10.0 - 30.0 ng/ml suspit of malignancy Above 30 ng/ml Highly suspicious of malignant

DR. NAITIK BHATIA
CONSULTANT PATHOLOGIST
(M.B.B.S,D.C.P)

DR. KETAN KAPADIA
CONSULTANT PATHOLOGIST
(M.B.B.S,M.D)

Unconfirmed Diagnosis



SN FN 52001657

12.03.00 V2B.4.1



CHARUSAT HOSPITAL

Care with compassion...

CHARUSAT HEALTHCARE & RESEARCH FOUNDATION

CHARUSAT Campus, Changa, District ANAND 388421 (GUJ) India. Ph No. +91-2697-265502

Receipt

Receipt No. : 2024/03/0019080

Patient ID : CH-2024-0054574



Visit : OPD/2024/03/0001272 (OPD)

Bill No. : OPD/2024/03/0014906

Name : RAJENDRA BANDHARINATH DARWAI

Date : 23-Mar-2024 14:02

Pay Mode : Cash

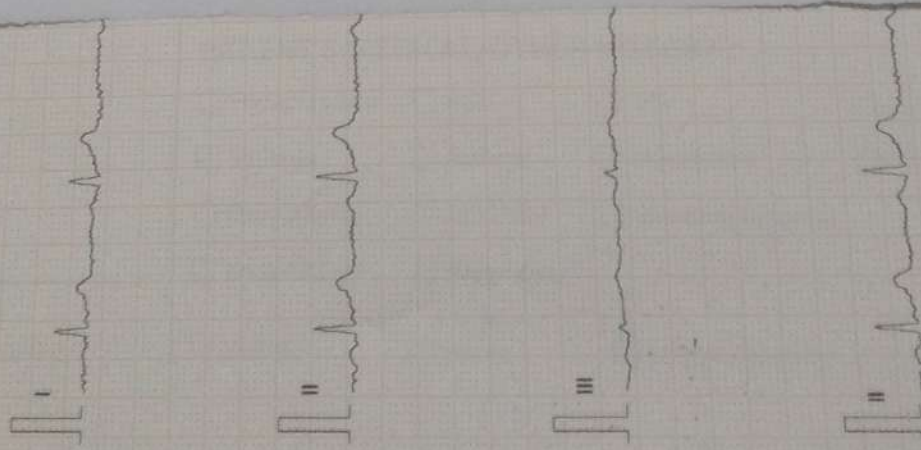
Sr	Particulars	Amount(Rs)
1	Advance Patient Payment	400.0
Total		400.0

(Four Hundred Only)

Generated By : (KRUNAL VYAS)

For, Changa

ID: 0054574
Name: Darwai, Rajendra
Age: 45 Years
Gender: Male



10 mm/mV

25 mm/s



ID: 0054574
 Name: Dorwa, Regendra
 Age: 45 years
 Gender: Male

23-03-2024 09:51:55 AM

Vent. Rate 67 bpm
 PR Interval 150 ms
 QRS Duration 86 ms
 QT/QTc Interval 364/376 ms
 P/QRS/T Axis 48/38/44 deg

Sinus rhythm

Unconfirmed Diagnosis

CHANGSAI HOSPITAL

02 03 2024 11:31 PM (20240302)

25 mm/s
 10 mm/mV
 50 Hz
 RDR 20 Hz

5/2/24
 (Rajniya 21)
 (Rajniya 21)
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 (Rajniya 21)



LALITABEN P. D. PATEL OPD SERVICES
REGISTRATION FORM (OPD)



Date & Time: 23/3/24
Registration No.: 24-24-0054174

Dr. Jainish

Name: Rajendra B. Daxwar
Age: 45 Sex: M

Address: 80 Teriulk SpO₂: 98% Pa
B.P.: 130/80 mmHg
BMI: Height: Weight:

OPD-INITIAL ASSESSMENT FORM

Chief Complaints: Health weak of

CASE ANALYSIS

Past History: NAD

Present History:

G/E Vitals:
Systemic Examination:

FAMILY HISTORY:

- Diabetes
- Hypertension
- IHD
- Others (Specify):

PATIENT'S MEDICAL/OTHER HISTORY:

- Hypertension
- IHD
- Epilepsy
- Asthma
- Food Allergy
- Drug Allergy
- Jaundice
- T.B.
- Hepatitis B
- Hepatitis C
- AIDS/HIV
- Bleeding Disorder
- Pregnancy
- Alcohol
- Tobacco
- Others (Specify):

HABBITTS:

- Smoking
- Alcohol
- Tobacco
- Others (Specify):

DENTAL REGISTRATION FORM



Date & Time : 23/3/24
Registration No. : CH 2024-0054374

Name : Rajendra Dorwani
Age : 45
Sex : M

OPD-INITIAL ASSESSMENT FORM

Chief Complain : Routine checkup

- Family History :**
- Diabetes
 - Hypertension
 - IHD
 - Others (Specify) :
- Habits :** Tobacco

- Medical/Other History :**
- IHD
 - Hypertension
 - Diabetes
 - Epilepsy
 - Bleeding Disorder
 - Smoking
 - T.B.
 - Hepatitis B
 - AIDS/HIV
 - Food Allergy
 - Pregnancy
 - Other (Specify) :

- Jaundice
- Hepatitis C
- Drug Allergy

સંમતિ પત્રક

હું, નીચેના નામના ડૉક્ટર અને મારા સંબંધીઓને સમજૂતી આપેલ છે. મેં સંમતિ આપી છે કે સંમતિ આપી શકાય તેવા તમામ જરૂરી ઇલાજો આપવા માટે તમારું સહયોગ કરવાનું છે. જો કોઈપણ સંબંધીઓના સારવાર અટકી જાય તો તેની નિષ્ક્રમતા માટે સંમતિ આપવાનું છે. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દવાની જવાબદારી નથી. તમારું સહયોગ વિના કોઈપણ સારવાર આપવામાં આવશે નહીં. આ સંમતિ હું સ્વેચ્છાએ કોઈપણ દવાની જવાબદારી નથી.

દર્દી / સગાની સહી

CONSENT

I, _____ hereby request and authorize Doctor _____ to perform the required dental treatment. Doctor has informed me and my relatives about the treatment plan in details with success and failure of the treatment with all expenditure, possible complications from medicines or local anesthesia. I have informed the Doctor about my medical history and drug history in details. If in any circumstances, I am irregular or leave the treatment in between, the doctor and CHARUSAT Hospital will not be responsible for the same and treatment charges will not be returned back.

I give my consent to proceed with my dental treatment.

Patient's / Relative's Sign.

Investigation Advised :

Final Diagnosis :

Treatment Plan :

Date : 23/3/24

Time :

Calculus + Scaling

Name of Doctor

Signature :

Dr. Shashwath



OPHTHALMIC REGISTRATION FORM

Reg. No. 23/20/2024/4574

Date: 23/3/24

Age: 45

Patient's Name: Regenda Doshi

Address: _____

Telephone No.: _____

Referred by / Care of: _____

Profession: IT Professionalist

Type or work in daily routine: Driving / Watching TV / Computer / Reading /

History / Complaint of: Diplopia, Pain, Watery, Redness, Headache, Itching, Routine eye check-up

Stickiness / Swelling / Irritation / Burning / F. B. Sensation / Photophobia / eye check-up

Duration: _____

Ophthalmic History: Surgery / Laser / FFA / Oct / Glaucoma / RP / Corneal Opacity / Injury / Amblyopia /

Treatment: _____

Any Surgery: Cataract / Glaucoma / None / RE / LE / BE

Family History: Glaucoma / RP / DM / None

SYSTEMIC: DM / HT / IHD / COPD / PROSTATE / WROID / ALLERGY / SMOKING / ALCOHOL

EYE DETAILS:

V/A with PH: RE 6/9, LE 6/9

IOP: 11 mm/Hg

OWN GLASS: Not using

AR: -0.75 / -0.50 x 70°

GLASS PRESCRIPTION

	R. E. V/A			L. E. V/A		
	CYL	AXIS	SPH.	CYL	AXIS	SPH.
Dis	-0.50	70°	-	-0.75	90°	-6/6
Mic	+0.25		+0.75	DSPH		MG
Comp						

Bifocal / Distant / Near only / Constant / Progressive / Photocromatic

Signature: _____

Remark: _____