MEDICOVER HOSPITALS | KLE Belagavi

Place Label Here
Pt. Name :
UMR :
Age : Sex :
IP :
If lable not available, write Pt. Name, IP No., Sex, Date, Name of Treating Physician

OPD Nursing Assessment - Adult

Name: Madhavi Kalolikar Date of Birth : - Age/Sex: 39/F UMR No.: 20935

Assessment :

Height: 155 cms Weight: 79 kg. BMI: - Respiration: 20 /min Pulse H/R : 87 /min

BP: 143 / 103 mmHG Temperature : - °F/°C SpO2 97 % BSL -

Chief Complaints : Health checkup

Tick Appropriate :

Interpreter Needed	☐ Yes	☑ No	
Nutritional Status: Weight Loss/Gain in Last 3 Months	☐ Yes	☑ No	
If Weight Loss / ain-Dietary Referral	☐ Yes	☑ No	
Psychological Assessment Agitated Anxious	☐ Yes	☑ No	☐ Normal
(If Agitated, Inform Physician)	☐ Irritable		

Any Allergies Known Including Drugs : No

Past History: Any Surgeris Explain : No

Any Other illness: Explain : HTN , DM , TSH .

Pain Score: Numerical Scales (1-10) - Location - Characteristics -

Need to be seen immediately by the Doctor - ☐ Yes ☐ No

Fall risk: Age 65Yrs. - Tremors - High Grade Fever - H/O Fall in last 3 months -

Cardiac Medicines - Seizure Medications - Fall Prevention Education Done -

Name of Nurse	ID No. of Nurse	Signature of Nurse	Date & Time
Kavishmer. L	021384		29/3/24.

MEDICOVER HOSPITALS | KLE Pune

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	Age /Gender	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:24 am	Report Date	: 29-Mar-24 06:46 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals
CUE(COMPLETE URINE EXAMINATION)			
GENERAL EXAMINATION			
VOLUME	Urine	15	10 ml to 25 ml
COLOUR		PALE YELLOW	PALE YELLOW
APPEARANCE		SLIGHTLY TURBID	CLEAR
SPECIFIC GRAVITY		1.030	1.010 - 1.030
PH		5.0	4.5 - 8.0
CHEMICAL EXAMINATION			
PROTEIN	Urine	++	ABSENT
GLUCOSE		ABSENT	ABSENT
BLOOD		NIL	ABSENT
LEUCOCYTES		NEGATIVE	NEGATIVE
UROBILINOGEN		NORMAL	NORMAL
KETONE		ABSENT	ABSENT
BILIRUBIN		NEGATIVE	NEGATIVE
NITRITE		NEGATIVE	NEGATIVE
MICROSCOPIC EXAMINATION			
PUS CELLS	Urine	5-6	0 - 5 /hpf
RBC		0-1	0 - 2 /hpf
EPITHELIAL CELLS		15-20	0 - 5 /hpf
CRYSTALS		NIL	ABSENT
CASTS		ABSENT	ABSENT
OTHERS		BUDDING YEASTS ABSENT	

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:24 am	**Report Date**	: 29-Mar-24 03:57 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	EDTA Blood	11.7	11.7 - 15.5 g/dL	Spectrophotometry
WHITE BLOOD CELLS (WBC)		8,150	4000 - 11000 Cells/cumm	Impedance, optical Absorbance, DHSS
PLATELET COUNT		314000	150000 - 450000 /cumm	Impedance
RED BLOOD CELLS		4.55	3.9 - 5.0 milli/cumm	Impedance
HEMATOCRIT/HCT (PCV)		34.8	36 - 46 %	Analogical integration
MCV		76.6	82 - 95 fl	Calculated
MCH		25.8	27 - 32 pg	Calculated
MCHC		33.7	32 - 36 g/dL	Calculated
RDW(cv)		13.4	11.5 - 14.0 %	Calculated
MPV		8.9	6 - 9.5 fl	
DIFFERENTIAL COUNT				
NEUTROPHILS	EDTA Blood	65.1	50 - 75 %	DHSS/Microscopy
LYMPHOCYTES		28.3	20 - 40 %	DHSS/Microscopy
EOSINOPHILS		2.5	00 - 06 %	DHSS/Microscopy
MONOCYTES		3.5	00 - 10 %	DHSS/Microscopy
BASOPHILS		0.6	00 - 01 %	DHSS/Microscopy
PERIPHERAL SMEAR EXAMINATION				
RBC morphology	EDTA Blood	Normocytic Normochromic, few microcytic		
WBC morphology		No Atypical Cells Seen		
PLATELETS		Adequate On Smear		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" O "		SLIDE AGGLUTINATION
RH TYPE		POSITIVE		
ESR		28	0 - 20 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 02:12 pm	**Report Date**	: 29-Mar-24 06:46 pm

Parameters	Specimen	Result	Biological Reference In	Method

System Name :

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	Age /Gender	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	Referred By	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 11:24 am	Report Date	: 29-Mar-24 05:47 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		10.3	Normal < 5.7 Pre diabetic 5.7 - 6.5 Diabetic > 6.5 : 5.7 - 6.5	TINIA
FBS (FASTING BLOOD SUGAR)				
FASTING BLOOD GLUCOSE		240.7	Normal Range : 70 - 99 mg/dL Impaired Glucose tolerance : 100 - 125 mg/dL Diabetes Mellitus : - > 126 mg/dL	Hexokinase
SERUM CREATININE		0.55	0.6 - 1.2 mg/dL	Jaffe
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.36	0.1 - 1.2 mg/dL	Colorimetric diazo method
DIRECT BILIRUBIN		0.15	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.21	<= 1.0 mg/dL	
SGPT (ALT)		18.1	<= 33 U/L	Enzymatic
SGOT (AST)		14.9	<= 32 U/L	Enzymatic
ALKALINE PHOSPHATASE (ALP)		97	35 - 104 U/L	PNPP
TOTAL PROTEINS		7.74	6.4 - 8.3 g/dL	Method : Biuret method
SERUM ALBUMIN		4.40	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.34	1.8 - 3.6 g/dL	
A/G RATIO		1.32	1.1 - 2.2	
GAMMA GLUTAMYL TRANSFERASE(GGT)		20	6 - 42 U/L	Enzymatic colorimetric assay (IFCC)
NOTE				

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 02:11 pm	**Report Date**	: 29-Mar-24 05:47 pm

Parameters	Specimen	Result	Biological Reference In	Method
LIPID PROFILE				
TOTAL CHOLESTEROL		166.7	Borderline High : 200 - 240 mg/dL High risk : > 240 mg/dL Desirable: : < 200 mg/dL	Enzymatic, Colorimetric Method
HDL CHOLESTEROL		39.3	Major risk factor for heart disease : : < 40 mg/dL Negative risk factor for heart disease : : > 60 mg/dL	Homogeneous enzymatic colorimetric assay
LDL CHOLESTEROL		98.96	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	
VLDL		28.44	6 - 38 mg/dl	
SERUM TRYGLYCERIDES		142.2	Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL Normal : < 150 mg/dL	Enzymatic colorimetric test
CHO/HDL RATIO		4.24	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.52	2.5 - 3.5	
COMMENT		10-12 hours fasting is mandatory for Lipid profile parameters. If not ,Values may not be accurate.		
SERUM URIC ACID		4.2	2.4 - 5.7 mg/dL	Enzymatic colorimetric test
T3,T4 AND TSH				
T3		1.19	0.8 - 2.0 ng/mL	Method : ECLIA
T4		11.43	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		0.357	0.27 - 4.2 uIU/mL	Method : ECLIA
PPBS (POST PRANDIAL BLOOD SUGAR)				
PPBS (POST PRANDIAL BLOOD SUGAR)		318.9	Normal range : < 140 mg/dL Impaired glucose tolerance : <= 199 mg/dL Diabetes Milletus : >= 200 mg/dL	Hexokinase
BUN(BLOOD UREA NITROGEN)				

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. MADHAVI KALOLIKAR	**Age /Gender**	: 39 Y(s)/Female
Bill No/ UMR No	: PUBC20926/PUU20935	**Referred By**	: Dr. GENERAL MEDICINE CONSUL
Received Dt	: 29-Mar-24 02:11 pm	**Report Date**	: 29-Mar-24 05:47 pm

Specimen

BUN (Blood Urea Nitrogen.)	7.1	7.0 - 21.0 mg/dL	Calculatead

*** End Of Report ***

Lab Incharge

Dr. PAWAR PRIYA VASANTRAO, MBBS, DNB
CONSULTANT PATHOLOGIST
Pathology

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System Name : f

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Patient ID:	PUU20935	Patient Name:	MADHAVI KALOLIKAR
Age:	39 Years	Sex:	F
Accession Number:	PUR20935 AK	Modality:	DX
Referring Physician:	HC	Study:	CHEST
Study Date:	29-Mar-2024		

X RAY CHEST PA VIEW

FINDINGS : Chest PA view with no comparison study shows.

- Visualized lung fields are clear.
- No obvious consolidation is seen.
- There is no pleural effusion or pneumothorax seen.
- No pneumoperitoneum is seen.
- The cardiac silhouette appears within normal limits.
- The diaphragmatic shadow and mediastinal structures are within normal limits.
- Visualized osseous structures demonstrate no obvious abnormality.

IMPRESSION :

- **No radiographically evident acute cardiopulmonary process in the present study.**

Dr. Amaya Mahajan
Consultant Radiologist
MBBS DMRD DNB

Date: 29-Mar-2024 19:05:40

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DEPARTMENT OF RADIOLOGY

Patient Name : Mrs. Madhavi Kalolikar	**Age : 39 yrs / F**
Ref. By : Dr. Health check up	**OPD/IPD No: PUU: 20935**
Date of USG: 29/03/2024	**Date of Reporting: 29/03/2024**

USG ABDOMEN AND PELVIS

CLINICAL DETAILS: Routine screening. LMP: 08/03/2024

FINDINGS:

Liver : It is mildly enlarged in size. It measures 162 mm along maximum craniocaudal axis. It shows normal surface regularity. It shows raised parenchymal echotexture in both the lobes. No obvious focal lesion is seen. No evidence of intrahepatic biliary radicle dilatation. Common bile duct appears undilated. The hepatic veins and inferior vena cava appears unremarkable. The portal vein appears unremarkable.

Gall Bladder : It is partially distended. No evidence of obvious intraluminal calculus/ mass seen. No evidence of obvious wall thickening or pericholic collection.

Pancreas : It is well visualised. The head, body and tail appears normal in size and shows homogenous echotexture. The pancreatic duct appears undilated.

Spleen : It is normal in size. It measures 114 mm along its maximum length. It shows normal shape and parenchymal echotexture. No obvious focal lesion is noted.

Kidneys : Right kidney measures 108 x 40 mm in size & Left kidney measures 120 x 41 mm in size. They appear normal in size, shape, location and axis. They show normal parenchymal echotexture with well maintained corticomedullary differentiation. No evidence of hydronephrosis on either side.No focal lesion or calculus is noted on either side.

Urinary Bladder: It is well distended. It shows smooth outlines and internal mucosal regularity with normal wall thickness.No obvious intraluminal calculus/focal lesion is seen.

Uterus : It is mildly retroverted in position. It is normal in size and shape. It measures 64 x 46 x 41 mm in size along its maximum cranio-caudal, transverse and anteroposterior extents respectively. It shows homogenous myometrial echotexture with distinct endomyometrial junction. No obvious focal lesion is seen.The endometrial echo is central and measures 6 mm in maximum thickness.

Ovaries : Both the ovaries are normal in size, shape and morphology. No obvious adnexal mass lesion is seen.

Retro peritoneum isobscured by bowel gases. No obvious enlarged retro peritoneal or mesenteric lymph nodes noted. The visualised bowel loops appear unremarkable. No evidence of obvious bowel wall thickening. No ascites seen.

IMPRESSION:

1. **Mild hepatomegaly with grade I fatty infiltration.**
2. **No other sonographically evident intra-abdominal pathology.**

Clinical/ lab parameter correlation/ further evaluation and follow up recommended.

Dr. Sunita Shewale
Consultant Radiologist

(Because of technical and technological limitation complete diagnosis cannot be assured on imaging sonography. Sonography has its limitation for evaluation of GIT lesion. Clinical correlation, consultation if required repeat imaging required in the event of controversies.)

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29/3/2024.

Madhavi Kalokikar

39/f.

C/o ⇒ Headache, Neck pain,
FB sensation.
Snoring.
uneasiness in chest.
Loss of sleep.

Adv
X Ray skull
Towne's view
for styloid bones.

℞

X Surecal D3 sach 60K IU
1 —— 0 x 8 wks
रविवारी दुपारी

— Clinical OT each
5-6 वेळा रोज
x 10 wks

Adv.
CBC, CRP, BSL random

L > R
both styloids palpable
deep at upper pole.

— X T. Tegrital 100 mg
1/2 — 1/2
AL 4D
सकाळी - संध्याकाळी जेवणानंतर
x 20 wks

— Diabetologist refer

— Cap Rabemac DSR 20 mg
0 —— 1 x 5 day

DR. SURAJ GIRI
M.B.B.S., MS-ENT
Reg. No. 08/2010/2603

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Mrs. Madhavi Kalokhe

39/F

NADR

O/E:

Adv - OPG xray.

8 | —

Adv Extract

stain ++ calculus ++

Adv: oral prophylaxis.

Tab, Ketorol -DT S-O-S x 3 days.

Dr. Roshani J. Kotian
B.D.S (NHDC)
Consultant General Dentist
Reg. : A-28340

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Date:- 29/03/24.

Name:- Mrs. Madhavi Kadolkar.

Age/Sex:- 39/F

S/B: Ophthalmologist: Dr Kirti Mane.

Eye	UCVA	PGVA	Pinhole	NEAR	COLOR VISION
Right	6/12	6/6 (-1.00 x 180)	>6/6	N6	WNL
Left	6/12.	6/6. (-0.50 x 10)			

Other findings:-

Squint — no.

Nystagmus — no.

Night blindness:-

Impression:-

Eye exam is within normal limits

for desired fitness for work.

Dr. Mane
2005105/2708.

NAME : MADHAVI KALOLIKAR	AGE/sex- 39 YRS /F
REFERRED BY- DR SONAM SHINDE	DATE- 29/3/2024

2D ECHO AND COLOUR DOPPLER REPORT

2D FINDINGS-

- ALL 4 CARDIAC CHAMBERS ARE NORMAL IN DIMENSIONS.
- NO RWMA.
- NORMAL LEFT VENTRICULAR EJECTION FRACTION- LVEF – 60%
- MILD MITRAL VALVE PROLAPSE.
- MILD MR / MILD TR.
- NO PULMONARY ARTERY HYPERTENSION , RVSP – 20 mmHg.
- NO DIASTOLIC DYSFUNCTION.
- NO CLOT /VEGETATION /EFFUSION.
- LEFT SIDED AORTIC ARCH , NO COARCTATION OF AORTA.
- IVC- 1.5 CM , MORE THAN 50 % PULSATILE.

M MODE FINDINGS-

AO	LA	LVIDd/s	IVS/PW	RV	LVEF
24	32	44/24	11/11	28	60%

IMPRESSION-

- NORMAL LEFT VENTRICULAR EJECTION FRACTION- LVEF – 60%
- NO PULMONARY ARTERY HYPERTENSION , RVSP – 20 mmHg.
- MILD MITRAL VALVE PROLAPSE.

DR SONAM SHAH SHINDE

DM CARDIOLOGY

CONSULTANT INTERVENTIONAL CARDIOLOGIST (MMC 2010/06/2218)

Age: 39 Years
Gender: Female

Rate	76 bpm
PR Interval	144 ms
QRS Duration	82 ms
QT/QTc Interval	402/430 ms
P/QRS/T Axes	26/28/-9 deg
QTc:Hodges	

Sinus rhythm
Inferior T wave abnormality is nonspecific

Borderline ECG

Unconfirmed Diagnosis

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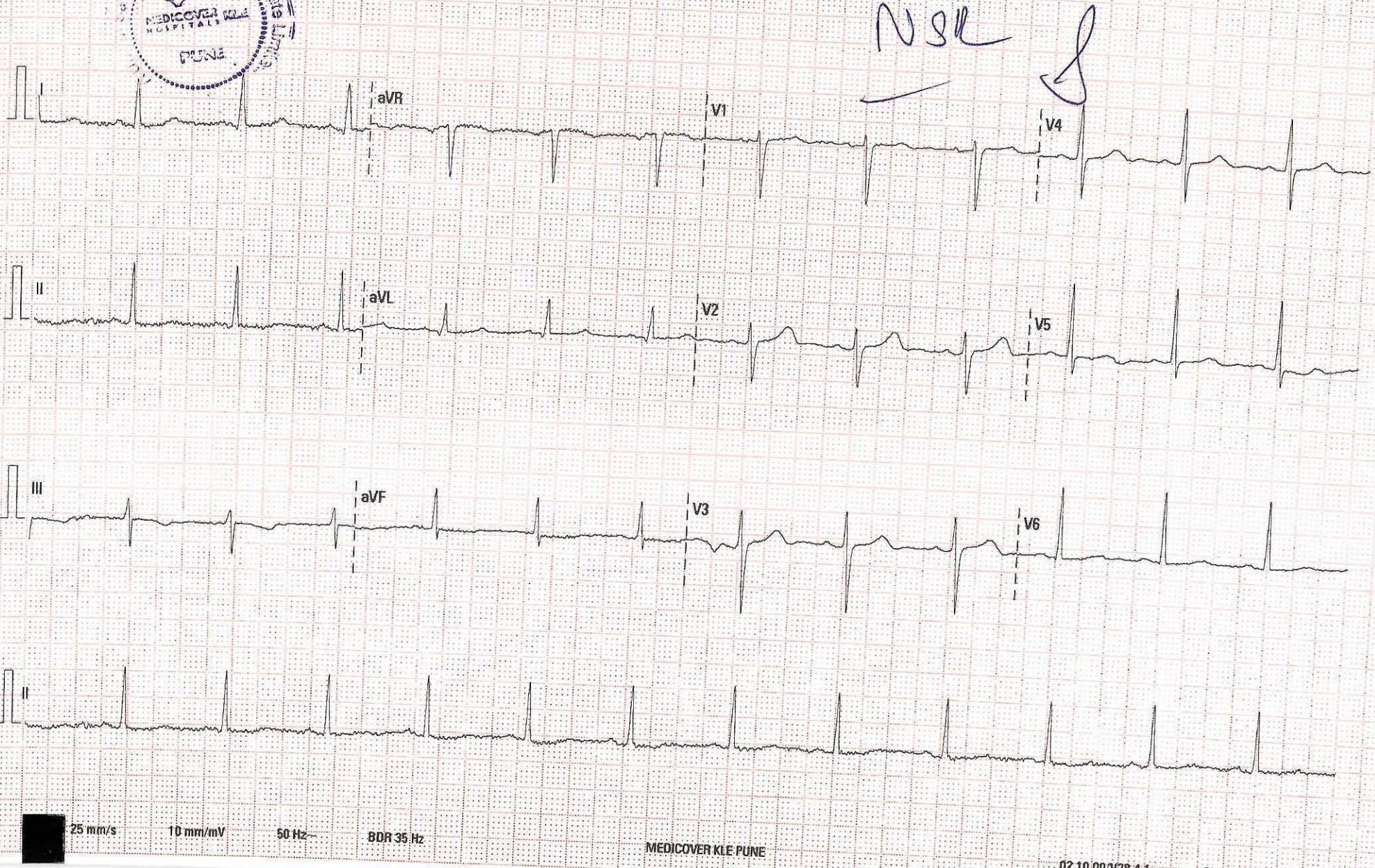

25 mm/s 10 mm/mV 50 Hz BDR 35 Hz

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02.10.00/V28.4.1 SN:FN-26035806