MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 23-Mar-24 05:31 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	1.015	1.000 - 1.030	Dipstick
PH		5.0	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microcsopy
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	6-8	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		1-2	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

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 23-Mar-24 05:31 pm

Parameters	Specimen	Result	Biological Reference In	Method
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 23-Mar-24 05:21 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.90	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		11.8	12.0 - 15.0 g/dl	
PCV/HCT		37.3	40 - 50 % 36 - 46 %	
MCV		76	83 - 101 fl 83 - 101 fl	
MCH		24.1	27 - 32 pg	
MCHC		31.7	31.5 - 34.5 g/dL	
RDW(cv)		14.5	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	212	150 - 400 10^3/µL	
MPV		9.1	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	6.4	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	52	40 - 80 %	
LYMPHOCYTES		36	20 - 40 %	
MONOCYTES		06	02 - 10 %	
EOSINOPHILS		06	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes and some target cells.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		1. Serum iron studies. 2. Haemoglobin electrophoresis/ HPLC assay.		
ESR	CITRATED BLOOD	10	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36 Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 23-Mar-24 06:17 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 23-Mar-24 02:32 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		86	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.5	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		105	98 - 107 mmol/L	ISE INDIRECT
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		78	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick
T3,T4 AND TSH				
T3		161.4	70 - 204 ng/dL	Method : ECLIA
T4		9.55	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.76	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.67	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		0.67	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		11.94	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)		17	<= 33 U/L	
SGOT (AST)		16	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		84	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		6.9	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.4	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.5	2.5 - 3.5 g/dL	

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. AYNA DHAND	**Age /Gender**	: 36Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 25-Mar-24 10:22 am

Parameters	Specimen	Result	Biological Reference In	Method
A/G RATIO		1.76	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		14	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		6.9	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		129	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		43	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		69	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		113	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.0	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		1.6		
SERUM URIC ACID		5.1	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		4.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		88	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	: Mrs. AYNA DHAND	**Age /Gender**	: 36Y(s)/Female
Bill No/ UMR No	: NMBC63400/NMU0048896	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 10:19 am	**Report Date**	: 25-Mar-24 10:22 am

Parameters	Specimen	Result	Biological Reference In	Method

Lab Incharge

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

Verified By : : 026560

Test results related only to the item tested.

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NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mrs Anya Dhand	Date:- 23/03/2024
Age / Sex	: 36 Yrs / Female	UMR No. 0048896
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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP-20mmHg
- No left ventricle clot / vegetation.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Trivial MR and 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	35	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	11	mm
LVPW(d)	11	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	7			Nil
TRICUSPID	20			Trivial
PULMONERY	5.3			Nil

hc48896 ayna dhand 1/7/2008 1:27:08 AM

Female

Age : 36 yrs

Rate 72 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation

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

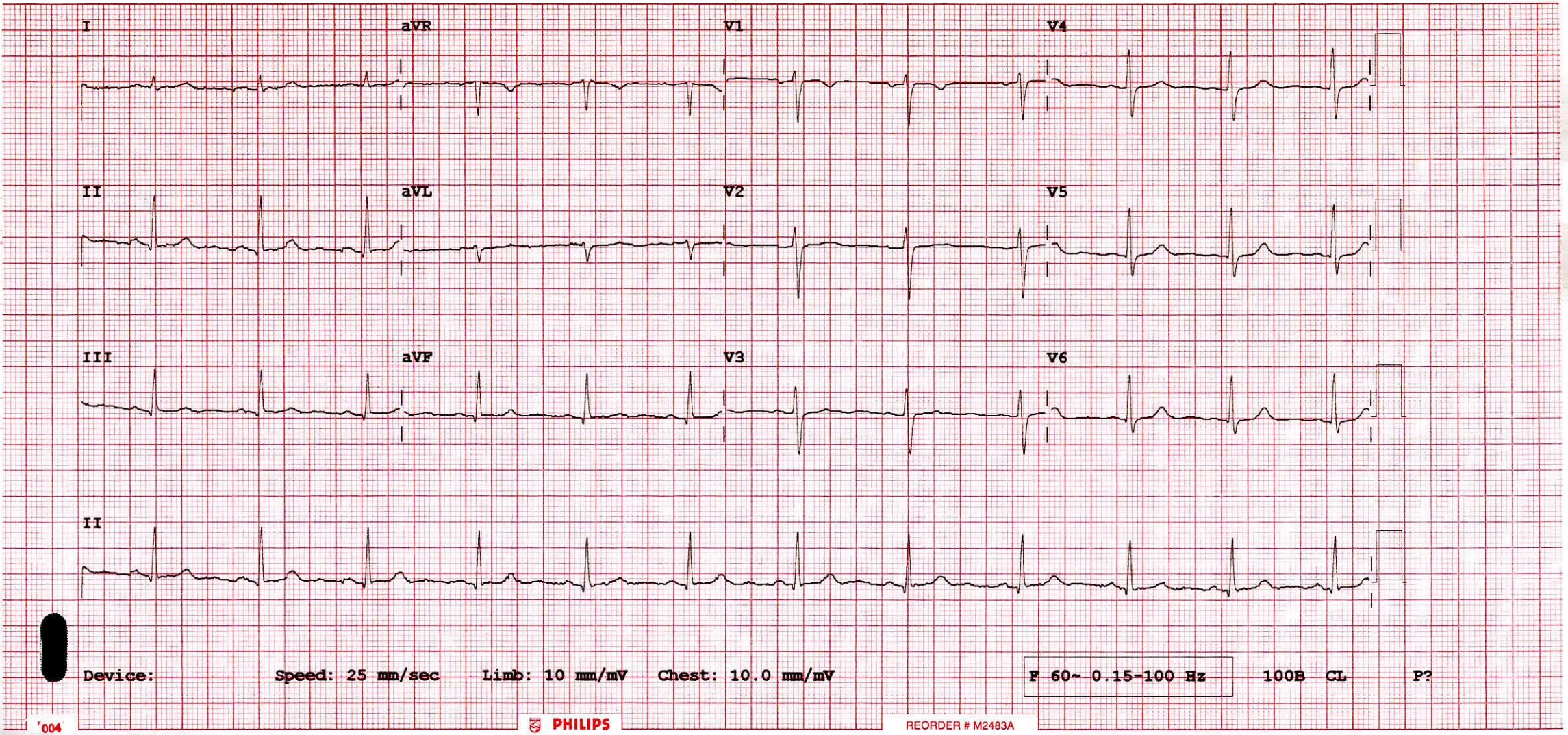
PR 150
QRSD 102
QT 357
QTc 391

--AXIS--
P 57
QRS 78
T 49

- 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?

'004 PHILIPS REORDER # M2483A

MEDICOVER
HOSPITALS

Patient ID:	*NMU0048896*	*Patient Name:*	*AYNA DHAND*
Age:	*36 Years*	*Sex:*	*F*
Accession Number:	*NMBC63400*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*23-Mar-2024*	*Study Time:*	*13:04:29*

USG ABDOMEN & PELVIS

The Liver is normal in size (15.2 cm) and shows grade I fatty change. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is contracted. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size (11.8 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 10.2 x 3.8 cm.
The Left Kidney measures 10.1 x 4.0 cm.
There is no evidence of a calculus, hydronephrosis, or hydroureter.

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

The uterus is normal in size and echotexture. It measures 6.5 x 3.8 x 4.2 cm.
No focal lesion is seen. The Endometrial thickness is 10.8 mm.

Both ovaries are well visualized and appear normal in size and echotexture.
The Right ovary measures 2.5 x 1.3 cm
The Left ovary measures 2.6 x 1.5 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:

Grade I fatty liver.
No other significant abnormality is seen.

DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 23-Mar-2024 19:13:20

MEDICOVER HOSPITALS
NAVI MUMBAI

Ayna Dhand.

S/B :- Dr. Mandira Kamble

O/E :- Caries c $\frac{8}{8\ 6|8}$.

Advice :- Oral prophylaxis.

Restoration c $\frac{}{86|8}$

Surgical extraction c $\frac{8}{}$

MKamble

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

MEDICOVER HOSPITALS

NAVI MUMBAI

Patient ID:	*NMU0048896*	*Patient Name:*	*AYNA DHAND*
Age:	*36 Years*	*Sex:*	*F*
Accession Number:	*NMBC63400*	*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.**

DR JAMILA FANI
Consultant Radiologist
MBBS, MD
Date: 25-Mar-2024 18:01:22