DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	**Report Date**	: 23-Mar-24 05:29 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	10 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.030	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		25-30	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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MEDICOVER
HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	**Report Date**	: 23-Mar-24 05:29 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	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	**Report Date**	: 23-Mar-24 12:21 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	3.89	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		7.0	12.0 - 15.0 g/dl	
PCV/HCT		24.1	40 - 50 % 36 - 46 %	
MCV		62	83 - 101 fl 83 - 101 fl	
MCH		17.9	27 - 32 pg	
MCHC		28.9	31.5 - 34.5 g/dL	
RDW(cv)		18.1	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	378	150 - 400 10^3/µL	
MPV		9.6	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	5.7	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	46	40 - 80 %	
LYMPHOCYTES		43	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		07	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Moderate anisopoikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes and some target cells.		
WBC		Normal morphology.		
PLATELETS		Adequate in smear.		
ADVISED		Serum iron studies.		
ESR	CITRATED BLOOD	22	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***

DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	Age /Gender	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	Referred By	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	Report Date	: 23-Mar-24 02:24 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	**Report Date**	: 23-Mar-24 10:47 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.3	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.7	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		117	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		109	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		ABSENT		
T3,T4 AND TSH				
T3		185.4	70 - 204 ng/dL	Method : ECLIA
T4		9.23	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		4.28	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.61	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.61	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		11.5	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.4	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		66	<= 33 U/L	Method : UV without P5P
SGOT (AST)		51	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		119	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.

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DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:27 am	**Report Date**	: 23-Mar-24 12:33 pm

Parameters	Specimen	Result	Biological Reference In	Method
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.55	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		53	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		155	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		36	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		100	Optimai : - < 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		22		
SERUM TRYGLYCERIDES		112	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.31	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.78		
SERUM URIC ACID		3.6	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		110	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Miss. ANJALI PATIL	**Age /Gender**	: 38 Y(s)/Female
Bill No/ UMR No	: NMBC63332/NMU0048884	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:47 am	**Report Date**	: 25-Mar-24 10:12 am

Parameter	Specimen	Result Values	Biological Reference	Method

Lab Incharge

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

Verified By : : 022633

Test results related only to the item tested.

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER
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NAVI MUMBAI

DATE: 23/3/24
PATIENT NAME: Ms Anjali patil
AGE / SEX : 38/F
UMR NO : NMMU0048884

	RE	LE
VA (DISTANCE)	6/9	6/9
VA(NEAR)	N8	N8
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA	Near
MRx	O	D	±	-0.50	180°	6/6	+1.25 → N6
	O	S	±	-0.50	180°	6/6	+1.25 → N6

HISTORY :

No H/o spectacle No H/o ocular trauma
No H/o DM, HTN.

OCULAR FINDINGS :

(BE) - Ant seg WNL
(undilated) Disc < 0.2 / 0.2

ADVICE: Zivifresh e/d qid 1 ? ? ? X 1 month

AS
(DR. ANUSHREE VANKAR)

MEDICOVER
HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

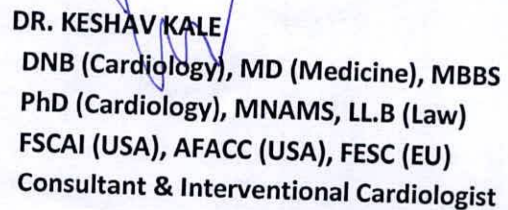
Name	: Mrs Anjali Patil	Date:- 23/03/2024
Age / Sex	: 41Yrs / Female	UMR No. 0048884
Referred By	: Health Checkup	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I 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-30mmHg
- 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:

- **Grade I left ventricle diastolic dysfunction**
- **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	30			Trivial
PULMONERY	5.3			Nil

MEDICOVER
HOSPITALS

Patient ID:	NMU0048884	Patient Name:	ANJALI PATIL
Age:	38 Years	Sex:	F
Accession Number:	NMBC63332	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	23-Mar-2024		

ULTRASOUND EXAMINATION OF THE BREAST

Real -Time Sonography of both the Breasts was done with a high resolution linear transducer.

Normal glandular breast parenchyma is seen in both breasts.

Small simple cyst measuring 2.6 mm is seen in peri-areolar region at 11 o' clock position of left breast.

Small cyst with septation measuring 5 x 2 mm is seen at 9 o' clock position in peri-areolar region of right breast.

There is no evidence of any ductal dilatation seen in the retro-areolar region.

Small reactive lymph nodes with maintained fatty hilum are seen in both axilla.

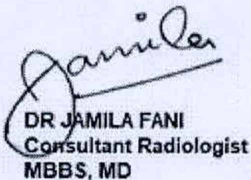
IMPRESSION:

- **Small cyst with septation in right breast.**
- **Small cyst in left breast.**

BIRADS II - (Benign findings)

***Suggest: X-raymammography after 1 year**

*(**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 12:40:20

MEDICOVER
HOSPITALS

Patient ID:	NMU0048884	Patient Name:	ANJALI PATIL
Age:	38 Years	Sex:	F
Accession Number:	NMBC63332	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	23-Mar-2024		

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size and shows a normal parenchymal reflectivity. No focal lesion is seen. The Hepatic veins appear normal. There is no evidence of any dilated IHBR. 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 shows homogeneous reflectivity. There is no evidence of any calcification or ductal dilatation.

The spleen is normal in size and shows a homogeneous echotexture. It measures 11.9 cm in long axis. There is no evidence of any focal lesion.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction. The Right Kidney measures 10.3 x 4.2 cm. The Left Kidney measures 10.2 x 5.2 cm.
There is no evidence of renal calculi, hydronephrosis, or mass noted.

There is no evidence of ascites or para aortic lymphadenopathy.

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

The uterus is Retroverted. It measures 9.9 x 5.1 x 4.0 cm.
The uterine myometrial echotexture is homogeneous. No focal lesion is seen.
The Endometrial thickness is 9-10 mm.

Multiple small nabothian cysts are seen at cervix.

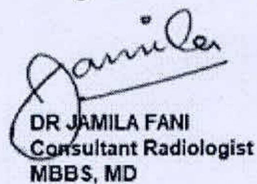
Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 2.6 x 2.3 cm. The Left ovary measures 3.7 x 2.0 cm.

There is no evidence of any ovarian or adnexal mass lesion.

No evidence of any fluid collection in the pelvis.

IMPRESSION:

No significant abnormality is seen.



DR JAMILA FANI
Consultant Radiologist
MBBS, MD
Date: 23-Mar-2024 12:41:25