MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 06:30 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		CLEAR	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.
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	0-1	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		NIL	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 06:30 pm

Parameters	Specimen	Result	Biological Reference In	Method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 12:27 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.40	4.5 - 5.5 10^6/µL	
HEMOGLOBIN		13.3	13.0 - 17.0 g/dl	
PCV/HCT		40.9	40 - 50 % 36 - 46 %	
MCV		93	83 - 101 fl 83 - 101 fl	
MCH		30.3	27 - 32 pg	
MCHC		32.6	31.5 - 34.5 g/dL	
RDW(cv)		14.6	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	120	150 - 400 10^3/µL	
MPV		11.9	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.2	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	56	40 - 80 %	
LYMPHOCYTES		34	20 - 40 %	
MONOCYTES		08	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisopoikilocytosis. Predominantly normocytic normochromic with ovalocytes.		
WBC		Normal morphology.		
PLATELETS		Mildly reduced in smear. Macroplatelets platelets are also seen.		
ESR	CITRATED BLOOD	22	0 - 10 mm/1st hour	WESTERGREN`S METHOD

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 04:06 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 11:43 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		114	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
SERUM CREATININE				
CREATININE		0.89	0.8 - 1.3 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		16	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.89	0.8 - 1.3 mg/dL	
BUN / CREATININE RATIO		17.97	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.9	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.3	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.6	<= 1.0 mg/dL	
SGPT (ALT)		35	<= 41 U/L	Method : UV without P5P
SGOT (AST)		22	<= 40 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		82	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.6	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.8	2.5 - 3.5 g/dL	
A/G RATIO		1.64	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		30	10 - 71 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		16	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				

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DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 08:57 am	**Report Date**	: 23-Mar-24 11:43 am

Parameters	Specimen	Result	Biological Reference In	Method
TOTAL CHOLESTEROL		169	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		39	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		112	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		26		
SERUM TRYGLYCERIDES		131	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.33	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.87		
SERUM URIC ACID		7.0	3.4 - 7.0 mg/dL	uricase
T3,T4 AND TSH				
T3		131.6	70 - 204 ng/dL	Method : ECLIA
T4		7.26	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.14	0.270 - 4.20 uIU/mL	Method : ECLIA
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		99	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		114	110 - 180 mg/dL	Hexokinase
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mr. LOKESH KUMAR	**Age /Gender**	: 36 Y(s)/Male
Bill No/ UMR No	: NMBC63349/NMU0048874	**Referred By**	: Dr. DMO
Received Dt	: 23-Mar-24 11:43 am	**Report Date**	: 25-Mar-24 10:15 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 HOSPITALS
NAVI MUMBAI

DATE: 23/03/24

PATIENT NAME: Mr Lokesh Kumar AGE / SEX 36/M

UMR NO : NAVU00 48874

	RE	LE
VA (DISTANCE)	6/6	6/6 CB)
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O (R)	D	±	———	———	6/6, N6
	O (L)	S	±	−0.50	160°	6/6, N6

HISTORY :

No H/O. Systemic Illness &. No H/O spectacle
No H/O ocular trauma Allegies & surgeries.

OCULAR FINDINGS : - H/o Lasik done in 2012 in (BE).

(BE) – Ant seg WNL

(Undilated) Disc – 0.4
0.3

ADVICE:

Refresh Tears eld gid 1 mm x 1 month
(BE) Dilated Eye Examination (Fundus)

AS
CDR-ANUSHREE VANKAR

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HC 48874 LOKESH KUMAR 3/23/2024 10:39:10 AM
36 Years Male

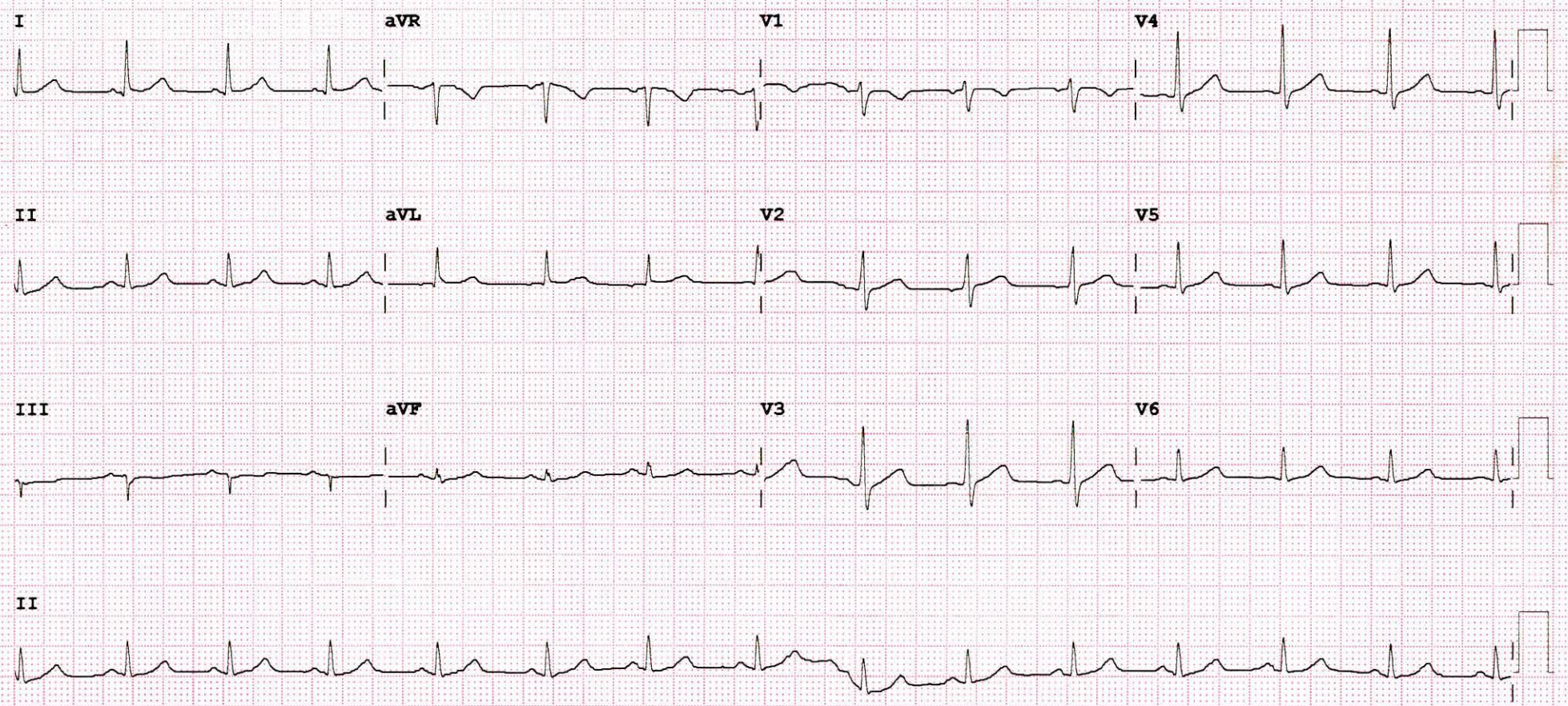
Rate	86	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. Borderline short PR interval.....PR int <120mS
PR	119	. Abnormal R-wave progression, early transition.....QRS area>0 in V2
QRSD	86	. Baseline wander in lead(s) II
QT	365	
QTc	437	

--AXIS--
P 66
QRS 9
T 22

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis

WNL



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.50~ 40 Hz W 100B CL P?

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: Mr. Lokesh Kumar	Date:- 23/03/2024
Age / Sex	: 36 Yrs / Male	UMR No. 0048974
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 = 25 mm Hg.
- 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 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	29	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	41	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	5			Nil
TRICUSPID	25			Trivial
PULMONERY	4.1			Nil

MEDICOVER HOSPITALS

Patient ID:	*NMU0048874*	*Patient Name:*	*LOKESH KUMAR*
Age:	*36 Years*	*Sex:*	*M*
Accession Number:	*NMBC63349*	*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 (14.8 cm) and shows mild increase in parenchymal reflectivity. 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 shows homogeneous reflectivity.

The spleen is normal size. It measures 9.2 cm in long axis. No focal lesion is seen.

Both kidneys are normal in position and size. They show normal cortical reflectivity and cortico-medullary distinction.
The Right Kidney measures 11.9 x 4.7 cm.
The Left Kidney measures 12.8 x 4.9 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 partially distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

The Prostate gland is normal in size.
It has smooth outlines and normal reflectivity.
It measures 3.8 x 3.1 x 3.1 cm corresponding to an estimated weight of 19.2 gms.

IMPRESSION:

- **Mild fatty infiltration of liver.**
- **No other significant abnormality is seen**

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 23-Mar-2024 10:18:48

MEDICOVER HOSPITALS

Patient ID:	*NMU0048874*	*Patient Name:*	*LOKESH KUMAR*
Age:	*36 Years*	*Sex:*	*M*
Accession Number:	*NMBC63349*	*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 17:17:44