MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:04 am	**Report Date**	: 25-Mar-24 12:54 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	25ML		
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.
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	2-3	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		10-12	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		OCCASIONAL		MICROSCOPIC EXAMINATION
YEAST		OCCASIONAL		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
SPERMATOZOA				MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:04 am	**Report Date**	: 25-Mar-24 12:54 pm

Parameters	Specimen	Result	Biological Reference In	Method

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DEPARTMENT OF LABORATORY

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Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:04 am	**Report Date**	: 25-Mar-24 10:57 am

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
ESR	CITRATED BLOOD	45	0 - 20 mm/1st hour	WESTERGREN`S METHOD
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.61	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		10.0	12.0 - 15.0 g/dl	
PCV/HCT		32.1	40 - 50 % 36 - 46 %	
MCV		70	83 - 101 fl 83 - 101 fl	
MCH		21.8	27 - 32 pg	
MCHC		31.2	31.5 - 34.5 g/dL	
RDW(cv)		15.1	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	433	150 - 400 10^3/µL	
MPV		7.7	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	9.9	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	68	40 - 80 %	
LYMPHOCYTES		26	20 - 40 %	
MONOCYTES		04	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC		Mild anisocytosis moderate poikilocytosis. Microcytic hypochromic with ovalocytes, elliptocytes and some target cells.		
WBC		Normal morphology.		
PLATELETS		Mildly increased in smear.		
ADVISED		Serum iron studies.		
BLOOD GROUPING AND RH				
BLOOD GROUP	Blood	" AB "		TUBE AGGLUTINATION
RH TYPE		NEGATIVE		

*** End Of Report ***

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Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:04 am	**Report Date**	: 25-Mar-24 03:56 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:05 am	**Report Date**	: 25-Mar-24 10:57 am

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		90	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
SERUM ELECTROLYTES				
SERUM SODIUM		145	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.8	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		106	98 - 107 mmol/L	ISE INDIRECT
T3,T4 AND TSH				
T3		112.0	70 - 204 ng/dL	Method : ECLIA
T4		6.43	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.64	0.270 - 4.20 uIU/mL	Method : ECLIA
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		0.66	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		0.66	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		12.12	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		Less than 0.2	< 1.2 mg/dL	
DIRECT BILIRUBIN		Less than 0.1	<= 0.20 mg/dL	
SGPT (ALT)		12	<= 33 U/L	Method : UV without P5P
SGOT (AST)		15	<= 32 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		7.6	6.0 - 8.0 g/dL	Method : Biuret method

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 10:04 am	**Report Date**	: 25-Mar-24 10:57 am

Parameters	Specimen	Result	Biological Reference In	Method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.1	2.5 - 3.5 g/dL	
A/G RATIO		1.45	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		11	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
NOTE		The results for Total and Direct Bilirubin have been reported as less than 0.2 and 0.1 mg/dL, respectively, as the values obtained are less than the lower detection limit of the assays. Hence, the Indirect Bilirubin could not be calculated.		
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		8	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.6	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		192	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		53	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		136	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		14		
SERUM TRYGLYCERIDES		69	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.62	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.57		
SERUM URIC ACID		3.9	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		115	110 - 180 mg/dL	Hexokinase

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Patient Name	: Mrs. SHRUTI SANKET JOSHI	**Age /Gender**	: 32 Y(s)/Female
Bill No/ UMR No	: NMBC63554/NMU0049048	**Referred By**	: Dr. DMO
Received Dt	: 24-Mar-24 12:46 pm	**Report Date**	: 25-Mar-24 10:57 am

Parameter	Specimen	Result Values	Biological Reference	Method
URINE SUGAR		NIL		Dipstick

*** End Of Report ***

Lab Incharge

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

Verified By : : 026560

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MEDICOVER HOSPITALS

Patient ID:	*NMU0049048*	*Patient Name:*	*SHRUTI SANKET JOSHI*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63554*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*24-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: 24-Mar-2024 12:38:31

MEDICOVER
HOSPITALS

Patient ID:	*NMU0049048*	*Patient Name:*	*SHRUTI SANKET JOSHI*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63554*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*24-Mar-2024*		

ULTRASOUND EXAMINATION OF ABDOMEN & PELVIS

The Liver is normal in size (14.5 cm) 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 8.9 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 9.7 x 3.4 cm.
The Left Kidney measures 10.3 x 4.3 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 7.6 x 5.0 x 3.7 cm.
The uterine myometrial echotexture is homogeneous. Few small intramural fibroids are seen in anterior and posterior wall largest measuring 5 mm in posterior wall.

The Endometrial thickness is 5.3 mm. Scar is seen in lower uterine segment.

Both ovaries are well visualized and appear normal in size and reflectivity.
The Right ovary measures 3.1 x 2.0 cm.
The Left ovary measures 3.2 x 2.2 cm.

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

No evidence of any fluid collection in the pelvis.

MEDICOVER HOSPITALS

Patient ID:	*NMU0049048*	*Patient Name:*	*SHRUTI SANKET JOSHI*
Age:	*32 Years*	*Sex:*	*F*
Accession Number:	*NMBC63554*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*24-Mar-2024*		

IMPRESSION:

- **Small uterine fibroids.**
- **No other significant abnormality is seen.**

DR JAMILA FANI
Consultant Radiologist
MBBS, MD

Date: 25-Mar-2024 16:12:50

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. Shrushti Joshi**	**Date:-24/03/2024**
Age / Sex	: **32 Yrs / Female**	**UMR No. 0049048**
Referred By	: **Health check up**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 25 mm Hg.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal left atrium and left ventricle dimensions.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Trivial TR. No PH.**
- **Normal LV and RV systolic function.**

DR. SAMEER VANKAR
MD DM CARDIOLOGY

M-MODE MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Nil
AORTIC	78			Nil
TRICUSPID	25			Trivial
PULMONERY	4.1			Nil

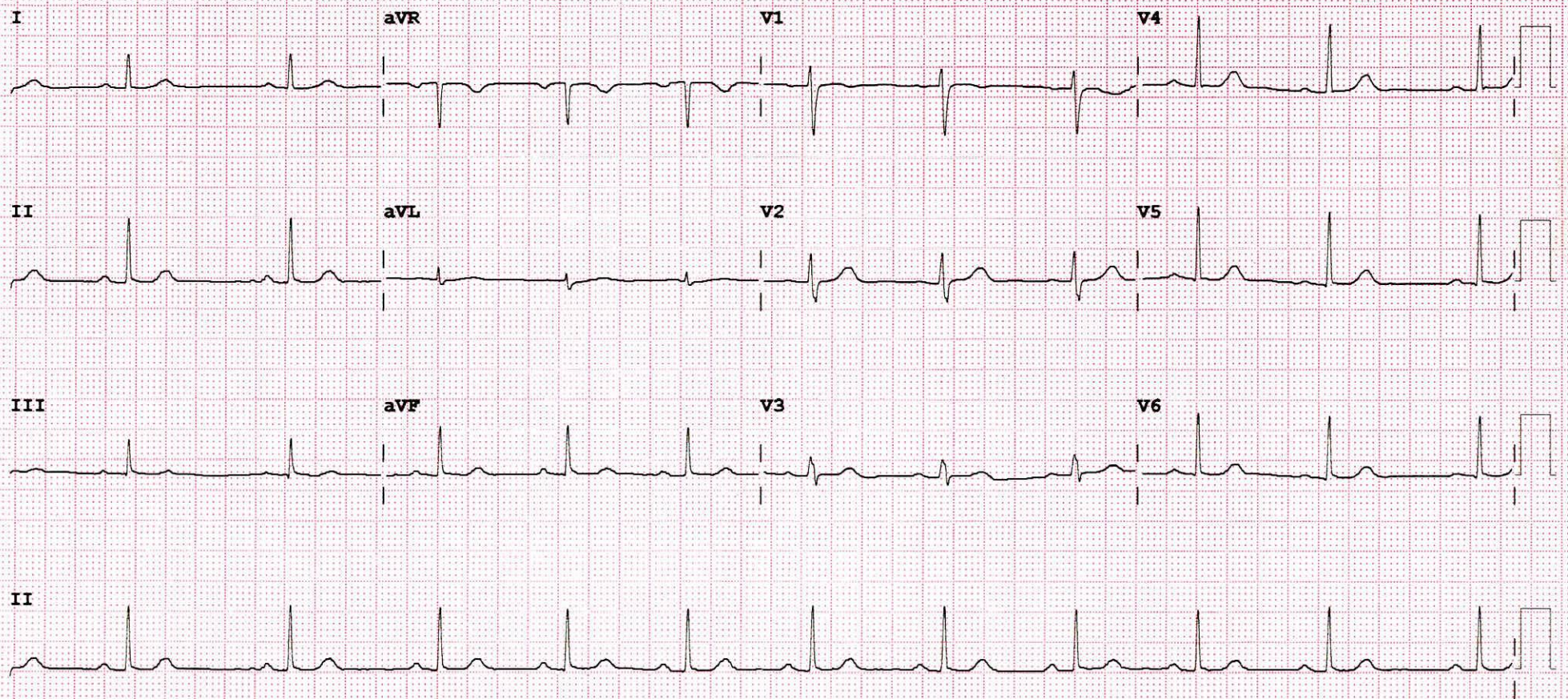
NMU0049048 SHRUTI JOSHI 3/24/2024 11:19:35 AM
32 Years Female

Rate 68 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Baseline wander in lead(s) V3
PR 174
QRSD 75
QT 367
QTc 391

--AXIS--
P 50
QRS 56
T 39

- NORMAL ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis



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