



UHID : _____
 NAME : _____
 AGE : _____ SEX : _____
 Doctor In Charge: _____



OPD Nursing Assessment - Adult

Date :

Name: Shital jagare Date of Birth : 39 Age/Sex: F UMR No.: 278180

Assessment :

Height: 163 cms Weight: 53.5 kg. BMI: _____ Respiration: _____ /min Pulse H/R : 83 /min
 BP: 120/80 mmHG Temperature : _____ SpO2 99 % BSR _____ mg/dl

Chief Complaints : H.C

Nutritional Screening :

Diet : med diet

Remark : _____

- Status : Weight Loss / Gain in Last 3 Months Yes No
- If Weight Loss / Gain-Dietary Referral Yes No
- Psychological Assessment Agitated Anxious Yes No
(If Agitated, Inform Phys cian) Irritable

Any Allergies Known Including Drugs : _____

Past History: Any Surgeris Explain : No

Any Other illness: Explain No

Pain Score: Numerical Scales (1-10) _____ Location No Characteristics _____

Need to be seen immediately by the Doctor no 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
<u>Anuradha</u>	<u>20787</u>	<u>[Signature]</u>	<u>20/3/24</u>



DEPARTMENT OF HAEMATOLOGY

Patient Name : Mrs. SHITAL VISHAL PAGAR	Age /Gender : 39 Y(s)/Female
Bill No/ UMR No : NSB278180/NSU135564	Referred By : Dr. ER PHYSICIAN
Received Dt : 29-Mar-24 10:53 am	Report Date : 29-Mar-24 01:05 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
HAEMOGLOBIN	Blood	13.4	11.7 - 15.5 g/dL	Automated Cell Counter cyanmethemoglobin
RED BLOOD CELLS		4.33	3.9 - 5.0 milli/cumm	Automated Cell Counter Electrical Impedance
PCV (PACKED CELL VOLUME)		40.2	39 - 49 %	Automated Cell Counter Calculated
MCV (MEAN CORPUSCULAR VOLUME)		93	35 - 45 %	Automated Cell Counter Calculated
MCH (Mean Corpuscular Hemoglobin)		30.8	82 - 95 fl	Automated cell counter calculated
MCHC (Mean Corpuscular Hemoglobin Concentration)		33.2	27 - 31 pg	Automated cell counter calculated
RDW (Red cell Distribution Width)		12.6	32 - 36 g/dL	Automated cell counter calculated
WHITE BLOOD CELLS (WBC)		4700	11.5 - 14.0 %	Automated Cell Counter Calculated
NEUTROPHILS		52	4000 - 11000 Cells/cumm.	Automated Cell Counter Electrical Impedance
LYMPHOCYTES		42	50 - 75 %	Microscopy
MONOCYTES		04	20 - 40 %	Microscopy
EOSINOPHILS		02	0 - 10 %	Microscopy
BASOPHILS		00	0 - 6 %	Microscopy
PLATELET COUNT		266000	0 - 1 %	Microscopy
MPV (Mean Platelet Volume)		8.6	150000 - 450000 /cumm.	Automated Cell Counter Electrical Impedance
			6 - 9.5 fL	Automated cell counte calculated
BLOOD GROUPING RH TYPING				
BLOOD GROUP		B		
RH (D) TYPING		Positive		
Erythrocyte Sedimentation Rate (ESR)		20	0 - 20 mm at 1 hr	westergren's

*** End Of Report ***



DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. SHITAL VISHAL PAGAR	Age / Gender : 39 Y(s)/Female
Bill No/ UMR No : NSB278180/NSU135564	Referred By : Dr. ER PHYSICIAN
Received Dt : 29-Mar-24 10:53 am	Report Date : 29-Mar-24 01:05 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
T3 T4 TSH				
TRI ICDO THYRONINE (T3)		0.88	0.8 - 2.0 ng/mL	ECLIA
THYROXINE (T4)		5.53	5.1 - 14.1 µg/dL	ECLIA
THYROID STIMULATING HORMONE (TSH)		2.77	0.27 - 4.2 µIU/mL	ECLIA
SERUM CREATININE				
SERUM CREATININE		0.61	0.50 - 0.90 mg/dL	Kinetic Jaffe's reaction (Roche)
BLOOD UREA NITROGEN (BUN)		4.53	6.0 - 20.0 mg/dL	Calculated
LIVER FUNCTION TEST (LFT)				
TOTAL SERUM PROTEINS		7.14	6.4 - 8.3 g/dL	Biuret reaction
SERUM ALBUMIN		4.38	3.5 - 5.2 g/dL	Colorimetric (BCG)
GLOBULINS		2.76	1.8 - 3.6 g/dl	Calculated
A/G RATIO		1.59	0.8 - 2.0	Calculated
SGPT (ALT)		16.60	0 - 33 U/L	Kinetic (IFCC)
SGOT (AST)		21.00	0 - 32 U/L	Kinetic (IFCC)
TOTAL BILIRUBIN		0.64	0.1 - 1.2 mg/dL	Colorimetric (Diazo)
DIRECT BILIRUBIN		0.23	0.0 - 0.4 mg/dL	Colorimetric (Diazo)
INDIRECT BILIRUBIN		0.41	0.2 - 1.5 mg/dL	Calculated
ALKALINE PHOSPHATASE(ALP)		51.00	35 - 104 U/L	Colorimetric (IFCC)
LIPID PROFILE				
TOTAL CHOLESTEROL		153.40	Desirable : < 200 mg/dL Borderline high : 200 - 239 mg/dL High : >= 240 mg/dL 0 - 200 mg/dL	CHOD-PAP
SERUM TRYGLYCERIDES		27.70	Desirable : < 200 mg/dL High : > 400 mg/dL Border line : 200 - 240 mg/dL 0 - 200 mg/dL	Lipoprotein Lipase
HDL CHOLESTEROL		70.90	40 - 60 mg/dL Desirable : >= 40 mg/dL	Direct Measure - PEG
LDL CHOLESTEROL		92.20	Border line : 100 - 130 mg/dL High : > 130 mg/dL Desirable : < 100 mg/dL	Direct Estimation
VLDL		5.54	0 - 40 mg/dL	Calculated



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DEPARTMENT OF BIOCHEMISTRY

Patient Name : Mrs. SHITAL VISHAL PAGAR	Age /Gender : 39 Y(s)/Female
Bill No/ UMR No : NSB278180/NSU135564	Referred By : Dr. ER PHYSICIAN
Received Dt : 29-Mar-24 10:53 am	Report Date : 29-Mar-24 02:46 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
LDL/HDL RATIO		1.30	2.5 - 3.5	
CHOL/HDL RATIO		2.16	3.5 - 5	
SERUM URIC ACID		3.10	2.4 - 5.7 mg/dL	Enzymatic Colorimetric Assay (Uricase)
GAMMA GT				
GAMMA GLUTAMYL TRANSFERASE(GGT)		18.00	< 38 U/L	Enzymatic IFCC
POST PRANDIAL PLASMA / SERUM GLUCOSE(PPBS)		96.6	80 - 140 mg/dL	Hexokinase
GLYCOSYLATED HAEMOGLOBIN (HbA1c)		5.47	NORMAL : 4.0 - 6.0 % increased risk of diabetes : 6.0 - 6.4 % indicate diabetes : > 6.5 %	Enzymatic
FASTING PLASMA /SERUM GLUCOSE (FBS)		85.2	70 - 110 mg/dL	

*** End Of Report ***

Lab Incharge

Dr. KAVITA GITE, MBBS, MD Path
CONSULTANT PATHOLOGIST



A Unit of Sahrudaya Health Care Private Limited

DEPARTMENT OF LABORATORY

Patient Name : Mrs. SHITAL VISHAL PAGAR	Age /Gender : 39 Y(s)/Female
Bill No/ UMR No : NSB278180/NSU135564	Referred By : Dr. ER PHYSICIAN
Received Dt : 29-Mar-24 10:52 am	Report Date : 29-Mar-24 03:23 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
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COMPLETE URINE TEST

PHYSICAL EXAMINATION

COLOUR	Urine	Pale yellow		
APPEARANCE		Hazy		
PH		6.0	4.6 - 8.0	Dipstick
SP. GRAVITY		1.005	1.005 - 1.030	Dipstick

CHEMICAL EXAMINATION

PROTEIN	Urine	Absent		
SUGAR		Absent		
KETONE BODIES		Absent		
BILE SALTS		Absent		
BILE PIGMENTS		Absent		
BLOOD		PRESENT (Trace)		
NITRITE		Absent		

MICROSCOPIC EXAMINATION

PUS CELLS	Urine	16-18		Microscopy
EPITHELIAL CELLS		1-2		Microscopy
RBC		Occasional		
CASTS		Absent		
CRYSTALS		Absent		
BACTERIA		PRESENT (+)		

*** End Of Report ***



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Transthoracic Echocardiography Report

Name: Mrs. Shata. Pagar

Age / Sex: 39year / F

UMR No: 135564

Date: 29/03/2024

Comments on Echo Doppler evaluation

DIMENSIONS			
	In mm		In mm
Left Ventricle (ED)	40	Left Ventricle (ES)	24
Aorta	20	Left Atrium	20
IVS Thickness (ED)	08	LVPW Thickness (ED)	08
Right Ventricular (ED)			
LV EF	60-65 %.		

- All valves are structurally normal.
- Normal dimensions of all cardiac chambers. LV is of normal shape, with normal cavity size & normal wall thickness
- No regional wall motion abnormalities at rest.
- Normal left ventricular systolic function. The LVEF is 60-65 %.
- No Diastolic Dysfunction.
- No FH.
- There are no intracardiac clots or vegetation. No pericardial effusion.
- IVC collapsing with inspiration. Normal Arch.

Summary :

- Normal dimensions of all cardiac chambers.
- Normal biventricular systolic function, LVEF = 60-65%

Dr. Kanchan Bhavare
MBBS, DNB (Med), DNB (Cardiology)
Reg No : 2011/06/1869
Consultant – Interventional Cardiology

Dr. Girish V. Bachhav
MBBS, DNB (Medicine), DNB (Cardiology)
Reg. No. : 2008/09/3367
Consultant Interventional Cardiology

Note: A Normal echo does not rule out CAD. To correlate clinically.

Rate 68 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
 . Sinus rhythm.....normal P axis, V-rate 50- 99
 PR 134 . Minimal ST depression, inferior leads.....ST <-0.04mV, II III aVF
 QRSD 84 . Baseline wander in lead(s) V3,V5
 QT 417
 QTc 444

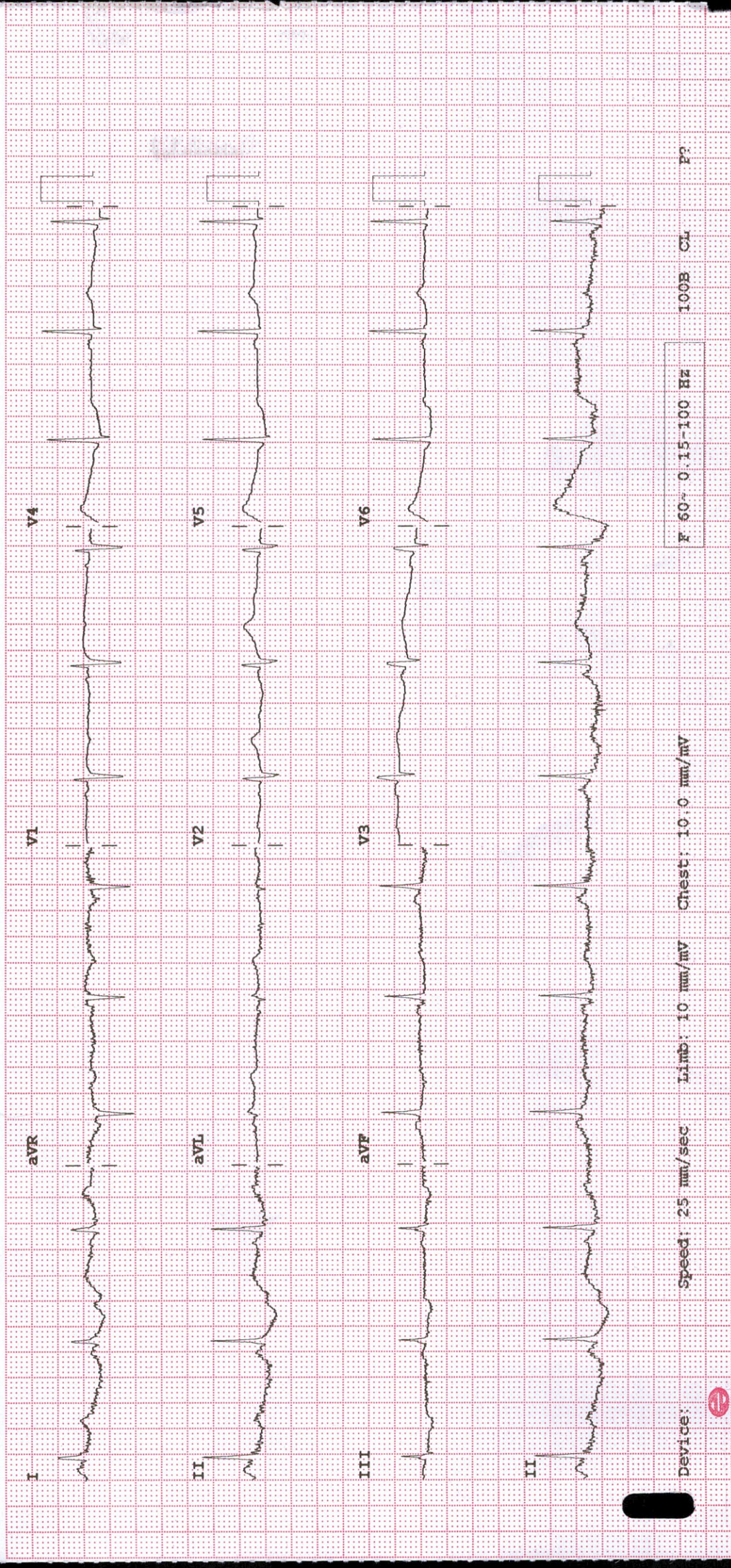
--AXIS--

P 51
 QRS 58
 T 4

12 Lead; Standard Placement

- OTHERWISE NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 60- 0.15-100 Hz

100B CL P2



Patient ID:	NSU135564	Patient Name:	SHITAL VISHAL PAGAR
Age:	39 Years	Sex:	F
Accession Number:	NSB278180	Modality:	US
Referring Physician:	DR.ER PHYSICIAN	Study:	USG ABDOMEN WITH PELVIS
Study Date:	29-Mar-2024		

ULTRASOUND REPORT - ABDOMEN & PELVIS

LIVER: Is normal in size with normal parenchymal echotexture. No mass lesion. No IHBRD. Portal vein is normal. CBD is normal.

GALL BLADDER: Is distended. Luminal surface is regular. No gall stones. No pericholecystic collection. Wall thickness is normal.

SPLEEN: Is normal in size and shows normal echotexture. No focal lesion.

PANCREAS: Head and body appear normal. Tail is obscured by bowel gases. Para aortic region appears normal.

KIDNEYS:

Both kidneys are normal in size & show normal parenchymal echogenicity with maintained CMD.

Right kidney measures 9.7x4.3 cm. No calculus identified. No hydronephrosis. Ureter is not dilated.

Left kidney measures 10.6x5.0 cm. No calculus identified. No hydronephrosis. Ureter is not dilated.

URINARY BLADDER: Is well distended. Lumen is clear. Wall thickness is normal.

UTERUS : Is anteverted and normal (5.0x2.6x8.6cm). No myometrial lesion. ET is thin. IUCD is seen in situ.

OVARIES: Are normal. Right ovary measures 3.0x2.0cm. Left ovary measures 3.1x1.7cm

Bowel loops not dilated.

No ascites.

IMPRESSION:

No significant abnormality.

Clinical correlation is suggested.