



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Kiran Pandey
Age / Gender : 53 Y(s)/Female
Bill No/ UMR No : NMBC60833/NMU0047212
Referred By : Dr. DMO
Received Dt : 09-Mar-24 10:23 am
Report Date : 09-Mar-24 01:59 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.73	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		13.7	12.0 - 15.0 g/dl	
PCV/HCT		40.5	40 - 50 %	
MCV		86	36 - 46 %	
MCH		29.1	83 - 101 fl	
MCHC		34.0	83 - 101 fl	
RDW(cv)		12.1	27 - 32 pg	
PLATELETS				
PLATELET COUNT	Blood	187	31.5 - 34.5 g/dL	
MPV		11.3	11.6 - 14.0 %	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	7.0	150 - 400 $10^3/\mu\text{L}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	57	7.5 - 11.5 fl	
LYMPHOCYTES		33	4.0 - 11.0 $10^3/\mu\text{l}$	
MONOCYTES		08	40 - 80 %	
EOSINOPHILS		02	20 - 40 %	
BASOPHILS		00	02 - 10 %	
ESR	CITRATED BLOOD	90	00 - 06 %	
			0 - 20 mm/1st hour	WESTERGREN'S METHOD

*** End Of Report ***





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Patient Name : Mrs. Kiran Pandey	Age / Gender : 53 Y(s)/Female
Bill No/ UMR No : NMBC60833/NMU0047212	Referred By : Dr. DMO
Received Dt : 09-Mar-24 10:24 am	Report Date : 09-Mar-24 12:54 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		87	Normal Range : 70 - 99 mg/dL	Hexokinase
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.7	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.9	< 5.7 Normal Prediabetic 5.7 - 6.4 % >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		123	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
T3,T4 AND TSH				
T3		95.23	70 - 204 ng/dL	Method : ECLIA
T4		9.93	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		3.12	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.60	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.60	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		20	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.6	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		38	<= 33 U/L	Method : UV without P5P
SGOT (AST)		38	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		106	40 - 129 U/L	Method : PNPP, AMP
TOTAL PROTEINS		8.6	35 - 105 U/L 6.0 - 8.0 g/dL	Buffer - IFCC Ref. Method : Biuret method





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Kiran Pandey	Age / Gender : 53 Y(s)/Female
Bill No/ UMR No : NMBC60833/NMU0047212	Referred By : Dr. DMO
Received Dt : 09-Mar-24 10:23 am	Report Date : 09-Mar-24 04:11 pm

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
SERUM ALBUMIN		4.6	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		4.0	2.5 - 3.5 g/dL	
A/G RATIO		1.15	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		32	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		12	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		8.6	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		197	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		64	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		118	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		19		
SERUM TRYGLYCERIDES		97	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.08	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		1.84		
SERUM URIC ACID		6.3	2.4 - 5.7 mg/dL	uricase
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		98	110 - 180 mg/dL	Hexokinase

*** End Of Report ***





MEDICOVER HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. Kiran Pandey	Age / Gender : 53 Y(s)/Female
Bill No/ UMR No : NMBC60833/NMU0047212	Referred By : Dr. DMO
Received Dt : 09-Mar-24 01:57 pm	Report Date : 11-Mar-24 08:37 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Consultant in Pathology Services

Verified By : : 022633

Test results related only to the item tested.

No part of the report can be reproduced without written permission of the laboratory.

Page 4 of 4



Patient ID:	NMU0047212	Patient Name:	KIRAN PANDEY
Age:	53 Years	Sex:	F
Accession Number:	NMBC60833	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	13:03:56

USG ABDOMEN & PELVIS

The Liver is normal in size (14 cm) and shows normal echotexture. No focal lesion is seen. The Hepatic veins appear normal. There is no IHBR dilatation. The portal vein appears normal.

The gall bladder is not visualised post cholecystectomy status. C.B.D. is of normal caliber.

The Pancreas is normal in size and echotexture.

The spleen is normal size (7.0 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 9.0 x 3.6 cm.

The Left Kidney measures 9.0 x 4.0 cm.

There is no evidence of a calculus, hydronephrosis, or hydroureter.

The Urinary bladder is partially distended. No evidence of any intraluminal mass or calculi.

The uterus is normal in size and echotexture. It measures 6.7 x 4.3 x 3.3 cm.

No focal lesion is seen. The Endometrial thickness is 2.0 mm.

Both ovaries are well visualized and appear normal in size and echotexture.

The Right ovary measures 2.1 x 1.3 cm

The Left ovary measures 2.1 x 1.4 cm

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

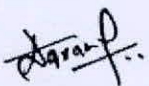
Visualised bowel loops are unremarkable.

There is no evidence of significant lymphadenopathy.

No ascitis is seen.

IMPRESSION:

- No significant abnormality is seen.



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 09-Mar-2024 13:16:50

Patient ID:	NMU0047212	Patient Name:	KIRAN PANDEY
Age:	53YRS	Sex:	F
Accession Number:		Modality:	CR
Referring Physician:		Study:	BREAST
Study Date:	09-Mar-2024		

X-RAY MAMMOGRAPHY

INDICATION: Routine screening.

MAMMOGRAPHY

Bilateral mammograms were obtained in the oblique mediolateral and craniocaudad projections.

The film markers are placed on the axillary / lateral part of the breast.

Both breasts display almost entirely fatty parenchyma (ACR category a).

There is no focal spiculated mass lesion seen.

There are no clusters of microcalcification, distortion of the lobular architecture or nipple retraction.

Skin and subcutaneous tissues are normal.

Small subcentimeter sized lymph nodes are seen in both axilla.

IMPRESSION :-

- No significant abnormality is seen.

BIRADS Category I (Negative)

Suggest a routine screening mammography after one year.

(BIRADS CATEGORY : BIRADS 0 - 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.)

YS
DR. YOGINI SHAH
DMRD, DNB
CONSULTANT RADIOLOGIST

NMU0047212
53 Years

KIRAN PANDEY
Female

3/9/2024 2:10:06 PM

Rate 83 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 141
QRSD 90
QT 344
QTc 405

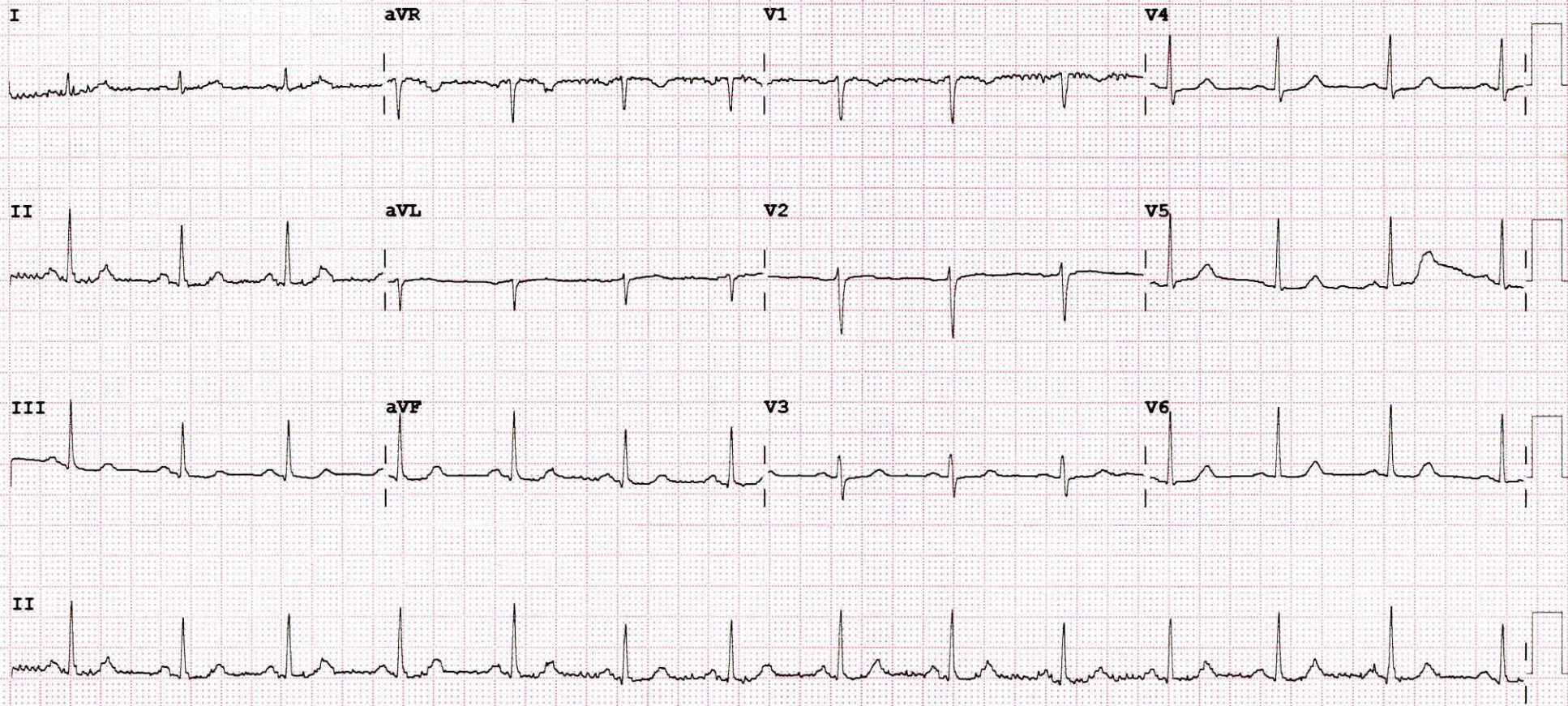
--AXIS--
P 73
QRS 77
T 40

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis

*NIR
LW
Σ*



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.15-100 Hz 100B CL P?



2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mrs. Kiran pandey

Date:-09/03/2024

Age / Sex : 53 Yrs /Female

UMR No. 0047212

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.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 20 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 MR and TR. No PH.
- Normal LV and RV systolic function.



DR. SAMEER VANKAR
MD DM CARDIOLOGY



MEDICOVER
HOSPITALS

NAVI MUMBAI

M-MODE MEASUREMENTS:

LA	34	mm
AO root	28	mm
AO CUSP SEP	19	mm
LVID(s)	32	mm
LVID(d)	43	mm
IVS(d)	10	mm
LVPW(d)	10	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	5			Nil
TRICUSPID	20			Trivial
PULMONERY	4.4			Nil





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 09/03/24

PATIENT NAME: Mrs. Kiron Pande

AGE / SEX:

NAVI MUMBAI

UMR NO: NM000047212

53/F

	RE	LE
VA (DISTANCE)	6/12.	6/12p.
VA (NEAR)	N18	N18
COLOUR VISION	Normal	Normal

		SPHERE	CYLINDER	AXIS	VA	
MRx	O D Ⓡ	+1.00	_____		6/6p	<u>Aeon</u> +2.50 NG
	O S Ⓛ	+1.00	_____		6/6	+2.50 NG

HISTORY :

No h/o HT/Dm/Thyroid.

No spectacle use for near.

No h/o ocular Trauma (BE)

OCULAR FINDINGS :

(BE) - Len - Early NS I

(Unilateral) Disc < 0.3
0.3

ADVICE:

Zivifresh eld qid 1777 X 1month

AI
DR. ANUSHREE VANSHAR





MEDICOVER
HOSPITALS

NAVI MUMBAI

Kian

OE:

	3	4	Missing
6	21	12	7

Stains +++

Calculus +++

Severe Abrasion (Cervical) $\bar{c} \frac{3}{+}$

Adv: complete oral prophylaxis

Dr. Sayali Vasant Mandekar
MDS In Conservative Dentistry
And Endodontics
Reg. No. A-32634.



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Kiran Pandey

DATE: 9/3/24

AGE : 53yrs

SEX: Male/ Female
✓

NMU: NMU000 47212

DOCTOR'S NAME:
Health Package

TEMP :	<u>97.6</u>	° f	BP :	<u>120/70</u>	mmHg
PULSE :	<u>72</u>	b/m	HEIGHT :	<u>148</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>57.1</u>	kg
SPO2 :	<u>99</u>	% RA	HGT:	<u>—</u>	

REMARK:

Patient ID:	NMU0047212	Patient Name:	Kiran Pandey
Age:	53 Years	Sex:	F
Accession Number:	NMBC60833	Modality:	DX
Referring Physician:	DR.DMO	Study:	CHEST
Study Date:	09-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. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 11-Mar-2024 15:01:39