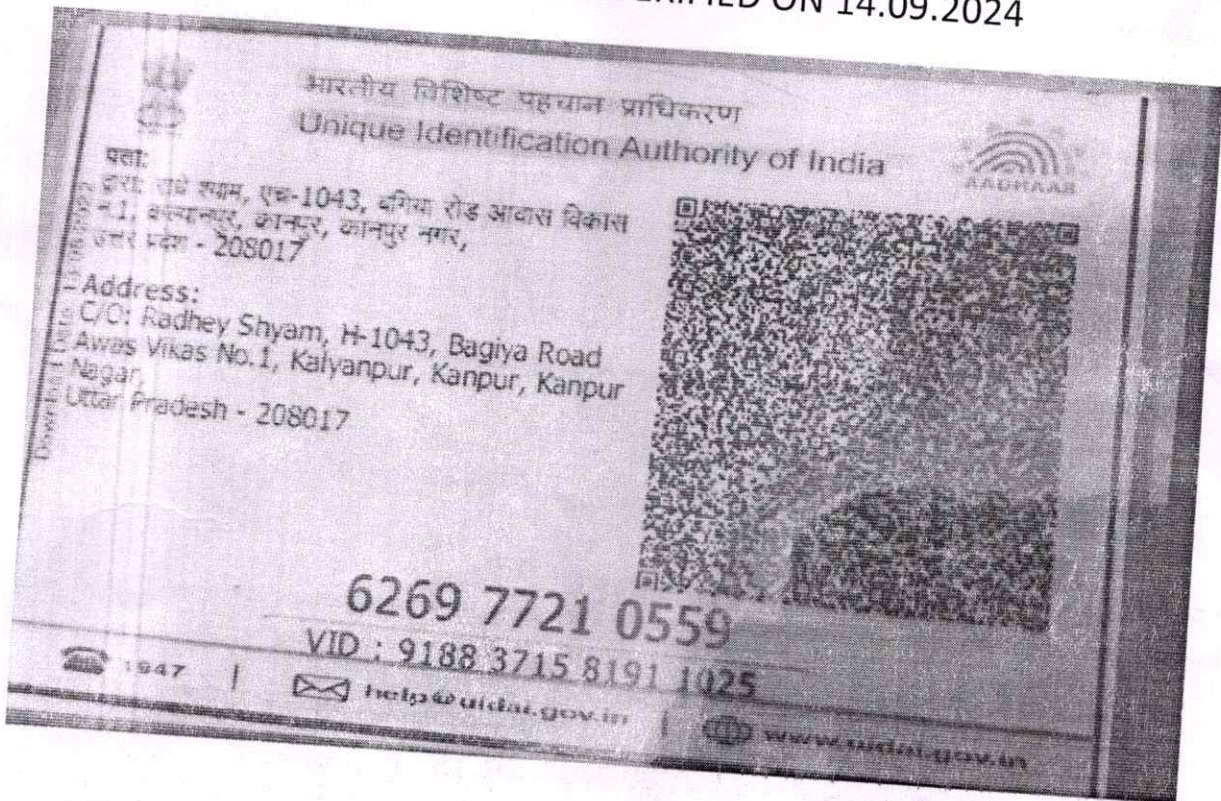


ORIGINAL SEEN AND VERIFIED ON 14.09.2024



POLICY HOLDER SIGNATURE

Handwritten signature





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TOURUS HOSPITAL

(A Unit of Taurus Medicare Pvt. Ltd.)

208, Safipur 1st Ramadevi, G. T. Road, Kanpur-208 007

Ph.: 0512-2400779, 2400774, 2400737, 8601955058 • E-mail: tourushospital@gmail.com



Patient Name	PAVITRI KUREEL	Patient ID	140924-3
Age/D.O.B	50 YRS	Gender	F
Ref Doctor	SELF	Date	14 Sep 24

XRAY RADIOGRAPH CHEST - PA

Observations

Left upper lobe collapse noted.
Mild tenting of right hemidiaphragm.
Dense opacity obscuring vessels with air bronchogram noted in bilateral middle zone suggestive of consolidation.
Hazy opacity obscuring vessels with air bronchogram noted in right upper zone suggestive of consolidation.
The cardiac silhouette is normal.
Both hila are normal.
No focal lung lesion is seen.
Bones of the thoracic cage are normal.

Impression

Left upper lobe collapse noted.
Mild tenting of right hemidiaphragm.
Dense opacity obscuring vessels with air bronchogram noted in bilateral middle zone suggestive of consolidation. Infective etiology needs consideration.
Hazy opacity obscuring vessels with air bronchogram noted in right upper zone suggestive of consolidation. Infective etiology needs consideration.

Reported By,





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14/9/24

PAVITRI

59/F

QDECHO

Normal size LA/LV

NO RWMA

Trace TRIMR (+)

NO PE 1 Apical clot

IVC ~ 12 mm
collapsing 50%
- Rpt

LVEF - 60%



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Pathology Report

Lab. No. : 1027	Date : 14/Sep/2024
Patient Name : Mrs. pavitri kureel	Guardian Name : C/O SANJEEV
Age/Sex : 51 Years/Female	Address : KANPUR,
Referred By : SELF	
0	

Test Name	Observed Values	Unit	Normal Values
Blood Chemistry			
KFT			
CRET	0.67	mg/dl	0.60 - 1.20 mg/dl
UREA	12.69	mg/dl	15.00 - 45.00 mg/dl
BUN	5.31	mg/dl	5.00 - 25.00 mg/dl
UAC	2.65	mg/dl	2.50 - 7.50 mg/dl
Haematology			
ESR-Wintrobe (Erythrocyte Sediment)	14	mm/hr.	
CBC (Complete Blood Counts)			
HB	10.90	mg/dl	10.10 - 15.50 mg/dl
TLC	11500	/CU MM	4000-11000
DLC		%	
NEUTROPHILL	70	%	40.0-80.0
LYMPHOCYTE	23	%	20.0-40.0
MONOCYTE	03	%	2.0-10.0
EOSINOPHILL	04	%	1.0-6.0
BASOPHILL		%	2.00 - 2.00 %
RBC	4.29	U/L	4.7-7.1
PCV	34.6	%	36.0-46.0
MCV	80.7	FL	83.0-101.0
MCH	25.4	%	11-20
MCHC	31.5	g/dl	31.5-34.5
PLatelet count	2.48	lakh/cum	1.50-4.0
RDW-CV	13.6	%	11.6-14.0

Serology

Blood Group ABO+ Rh "O" POSITIVE



Dr. Vishakha Pal
(MD. Path)

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Pathology Report

Lab. No. : 1027
Patient Name : Mrs. pavitri kureel
Age/Sex : 51 Years/Female
Referred By : SELF
0

Date : 14/Sep/2024
Guardian Name : C/O SANJEEV
Address : KANPUR,

Test Name	Observed Values	Unit	Normal Values
Biochemistry			
Lipid Profile (With Direct - HDL & L)			
Cholestrol	131.00	mg/dl	0.00 - 200.00 mg/dl
triglycerides	92.00	mg/dl	0.00 - 150.00 mg/dl
HDL	49.00	mg/dl	35.00 - 80.00 mg/dl
LDL	93.00	mg/dl	0.00 - 130.00 mg/dl
VLDL	22.0	mg/dl	2.00-30.00
Cholesterol/HDL Ratio	2.67		<4.00
LDL/HDL cholesterol Ratio	1.89		<3.50
HDL/LDL Cholestrol Ratio	0.52		<3.50
Blood Chemistry			
L.F.T.			
BILI TOTAL	0.58	mg/dl	0-2.0 mg/dl
BILI DIRECT	0.17	mg/dl	0-0.20 mg/dl
BILI (IND)	0.41	mg/dl	0.20-0.60mg/dl
SGPT(ALT)	28.29	IU/L	up- 34 U/L
SGOT	31.82	IU/L	up-31 IU/L
ALP(ALKALINE PHOSPHATASE)	76.89	IU/L	54-369 IU/L
TOTAL PROTEIN	6.71	g/dl	6.4-8.3 g/dl
ALBUMIN(ALB)	3.62	g/dl	3.5-4.6 g/dl



Dr. Vishakha Pal
(MD. Path)

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Pathology Report

Lab. No. : 1027	Date : 14/Sep/2024
Patient Name : Mrs. pavitri kureel	Guardian Name : C/O SANJEEV
Age/Sex : 51 Years/Female	Address : KANPUR,
Referred By : SELF	
0	

Test Name	Observed Values	Unit	Normal Values
Biochemistry			
BLOOD S/F	70.32	mg/dl	70-100
Clinical			
URINE R/M			
Colour	STRAW		
Appearance	CLEAR		
Specific Gravity	1.015		
Ph	5.0		1,005-1,030
Protien	Nil		4.5-8.0
Glucose	Nil		Nil
Pus Cells	1-2	/hpf	Nil
Epithelial Cells	2-3	/hpf	0-5
RBC	Nil	/hpf	0-5
Casts	Not Seen	/hpf	Nil
Crystals	Not Seen		Not Seen
			Not Seen
Haematology			
HbA1C	5.6	g/dl	< 5.6 % Normal 5.7-6.4% Pre-Diabetes >6.5 % Diabetes 6.5-7.0% Good control 7.0-8.0% Poor control >8.0% Bad control
Hormones & Related Test			
T3, T4 (Total) & TSH 3rd Generation			
T3	1.35		1.30-3.10nmol/L
T4	67.01		66.00-181.00nmol/L
TSH	3.45		0.45-4.50MIU/L



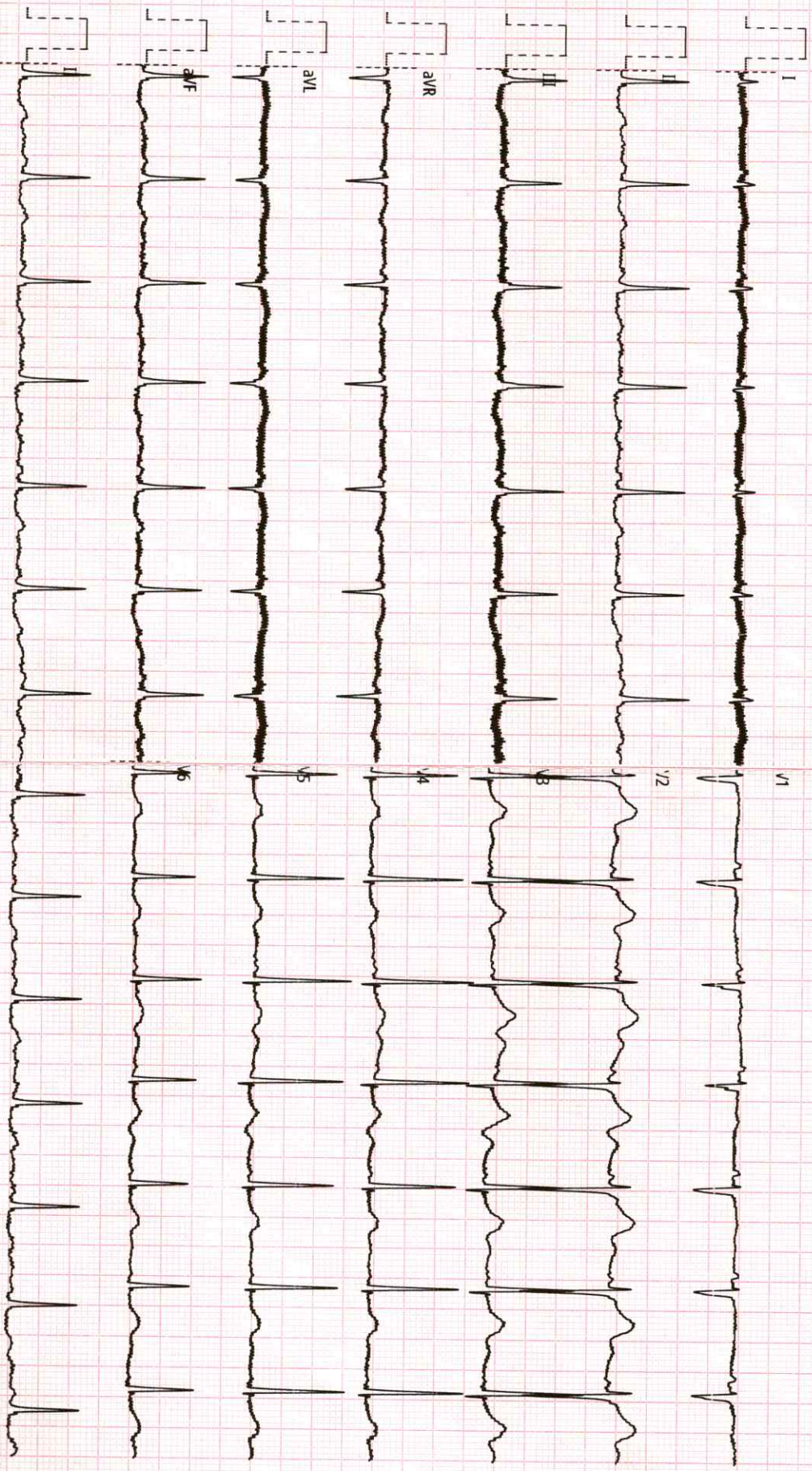
Dr. Vishakha Pal
(MD. Path)

ID : 20240914082534
Name : Pavtri Kureel
Gender : F
Age :
Dept :
Bed No :

HR : 86 bpm
PR : 112 ms
QRS : 72 ms
QT/QTc : 364/410 ms
P/QRS/T : 33/83/-27°
RV5/SV1 : 1.436/0.614 mV
RV5+SV1 : 2.050 mV

ECG report

<< Interpretations >>
Sinus rhythm
-- Interpretation made without knowing patient's
Inferior ST-T abnormality
~ is nonspecific
Borderline ECG



0.3Hz-35Hz -AC 50Hz 25mm/s 10mm/mv 1.0.25 Simultaneous

Examination time : 2024-09-14 08:29:52



RAJNI HOSPITAL

A Unit of Shrimati Rajani Dwivedi Charitable Society
1518/5, Daheli Sujanpur, By Pass Road, Kanpur-208013
(Near Koyla Nagar Police Chowki)
GST NO:- 09AARTS9188A1ZR



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+91 -8004991515

+91 -8004991616

+91 -8933048215

Web : www.rajnihospitalin

Email : rajnihospitalknp@gmail.com

Patient Name : Mrs. PAVITRI PURE

Age : 51years/F

Referred by : Dr. SELF

Date : 14/09/2024

Investigation : USG Whole Abdomen

Liver:

- Liver is normal in size (102mm) and echogenicity. No focal or diffuse lesion seen. Hepatic veins appear normal. No dilation of intrahepatic biliary ducts is seen.

Gall bladder:

- Gall bladder is contracted with Single calculus seen in lumen of the gall bladder. It mea(11mm).

Portal vein:

- Normal in size (mm) and shows normal appearance.

C.B.D.:

- Normal in size (mm) and shows normal caliber.

Pancreas:

- Pancreas is normal in size. No calcification or mass lesion seen.

Spleen:

- Spleen is normal in size. Splenic vein appears normal. No mass lesion or calcification seen.

Right kidney:

- Normal in size (85x37mm) seen in respective renal areas.
- Cortico - medullary differentiation appears to be normal.
- No calculus or mass lesion seen. No hydronephrosis is seen.





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Left kidney:

- Normal in size (96x41mm) seen in respective renal areas.
- Cortico - medullary differentiation appears to be normal.
- No calculus or mass lesion seen. No hydronephrosis is seen.

Ureter:

- Both ureters are normal.

Urinary bladder:

- Normal in size & shape, Wall thickness is normal limit.
- No calculus or mass lesion seen.

Uterus:

- Is atrophied.

Peritoneum/Retroperitoneum:

- **Bowel inflammation loops with gas seen in whole abdomen.**
- No free fluid seen with cul-de-sac. No lymphadenopathy is seen.

Impression:

- **CHOLELITHIASIS**
- **BOWEL INFLAMMATION LOOPS WITH GAS**

ADV: CT- Scan Please correlate clinically.

