



Name : Mr. KUNAL PAWAR  
 Lab ID. : 213193  
 Age/Sex : 21Years / Male  
 Ref By : JINKUSHAL CARDIAC CARE & SUPER SPECIALITY HOS

Collected On : 9/11/2024 11:39 am  
 Received On : 9/11/2024 11:49 am  
 Reported On : 10/11/2024 3:25 pm  
 Report Status : FINAL

**\*LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)</b>	148.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
<b>S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)</b>	33.7	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl.
<b>S. TRIGLYCERIDE (ENZYMATIC, END POINT)</b>	84.8	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
<b>VLDL CHOLESTEROL (CALCULATED VALUE)</b>	17	mg/dL	UPTO 40
<b>S.LDL CHOLESTEROL (CALCULATED VALUE)</b>	97	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
<b>LDL CHOL/HDL RATIO (CALCULATED VALUE)</b>	2.88		UPTO 3.5
<b>CHOL/HDL CHOL RATIO (CALCULATED VALUE)</b>	4.39		<5.0

Above reference ranges are as per **ADULT TREATMENT PANEL III** recommendation by **NCEP (May 2015)**.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By  
 Pathologist

**DR. SMITA RANVEER.**  
**M.B.B.S.M.D. Pathology(Mum)**  
**Consultant Histocytopathologist**  
 Regd.No.: 3401/09/2007





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**COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>HEMOGLOBIN</b>	17.0	gm/dl	13 - 18
HEMATOCRIT (PCV)	50.9	%	42 - 52
RBC COUNT	4.83	x10 <sup>6</sup> /uL	4.70 - 6.50
MCV	<b>105</b>	fl	80 - 96
MCH	<b>35.2</b>	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.9	%	11.5 - 14.5
<b>TOTAL LEUCOCYTE COUNT</b>	7310	/cumm	4000 - 11000
<b><u>DIFFERENTIAL COUNT</u></b>			
NEUTROPHILS	71	%	40 - 80
LYMPHOCYTES	21	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
<b>PLATELET COUNT</b>	257000	/cumm	150 to 410
MPV	10	fl	6.5 - 11.5
PDW	16.6	%	9.0 - 17.0
PCT	0.260	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

**Result relates to sample tested, Kindly correlate with clinical findings.**

----- END OF REPORT -----

Checked By  
SHAISTA Q

**DR. SMITA RANVEER.**  
**M.B.B.S.M.D. Pathology(Mum)**  
**Consultant Histocytopathologist**  
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**URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>URINE ROUTINE EXAMINATION</u></b>			
<b><u>PHYSICAL EXAMINATION</u></b>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Slightly hazy		Clear
<b><u>CHEMICAL EXAMINATION</u></b>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.020		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<b><u>MICROSCOPIC EXAMINATION</u></b>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	3-5	/ HPF	0 - 5
EPITHELIAL	1-2	/ HPF	0 - 5
CASTS	Absent		
CRYSTALS	Absent		

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**URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		
REMARK	Result relates to sample tested. Kindly correlate with clinical findings.		

**Result relates to sample tested, Kindly correlate with clinical findings.**

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**IMMUNO ASSAY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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**TFT (THYROID FUNCTION TEST )**

SPECIMEN	Serum		
T3	113.0	ng/dl	84.63 - 201.8
T4	8.90	µg/dl	5.13 - 14.06
TSH	1.70	µIU/ml	0.35 - 4.94

DONE ON FULLY AUTOMATED ANALYSER MAGLUMI SNIBE X3

T3 (Triiodo Thyronine)		T4 (Thyroxine)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

**INTERPRETATION :**

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

**Result relates to sample tested, Kindly correlate with clinical findings.**

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**\* BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b><u>CREATININE, SERUM</u></b>			
* <b>SERUM CREATININE</b>	0.89	mg/dL	0.7 - 1.3
METHOD	Enzymatic Colourimetric Method		

Creatinine is critically important in assessing renal function. In blood, it is a marker of glomerular filtration rate. As the kidneys become impaired for any reason, the creatinine level in the blood will rise due to poor clearance of creatinine by the kidneys. Abnormally high levels of creatinine thus warn of possible malfunction or failure of the kidneys.

**Result relates to sample tested, Kindly correlate with clinical findings.**

----- END OF REPORT -----

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**HAEMATOLOGY**

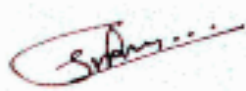
TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<b>ESR</b>			
<b>ESR</b>	05	mm/1hr.	0 - 20

METHOD - WESTERGREN

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**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
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**BLOOD GLUCOSE FASTING & PP**

BLOOD GLUCOSE FASTING	76.8	mg/dL	70 - 110
BLOOD GLUCOSE PP	83.7	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water ) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

**INTERPRETATION**

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus :  $\geq 126$  mg/dl

**POSTPRANDIAL/POST GLUCOSE (75 grams)**

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus :  $\geq 200$  mg/dl

**CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS**

- Fasting plasma glucose  $\geq 126$  mg/dl
- Classical symptoms + Random plasma glucose  $\geq 200$  mg/dl
- Plasma glucose  $\geq 200$  mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin  $> 6.5\%$

\*\*\*Any positive criteria should be tested on subsequent day with same or other criteria.

**GLYCOCELATED HEMOGLOBIN (HBA1C)**

<b>HBA1C (GLYCOSALATED HAEMOGLOBIN)</b>	5.1	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G. )	99.7	mg/dL	NON - DIABETIC : $\leq 5.6$ PRE - DIABETIC : 5.7 - 6.4 DIABETIC : $> 6.5$
METHOD	Particle Enhanced Immunospectrometry		

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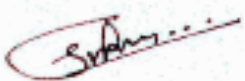
**BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<b><u>BLOOD UREA NITROGEN, SERUM</u></b>			
* <b>BLOOD UREA NITROGEN</b>	9.71	mg/dL	7 - 18
<b><u>TOTAL PROTEIN</u></b>			
S. TOTAL PROTIEN	6.85	g/dl	6.4 - 8.3
S. ALBUMIN	4.30	g/dl	3.2 - 5.0
S. GLOBULIN	2.55	g/dl	1.9 - 3.5
A/G RATIO	1.69		0 - 2
Method: Biuret			
* <b>SERUM URIC ACID</b>	5.8	mg/dL	2.6 - 7.2
Method: Uricase -POD			
GAMMA GT	20.2	U/L	13 - 109
<b><u>BILIRUBIN (TOTAL,DIRECT,INDIRECT)</u></b>			
<b>TOTAL BILLIRUBIN</b>	0.78	mg/dL	0.1 - 1.2
<b>BILLIRUBIN (DIRECT)</b>	<b>0.41</b>	mg/dL	0.0 - 0.4
<b>BILLIRUBIN (INDIRECT)</b>	0.37	mg/dL	0.0 - 1.1
Method(Diazo)			
*S.ALKALINE PHOSPHATASE	87.0	U/L	53 - 128
Method: PNP AMP KINETIC			

**Result relates to sample tested, Kindly correlate with clinical findings.**

----- END OF REPORT -----

Checked By  
SHAISTA Q



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**M.B.B.S.M.D. Pathology(Mum)**  
**Consultant Histocytopathologist**  
**Regd.No.: 3401/09/2007**





kunal patwar  
Male 21Years  
Req. No. :

HR : 74 bpm  
P : 88 ms  
PR : 138 ms  
QRS : 83 ms  
QT/QTcBz : 352/391 ms  
PQRS/T : 72/97/70 °  
RV5/SV1 : 1.284/0.384 mV

Diagnosis :  
Sinus Arrhythmia  
Largcd PtfV1  
Slight ST Elevation(V4,V5)  
Right Axis Deviation

Report Confirmed by:



5.25Hz 50 25mm/s 10mm/mV 4\*2.5\*1r SF 1200Express V2.22 SEMIP V192






**CERTIFICATE OF MEDICAL FITNESS**

This is to certify that I have conducted the clinical examination of,

Mr./Ms./Mrs. Mr. Kunal Pawar on { DD / MM / YYYY }.

After reviewing the medical history and upon clinical examination, it has been found that he/she is:

Fitness Status	Mark (✓) Below, where applicable
<ul style="list-style-type: none"> <li>Medically Fit</li> </ul>	✓
<ul style="list-style-type: none"> <li>Fit with restriction/recommendations Though following restriction have been revealed, in my opinion, these are not impediments to the prospective job</li> <li>1. ....</li> <li>2. ....</li> <li>3. ....</li> <li>However the employee should follow the advice/medication that has been communicated to him/her.</li> <li>Review after _____ days is recommended.</li> </ul>	<p>He is Fit to Resume his work.</p>
<ul style="list-style-type: none"> <li>Currently Unfit Review after _____ days is recommended.</li> </ul>	
<ul style="list-style-type: none"> <li>Unfit</li> </ul>	

  
Signature  
Dr. Mayur Jain  
Medical Officer

**DR. MAYUR JAIN**  
**DM CARDIOLOGY**  
**2007/04/0818**

Jinkushal Cardiac Care and Super specialty Hospital  
Second floor, Rosa Vista, Opp. Suraj Water Park,  
Kavesar, Ghodbunder Road, Thane(W) - 400607.

*This certificate is not meant for medico-legal purposes.*

# SEFRA DIGITAL X-RAY

JINKUSHAL HOSPITAL, Rosa Vista, Opp. Suraj Water Park, Waghbill, G.B. Road, Thane (W)

Mob.: 7678031047 / 9833520607 | Time : 9 am. to 9 pm. | SUNDAY ON CALL)

PORTABLE X-RAY AVAILABLE

PATIENT NAME : MR. KUNAL PAWAR	AGE / SEX 21 YRS / M
REF BY DR: JINKUSHAL HOSPITAL	DATE : 09/11/2024

## X-ray Chest PA

Bilateral lung fields appear clear. No obvious pleural/parenchymal lesion noted.

Bilateral hila are normal.

Both costo-phrenic and cardio-phrenic angles appear clear.

Cardiac silhouette is within normal limits.

Both domes of diaphragm appear normal.

Bony thoracic cage & soft tissues appear normal.

**Impression: No significant abnormality detected.**

Suggest Clinical correlation and further evaluation.

Thanks for referral

*Dr. Patil*

**Dr. Devendra Patil**  
**MD Radiology**

Disclaimer: report is done by teleradiology after the images acquired by PACS ( picture archiving and communication system) and this report is not meant for medicolegal purpose Investigations have their limitations. Solitary pathological/Radiological and other investigations never confirm the final diagnosis. They only help in diagnosing the disease in correlation to clinical symptoms and other related tests. Please interpret accordingly. Patient's identification in online reporting is not established, so in no way patient identification is possible for medico-legal cases.

## MEDICAL EXAMINATION REPORT

Name Mr./Mrs./Miss	Kunal Pawar	
Sex	Male/ <del>Female</del> Male	
Age (yrs.) 22	UHID :	
Date	09 / 11 / 20	Bill No. :
Marital Status	Married/ No. of Children / Unmarried/ Widow :	
Present Complaints	No Any Complaints.	
Past Medical : History Surgical :	No - Any Medical Surgery.	
Personal History	Diet : Veg <input type="checkbox"/> / Mixed <input checked="" type="checkbox"/> : Addiction : Smoking <input type="checkbox"/> / Tobacco Chewing <input type="checkbox"/> / Alcohol <input type="checkbox"/> / Any Other	
Family History	Father =	HT / DM / IHD / Stroke / Any Other
	Mother =	Mother = HT / DM / IHD / Stroke / Any Other
	Siblings =	Siblings = HT / DM / IHD / Stroke / Any Other
History of Allergies	Drug Allergy	Not known.
	Any Other	
History of Medication	For HT / DM / IHD / Hypothyroidism	
	Any Other	No Any History.
On Examination (O/E)	G.E. : N.A.D. R.S. : AEBE clear C.V.S. : S <sub>1</sub> S <sub>2</sub> ⊕ C.N.S. : Conscious & Oriented P/A : Soft / Non tender. Any Other Positive Findings :	

Height	170 cms	Weight	58 Kgs
BMI			
Pulse (per min.)	82/min	Blood Pressure ( mm of Hg)	120/80 mm of Hg
<b>Gynaecology</b>			
Examined by	Dr.		
Complaint & Duration			
Other symptoms (Mict, bowels etc)			
Menstrual History	Menarche _____ Cycle _____ Less _____ Pain _____ I.M.B. _____ P.C.B. _____ L.M.P. _____ Vaginal Discharge _____ Cx. Smear _____ Contraception _____		
Obstetric History			
Examination :			
Breast			
Abdomen			
P.S.			
P.V.			
<b>Gynaecology Impression &amp; Recommendation</b>			
Recommendation	No Any fresh Complaints. Trace Report.		
Physician Impression	No Any other Complaints. Or History.		
Examined by :	- Overweight = To Reduce Weight - Underweight = To Increase Weight		