OPD INITIAL ASSESSMENT

Patient Name	: Mrs. MARINA JACKSON	**UHID**	: SHHM.99212
Prescription No	: OPCS203569	**Age/Sex**	: 52 Year(s) / Female
Doctor Name	: Dr. Shweta Rajesh Chavan	**Referred By**	: self
Facility Name	: SEVENHILLS HOSPITAL, MUMBAI	**Bill Date**	: 06-Jul-2024
Address	: 2/26, GANGA, NARAYAN GURU C.H.S, P.L LOKHANDE MARG Mumbai Chembur Maharashtra 400071		

Chief Complaints

ROUTINE ORAL HEALTH CHECK UP
K/C/O DERANGED CHOLESTEROL, ON RX
PATIENT IS CONSCIOUS, COOPERATIVE, COHERENT AND VITALLY

Allergies And Habits

ENZOFLAM?

Diagnosis

1. Dental examination - ICD-Z01.2-25, 46: IMPLANT PROSTHESIS NOTED, RECURRENT FOOD LODGEMENT NOTED LEADING TO LOCALIZED INFLAMMATION

Advise

1. 25, 46: ADVISE REPLACEMENT OF CROWN PROSTHESIS OF THE IMPLANT

Signed by: Dr. Shweta Rajesh Chavan
BDS,MBA - HAHM
Consultant
reg no.: A-43932

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Patient Name	: Mrs. MARINA JACKSON	**UHID**	: SHHM.99212
Prescription No	: OPCS203569	**Age/Sex**	: 52 Year(s) / Female
Doctor Name	: Dr. Snehal Hanumant Shinde	**Referred By**	: self
Facility Name	: SEVENHILLS HOSPITAL, MUMBAI	**Bill Date**	: 06-Jul-2024
Address	: 2/26, GANGA, NARAYAN GURU C.H.S, P.L LOKHANDE MARG Mumbai Chembur Maharashtra 400071		

History of Present Illness

Has come for routine eye check
Vision
OD – 6/6
OS – 6/6
Near Vision (With Glasses) – N6
Anterior segment – WNL
Posterior segment – CDR-0.3, HNRR Healthy, Retina on
IOP DFN

Signed by: Dr. Snehal Hanumant Shinde
MS,MBBS
Chief Consultant
Ophthalmology
reg no.: 2016/08/3156

LABORATORY INVESTIGATION REPORT

Patient Name	: Mrs. MARINA JACKSON	**Age/Sex**	: 52 Year(s) / Female
UHID	: SHHM.99212	**Order Date**	: 06/07/2024 08:53
Episode	: OP		
Ref. Doctor	: self	**Mobile No**	: 9867550256
		DOB	: 31/07/1971
		Facility	: SEVENHILLS HOSPITAL, MUMBAI

IMMUNOLOGY

Sample No : O0342921C Collection Date : 06/07/24 08:59 Ack Date : 06/07/2024 09:14 Report Date : 06/07/24 15:38

Test Name	Result	Unit	Biological Reference Interval
FREE TFT (FT3,FT4,TSH BY CLIA)			
Free T3 - SERUM	2.90	pg/ml	2 - 4.4
Free T4 - SERUM	1.20	ng/dl	0.93 - 1.7
TSH - SERUM *Method - CLIA*	3.08	uIU/ml	0.4 - 4.5

Reference Ranges (TSH) Pregnancy:
1st Trimester : 0.1 – 2.5
2nd Trimester : 0.2 – 3.0
3rd Trimester : 0.3 – 3.0

Reference:
1.Clinical Chemistry and Molecular Diagnostics, Tietz Fundamentals, 7th Edition & Endocronology Guideliens

Interpretation :-
It is recommended that the following potential sources of variation should be considered while interpreting thyroid hormone results:
1. Thyroid hormones undergo rhythmic variation within the body this is called circadian variation in TSH secretion: Peak levels are seen between 2-4 am. Minimum levels seen between 6-10 am. This variation may be as much as 50% thus, influence of sampling time needs to be considered for clinical interpretation.
2. Circulating forms of T3 and T4 are mostly reversibly bound with Thyroxine binding globulins (TBG), and to a lesser extent with albumin and Thyroid binding PreAlbumin. Thus the conditions in which TBG and protein levels alter such as chronic liver disorders, pregnancy, excess of estrogens, androgens, anabolic steroids and glucocorticoids may cause misleading total T3, total T4 and TSH interpretations.
3. Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment.
4. T4 may be normal the presence of hyperthyroidism under the following conditions : T3 thyrotoxicosis, Hypoproteinemia related reduced binding, during intake of certain drugs (eg Phenytoin, Salicylates etc)
5. Neonates and infants have higher levels of T4 due to increased concentration of TBG
6. TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism, pregnancy, phenytoin therapy etc.
7. TSH values of <0.03 uIU/mL must be clinically correlated to evaluate the presence of a rare TSH variant in certain individuals which is undetectable by conventional methods.
8. Presence of Autoimmune disorders may lead to spurious results of thyroid hormones

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9. Various drugs can lead to interference in test results.
10. It is recommended that evaluation of unbound fractions, that is free T3 (fT3) and free T4 (fT4) for clinic-pathologic correlation, as these are the metabolically active forms.

VITAMIN D -TOTAL(25 HYDROXY)			
Vitamin D3 - SERUM *Method - CLIA*	73.27	ng/ml	DEFICIENCY :- < 10 MODERATE INSUFFICIENCY :- 11 - 20 MILD INSUFFICIENCY :- 21 - 25 SUFFICIENCY :- 26 - 70 TOXICITY :- > 70

Interpretation :-
Vitamin D is a lipid-soluble steroid hormone that is produced in the skin through the action of sunlight or is obtained from dietary sources The role of vitamin D in maintaining homeostasis of calcium and phosphorus is well established.

The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D. Vitamin D status is best determined by measurement of 25 hydroxy
vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs)

The reference ranges discussed in the preceding are related to total 25-OHD; as long as the combined total is 30 ng/mL or more, the patient has sufficient vitamin D. Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels (20–30 ng/mL). In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL.

Vitamin B12 - SERUM			
Vitamin B12 - SERUM *Method - CLIA*	713.10	pg/ml	211 - 911

Interpretation :-
Vitamin B12 is a coenzyme that is involved in two very important metabolic functions vital to normal cell growth and DNA synthesis: 1) the synthesis of methionine,
and 2) the conversion of methylmalonyl CoA to succinyl CoA. Deficiency of this vitamin can lead to megaloblastic anemia and ultimately to severe neurological problems. Also causes macrocytic anemia, glossitis, peripheral

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neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency.

Patients taking vitamin B12 supplementation may have misleading results. A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 .The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concerations are normal.

End of Report

Dr.Ritesh Kharche
MD, PGD-HM
Consultant Pathologist and Director of Laboratory Services
RegNo: 2006/03/1680