MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NEETHU HEMANT	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 14-Mar-24 03:17 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
CUE(COMPLETE URINE EXAMINATION)				
PHYSICAL EXAMINATION				
VOLUME	Urine	20 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
CHEMICAL EXAMINATION				
SPECIFIC GRAVITY	Urine	1.000	1.000 - 1.030	Dipstick
PH		5.0	5.0 - 8.0	Dipstick
PROTEIN		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
GLUCOSE		ABSENT	ABSENT	Dipstick/Benedict's test
UROBILINOGEN		NORMAL	NORMAL	Dipstick
KETONE		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
BILIRUBIN		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
BILE SALT		NEGATIVE	NEGATIVE	Hay's sulpher powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
MICROSCOPIC EXAMINATION				
PUS CELLS	Urine	2-3	0 - 5 /hpf	
RBC		NIL	0 - 5 /hpf	
EPITHELIAL CELLS		1-2	0 - 5 /hpf	
CRYSTALS		NIL	NIL	
CASTS		NIL	NIL	
BACTERIA		ABSENT		MICROSCOPIC EXAMINATION
YEAST		ABSENT		MICROSCOPIC EXAMINATION
AMORPHOUS DEPOSITS		ABSENT		MICROSCOPIC EXAMINATION
MUCUS THREAD		ABSENT		MICROSCOPIC EXAMINATION
NOTE		Microscopic examination of urine is carried out on centrifuged urinary sediment.		

*** End Of Report ***

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

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Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 14-Mar-24 03:17 pm

Parameters	Specimen	Result	Biological Reference In	Method

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NAVI MUMBAI

DEPARTMENT OF LABORATORY

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Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 13-Mar-24 12:46 pm

FINAL REPORT

Parameter	Specimen	Result Values	Biological Reference	Method
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.07	3.8 - 4.8 10^6/µL	
HEMOGLOBIN		12.1	12.0 - 15.0 g/dl	
PCV/HCT		36.0	40 - 50 % 36 - 46 %	
MCV		88	83 - 101 fl 83 - 101 fl	
MCH		29.8	27 - 32 pg	
MCHC		33.7	31.5 - 34.5 g/dL	
RDW(cv)		12.8	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	348	150 - 400 10^3/µL	
MPV		6.8	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	8.5	4.0 - 11.0 10^3/µl	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	44	40 - 80 %	
LYMPHOCYTES		47	20 - 40 %	
MONOCYTES		07	02 - 10 %	
EOSINOPHILS		02	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	52	0 - 20 mm/1st hour	WESTERGREN`S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" A "		TUBE AGGLUTINATION
RH TYPE		NEGATIVE		

*** End Of Report ***

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NEETHU HEMANT	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 14-Mar-24 04:23 pm

Parameters	Specimen	Result	TUBE AGGLUTINATI

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NEETHU HEMANT	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 13-Mar-24 12:23 pm

FINAL REPORT

Parameters	Specimen	Result	Biological Reference Intervals	Method
SERUM ELECTROLYTES				
SERUM SODIUM		140	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.1	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		103	98 - 107 mmol/L	ISE INDIRECT
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		88	Normal Range : 70 - 99 mg/dL	Hexokinase
FASTING URINE SUGAR		NIL		
T3,T4 AND TSH				
T3		136.3	70 - 204 ng/dL	Method : ECLIA
T4		7.80	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		1.63	0.270 - 4.20 uIU/mL	Method : ECLIA
SERUM CREATININE				
CREATININE		0.63	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.63	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		14.28	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.2	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.3	<= 1.0 mg/dL	
SGPT (ALT)		9	<= 33 U/L	Method : UV without P5P
SGOT (AST)		12	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		65	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.5	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.55	1.2 - 2.5	

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DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NEETHU HEMANT	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 10:09 am	**Report Date**	: 13-Mar-24 01:52 pm

Parameters	Specimen	Result	Biological Reference In	Method
GAMMA GLUTAMYL TRANSFERASE(GGT)		13	6 - 42 U/L	Method : G-glutamyl-carboxy-nitroanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		9	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		7.4	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				
TOTAL CHOLESTEROL		210	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		49	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		150	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		16		
SERUM TRYGLYCERIDES		80	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		4.29	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		3.06		
SERUM URIC ACID		4.4	2.4 - 5.7 mg/dL	uricase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.6	< 5.7 Normal Prediabetic 5.7 - 6.4 & >/=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		114	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		116	110 - 180 mg/dL	Hexokinase
URINE SUGAR		Nil		Dipstick

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MEDICOVER HOSPITALS
NAVI MUMBAI

DEPARTMENT OF LABORATORY

Patient Name	: Mrs. NEETHU HEMANT	**Age /Gender**	: 35 Y(s)/Female
Bill No/ UMR No	: NMBC61702/NMU0047803	**Referred By**	: Dr. DMO
Received Dt	: 13-Mar-24 02:00 pm	**Report Date**	: 14-Mar-24 08:31 am

Parameter	Specimen	Result Values	Biological Reference	Method

*** End Of Report ***

Lab Incharge

Dr. VISHAL MEHROTRA, MD Pathology
Head- Laboratory Services
Consultant Hematopathologist

Verified By : : 022633

Test results related only to the item tested.

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MEDICOVER HOSPITALS

Patient ID:	*NMU0047803*	*Patient Name:*	*NEETHU HEMANT*
Age:	*35 Years*	*Sex:*	*F*
Accession Number:	*NMBC61702*	*Modality:*	*DX*
Referring Physician:	*DR.DMO*	*Study:*	*CHEST*
Study Date:	*13-Mar-2024*	*Study Time:*	*10:32:33*

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: 13-Mar-2024 14:35:16

MEDICOVER HOSPITALS

Patient ID:	*NMU0047803*	*Patient Name:*	*NEETHU HEMANT*
Age:	*35 Years*	*Sex:*	*F*
Accession Number:	*NMBC61702*	*Modality:*	*US*
Referring Physician:	*DR.DMO*	*Study:*	*USG ABDOMEN WHOLE*
Study Date:	*13-Mar-2024*	*Study Time:*	*11:35:43*

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion. The portal vein appears normal & shows normal hepato-petal flow. No evidence of intra-hepatic biliary duct dilatation.

GALL BLADDER appears partially distended with normal wall thickness. There is no obvious calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal.

SPLEEN is normal in size and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis or calculi or mass seen.

URINARY BLADDER is adequately distended; no e/o wall thickening or mass or calculi seen. Post-void residue is not significant.

UTERUS is retroverted and is normal in size, shape and echotexture; No focal lesion seen; ET measures – 7.6 mm.

Both ovaries are normal in size, shape and position.
RIGHT OVARY: 3.4 x 1.8 cm, LEFT OVARY: 3.6 x 1.8 cm.

Visualised bowel loops appear normal. There is no free fluid seen.

NB:- This scan does not rule out all pathologies related to bowel and appendix.

IMPRESSION –

- **No significant abnormality detected.**

Dr. Ashwin Y.
M.D. (Radio-Diagnosis)

DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS
NAVI MUMBAI

DATE: 13/03/24

PATIENT NAME: Mrs Neethu Hemant AGE / SEX 35/F

UMR NO : NMU0047803.

	RE	LE
VA (DISTANCE)	6/9	6/6p.
VA(NEAR)	N6	N6
COLOUR VISION	Normal	Normal

			SPHERE	CYLINDER	AXIS	VA
MRx	O	D	+0.50	-0.50	180°	6/6,N6
	O	S	+0.00	-0.50	50°	6/6,N6

HISTORY :

-NO H/O systemic illness (DM, HTN, thyroid H/O using speedate (previously)
-NO H/O Ocular trauma Allegies & Surgeries.

OCULAR FINDINGS : H/O chickenpox 1½ month back

(BE) Lens - clear

(Medicated) Disc < 0-2 / 0-3

ADVICE:

Zivifresh eld tds 1 m x 1 month.

DS

(DR. ANUSHREE VANKAR)

MEDICOVER HOSPITALS
NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name	: **Mrs. Neethu Hemant**	**Date:-13/03/2024**
Age / Sex	: **35 Yrs / Female**	**UMR No. 0047803**
Referred By	: **Health Checkup**	

FINDINGS:

- No left ventricle regional wall motion abnormality.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- No left ventricle clot / vegetation/pericardial effusion.
- Intact IAS and IVS.
- Normal right atrium and right ventricle dimensions.
- Normal right ventricle systolic function. No hepatic congestion.

IMP:

- **No RWMA.**
- **Trivial MR.**
- **Normal LV and RV systolic function.**

DR. KESHAV KALE
DNB (Cardiology), MD (Medicine), MBBS
PhD (Cardiology), MNAMS, LL.B (Law)
FSCAI (USA), AFACC (USA), FESC (EU)
Consultant & Interventional Cardiologist

M-MODE MEASURMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	33	mm
LVID(d)	41	mm
IVS(d)	11	mm
LVPW(d)	10	mm
RVID(d)	29	mm
RA	32	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	7			Nil
TRICUSPID	N			Nil
PULMONERY	4.4			Nil

NEETHU HEMANT 47803 3/13/2024 12:04:54 PM

35 Years Female

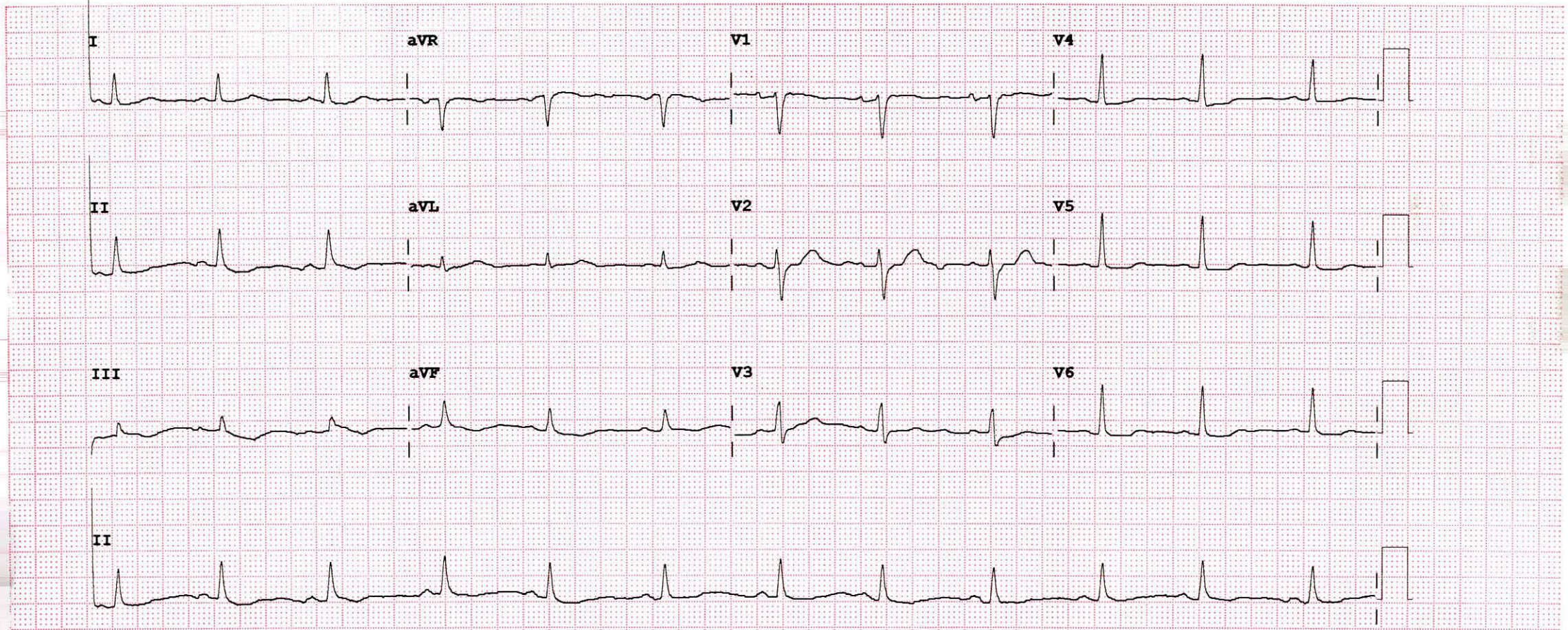
Rate 71 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Borderline T abnormalities, inferior leads.....T flat/neg, II III aVF
PR 161 . Baseline wander in lead(s) II,III,aVF
QRSD 91
QT 416
QTc 453

--AXIS--
P 42
QRS 49
T -50

mild ST-T change

- BORDERLINE ECG -

12 Lead; Standard Placement Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 60~ 0.50~ 40 Hz W 100B CL P?