



**DEPARTMENT OF LABORATORY**

NAVI MUMBAI

<b>Patient Name</b> : Mrs. Sneha Kalyane	<b>Age / Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60798/NMU0047179	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 09:07 am	<b>Report Date</b> : 09-Mar-24 06:45 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>CUE(COMPLETE URINE EXAMINATION)</b>				
<b><u>PHYSICAL EXAMINATION</u></b>				
<b>VOLUME</b>	Urine	10 ML		
<b>COLOUR</b>		PALE YELLOW	PALE YELLOW	
<b>APPEARANCE</b>		SLIGHTLY HAZY	CLEAR	
<b>DEPOSIT</b>		ABSENT	ABSENT	
<b><u>CHEMICAL EXAMINATION</u></b>				
<b>SPECIFIC GRAVITY</b>	Urine	1.030	1.000 - 1.030	Dipstick
<b>PH</b>		5.0	5.0 - 8.0	Dipstick
<b>PROTEIN</b>		NEGATIVE	NEGATIVE	Dipstick/Heat coagulation test
<b>GLUCOSE</b>		ABSENT	ABSENT	Dipstick/Benedict's test
<b>UROBILINOGEN</b>		NORMAL	NORMAL	Dipstick
<b>KETONE</b>		NEGATIVE	NEGATIVE	Dipstick/Rothera's Nitroprusside test.
<b>BILIRUBIN</b>		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
<b>BILE SALT</b>		NEGATIVE	NEGATIVE	Hay's sulphur powder test
<b>BILE PIGMENT</b>		NEGATIVE	NEGATIVE	Fouchet test
<b>NITRITE</b>		NEGATIVE	NEGATIVE	Dipstick
<b>LEUCOCYTE ESTERASE</b>		NEGATIVE	NEGATIVE	
<b><u>MICROSCOPIC EXAMINATION</u></b>				
<b>PUS CELLS</b>	Urine	3-4	0 - 5 /hpf	<b>MICROSCOPIC EXAMINATION</b>
<b>RBC</b>		8-10	0 - 5 /hpf	<b>MICROSCOPIC EXAMINATION</b>
<b>EPITHELIAL CELLS</b>		6-8	0 - 5 /hpf	<b>MICROSCOPIC EXAMINATION</b>
<b>CRYSTALS</b>		NIL	NIL	<b>MICROSCOPIC EXAMINATION</b>
<b>CASTS</b>		NIL	NIL	<b>MICROSCOPIC EXAMINATION</b>
<b>BACTERIA</b>		ABSENT		<b>MICROSCOPIC EXAMINATION</b>
<b>YEAST</b>		ABSENT		<b>MICROSCOPIC EXAMINATION</b>
<b>AMORPHOUS DEPOSITS</b>		ABSENT		<b>MICROSCOPIC EXAMINATION</b>
<b>SPERMATOZOA</b>				<b>MICROSCOPIC EXAMINATION</b>
<b>MUCUS THREAD</b>		ABSENT		<b>MICROSCOPIC EXAMINATION</b>





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<b>Received Dt</b> : 09-Mar-24 09:07 am	<b>Report Date</b> : 09-Mar-24 06:45 pm

NAVI MUMBAI

**Parameters**  
**NOTE**

**Specimen**

**Result**

**Biological Reference In Method**

Microscopic examination of urine is carried out on centrifuged urinary sediment.

\*\*\* End Of Report \*\*\*







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<b>Patient Name</b> : Mrs. Sneha Kalyane	<b>Age / Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60798/NMU0047179	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 09:07 am	<b>Report Date</b> : 09-Mar-24 01:13 pm

**FINAL REPORT**

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
<b>COMPLETE BLOOD COUNT</b>				
<b>RBC</b>				
R B C COUNT	Blood	3.89	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		10.8	12.0 - 15.0 g/dl	
PCV/HCT		32.3	40 - 50 % 36 - 46 %	
MCV		83	83 - 101 fl 83 - 101 fl	
MCH		27.8	27 - 32 pg	
MCHC		33.5	31.5 - 34.5 g/dL	
RDW(cv)		13.5	11.6 - 14.0 %	
<b>PLATELETS</b>				
PLATELET COUNT	Blood	265	150 - 400 $10^3/\mu\text{L}$	
MPV		9.1	7.5 - 11.5 fl	
<b>WBC</b>				
TC (TOTAL LEUCOCYTE COUNT)	Blood	4.3	4.0 - 11.0 $10^3/\mu\text{l}$	
<b>DIFFERENTIAL COUNT</b>				
NEUTROPHILS	Blood	52	40 - 80 %	
LYMPHOCYTES		32	20 - 40 %	
MONOCYTES		11	02 - 10 %	
EOSINOPHILS		05	00 - 06 %	
BASOPHILS		00	00 - 01 %	
ESR	CITRATED BLOOD	25	0 - 20 mm/1st hour	WESTERGREN'S METHOD
<b>BLOOD GROUPING AND RH</b>				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

\*\*\* End Of Report \*\*\*





# MEDICOVER HOSPITALS

## DEPARTMENT OF LABORATORY

NAVI MUMBAI

**Patient Name** : Mrs. Sneha Kalyane      **Age / Gender** : 23 Y(s)/Female  
**Bill No/ UMR No** : NMBC60798/NMU0047179      **Referred By** : Dr. DMO  
**Received Dt** : 09-Mar-24 09:07 am      **Report Date** : 09-Mar-24 05:15 pm

Parameters

Specimen

Result

TUBE AGGLUTINATI







**DEPARTMENT OF LABORATORY**

<b>Patient Name</b> : Mrs. Sneha Kalyane	<b>Age /Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60798/NMU0047179	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 09:07 am	<b>Report Date</b> : 09-Mar-24 12:49 pm

**FINAL REPORT**

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
<b>SERUM ELECTROLYTES</b>				
SERUM SODIUM		141	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		5.0	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		105	98 - 107 mmol/L	ISE INDIRECT
<b>FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)</b>				
FASTING BLOOD GLUCOSE		84	Normal Range : 70 - 99 mg/dL	Hexokinase
<b>SERUM CREATININE</b>				
CREATININE		0.51	0.6 - 1.2 mg/dl	Method : jaffe
<b>BUN / CREATININE RATIO</b>				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.51	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		13.72	10 - 20	
<b>LFT(LIVER FUNCTION TEST)</b>				
TOTAL BILIRUBIN		0.2	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	
INDIRECT BILIRUBIN		0.1	<= 1.0 mg/dL	
SGPT (ALT)		12	<= 33 U/L	Method : UV without P5P
SGOT (AST)		15	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		96	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		4.7	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		3.0	2.5 - 3.5 g/dL	
A/G RATIO		1.57	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		9	6 - 42 U/L	Method : G-glutamyl-carboxy-nitropanilide - IFCC Ref.
<b>BUN(BLOOD UREA NITROGEN)</b>				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
<b>TOTAL PROTEIN</b>				
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL	Method : Biuret method







**DEPARTMENT OF LABORATORY**

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<b>Bill No/ UMR No</b> : NMBC60798/NMU0047179	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 09:07 am	<b>Report Date</b> : 09-Mar-24 12:49 pm

NAVI MUMBAI

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference</u>	<u>In Method</u>
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL		119	Desirable : ; < 200 mg/dL Borderline High : ; 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		35	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		81	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		8		
SERUM TRYGLYCERIDES		40	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.4	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.31		
SERUM URIC ACID		2.6	2.4 - 5.7 mg/dL	uricase
<b>T3,T4 AND TSH</b>				
T3		132.9	70 - 204 ng/dL	Method : ECLIA
T4		6.00	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.92	0.270 - 4.20 uIU/mL	Method : ECLIA
<b>HBA1C (GLYCOSYLATED HAEMOGLOBIN)</b>				
HBA1C		5.3	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		105	Excellent Control ; 90 - 120 mg/dL Good Control ; 121 - 150 mg/dL	
<b>PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)</b>				
PLBS (POST LUNCH BLOOD GLUCOSE)		68	110 - 180 mg/dL	Hexokinase

\*\*\* End Of Report \*\*\*





# MEDICOVER HOSPITALS

## DEPARTMENT OF LABORATORY

<b>Patient Name</b> : Mrs. Sneha Kalyane	<b>Age / Gender</b> : 23 Y(s)/Female
<b>Bill No/ UMR No</b> : NMBC60798/NMU0047179	<b>Referred By</b> : Dr. DMO
<b>Received Dt</b> : 09-Mar-24 12:28 pm	<b>Report Date</b> : 11-Mar-24 08:31 am

NAVI MUMBAI

**Parameter**                      **Specimen**                      **Result Values**                      **Biological Reference**                      **Method**

Lab Incharge

*Amendra*  
Dr. VISHAL MEHROTRA, MD Pathology  
Clinical 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.





Patient ID:	NMU0047179	Patient Name:	SNEHA KALYANE
Age:	23 Years	Sex:	F
Accession Number:	NMBC60798	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	15:27:49

### USG ABDOMEN & PELVIS

**The Liver** is normal in size (13.4 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 physiologically distended with normal wall thickness. There is no evidence of gallstones. C.B.D. is of normal caliber.

**The Pancreas** is normal in size and echotexture.

**The spleen** is normal size ( 8.7 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 10.6 x 4.0 cm.

The Left Kidney measures 10.7 x 4.4 cm.

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

**The Urinary bladder** is adequately distended and shows normal wall thickness. No evidence of any intraluminal mass or calculi.

**The uterus** is normal in size and echotexture. It measures 8.0 x 4.0 x 4.0 cm. No focal lesion is seen. The Endometrial thickness is 7.4 mm.

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

The Right ovary measures 3.0 x 2.4 cm

The Left ovary measures 3.2 x 2.1 cm

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

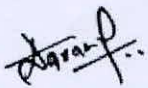
Visualised bowel loops are unremarkable.

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 15:49:15



Rate 73 . Sinus rhythm.....normal P axis, V-rate 50- 99  
 . Borderline short PR interval.....PR int <120ms  
 PR 116 . Baseline wander in lead(s) I,III,aVL  
 QRSD 71  
 QT 385  
 QTc 425

*NIR  
 WNL  
 S*

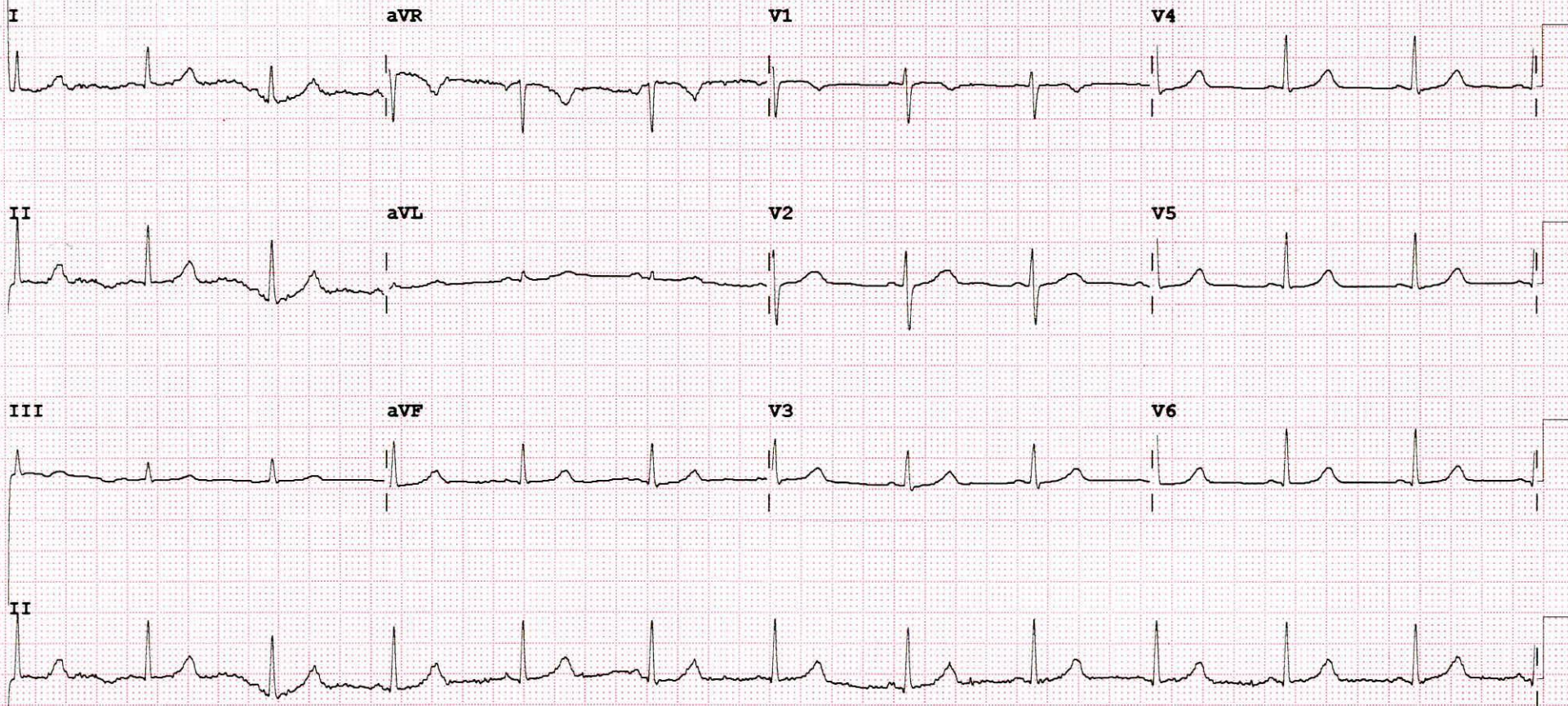
--AXIS--

P 15  
 QRS 52  
 T 44

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis





## 2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

*Name* : Mrs. Sneha kalyane

Date:-09/03/2024

*Age / Sex* : 23 Yrs /Female

UMR No. 0047177

*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.
- Mild tricuspid regurgitation. No pulmonary hypertension.  
PASP – 30 mmHg.
- 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. Mild 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)	09	mm
RVID(d)	28	mm
RA	31	mm
LVEF	60	%

	PEAK	MEAN	Vmax	Gradient of Regurgitation
MITRAL	N			Trivial
AORTIC	5			Nil
TRICUSPID	30			Mild
PULMONERY	4.4			Nil



<b>Patient ID:</b>	<b>NMU0047179</b>	<b>Patient Name:</b>	<b>Sneha Kalyane</b>
<b>Age:</b>	<b>23 Years</b>	<b>Sex:</b>	<b>F</b>
<b>Accession Number:</b>	<b>NMBC60798</b>	<b>Modality:</b>	<b>DX</b>
<b>Referring Physician:</b>	<b>DR.DMO</b>	<b>Study:</b>	<b>CHEST</b>
<b>Study Date:</b>	<b>09-Mar-2024</b>		

**X RAY CHEST PA VIEW**

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

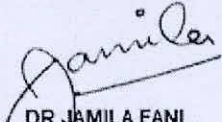
Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

**Impression:**

- **No significant abnormality is seen.**



DR JAMILA FANI  
Consultant Radiologist  
MBBS, MD

Date: 10-Mar-2024 14:12:34





**MEDICOVER**  
HOSPITALS

NAVI MUMBAI

Sneha Kalyane.

O/E: Missing  $\bar{c}$   $\frac{4}{4} / \frac{4}{4}$  (ortho ext<sup>n</sup>)

peri-coronitis  $\bar{c}$   $\frac{8}{8}$

Stains ++

Calculus +++

Adv: Complete Oral prophylaxis.

*S. Mandekar*

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





# DEPARTMENT OF OPHTHALMOLOGY

# MEDICOVER HOSPITALS

DATE: 9/8/24

PATIENT NAME: rono sneha kalyane

AGE / SEX: 23 / F. NAVI MUMBAI

UMR NO: N00004719.

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

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	+ -	0.50.	180°	6/6 Ng.
	O S	0.50	0.75	180°	6/6 Ng

### HISTORY :

No h/o DM/HT/Thyroid  
no h/o ocular Trauma (BE)

### OCULAR FINDINGS :

(BE) - Ant seg WNL.  
(undilated) Disc ← 0.2 - 0.3  
0.2 - 0.3

### ADVICE:

Zivifresh / Refresh Tears 1777 x 1month

AS  
C.D.R. ANUSHREE VANAKAR







# MEDICOVER HOSPITALS

## MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / (Mrs) Sneha Kalyane

DATE: 09/03/24

AGE : 23 YRS / F

SEX: Male / (Female)

NMU: NMU00047179

DOCTOR'S NAME:

TEMP :	<u>97.3</u>	<sup>o</sup> f	BP :	<u>110/70</u>	mmHg
PULSE :	<u>75</u>	b/m	HEIGHT :	<u>152</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>57.8</u>	kg
SPO2 :	<u>99</u> %		HGT:	<u>—</u>	

REMARK: