



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. HARSHITA NITESH PANCHAL	Age / Gender : 36 Y(s)/Female
Bill No/ UMR No : NMBC59439/NMU0046135	Referred By : Dr. DMO
Received Dt : 02-Mar-24 11:28 am	Report Date : 02-Mar-24 02:44 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
CUE (COMPLETE URINE EXAMINATION)				
<u>PHYSICAL EXAMINATION</u>				
VOLUME	Urine	20 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.025	1.000 - 1.030	Dipstick
PH		6.0	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.
BLOOD		NEGATIVE	NEGATIVE	Dipstick/Microscopy
BILIRUBIN		NEGATIVE	NEGATIVE	Dipstick/Fouchet's test
BILE SALT		NEGATIVE	NEGATIVE	Hay's sulphur powder test
BILE PIGMENT		NEGATIVE	NEGATIVE	Fouchet test
NITRITE		NEGATIVE	NEGATIVE	Dipstick
LEUCOCYTE ESTERASE		NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>				
PUS CELLS	Urine	4-6	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		8-10	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
BACTERIA		+		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.		





MEDICOVER
HOSPITALS

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<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In Method</u>
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*** End Of Report ***





DEPARTMENT OF LABORATORY

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Bill No/ UMR No : NMBC59439/NMU0046135	Referred By : Dr. DMO
Received Dt : 02-Mar-24 11:28 am	Report Date : 02-Mar-24 02:08 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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COMPLETE BLOOD COUNT

RBC

R B C COUNT	Blood	4.46	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		12.4	12.0 - 15.0 g/dl	
PCV/HCT		37.1	40 - 50 % 36 - 46 %	
MCV		83	83 - 101 fl 83 - 101 fl	
MCH		27.9	27 - 32 pg	
MCHC		33.5	31.5 - 34.5 g/dL	
RDW(cv)		13.4	11.6 - 14.0 %	

PLATELETS

PLATELET COUNT	Blood	321	150 - 400 $10^3/\mu\text{L}$	
MPV		7.2	7.5 - 11.5 fl	

WBC

TC (TOTAL LEUCOCYTE COUNT)	Blood	5.5	4.0 - 11.0 $10^3/\mu\text{l}$	
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DIFFERENTIAL COUNT

NEUTROPHILS	Blood	62	40 - 80 %	
LYMPHOCYTES		32	20 - 40 %	
MONOCYTES		05	02 - 10 %	
EOSINOPHILS		01	00 - 06 %	
BASOPHILS		00	00 - 01 %	

ESR	CITRATED BLOOD	25	0 - 20 mm/1st hour	WESTERGREN`S METHOD
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BLOOD GROUPING AND RH

BLOOD GROUP	" B "	TUBE AGGLUTINATION
RH TYPE	POSITIVE	

*** End Of Report ***





MEDICOVER HOSPITALS

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Received Dt : 02-Mar-24 11:28 am	Report Date : 02-Mar-24 03:58 pm

Parameters

Specimen

Result

TUBE AGGLUTINATI





DEPARTMENT OF LABORATORY

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Patient Name : Mrs. HARSHITA NITESH PANCHAL	Age / Gender : 36 Y(s)/Female
Bill No/ UMR No : NMBC59439/NMU0046135	Referred By : Dr. DMO
Received Dt : 02-Mar-24 11:29 am	Report Date : 02-Mar-24 01:22 pm

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
T3,T4 AND TSH				
T3		93.45	70 - 204 ng/dL	Method : ECLIA
T4		5.39	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.38	0.270 - 4.20 uIU/mL	Method : ECLIA
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		110	Normal Range : 70 - 99 mg/dL	Hexokinase
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
HBA1C		5.8	< 5.7 Normal Prediabetic 5.7 - 6.4 & >=6.5 Diabetic %	TINIA
MPG(Mean Plasma Glucose)		120	Excellent Control : 90 - 120 mg/dL Good Control : 121 - 150 mg/dL	
SERUM CREATININE				
CREATININE		0.87	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.87	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		8.0	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.5	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.4	<= 1.0 mg/dL	
SGPT (ALT)		18	<= 33 U/L	Method : UV without P5P
SGOT (AST)		15	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		87	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		5.0	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.7	2.5 - 3.5 g/dL	
A/G RATIO		1.85	1.2 - 2.5	





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Bill No/ UMR No : NMBC59439/NMU0046135	Referred By : Dr. DMO
Received Dt : 02-Mar-24 11:28 am	Report Date : 04-Mar-24 08:48 am

Parameters	Specimen	Result	Biological Reference In Method
GAMMA GLUTAMYL TRANSFERASE(GGT)		28	6 - 42 U/L
BUN(BLOOD UREA NITROGEN)			
BUN (Blood Urea Nitrogen.)		7	7.0 - 21.0 mg/dL Calculated
TOTAL PROTEIN			
TOTAL PROTEINS		7.7	6.0 - 8.0 g/dL Method : Biuret method
LIPID PROFILE			
TOTAL CHOLESTEROL		246	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		37	Low : : < 40 mg/dL High : : > 60 mg/dL Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		196	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		24	
SERUM TRYGLYCERIDES		119	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL METHOD: Enzymatic colorimetric
CHO/HDL RATIO		6.65	Normal : - < 3.5 High Risk : - > 5.0
LDL/HDL RATIO		5.3	
SERUM URIC ACID		5.7	2.4 - 5.7 mg/dL uricase
SERUM ELECTROLYTES			
SERUM SODIUM		139	136 - 145 mmol/L ISE INDIRECT
SERUM POTASSIUM		4.7	3.5 - 5.1 mmol/L ISE INDIRECT
SERUM CHLORIDES		101	98 - 107 mmol/L ISE INDIRECT
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)			
PLBS (POST LUNCH BLOOD GLUCOSE)		92	110 - 180 mg/dL Hexokinase

*** End Of Report ***





MEDICOVER HOSPITALS

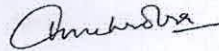
DEPARTMENT OF LABORATORY

NAVI MUMBAI

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Bill No/ UMR No : NMBC59439/NMU0046135	Referred By : Dr. DMO
Received Dt : 02-Mar-24 11:19 am	Report Date : 04-Mar-24 08:48 am

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
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Lab Incharge


Dr. VISHAL MEHROTRA, MD Pathology
Consultant in Hematology

Verified By : : 022633

Test results related only to the item tested.

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DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 02/08/24

PATIENT NAME: Mrs. Harshita Panchal

AGE / SEX 36 / f NAVI MUMBAI

UMR NO: NRM00046185

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

		SPHERE	CYLINDER	AXIS	VA
MRx	O D	Plano	_____		6/6 NC
	O S	Plano	_____		6/6 NC

HISTORY :

• No systemic illness (DM, HTN, Thyroid). • No. spectacle use,
 • No Ocular trauma Allergies & surgeries.

OCULAR FINDINGS :

(BE) - Lens - clear
 ALc - peripheral shallow ALc
 peripheral R > L

(undilated) Disc ≤ 0.3 , slightly pale disc
 0.3

ADVICE:

Refresh tears 4x qd 1777 X 1 month

AI
 DR. ANUSHREE VANKAR





MEDICOVER
HOSPITALS

NAVI MUMBAI

Hausita

pit & tissue
Caries : $\frac{76}{87} \mid \frac{678}{678}$

periocoronitis : $\frac{\quad}{8} \mid \frac{\quad}{8}$

chuck bite seen in lower
left back
region
of jaw

Abrasion : $\frac{\quad}{654} \mid \frac{\quad}{456}$ <

Buccally placed : $\frac{\quad}{8} \mid \frac{\quad}{\quad}$
Stains++, calculus++

Adv: Complete Oral prophylaxis.

Rest^r : $\frac{876}{87654} \mid \frac{678}{45678}$
Extⁿ : $\frac{\quad}{8} \mid \frac{\quad}{\quad}$

Sayali Mandekar

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



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs Haxshila-----

DATE: 2/3/2024

AGE : 36 yrs

SEX: Male/ Female

NMU: NMU000 46135 .

DOCTOR'S NAME: Health Package

TEMP :	<u>97</u>	° f	BP :	<u>100/60</u>	mmHg
PULSE :	<u>86</u>	b/m	HEIGHT :	<u>154</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>71.8</u>	kg
SPO2 :	<u>97</u>	% R.A	HGT:	<u>-</u>	

REMARK:

Patient ID:	NMU0046135	Patient Name:	HARSHITA PANCHAL 36YRS
Age:		Sex:	F
Accession Number:		Modality:	US
Referring Physician:		Study:	
Study Date:	02-Mar-2024		

USG WHOLE ABDOMEN (TAS)

LIVER is normal in size (15.7 cm), normal in shape with bright 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 (9.3 cm) 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 anteverted and is normal in size, shape and echotexture; No focal lesion seen. It measures 6.7 x 4.1 x 4.9 cm; ET measures -10 mm.

Both ovaries are normal in size, shape and position.

RIGHT OVARY: 2.5 x 1.1 cm, LEFT OVARY: 2.6 x 1.8 cm.

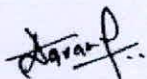
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **Grade I fatty infiltration of liver.**
- **No other significant abnormality detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE. THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.



DR. ANUPKUMAR AGRAWAL
Consultant & HOD Radiology
MBBS, MD

Date: 02-Mar-2024 11:50:38

Patient ID:	NMU0046135	Patient Name:	HARSHITA PANCHAL
Age:	36 Years	Sex:	F
Accession Number:		Modality:	DX
Referring Physician:		Study:	CHEST
Study Date:	02-Mar-2024		

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. Sofiya I Modak
MBBS, MD Radiology
Consultant Radiologist

Date: 02-Mar-2024 15:32:49

Rate 73 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 144
QRSD 75
QT 372
QTc 410

--AXIS--

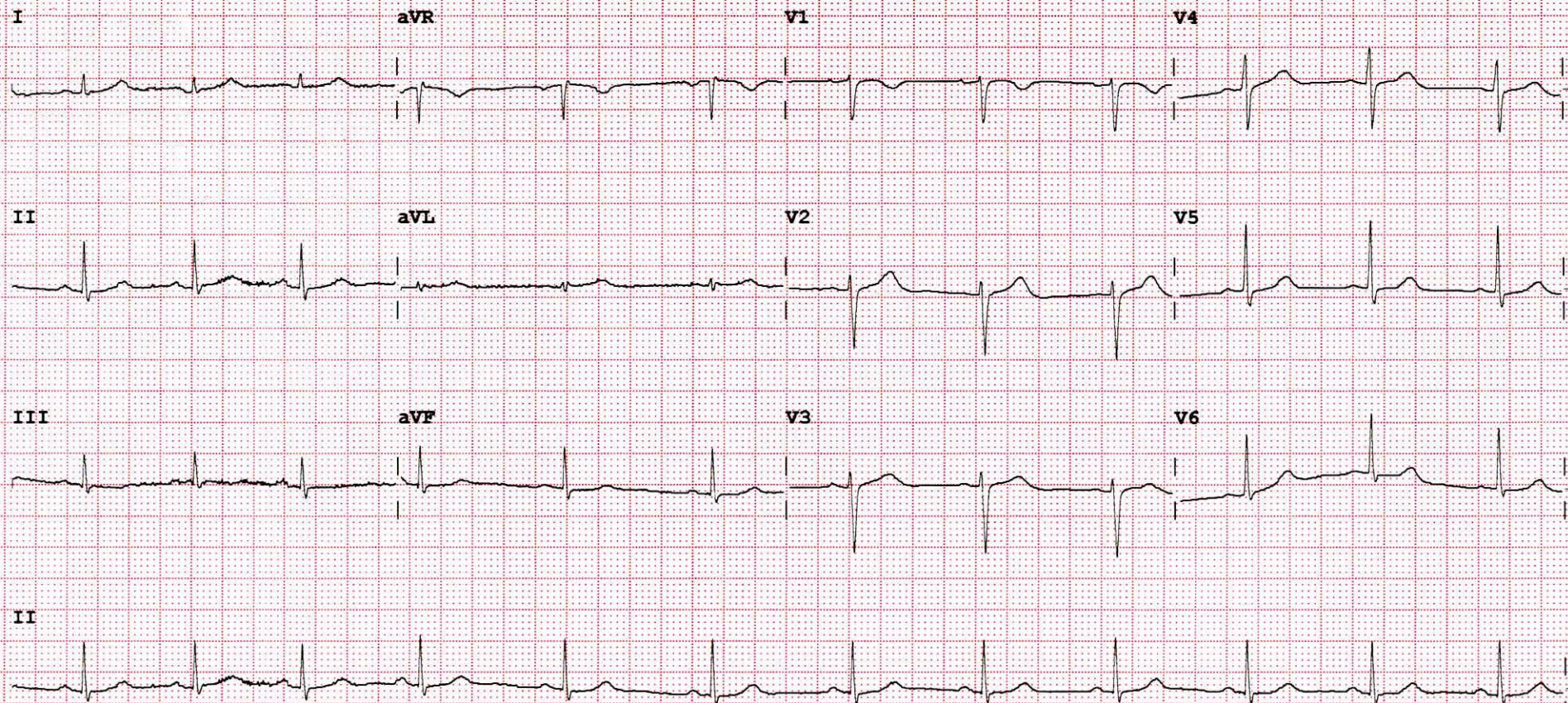
P 52
QRS 51
T 24

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

DMR
Wu
[Signature]



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 60~ 0.15-100 Hz

100B CL

P?





MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mrs. Harshita Panchal

Date:-02/03/2024

Age / Sex : 36 Yrs / Female

UMR No. 0046135

Referred By : Health Check up

FINDINGS:

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

IMP:

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

DR. SAMEER VANKAR
MD DM CARDIOLOGY





MEDICOVER
HOSPITALS

NAVI MUMBAI

M MODE MEASUREMENTS:

LA	35	mm
AO root	29	mm
AO CUSP SEP	18	mm
LVID(s)	32	mm
LVID(d)	44	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	4.3			Nil

