



DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. ASHWINI PANKAJ KOTHE	Age / Gender : 31 Y(s)/Female
Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 06:54 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	30 ML		
COLOUR		PALE YELLOW	PALE YELLOW	
APPEARANCE		SLIGHTLY HAZY	CLEAR	
DEPOSIT		ABSENT	ABSENT	
<u>CHEMICAL EXAMINATION</u>				
SPECIFIC GRAVITY	Urine	1.015	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	2-3	0 - 5 /hpf	MICROSCOPIC EXAMINATION
RBC		NIL	0 - 5 /hpf	MICROSCOPIC EXAMINATION
EPITHELIAL CELLS		6-8	0 - 5 /hpf	MICROSCOPIC EXAMINATION
CRYSTALS		NIL	NIL	MICROSCOPIC EXAMINATION
CASTS		NIL	NIL	MICROSCOPIC EXAMINATION
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.		





MEDICOVER
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Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 06:54 pm

Parameters

Specimen

Result

Biological Reference In Method

*** End Of Report ***





DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. ASHWINI PANKAJ KOTHE	Age / Gender : 31 Y(s)/Female
Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 02:00 pm

FINAL REPORT

<u>Parameter</u>	<u>Specimen</u>	<u>Result Values</u>	<u>Biological Reference</u>	<u>Method</u>
COMPLETE BLOOD COUNT				
RBC				
R B C COUNT	Blood	4.79	3.8 - 4.8 $10^6/\mu\text{L}$	
HEMOGLOBIN		10.6	12.0 - 15.0 g/dl	
PCV/HCT		33.3	40 - 50 % 36 - 46 %	
MCV		70	83 - 101 fl 83 - 101 fl	
MCH		22.1	27 - 32 pg	
MCHC		31.8	31.5 - 34.5 g/dL	
RDW(cv)		15.7	11.6 - 14.0 %	
PLATELETS				
PLATELET COUNT	Blood	309	150 - 400 $10^3/\mu\text{L}$	
MPV		9.0	7.5 - 11.5 fl	
WBC				
TC (TOTAL LEUCOCYTE COUNT)	Blood	4.7	4.0 - 11.0 $10^3/\mu\text{l}$	
DIFFERENTIAL COUNT				
NEUTROPHILS	Blood	45	40 - 80 %	
LYMPHOCYTES		44	20 - 40 %	
MONOCYTES		08	02 - 10 %	
EOSINOPHILS		03	00 - 06 %	
BASOPHILS		00	00 - 01 %	
PERIPHERAL SMEAR EXAMINATION		:		
RBC			Mild anisocytosis moderate poikilocytosis. Microcytic hypochromic with ovalocytes and elliptocytes.	
WBC			Normal morphology.	
PLATELETS			Adequate in smear.	
ADVISED			1. Serum iron studies. 2. Haemoglobin electrophoresis/ HPLC assay.	
ESR	CITRATED BLOOD	15	0 - 20 mm/1st hour	WESTERGREN'S METHOD
BLOOD GROUPING AND RH				
BLOOD GROUP		" O "		TUBE AGGLUTINATION
RH TYPE		POSITIVE		

*** End Of Report ***





MEDICOVER
HOSPITALS

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Patient Name : Mrs. ASHWINI PANKAJ KOTHE	Age / Gender : 31 Y(s)/Female
Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 04:41 pm

Parameters

Specimen

Result

TUBE AGGLUTINATI





DEPARTMENT OF LABORATORY

NAVI MUMBAI

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Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 11:51 am

FINAL REPORT

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference Intervals</u>	<u>Method</u>
SERUM ELECTROLYTES				
SERUM SODIUM		138	136 - 145 mmol/L	ISE INDIRECT
SERUM POTASSIUM		4.8	3.5 - 5.1 mmol/L	ISE INDIRECT
SERUM CHLORIDES		102	98 - 107 mmol/L	ISE INDIRECT
SERUM CREATININE				
CREATININE		0.52	0.6 - 1.2 mg/dl	Method : jaffe
BUN / CREATININE RATIO				
BUN (Blood Urea Nitrogen.)		13	7.0 - 21.0 mg/dL	Calculated
SERUM CREATININE		0.52	0.6 - 1.2 mg/dL	
BUN / CREATININE RATIO		25	10 - 20	
LFT(LIVER FUNCTION TEST)				
TOTAL BILIRUBIN		0.3	< 1.2 mg/dL	Method : Diazo Method
DIRECT BILIRUBIN		0.1	<= 0.20 mg/dL	Method: Diazo Method
INDIRECT BILIRUBIN		0.2	<= 1.0 mg/dL	
SGPT (ALT)		15	<= 33 U/L	Method : UV without P5P
SGOT (AST)		19	<= 32 U/L	Method : UV without P5P
ALKALINE PHOSPHATASE (ALP)		73	40 - 129 U/L 35 - 105 U/L	Method : PNPP, AMP Buffer - IFCC Ref.
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
SERUM ALBUMIN		5.1	3.5 - 5.2 g/dL	Method : Bromcresol Green (BCG)
GLOBULINS		2.9	2.5 - 3.5 g/dL	
A/G RATIO		1.76	1.2 - 2.5	
GAMMA GLUTAMYL TRANSFERASE(GGT)		10	6 - 42 U/L	Method : G-glutamyl-carboxy-nitr oanilide - IFCC Ref.
BUN(BLOOD UREA NITROGEN)				
BUN (Blood Urea Nitrogen.)		13	7.0 - 21.0 mg/dL	Calculated
TOTAL PROTEIN				
TOTAL PROTEINS		8.0	6.0 - 8.0 g/dL	Method : Biuret method
LIPID PROFILE				





MEDICOVER HOSPITALS

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NAVI MUMBAI

Patient Name : Mrs. ASHWINI PANKAJ KOTHE	Age / Gender : 31 Y(s)/Female
Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 08:21 am	Report Date : 09-Mar-24 11:51 am

<u>Parameters</u>	<u>Specimen</u>	<u>Result</u>	<u>Biological Reference In</u>	<u>Method</u>
TOTAL CHOLESTEROL		169	Desirable : : < 200 mg/dL Borderline High : : 200 - 239 mg/dL High risk : > 240 mg/dL	METHOD : Enzymatic colorimetric
HDL CHOLESTEROL		48	Low : : < 40 mg/dL High : : > 60 mg/dL	Homogeneous enzymatic colorimetric
LDL CHOLESTEROL		116	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 SERUM TRYGLYCERIDES		13 65	< 150 mg/dL Borderline High : 150 - 199 mg/dL High : 200 - 499 mg/dL	METHOD: Enzymatic colorimetric
CHO/HDL RATIO		3.52	Normal : - < 3.5 High Risk : - > 5.0	
LDL/HDL RATIO		2.42		
SERUM URIC ACID		3.5	2.4 - 5.7 mg/dL	uricase
FBS (FASTING BLOOD GLUCOSE WITH URINE GLUCOSE)				
FASTING BLOOD GLUCOSE		92	Normal Range : 70 - 99 mg/dL	Hexokinase
T3,T4 AND TSH				
T3		119.9	70 - 204 ng/dL	Method : ECLIA
T4		7.93	5.1 - 14.1 ug/dL	Method : ECLIA
TSH(THYROID STIMULATING HORMONE)		2.92	0.270 - 4.20 uIU/mL	Method : ECLIA
HBA1C (GLYCOSYLATED HAEMOGLOBIN)				
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	
PLBS (POST LUNCH BLOOD SUGAR WITH URINE SUGAR)				
PLBS (POST LUNCH BLOOD GLUCOSE)		95	110 - 180 mg/dL	Hexokinase

*** End Of Report ***

THIS IS A MODIFIED REPORT





MEDICOVER
HOSPITALS

DEPARTMENT OF LABORATORY

NAVI MUMBAI

Patient Name : Mrs. ASHWINI PANKAJ KOTHE	Age / Gender : 31 Y(s)/Female
Bill No/ UMR No : NMBC60786/NMU0047171	Referred By : Dr. DMO
Received Dt : 09-Mar-24 12:09 pm	Report Date : 11-Mar-24 08:29 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 Internal Medicine

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.



<i>Patient ID:</i>	<i>NMU0047171</i>	<i>Patient Name:</i>	<i>ASHWINI PANKAJ KOTHE</i>
<i>Age:</i>	<i>31 Years</i>	<i>Sex:</i>	<i>F</i>
<i>Accession Number:</i>	<i>NMBC60786</i>	<i>Modality:</i>	<i>DX</i>
<i>Referring Physician:</i>	<i>DR.DMO</i>	<i>Study:</i>	<i>CHEST</i>
<i>Study Date:</i>	<i>09-Mar-2024</i>	<i>Study Time:</i>	<i>08:51:24</i>

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: 09-Mar-2024 14:30:45

Patient ID:	NMU0047171	Patient Name:	ASHWINI PANKAJ KOTHE
Age:	31 Years	Sex:	F
Accession Number:	NMBC60786	Modality:	US
Referring Physician:	DR.DMO	Study:	USG ABDOMEN WHOLE
Study Date:	09-Mar-2024	Study Time:	08:53:35

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 anteverted and is normal in size, shape and echotexture; No focal lesion seen. ET measures – 8.9 mm.

Both ovaries are normal in size, shape and position.

RIGHT OVARY Vol: 5-6 ml. LEFT OVARY Vol: 6-7 ml.

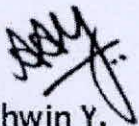
Visualised bowel loops appear normal. There is no free fluid seen.

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

IMPRESSION –

- **No significant abnormality detected.**

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



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

NMU0047171
31 Years

ASHWINI KOTHE
Female

3/9/2024 9:08:20 AM

Rate 67 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Baseline wander in lead(s) V3,V6

PR 141
QRSD 99
QT 378
QTc 399

--AXIS--

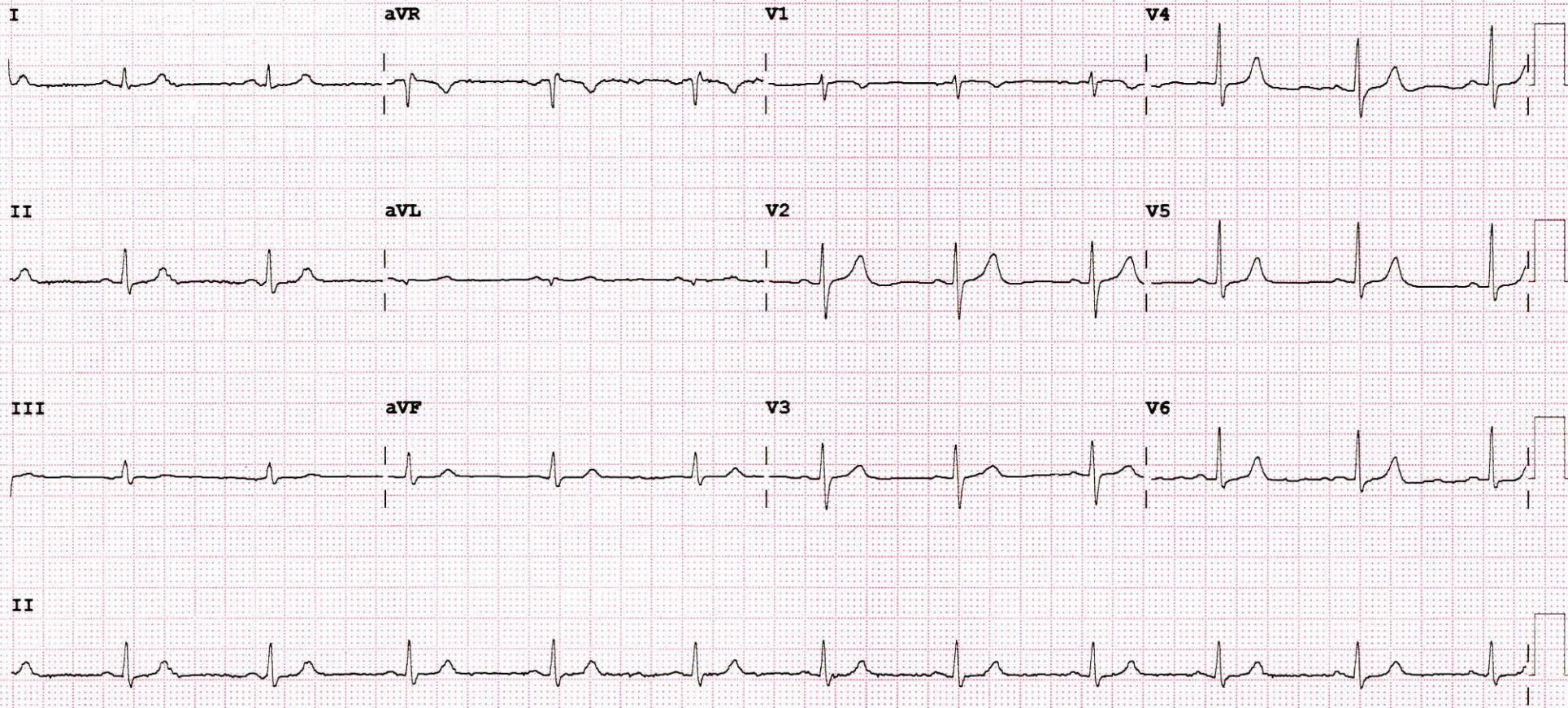
P 16
QRS 54
T 40

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

*NIR
LOWL
2*





MEDICOVER
HOSPITALS

NAVI MUMBAI

2D ECHO CARDIOGRAPHY WITH COLOUR DOPPLER

Name : Mrs. Ashwini Kothe

Date:-09/03/2024

Age / Sex : 31 Yrs /Female

UMR No. 0047171

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.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 30 mm Hg.
- 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 and 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			Trivial
PULMONERY	4.4			Nil





MEDICOVER
HOSPITALS

NAVI MUMBAI

Ashwini Kothre

OE: Missing \bar{c} $\frac{1}{6}$
Root piece \bar{c} $\frac{6}{1}$
Deep proximal caries \bar{c} $\frac{6}{1}$

Stains ++
Calculus ++

Adv: Complete Oral prophylaxis
Ext^h \bar{c} $\frac{1}{6}$
RCT \bar{c} $\frac{6}{1}$



Sayali Mandekar

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





DEPARTMENT OF OPHTHALMOLOGY

MEDICOVER HOSPITALS

DATE: 09/03/24

PATIENT NAME: Mrs. Ashwini Kothhe.

AGE / SEX: 31 / F. NAVI MUMBAI

UMR NO: N00004771

	RE	LE
VA (DISTANCE)	6/6.p	6/6.p.
VA(NEAR)	NG	NG
COLOUR VISION	NORMAL	NORMAL

		SPHERE	CYLINDER	AXIS	VA
MRx	O D Ⓡ	-0.50	_____		6/6, NG
	O S Ⓛ	-0.50	_____		6/6, NG

HISTORY :

· No Ocular trauma Allergies & surgeries.

· No systemic illness (DM, HTN, Thyroid).

OCULAR FINDINGS : No spectacle use

ADVICE:



MEDICAL HEALTH CHECK- UP ASSESMENT FORM

NAME : Mr / Mrs [✓] Aswini Kato

DATE: 9/3/24

AGE : 31y

SEX: Female / Male

NMU: NMU000 47171

DOCTOR'S NAME:

Health-Package

TEMP :	<u>97</u>	^o f	BP :	<u>110/70</u>	mmHg
PULSE :	<u>101</u>	b/m	HEIGHT :	<u>159</u>	cm
RR :	<u>20</u>	b/m	WEIGHT :	<u>54.3</u>	kg
SPO2 :	<u>99</u>	% RA	HGT:	<u>-</u>	

REMARK: