

# Dr. Swati Jain

Obstetrician & Gynaecologist

MBBS, DGO

Reg No. 52369

# HEALIC

The Good Hospital

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Patient Name Pooje Rani

Date 27-8-24

Patient Age/Gender 35/F

MF - 1 year.

UMP → 25-6-24

Polo A1, I Secondary infertility

M/L → 3/28 days cycle

Emb abn (medically terminated)  
Hybau.

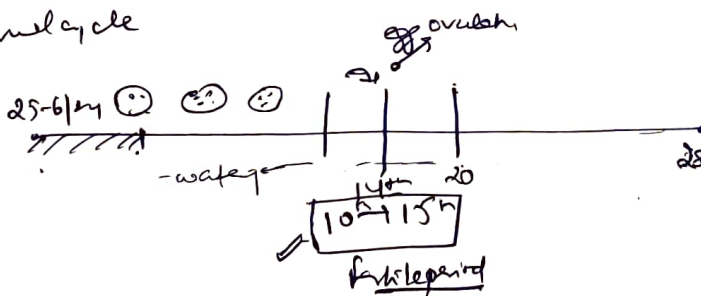
W/C/O Renelstones.

Othe

Yoga, Exercise  
meditation

Adv →  
Tab Folites re OD  
VIT D sachet weekly

Menstrual cycle



- Plenty of cool fluids  
(3-4L)

- Diet (No outside food)  
(No alcohol/smoking for both partners)

Sp period desit reme till 29 to 30/7/24  
then do S/S HCG & infam

USG whole abdomen & KUB.  
USG pelvis (crossed)

- Papsmeas.  
- follow i Reports

Husband semen analysis  
3 days abstinence ✓  
Signature \_\_\_\_\_

Follow Up Date With reports.

The Good Hospital

C-3, Plot no. GH 11, Saya Zenith Apartments,  
Ahinsa Khand II, Indrapuram, Ghaziabad, 201014,  
UP, India



App Store



Multispecialty Clinic  
ECG II TMT II Ultrasound  
X-Ray II Path Lab



# GAUR VISION CARE

(COMPLETE EYE CLINIC)

**SAPNA SINGH**

D.R. OPT., F.C.L.I., C.C.L.P.  
Consultant Optometrist &  
Contact Lens Specialist  
Mob.: 9873634857

**SANJAY SINGH**

D.R. OPT., F.C.L.I., C.C.L.P.  
Consultant Optometrist & Contact Lens Specialist  
LM : IOA # 432 World Council of Optometry  
Mob.: 9873914888

**Apollo Clinic**  
Expertise. Closer to you.

Gaur Gravity Indirapuram

Ex. Sr. Consultant Optometrist



Timing :

11:00 am to 2:00 pm  
05:30 pm to 8:30 pm

Facilities Available

- Eye Examination
- All Type of Contact Lenses
- Low Visual AIDS & Progressive Lenses

Mrs Puja Rani

VD  $\left\{ \begin{array}{l} \nearrow 6/9 \\ \searrow 6/9 \end{array} \right.$

RD 1/F

4. PVR 2.00

Myo. Systemic Med

RA + / - 1.25  $\times 70$

- 1.00  $\times 90$

B

R = - 1.00 DC  $\times 175$  65  $\times 6$   
L = - 0.75 DC  $\times 90$  65

Mean Vision BE - 2/4  
Edon Vision BE - 2/4

R

Refract Tom C 10

BP  
= 15 dcf

B  
27/07/24

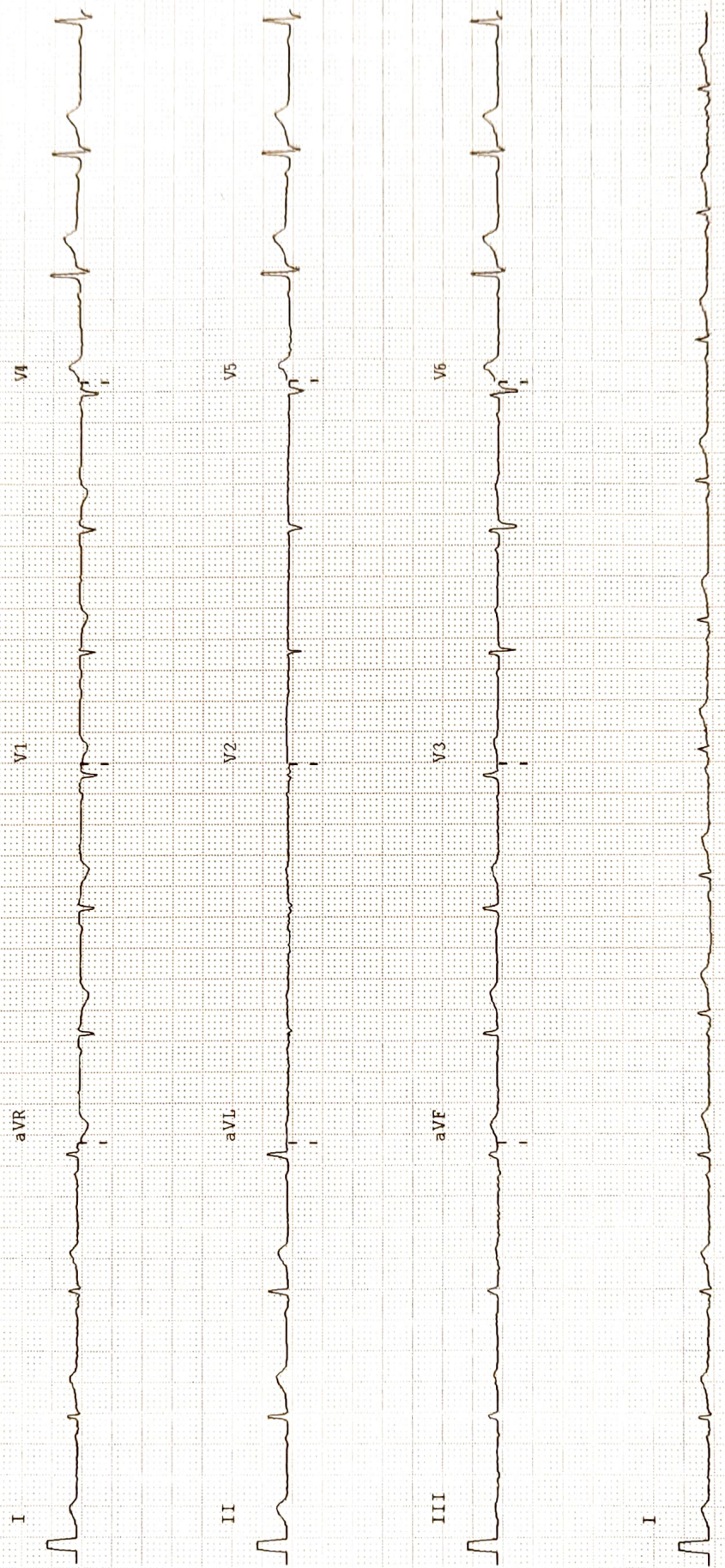
POOJA RANI  
 FEMALE

ID: 106 CASE  
 AGE: 35Y M D  
 Cms Kg

RATE : 67 bpm SINUS RHYTHM  
 P-R : 887 ms  
 P-R : 140 ms  
 QRS : 70 ms  
 QT : 376 ms  
 QTc : 388 ms

--AXIS--  
 P : 06°  
 QRS : 57°  
 T : 51°

12 SL. REPORT FORMAT: 3x4+1L SM REF: SELF Dr.





Barcode No	: 0121254	Registration	: 27/Jul/2024 05:16PM
Patient Name	: MRS. POOJA RANI	Received	: 27/Jul/2024 05:25PM
Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:56PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

### HAEMATOLOGY

Test Description	Observed Value	Unit	Reference Range
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#### COMPLETE BLOOD COUNT+ESR (CBC+ESR)

HAEMOGLOBIN (Hb) Colorimetric SLS	12.5	gm/dl	12.00-15.00
RED BLOOD CELLS- RBC COUNT Electrical Impedance	4.6	10 <sup>6</sup> /uL	4.50-5.50
PACKED CELL VOLUME (PCV) -HEMATOCRIT Calculated	38.1	%	36 - 46
MCV Calculated	86.7	fL	83-101
MCH Calculated	29.5	pg	27-32
MCHC Calculated	34	g/dl	32-36
RED CELL DISTRIBUTION WIDTH (RDW-CV) Whole blood EDTA,Flow Cytometry	12	%	11.5-14.5
RED CELL DISTRIBUTION WIDTH (RDW - SD) Whole Blood EDTA,Calculated	38.5	fl	39.0-46.0
PLATELET COUNT Electrical Impedance	155	10 <sup>3</sup> /uL	150-410
PLATELET DISTRIBUTION WIDTH (PDW) Whole Blood EDTA,Calculated	20.7	fL	9.00-17.00
PCT(PLATELETCRIT) Whole blood EDTA,Flow Cytometry	0.12	%	0.108-0.282
MEAN PLATELET VOLUME - MPV Calculated	13.6	fL	7.00-12.00
P-LCR	66		
P-LCC Calculated	57.20	%	30.0-90.0
TOTAL LEUKOCYTE COUNT (TLC) Laser - Based Flow Cytometry / Microscopy	5.16	10 <sup>3</sup> /uL	4.0-10.0
<b>DIFFERENTIAL LEUKOCYTE COUNT</b>			
Neutrophils Laser - Based Flow Cytometry / Microscopy	50.3	%	40-80




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**HAEMATOLOGY**

Test Description	Observed Value	Unit	Reference Range
Lymphocytes Laser - Based Flow Cytometry / Microscopy	40.8	%	20-40
Eosinophils Laser - Based Flow Cytometry / Microscopy	3.1	%	1-6
Monocytes Laser - Based Flow Cytometry / Microscopy	5	%	2-10
Basophils Whole blood EDTA,Flow Cytometry	0.8	%	0.00-1.00
ABSOLUTE NEUTROPHIL COUNT Whole Blood EDTA,Calculated	2.6	10 <sup>3</sup> /μL	2.00-7.00
ABSOLUTE LYMPHOCYTE COUNT Calculated	2.11	10 <sup>3</sup> /μL	1.00-3.00
ABSOLUTE EOSINOPHIL COUNT Calculated	0.16	10 <sup>3</sup> /μL	0.02-0.50
ABSOLUTE MONOCYTE COUNT Calculated	0.26	10 <sup>3</sup> /μL	0.20-1.00
ABSOLUTE BASOPHIL COUNT Calculated	0.04	10 <sup>3</sup> /μL	0.02-0.10
ESR [WESTERGREIN] Sedimentation	15.00	mm/1st	0-15

**INTERPRETATION:**

A complete blood count (CBC), also known as a full blood count (FBC), is a set of medical laboratory tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells and platelets, the concentration of hemoglobin, and the hematocrit (the volume percentage of red blood cells). The red blood cell indices, which indicate the average size and hemoglobin content of red blood cells, are also reported, and a white blood cell differential, which counts the different types of white blood cells, may be included. The CBC is often carried out as part of a medical assessment and can be used to monitor health or diagnose diseases. The results are interpreted by comparing them to reference ranges, which vary with sex and age. Conditions like anemia and thrombocytopenia are defined by abnormal complete blood count results. The red blood cell indices can provide information about the cause of a person's anemia such as iron deficiency and vitamin B12 deficiency, and the results of the white blood cell differential can help to diagnose viral, bacterial and parasitic infections and blood disorders like leukemia. Not all results falling outside of the reference range require medical intervention.




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Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### LIVER FUNCTION TEST

TOTAL BILIRUBIN	0.63	mg/dL	0.10 - 1.2
Diazo			
CONJUGATED ( D. Bilirubin)	0.15	mg/dL	0.0 - 0.30
Diazo			
UNCONJUGATED ( I.D. Bilirubin)	0.48	mg/dl	0.0 - 1.0
Calculated			
S.G.P.T	25	U/L	0-35
UV without P5P			
SGOT	21	U/L	0-40
UV without P5P			
ALKALINE PHOSPHATASE	75.90	U/L	42 - 98
AMP			
TOTAL PROTEINS	7.0	g/dL	6.4 - 8.3
Biuret			
ALBUMIN	4.1	g/dL	3.5 - 5.2
Bromocresol Green			
GLOBULIN	2.91	g/dL	2.30-4.50
Calculated			
A/ G RATIO	1.41		1.0-2.3
Calculated			

#### INTERPRETATION

Bilirubin Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice).

Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis; drug reactions, alcoholic liver disease conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts.

Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.

AST levels increase in viral hepatitis, blockage of the bile duct ,cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart atck or strenuous activity.

ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.

GGT may be higher with diabetes, heart failure, hyperthyroidism, or pancreatitis. Higher GGT levels also may mean liver damage from heavy, chronic alcohol abuse. GGT levels that are higher than normal may also signal a viral infection

Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, paget`s disease, Rickets, Sarcoidosis etc. Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc.

Serum total protein, in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation




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Sample Type	: SERUM		

**BIOCHEMISTRY**

Test Description	Observed Value	Unit	Reference Range
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or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition,




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### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### LIPID PROFILE

TOTAL CHOLESTEROL Cholesterol Oxidase,PAP	172.6	mg/dl	<200 Desirable~200 – 239 Borderline >240 High Risk
TRIGLYCERIDES GPO-TRINDER	89.5	mg/dL	Normal : <161~High : 161 - 199~Hyper Triglyceridemic : 200 - 499~Very High : >499
H D L CHOLESTEROL Direct Enzymatic Colorimetric	46.2	mg/dl	>40 Recommended Range
L D L CHOLESTEROL Calculated	108.5	mg/dl	70-130
VLDL Spectrophotometry/Calculated	17.9	mg/dl	0.00-45.0
T. CHOLESTEROL/ HDL RATIO Calculated	3.74	Ratio	3.40-4.40
LDL/ HDL RATIO Calculated	2.35	Ratio	1.0-3.5

#### COMMENT :-

(#). A lipid panel measures five different types of lipids from a blood sample, including:

- (1). Total cholesterol: This is your overall cholesterol level — the combination of LDL-C, VLDL-C and HDL-C.
- (2). Low-density lipoprotein (LDL) cholesterol: This is the type of cholesterol that's known as "bad cholesterol." It can collect in your blood vessels and increase your risk of cardiovascular disease.
- (3). Very low-density lipoprotein (VLDL) cholesterol: This is a type of cholesterol that's usually present in very low amounts when the blood sample is a fasting samples since it's mostly comes from food you've recently eaten. An increase in this type of cholesterol in a fasting sample may be a sign of abnormal lipid metabolism.
- (4). High-density lipoprotein (HDL) cholesterol: This is the type of cholesterol that's known as "good cholesterol." It helps decrease the buildup of LDL in your blood vessels.
- (5). Triglycerides: This is a type of fat from the food we eat. Excess amounts of triglycerides in your blood are associated with cardiovascular disease and pancreatic inflammation.




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Sample Type	: WHOLE BLOOD EDTA		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### HBA1C

HBA1c HPLC	5.1	%	
ESTIMATED AVG. GLUCOSE	99.67	mg/dl	

#### Ref Range for HBA1c

**Non-Diabetic :-** 4.0 – 5.6

**Increased Risk:-** 5.7 – 6.4

#### In Diabetics:

**Excellent Control:** 6.5 – 7.0

**Fair To Good Control:** 7.0 – 8.0

**Unsatisfactory Control:-** 8.0 – 10

**Poor Control:** >10

#### COMMENT:

The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months.

This test is used to monitor treatment in someone who has been diagnosed with diabetes.

It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes.

Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year.

The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year.

When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.

**Note:** If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low.

If someone is iron-deficient, the HbA1c level may be increased.

If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months.




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Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: FLOURIDE PLASMA		

**BIOCHEMISTRY**

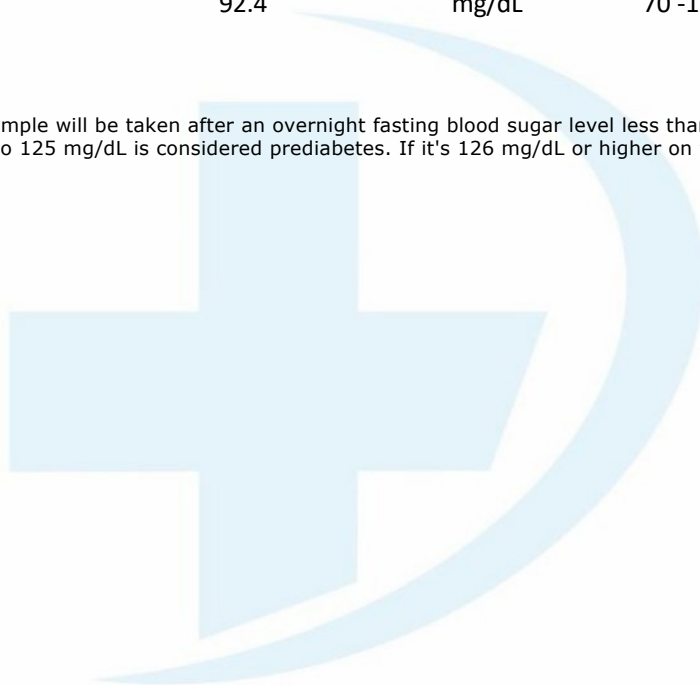
Test Description	Observed Value	Unit	Reference Range
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**FASTING BLOOD SUGAR**

Plasma Glucose Fasting Glucose Oxidase/Peroxidase	92.4	mg/dL	70 -110
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**INTERPRETATION:**

Fasting blood sugar test. A blood sample will be taken after an overnight fasting blood sugar level less than 100mg/dL is normal. A fasting blood sugar level from 100 to 125 mg/dL is considered prediabetes. If it's 126 mg/dL or higher on two separate tests, you have diabetes.



*Shabnam*

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Sample Type	: SERUM		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### KIDNEY FUNCTION TEST

SERUM UREA Serum,Urease GLDH	26.30	mg/dL	19.0 - 45.0
SERUM CREATININE Enzymatic	0.89	mg/dL	0.7-1.30
SERUM URIC ACID Serum,Uricase	4.5	mg/dl	2.6 - 6.0
SERUM SODIUM ISE, Direct	140.2	mmol/L	135-150
SERUM POTASSIUM ISE, Direct	4.4	mmol/L	3.5-5.5
SERUM CHLORIDE ISE, Direct	103.8	mmol/L	94-110
Blood Urea Nitrogen (BUN) Calculated	12.29	mg/dl	8.00-23.0
UREA / CREATININE RATIO	29.55		
SERUM TOTAL CALCIUM BAPTA	9.10	mg/dl	8.4-10.6

#### INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20.

To Differentiate between pre- and postrenal azotemia.

**INCREASED RATIO (>20:1) WITH NORMAL CREATININE:**

- 1.Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.
- 2.Catabolic states with increased tissue breakdown.
- 3.GI hemorrhage.
- 4.High protein intake.
- 5.Impaired renal function plus .
- 6.Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high




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**BIOCHEMISTRY**

Test Description	Observed Value	Unit	Reference Range
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protein diet, burns,surgery, cachexia, high fever).

- 7.Urine reabsorption (e.g. ureterocolostomy)
- 8.Reduced muscle mass (subnormal creatinine production)
- 9.Certain drugs (e.g. tetracycline, glucocorticoids)

**INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**

- 1.Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
- 2.Prerenal azotemia superimposed on renal disease.

**DECREASED RATIO (<10:1) WITH DECREASED BUN :**

- 1.Acute tubular necrosis.
- 2.Low protein diet and starvation.
- 3.Severe liver disease.
- 4.Other causes of decreased urea synthesis.
- 5.Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- 6.Inherited hyperammonemias (urea is virtually absent in blood).
- 7.SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- 8.Pregnancy.

**DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**

- 1.Phenacimide therapy (accelerates conversion of creatine to creatinine).
- 2.Rhabdomyolysis (releases muscle creatinine).
- 3.Muscular patients who develop renal failure.

**INAPPROPRIATE RATIO:**

- 1.Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- 2.Cephalosporin therapy (interferes with creatinine measurement).




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Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:48PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: URINE		

**CLINICAL PATHOLOGY**

Test Description	Observed Value	Unit	Reference Range
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**URINE ROUTINE EXAMINATION**

**PHYSICAL EXAMINATION**

QUANTITY visual	20 ML	ml	0-50
COLOUR visual	PALE YELLOW		PALE YELLOW
TRANSPARENCY visual	CLEAR		Clear
SPECIFIC GRAVITY ION exchange	1.025		1.010 - 1.030
<b>CHEMICAL EXAMINATION</b>			
pH Double Indicator	6.0		5-7
PROTEIN Protein - error of Indicators	NEGATIVE	g/dL	
GLUCOSE GOD-POD	NEGATIVE	mg/dl	
UROBILINOGEN Ehrlichs Reaction	NIL		Nil
KETONE BODIES Legals Nitroprasside	NEGATIVE		NEGATIVE
BILIRUBIN Azo-coupling Reaction	NIL		Nil
BLOOD Pseudo-peroxidase	NIL		Nil
NITRITE Diazotization Reaction	NIL		Nil
<b>MICROSCOPIC EXAMINATION</b>			
PUS CELLS Microscopy	2-4	cells/HPF	0-5
RBCs Microscopy	NIL	Cells/HPF	Nil



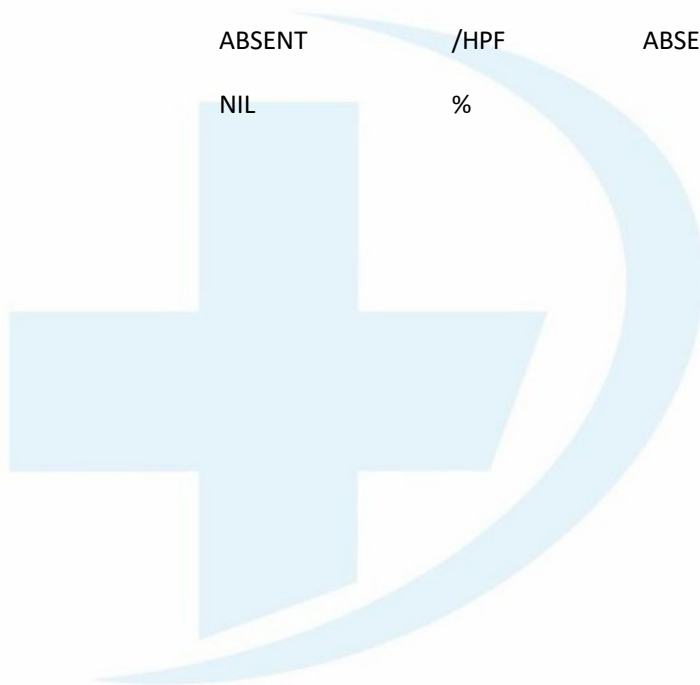

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Sample Type	: URINE		

**CLINICAL PATHOLOGY**

Test Description	Observed Value	Unit	Reference Range
EPITHELIAL CELLS Microscopy	2-4	Cells/HPF	0 - 5
CRYSTALS Microscopy	ABSENT	ABSENT	ABSENT
CASTS Microscopy	ABSENT	/HPF	ABSENT
OTHER	NIL	%	




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Sample Type	: SERUM		

**HORMONE ASSAYS**

Test Description	Observed Value	Unit	Reference Range
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**THYROID PROFILE (T3,T4,TSH)**

TRIODOXYRONINE TOTAL (T3) CLIA	0.84	ng/mL	0.8 - 1.9
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**Summary & Interpretation:-**

Triiodothyronine (T3) is the hormone principally responsible for the development of the effects of the thyroid hormones on the various target organs. T3 is mainly formed extrathyroidally, particularly in the liver, by deiodination of T4. A reduction in the conversion of T4 to T3 results in a fall in the T3 concentration. It occurs under the influence of medicaments such as propranolol, glucocorticoids or amiodarone and in severe non-thyroidal illness (NTI). The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism, the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

THYROXINE TOTAL (T4) CLIA	7.2	ug/dL	5.0 - 13.0
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**Summary & Interpretation:**

The hormone thyroxine (T4) is the main product secreted by the thyroid gland. The major part of total thyroxine (T4) in serum is present in protein-bound form. As the concentration of the transport proteins in serum are subject to exogenous and endogenous effects, the status of the binding proteins must also be taken into account in the assessment of the thyroid hormone concentration in serum. The determination of T4 can be utilized for the following indications: the detection of hyperthyroidism, the detection of primary and secondary hypothyroidism and the monitoring of TSH-suppression therapy.

THYROID STIMULATING HORMONE (TSH) CLIA	4.200	μIU/mL	0.35 - 4.75
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**Summary & Interpretation**

TSH is formed in specific basophil cells of the anterior pituitary and is subject to a circadian secretion sequence. The determination of TSH serves as the initial test in thyroid diagnostics. Accordingly, TSH is a very sensitive and specific parameter for assessing thyroid function and is particularly suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid.

**Note:**

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm. The variation is of the order of 50%. Hence time of the day has influence on the measured serum TSH concentrations.
2. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.
3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
4. Clinical Use: Primary Hypothyroidism, Hyperthyroidism, Hypothalamic - Pituitary hypothyroidism, Inappropriate TSH secretion, Nonthyroidal illness, Autoimmune thyroid disease, Pregnancy associated thyroid disorders.

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL
1st Trimester	0.05 - 3.70
2nd Trimester	0.31 - 4.35
3rd Trimester	0.41 - 5.18

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



*Shabnam*

Dr. SHABNAM MIRZA  
Consultant Pathologist



PULL

WEEKEND

 GPS Map Camera

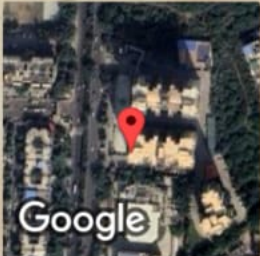
**Ghaziabad, Uttar Pradesh, India**

Tower-A, Saya Zenith, Indirapuram, Ghaziabad, Uttar Pradesh 201014, India

Lat 28.637774°

Long 77.378935°

27/07/24 12:58 PM GMT +05:30







Barcode No	: 0121254	Registration	: 27/Jul/2024 05:16PM
Patient Name	: MRS. POOJA RANI	Received	: 27/Jul/2024 05:25PM
Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:56PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

**HAEMATOLOGY**

Test Description	Observed Value	Unit	Reference Range
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**COMPLETE BLOOD COUNT+ESR (CBC+ESR)**

HAEMOGLOBIN (Hb) Colorimetric SLS	12.5	gm/dl	12.00-15.00
RED BLOOD CELLS- RBC COUNT Electrical Impedance	4.6	10 <sup>6</sup> /uL	4.50-5.50
PACKED CELL VOLUME (PCV) -HEMATOCRIT Calculated	38.1	%	36 - 46
MCV Calculated	86.7	fL	83-101
MCH Calculated	29.5	pg	27-32
MCHC Calculated	34	g/dl	32-36
RED CELL DISTRIBUTION WIDTH (RDW-CV) Whole blood EDTA,Flow Cytometry	12	%	11.5-14.5
RED CELL DISTRIBUTION WIDTH (RDW - SD) Whole Blood EDTA,Calculated	38.5	fl	39.0-46.0
PLATELET COUNT Electrical Impedance	155	10 <sup>3</sup> /uL	150-410
PLATELET DISTRIBUTION WIDTH (PDW) Whole Blood EDTA,Calculated	20.7	fL	9.00-17.00
PCT(PLATELETCRIT) Whole blood EDTA,Flow Cytometry	0.12	%	0.108-0.282
MEAN PLATELET VOLUME - MPV Calculated	13.6	fL	7.00-12.00
P-LCR	66		
P-LCC Calculated	57.20	%	30.0-90.0
TOTAL LEUKOCYTE COUNT (TLC) Laser - Based Flow Cytometry / Microscopy	5.16	10 <sup>3</sup> /uL	4.0-10.0
<b>DIFFERENTIAL LEUKOCYTE COUNT</b>			
Neutrophils Laser - Based Flow Cytometry / Microscopy	50.3	%	40-80




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Sample Type	: WHOLE BLOOD EDTA		

**HAEMATOLOGY**

Test Description	Observed Value	Unit	Reference Range
Lymphocytes Laser - Based Flow Cytometry / Microscopy	40.8	%	20-40
Eosinophils Laser - Based Flow Cytometry / Microscopy	3.1	%	1-6
Monocytes Laser - Based Flow Cytometry / Microscopy	5	%	2-10
Basophils Whole blood EDTA,Flow Cytometry	0.8	%	0.00-1.00
ABSOLUTE NEUTROPHIL COUNT Whole Blood EDTA,Calculated	2.6	10 <sup>3</sup> /μL	2.00-7.00
ABSOLUTE LYMPHOCYTE COUNT Calculated	2.11	10 <sup>3</sup> /μL	1.00-3.00
ABSOLUTE EOSINOPHIL COUNT Calculated	0.16	10 <sup>3</sup> /μL	0.02-0.50
ABSOLUTE MONOCYTE COUNT Calculated	0.26	10 <sup>3</sup> /μL	0.20-1.00
ABSOLUTE BASOPHIL COUNT Calculated	0.04	10 <sup>3</sup> /μL	0.02-0.10
ESR [WESTERGREIN] Sedimentation	15.00	mm/1st	0-15

**INTERPRETATION:**

A complete blood count (CBC), also known as a full blood count (FBC), is a set of medical laboratory tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells and platelets, the concentration of hemoglobin, and the hematocrit (the volume percentage of red blood cells). The red blood cell indices, which indicate the average size and hemoglobin content of red blood cells, are also reported, and a white blood cell differential, which counts the different types of white blood cells, may be included. The CBC is often carried out as part of a medical assessment and can be used to monitor health or diagnose diseases. The results are interpreted by comparing them to reference ranges, which vary with sex and age. Conditions like anemia and thrombocytopenia are defined by abnormal complete blood count results. The red blood cell indices can provide information about the cause of a person's anemia such as iron deficiency and vitamin B12 deficiency, and the results of the white blood cell differential can help to diagnose viral, bacterial and parasitic infections and blood disorders like leukemia. Not all results falling outside of the reference range require medical intervention.



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Barcode No	: 0121251	Registration	: 27/Jul/2024 05:16PM
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Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:46PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

**BIOCHEMISTRY**

Test Description	Observed Value	Unit	Reference Range
------------------	----------------	------	-----------------

**LIVER FUNCTION TEST**

TOTAL BILIRUBIN	0.63	mg/dL	0.10 - 1.2
Diazo			
CONJUGATED ( D. Bilirubin)	0.15	mg/dL	0.0 - 0.30
Diazo			
UNCONJUGATED ( I.D. Bilirubin)	0.48	mg/dl	0.0 - 1.0
Calculated			
S.G.P.T	25	U/L	0-35
UV without P5P			
SGOT	21	U/L	0-40
UV without P5P			
ALKALINE PHOSPHATASE	75.90	U/L	42 - 98
AMP			
TOTAL PROTEINS	7.0	g/dL	6.4 - 8.3
Biuret			
ALBUMIN	4.1	g/dL	3.5 - 5.2
Bromocresol Green			
GLOBULIN	2.91	g/dL	2.30-4.50
Calculated			
A/ G RATIO	1.41		1.0-2.3
Calculated			

**INTERPRETATION**

Bilirubin Elevated levels results from increased bilirubin production (eg hemolysis and ineffective erythropoiesis); decreased bilirubin excretion (eg; obstruction and hepatitis); and abnormal bilirubin metabolism (eg; hereditary and neonatal jaundice).  
 Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis; drug reactions, alcoholic liver disease conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts tumors & Scarring of the bile ducts.  
 Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome.  
 AST levels increase in viral hepatitis, blockage of the bile duct ,cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. Ast levels may also increase after a heart atck or strenuous activity.  
 ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.  
 GGT may be higher with diabetes, heart failure, hyperthyroidism, or pancreatitis. Higher GGT levels also may mean liver damage from heavy, chronic alcohol abuse. GGT levels that are higher than normal may also signal a viral infection  
 Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, paget` s disease, Rickets, Sarcoidosis etc. Elevated serum GGT activity can be found in diseases of the liver, Biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-including drugs etc.  
 Serum total protein, in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation




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Sample Type	: SERUM		

**BIOCHEMISTRY**

Test Description	Observed Value	Unit	Reference Range
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or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition,




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Sample Type	: SERUM		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### LIPID PROFILE

TOTAL CHOLESTEROL Cholesterol Oxidase,PAP	172.6	mg/dl	<200 Desirable~200 – 239 Borderline >240 High Risk
TRIGLYCERIDES GPO-TRINDER	89.5	mg/dL	Normal : <161~High : 161 - 199~Hyper Triglyceridemic : 200 - 499~Very High : >499
H D L CHOLESTEROL Direct Enzymatic Colorimetric	46.2	mg/dl	>40 Recommended Range
L D L CHOLESTEROL Calculated	108.5	mg/dl	70-130
VLDL Spectrophotometry/Calculated	17.9	mg/dl	0.00-45.0
T. CHOLESTEROL/ HDL RATIO Calculated	3.74	Ratio	3.40-4.40
LDL/ HDL RATIO Calculated	2.35	Ratio	1.0-3.5

#### COMMENT :-

(#). A lipid panel measures five different types of lipids from a blood sample, including:

- (1). Total cholesterol: This is your overall cholesterol level — the combination of LDL-C, VLDL-C and HDL-C.
- (2). Low-density lipoprotein (LDL) cholesterol: This is the type of cholesterol that's known as "bad cholesterol." It can collect in your blood vessels and increase your risk of cardiovascular disease.
- (3). Very low-density lipoprotein (VLDL) cholesterol: This is a type of cholesterol that's usually present in very low amounts when the blood sample is a fasting samples since it's mostly comes from food you've recently eaten. An increase in this type of cholesterol in a fasting sample may be a sign of abnormal lipid metabolism.
- (4). High-density lipoprotein (HDL) cholesterol: This is the type of cholesterol that's known as "good cholesterol." It helps decrease the buildup of LDL in your blood vessels.
- (5). Triglycerides: This is a type of fat from the food we eat. Excess amounts of triglycerides in your blood are associated with cardiovascular disease and pancreatic inflammation.




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Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: WHOLE BLOOD EDTA		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### HBA1C

HBA1c HPLC	5.1	%	
ESTIMATED AVG. GLUCOSE	99.67	mg/dl	

#### Ref Range for HBA1c

**Non-Diabetic :-** 4.0 – 5.6

**Increased Risk:-** 5.7 – 6.4

#### In Diabetics:

**Excellent Control:** 6.5 – 7.0

**Fair To Good Control:** 7.0 – 8.0

**Unsatisfactory Control:-** 8.0 – 10

**Poor Control:** >10

#### COMMENT:

The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months.

This test is used to monitor treatment in someone who has been diagnosed with diabetes.

It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes.

Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year.

The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year.

When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.

**Note:** If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low.

If someone is iron-deficient, the HbA1c level may be increased.

If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months.




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Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:46PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: FLOURIDE PLASMA		

**BIOCHEMISTRY**

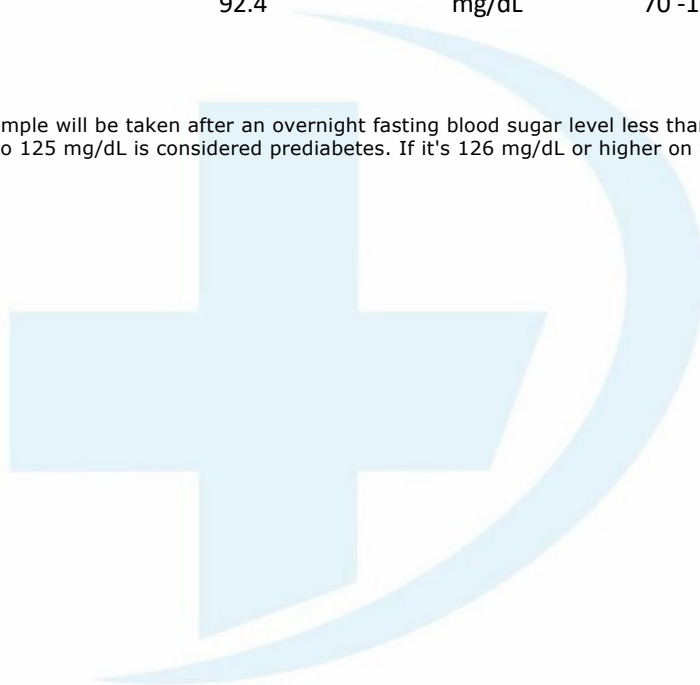
Test Description	Observed Value	Unit	Reference Range
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**FASTING BLOOD SUGAR**

Plasma Glucose Fasting Glucose Oxidase/Peroxidase	92.4	mg/dL	70 -110
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**INTERPRETATION:**

Fasting blood sugar test. A blood sample will be taken after an overnight fasting blood sugar level less than 100mg/dL is normal. A fasting blood sugar level from 100 to 125 mg/dL is considered prediabetes. If it's 126 mg/dL or higher on two separate tests, you have diabetes.



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Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:46PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

### BIOCHEMISTRY

Test Description	Observed Value	Unit	Reference Range
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#### KIDNEY FUNCTION TEST

SERUM UREA Serum,Urease GLDH	26.30	mg/dL	19.0 - 45.0
SERUM CREATININE Enzymatic	0.89	mg/dL	0.7-1.30
SERUM URIC ACID Serum,Uricase	4.5	mg/dl	2.6 - 6.0
SERUM SODIUM ISE, Direct	140.2	mmol/L	135-150
SERUM POTASSIUM ISE, Direct	4.4	mmol/L	3.5-5.5
SERUM CHLORIDE ISE, Direct	103.8	mmol/L	94-110
Blood Urea Nitrogen (BUN) Calculated	12.29	mg/dl	8.00-23.0
UREA / CREATININE RATIO	29.55		
SERUM TOTAL CALCIUM BAPTA	9.10	mg/dl	8.4-10.6

#### INTERPRETATION:

Normal range for a healthy person on normal diet: 12 - 20.

To Differentiate between pre- and postrenal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

- 1.Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion,dehydration, blood loss) due to decreased glomerular filtration rate.
- 2.Catabolic states with increased tissue breakdown.
- 3.GI hemorrhage.
- 4.High protein intake.
- 5.Impaired renal function plus .
- 6.Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushings syndrome, high




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**BIOCHEMISTRY**

Test Description	Observed Value	Unit	Reference Range
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protein diet, burns,surgery, cachexia, high fever).

- 7.Urine reabsorption (e.g. ureterocolostomy)
- 8.Reduced muscle mass (subnormal creatinine production)
- 9.Certain drugs (e.g. tetracycline, glucocorticoids)

**INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**

- 1.Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
- 2.Prerenal azotemia superimposed on renal disease.

**DECREASED RATIO (<10:1) WITH DECREASED BUN :**

- 1.Acute tubular necrosis.
- 2.Low protein diet and starvation.
- 3.Severe liver disease.
- 4.Other causes of decreased urea synthesis.
- 5.Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- 6.Inherited hyperammonemias (urea is virtually absent in blood).
- 7.SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
- 8.Pregnancy.

**DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**

- 1.Phenacimide therapy (accelerates conversion of creatine to creatinine).
- 2.Rhabdomyolysis (releases muscle creatinine).
- 3.Muscular patients who develop renal failure.

**INAPPROPRIATE RATIO:**

- 1.Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies,resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- 2.Cephalosporin therapy (interferes with creatinine measurement).



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Patient Name	: MRS. POOJA RANI	Received	: 27/Jul/2024 05:25PM
Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:48PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: URINE		

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range
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**URINE ROUTINE EXAMINATION**

**PHYSICAL EXAMINATION**

QUANTITY visual	20 ML	ml	0-50
COLOUR visual	PALE YELLOW		PALE YELLOW
TRANSPARENCY visual	CLEAR		Clear
SPECIFIC GRAVITY ION exchange	1.025		1.010 - 1.030
<b>CHEMICAL EXAMINATION</b>			
pH Double Indicator	6.0		5-7
PROTEIN Protein - error of Indicators	NEGATIVE	g/dL	
GLUCOSE GOD-POD	NEGATIVE	mg/dl	
UROBILINOGEN Ehrlichs Reaction	NIL		Nil
KETONE BODIES Legals Nitroprasside	NEGATIVE		NEGATIVE
BILIRUBIN Azo-coupling Reaction	NIL		Nil
BLOOD Pseudo-peroxidase	NIL		Nil
NITRITE Diazotization Reaction	NIL		Nil
<b>MICROSCOPIC EXAMINATION</b>			
PUS CELLS Microscopy	2-4	cells/HPF	0-5
RBCs Microscopy	NIL	Cells/HPF	Nil



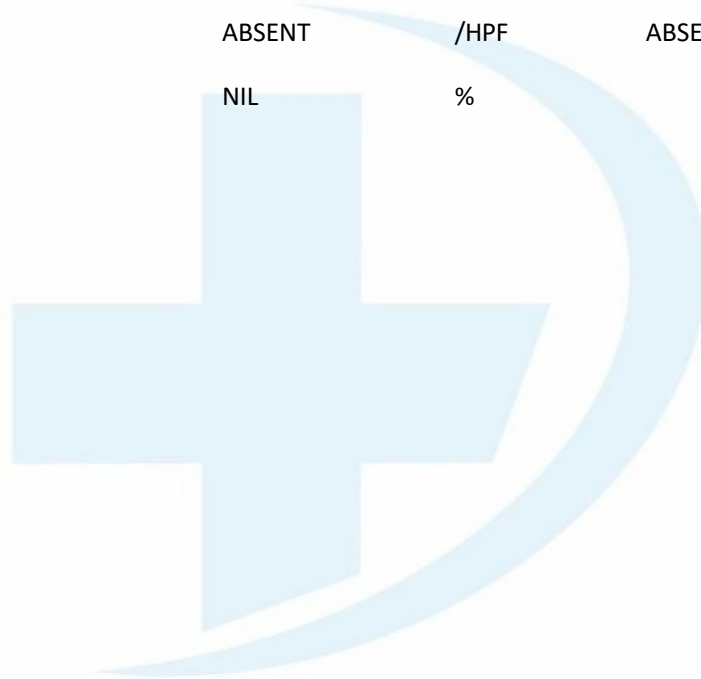

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Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: URINE		

CLINICAL PATHOLOGY

Test Description	Observed Value	Unit	Reference Range
EPITHELIAL CELLS Microscopy	2-4	Cells/HPF	0 - 5
CRYSTALS Microscopy	ABSENT	ABSENT	ABSENT
CASTS Microscopy	ABSENT	/HPF	ABSENT
OTHER	NIL	%	




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Age/Gender	: 35 Y 0 M 0 D /F	Reported	: 27/Jul/2024 08:46PM
Ref Doctor	: Dr.SELF	Client Code	: UP528
Collected By	: Dr.SELF	Client Add	: INDIRAPURAM
Sample Type	: SERUM		

**HORMONE ASSAYS**

Test Description	Observed Value	Unit	Reference Range
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**THYROID PROFILE (T3,T4,TSH)**

TRIODOXYRONE TOTAL (T3) CLIA	0.84	ng/mL	0.8 - 1.9
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**Summary & Interpretation:-**

Triiodothyronine (T3) is the hormone principally responsible for the development of the effects of the thyroid hormones on the various target organs. T3 is mainly formed extrathyroidally, particularly in the liver, by deiodination of T4. A reduction in the conversion of T4 to T3 results in a fall in the T3 concentration. It occurs under the influence of medicaments such as propranolol, glucocorticoids or amiodarone and in severe non-thyroidal illness (NTI). The determination of T3 is utilized in the diagnosis of T3-hyperthyroidism, the detection of early stages of hyperthyroidism and for indicating a diagnosis of thyrotoxicosis factitia.

THYROXINE TOTAL (T4) CLIA	7.2	ug/dL	5.0 - 13.0
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**Summary & Interpretation:**

The hormone thyroxine (T4) is the main product secreted by the thyroid gland. The major part of total thyroxine (T4) in serum is present in protein-bound form. As the concentration of the transport proteins in serum are subject to exogenous and endogenous effects, the status of the binding proteins must also be taken into account in the assessment of the thyroid hormone concentration in serum. The determination of T4 can be utilized for the following indications: the detection of hyperthyroidism, the detection of primary and secondary hypothyroidism and the monitoring of TSH-suppression therapy.

THYROID STIMULATING HORMONE (TSH) CLIA	4.200	μIU/mL	0.35 - 4.75
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**Summary & Interpretation**

TSH is formed in specific basophil cells of the anterior pituitary and is subject to a circadian secretion sequence. The determination of TSH serves as the initial test in thyroid diagnostics. Accordingly, TSH is a very sensitive and specific parameter for assessing thyroid function and is particularly suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid.

**Note:**

1. TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm. The variation is of the order of 50%. Hence time of the day has influence on the measured serum TSH concentrations.
2. Recommended test for T3 and T4 is unbound fraction or free levels as it is metabolically active.
3. Physiological rise in Total T3 / T4 levels is seen in pregnancy and in patients on steroid therapy.
4. Clinical Use: Primary Hypothyroidism, Hyperthyroidism, Hypothalamic - Pituitary hypothyroidism, Inappropriate TSH secretion, Nonthyroidal illness, Autoimmune thyroid disease, Pregnancy associated thyroid disorders.

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL
1st Trimester	0.05 - 3.70
2nd Trimester	0.31 - 4.35
3rd Trimester	0.41 - 5.18

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




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Consultant Pathologist

<b>NAME- POOJA RANI</b>	<b>ULTRASOUND WHOLE ABDOMEN 27-07-2024</b>
<b>AGE- 30YRS</b>	
<b>GENDER - FEMALE</b>	
<b>REF.BY - self</b>	

**LIVER:** Liver is normal in size (12.1cm) and echopattern. No focal intra-hepatic lesion is detected. Intra-hepatic biliary radicals are not dilated. Portal vein is normal in calibre.

**GALL BLADDER:** Gall bladder appears echofree with normal wall thickness. Common bile duct is normal in calibre.

**PANCREAS:** Pancreas is normal in size (12.1cm) and echopattern.

**SPLEEN: Spleen is mildly enlarged in size 12.2cm.**

**KIDNEYS:** Both kidneys are normal in position, size (RK 9x3.8cm and LK = 9.6x4.2cm) and outline. Cortico-medullary differentiation of both kidneys is maintained. Central sinus echoes are compact. No focal lesion seen. Bilateral pelvicalyceal systems are not dilated.

**Kidney shows approximately 2-3 calculus, largest measuring 4.3mm in middle calyx of right kidney and largest approximately measuring 4.4mm in middle calyx of left kidney.**

**URINARY BLADDER:** Urinary bladder is normal in wall thickness with clear contents. No significant intra or extraluminal mass is seen.

**UTERUS: It measures 7.8X4.4X4.6cm and shows a well defined hypoechoic lesion-13x7mm in intramural region of anterior fundal region. It is normal in size. Endometrium is central (9.4)**

**OVARIES:** Both ovaries are normal in size and echopattern.  
Right ovary measures - 2.4x1.2cm  
Left ovary measures- 2.0x1.8cm

Visualized parts of retroperitoneum do not reveal any lymphadenopathy.

No free fluid is detected in pouch of Douglas and Morissons pouch.

**IMPRESSION: MILD SPLENOMEGALY.  
: UTERINE FIBROID AS DESCRIBED.  
: BILATERAL RENAL CALCULI.**

ADV:- Clinical correlation.



**DR. ANANT SHARMA  
CONSULTANT RADIOLOGIST**

HEALIC MULTISPECIALTY CLINIC  
27/07/2024 12:45:39 pmADM

POOJA RANI 35YRS ,  
270724-122440PM

MI 0.8  
TIs 0.2  
4C  
Abdomen

28/07/2024  
01:38:18 pm



- 1 L 9.49 mm
- 2 L 12.96 mm
- 3 L 7.52 mm

FR	28
AO%	100
CHI	
Frg	4.0
Gn	58
S/A	5/4
Map	F/0
D	18.0
DR	95
Whizz	Off

TUI

Elasto

LOGIView

3D/4D

P4

P3

0.0 (0.15.2 s)



HEALIC MULTISPECIALTY CLINIC  
27/07/2024 12:40:12 pmADM

POOJA RANI 35YRS ,  
270724-122440PM

MI 1.2  
TIs 0.8

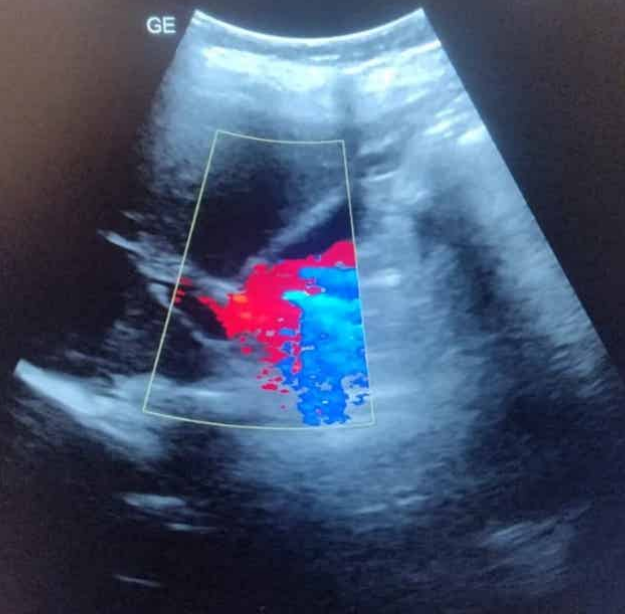
4C  
Abdomen



29/07/2024  
01:38:07 pm



GE



FR	11	<input type="checkbox"/>
AO%	100	<input type="checkbox"/>
CHI		<input type="checkbox"/>
Frq	4.0	<input type="checkbox"/>
Gn	63	<input type="checkbox"/>
D	17.0	<input type="checkbox"/>
Whizz	Off	<input type="checkbox"/>
CF		<input type="checkbox"/>
Frq	2.8	<input type="checkbox"/>
Gn	27.0	<input type="checkbox"/>
L/A	2/3	<input type="checkbox"/>
PRF	1.2	<input type="checkbox"/>
WF	180	<input type="checkbox"/>
S/P	3/10	<input type="checkbox"/>

P4  
P3  
P2

0.0 (0.2/0.3 s)





HEALIC MULTISPECIALTY CLINIC  
27/07/2024 12:44:42 pmADM

POOJA RANI 35YRS ,  
270724-122440PM

MI 0.9  
Tis 0.3

4C  
Abdomen

29/07/2024  
01:37:40 pm



FR 33  
AO% 100  
CHI  
Frq 4.0  
Gn 58  
S/A 5/4  
Map F/D  
D 15.0  
DR 96  
Whizz Off

- TVI
- Elasto
- LOGIQView
- 3D/4D

1 L 3.04 mm  
2 L 4.78 mm

- P4
- P3
- P2

1/1

Pointer P1



HEALIC MULTISPECIALTY CLINIC  
27/07/2024 12:43:34 pmADM

POOJA RANI 35YRS ,  
270724-122440PM

MI 0.9  
TIs 0.3

4C  
Abdomen

29/07/2024  
01:37:55 pm



FR 33  
AO% 100  
CHI  
Frq 4.0  
Gn 58  
S/A 5/4  
Map F/0  
D 15.0  
DR 96  
Whizz Off

- TVI
- Elasto
- LOGIQView
- 3D/4D

1 L 4.61 mm  
2 L 2.34 mm

- P4
- P3
- P2

0:0 (0.1:0.2 s)



भारत सरकार  
Government of India




पूजा रानी  
Pooja Rani  
जन्म तिथि/DOB: 05/10/1988  
लिंग/ Gender: FEMALE

3512 3964 3069



भारत आधार, भूरी पहचान

 GPS Map Camera

Ghaziabad, Uttar Pradesh, India

Tower-A, Saya Zenith, Indirapuram, Ghaziabad, Uttar Pradesh 201014, India

Lat 28.637769°

Long 77.378939°

27/07/24 12:57 PM GMT +05:30

