Hosp. Reg. No.: TMC - Zone C - 386

Veshali Prablum 30 yrs/ Female 17/02/24

No fresh complaints.

No comostoldities

No PIH.

No SIH.

LMP- 10/2/24 inregular

PLOS, Ro anyoling.

OIN-No any

F/H - Mother healthy.

BP-110/70 mm/mg P-80/min BPO2-98%

Pt is fit and can resume her normal duties

Consult with physician For blood changes





022 - 2588 3531

S-1, Vedant Complex, Vartak Nagar, Thane (W) 400 606 www.siddhivinayakhospitals.org





### Siddhivinayak Hospital



#### **Imaging Department**

Name - Mrs. Vaishari prabhu Dopple	Age 430 Y9F
Ref by Dr Siddhivinayak Hospital	Date - 17/02/2024

#### **USG ABDOMEN & PELVIS**

#### FINDINGS:

The **liver** dimension is normal in size(14.4 cm.) It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The GB-gallbladder is distended normally with no stones within.

The CBD- common bile duct is normal. The portal vein is normal.

The pancreas appears normal in morphology.

The spleen is normal in size 9.3 cm and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 8.6x3.9 cm.

The left kidney measures 9.2x4.5 cm.

**Urinary bladder**: normally distended. Wall thickness – normal.

**Uterus**: normal in size and morphology. Size: 9.3 x 4.1 x 5.8 cm.

**Endometrium**: 9.7 mm, it appears normal in morphology.

**Right ovary** is normal in size and morphology. **Left ovary** is normal in size and morphology.

Adnexa appear normal

No free fluid is seen.

#### IMPRESSION:

Fatty liver (Grade I)

DR. AMOL BENDRE

MBBS; DMRE

CONSULTANT RADIOLOGIST







### Siddhivinayak Hospital



Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

Name - Mrs. Vaishali Prabhu	Age - 30 Y/F
Ref by Dr Siddhivinayak Hospital	Date - 17/02/2024

#### X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

#### **IMPRESSION:**

· No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE MBBS; DMRE CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





### OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

**VAISHALI PRABHU** 

AGE

30

DATE - 17.02.2024

Spects: Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/6	6/6
Color Blind Test	NORMAL	

SIDDHIVINAYAK HOSPITALS





**Collected On** 

: 17/2/2024 9:23 am

Lab ID.

: 184004

Received On

. 17/2/2024 9:33 am

Age/Sex

: 30 Years

/ Female

Reported On

: 17/2/2024 5:12 pm

Ref By

: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

**Report Status** : FINAL

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TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDA SE)	229.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	32.5	mg/dL	Major risk factor for heart :<30 mg/dl.  Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	138.7	mg/dL	Desirable level: <161 mg/dl. High:>= 161 - 199 mg/dl. Borderline High:200 - 499 mg/dl. Very high:>499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	28	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	169	mg/dL	Optimal: <100 mg/dl.  Near Optimal: 100 - 129 mg/dl.  Borderline High: 130 - 159 mg/dl.  High: 160 - 189mg/dl.  Very high: >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	5.20		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	7.05		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** 

Priyanka\_Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

Page 1 of 12





. 17/2/2024 9:33 am Lab ID. Received On : 184004

Reported On : 17/2/2024 5:12 pm Age/Sex : 30 Years / Female

**Report Status** : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

#### **COMPLETE BLOOD COUNT**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
HEMOGLOBIN	14.1	gm/dl	12.0 - 15.0	
HEMATOCRIT (PCV)	42.3	%	36 - 46	
RBC COUNT	5.0	x10^6/uL	4.5 - 5.5	
MCV	85	fl	80 - 96	
MCH	28.2	pg	27 - 33	
MCHC	33	g/dl	33 - 36	
RDW-CV	13.7	%	11.5 - 14.5	
TOTAL LEUCOCYTE COUNT	10210	/cumm	4000 - 11000	
DIFFERENTIAL COUNT				
NEUTROPHILS	68	%	40 - 80	
LYMPHOCYTES	25	%	20 - 40	
EOSINOPHILS	02	%	0 - 6	
MONOCYTES	05	%	2 - 10	
BASOPHILS	00	%	0 - 1	
PLATELET COUNT	413000	/ cumm	150000 - 450000	
MPV	11.9	fl	6.5 - 11.5	
PDW	16.5	%	9.0 - 17.0	
PCT	0.490	%	0.200 - 0.500	
RBC MORPHOLOGY	Normocytic Normo	ochromic		
WBC MORPHOLOGY	Normal			
PLATELETS ON SMEAR	Adequate			
Markada EDTA Milada Dia al Tarta		Deal Call Country DDC	151 1 1 1 1	

Method: EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method). Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** 

Priyanka\_Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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. 17/2/2024 9:33 am Lab ID. Received On : 184004

Reported On : 17/2/2024 5:12 pm Age/Sex : 30 Years / Female

**Report Status** : FINAL Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

#### **URINE ROUTINE EXAMINATION**

**TEST NAME** UNIT REFERENCE RANGE **RESULTS** 

**URINE ROUTINE EXAMINATION PHYSICAL EXAMINATION** 

**VOLUME** 30 ml

**COLOUR** Pale yellow Pale Yellow

**APPEARANCE** Slightly Hazy Clear

**CHEMICAL EXAMINATION** 

REACTION Acidic Acidic

(methyl red and Bromothymol blue indicator)

1.005 - 1.022 SP. GRAVITY 1.010

(Bromothymol blue indicator)

**PROTEIN** Absent Absent

(Protein error of PH indicator)

**BLOOD** Absent Absent

(Peroxidase Method)

**SUGAR** Absent Absent

(GOD/POD)

**KETONES** Absent Absent

(Acetoacetic acid)

**BILE SALT & PIGMENT** Absent Absent

(Diazonium Salt)

**UROBILINOGEN** Normal Normal

(Red azodye)

**LEUKOCYTES** Absent Absent

(pyrrole amino acid ester diazonium salt)

Negative

(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)

**MICROSCOPIC EXAMINATION** 

**RED BLOOD CELLS** Absent Absent **PUS CELLS** 3-5 / HPF 0 - 5 **EPITHELIAL** 1-3 / HPF 0 - 5

**CASTS** Absent

**Checked By** 

SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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Name : Mrs. VAISHALI PRABHU (A) **Collected On** : 17/2/2024 9:23 am

. 17/2/2024 9:33 am Lab ID. Received On : 184004

: 17/2/2024 5:12 pm Reported On Age/Sex : 30 Years / Female

**Report Status** : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

#### **URINE ROUTINE EXAMINATION**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
CRYSTALS	Absent			
BACTERIA	Absent		Absent	
YEAST CELLS	Absent		Absent	
ANY OTHER FINDINGS	Absent		Absent	
REMARK	Result relates to s	Result relates to sample tested. Kindly correlate with clinical findings.		

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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Lab ID. : 184004

Reported On : 17/2/2024 5:12 pm Age/Sex : 30 Years / Female

**Report Status** : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

. 17/2/2024 9:33 am

#### **IMMUNO ASSAY**

Received On

TEST NAME		RESULTS		UNIT	REFERENCE RANGE	
TFT (THYROID	FUNCTION T	EST )				
SPACE				Space	-	
SPECIMEN		Serum				
T3		101.4		ng/dl	84.63 - 201.8	
T4		7.35		μg/dl	5.13 - 14.06	
TSH		2.78		μIU/ml	0.270 - 4.20	
T3 (Triido Thyr hormone)	onine)	T4 (Thyroxine	e)	TSH(Th	nyroid stimulating	
AGE	RANGE	AGE	RANGES	AGE	RANGES	
1-30 days	100-740	1-14 Days	11.8-22.6	0-14 D	ays 1.0-39	
1-11 months	105-245	1-2 weeks	9.9-16.6	2 wks -	5 months 1.7-9.1	
1-5 yrs	105-269	1-4 months	7.2-14.4	6 mon	ths-20 yrs 0.7-6.4	
6-10 yrs	94-241	4 -12 months	7.8-16.5	Pregn	ancy	
11-15 yrs	82-213	1-5 yrs	7.3-15.0	1st Tr	imester	
0.1-2.5						
15-20 yrs	80-210	5-10 yrs	6.4-13.3	2nd T	rimester	
0.20-3.0						
		11-15 yrs	5.6-11.7	3rd 7	rimester	
0.30-3.0						

0.30 - 3.0

#### INTERPRETATION:

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** 

Priyanka Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

Name : Mrs. VAISHALI PRABHU (A) Collected On

: 17/2/2024 9:23 am

Lab ID.

Received On

. 17/2/2024 9:33 am

Age/Sex

: 184004

Reported On

: 17/2/2024 5:12 pm

Ref By

: 30 Years / Female

**Report Status** 

: FINAL

**HAEMATOLOGY** 

TEST NAME **RESULTS**  UNIT

REFERENCE RANGE

**BLOOD GROUP** 

**SPECIMEN** WHOLE BLOOD EDTA & SERUM

\* ABO GROUP

'A'

RH FACTOR **POSITIVE** 

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ----

**Checked By** 

Priyanka\_Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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: Mrs. VAISHALI PRABHU (A) Name

**Collected On** 

: 17/2/2024 9:23 am

Lab ID.

: 184004

Received On Reported On . 17/2/2024 9:33 am

Age/Sex

/ Female

: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

: 17/2/2024 5:12 pm

Ref By

: 30 Years

**Report Status** 

: FINAL

*RENAL	<b>FUNCTION</b>	TEST
--------	-----------------	------

TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
BLOOD UREA	13.5	mg/dL	13 - 40	
(Urease UV GLDH Kinetic)				
<b>BLOOD UREA NITROGEN</b>	6.31	mg/dL	5 - 20	
(Calculated)				
S. CREATININE	0.60	mg/dL	0.6 - 1.4	
(Enzymatic)				
S. URIC ACID	3.7	mg/dL	2.6 - 6.0	
(Uricase)				
S. SODIUM	138.7	mEq/L	137 - 145	
(ISE Direct Method)				
S. POTASSIUM	4.50	mEq/L	3.5 - 5.1	
(ISE Direct Method)				
S. CHLORIDE	105.3	mEq/L	98 - 110	
(ISE Direct Method)				
S. PHOSPHORUS	4.49	mg/dL	2.5 - 4.5	
(Ammonium Molybdate)				
S. CALCIUM	9.7	mg/dL	8.6 - 10.2	
(Arsenazo III)				
PROTEIN	7.37	g/dl	6.4 - 8.3	
(Biuret)				
S. ALBUMIN	4.00	g/dl	3.2 - 4.6	
(BGC)				
S.GLOBULIN	3.37	g/dl	1.9 - 3.5	
(Calculated)				
A/G RATIO	1.19		0 - 2	
calculated	DIO 6::	EOT DONE ON THE	UT0114TED ( FM 200)	
NOTE	BIOCHEMISTRY T ANALYZER.	EST DONE ON FULLY A	AUTOMATED ( EM 200)	

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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Collected On

: 17/2/2024 9:23 am

Lab ID. <sup>:</sup> 184004 Received On Reported On . 17/2/2024 9:33 am

Age/Sex : 30 Years

/ Female

: 17/2/2024 5:12 pm

Ref By

**PLATELET** 

: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

**Report Status** : FINAL

#### **Peripheral smear examination**

**TEST NAME RESULTS** 

SPECIMEN RECEIVED Whole Blood EDTA

**RBC** Normocytic Normochromic

**WBC** Total leucocyte count is normal on smear.

> Neutrophils:65 % Lymphocytes:25 % Monocytes:07 % Eosinophils:03 % Basophils:00 % Adequate on smear. No parasite seen.

**HEMOPARASITE** Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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**Collected On** 

: 17/2/2024 9:23 am

Lab ID.

Received On Reported On . 17/2/2024 9:33 am

Age/Sex

: 184004

/ Female

: 17/2/2024 5:12 pm

Ref By

: 30 Years : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

**Report Status** 

: FINAL

#### **LIVER FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN	0.45	mg/dL	0.2 - 1.2
(Method-Diazo)			
DIRECT BILLIRUBIN	0.02	mg/dL	0.0 - 0.4
(Method-Diazo)			
INDIRECT BILLIRUBIN	0.43	mg/dL	0 - 0.8
Calculated			
SGOT(AST)	31.0	U/L	0 - 37
(UV without PSP)			
SGPT(ALT)	18.8	U/L	UP to 40
UV Kinetic Without PLP (P-L-P)			
ALKALINE PHOSPHATASE	42.0	U/L	42 - 98
(Method-ALP-AMP)			
S. PROTIEN	7.37	g/dl	6.4 - 8.3
(Method-Biuret)			
S. ALBUMIN	4.00	g/dl	3.5 - 5.2
(Method-BCG)			
S. GLOBULIN	3.37	g/dl	1.90 - 3.50
Calculated			
A/G RATIO	1.19		0 - 2
Calculated			

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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**Collected On** 

: 17/2/2024 9:23 am

Lab ID. : 184004 Received On

. 17/2/2024 9:33 am

Reported On

: 17/2/2024 5:12 pm

Age/Sex : 30 Years / Female : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

**Report Status** 

: FINAL

HAEMATOLOGY	HA	EM	ATC	LO	GY
-------------	----	----	-----	----	----

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	15	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** 

Priyanka\_Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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. 17/2/2024 9:33 am Lab ID. Received On : 184004

Reported On : 17/2/2024 5:12 pm Age/Sex : 30 Years / Female

**Report Status** : FINAL Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

#### **BIOCHEMISTRY**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GLYCOCELATED HEMOGLOBIN (HB	A1C)		
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.7	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G. )	117.0	mg/dL	65.1 - 136.3

**METHOD** Particle Enhanced Immunoturbidimetry

HbA1c: Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c: Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

#### **BLOOD GLUCOSE FASTING & PP**

BLOOD GLUCOSE FASTING	106.6	mg/dL	70 - 110
BLOOD GLUCOSE PP	112.0	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

- 1. Fasting is required (Except for water ) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
- 2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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. 17/2/2024 9:33 am Lab ID. Received On : 184004

Reported On : 17/2/2024 5:12 pm Age/Sex : 30 Years / Female

**Report Status** : FINAL Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

#### **BIOCHEMISTRY**

UNIT REFERENCE RANGE TEST NAME **RESULTS** 

#### **INTERPRETATION**

- Normal glucose tolerance : 70-110 mg/dl

- Impaired Fasting glucose (IFG) : 110-125 mg/dl

- Diabetes mellitus : >=126 mg/dl

#### POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl - Impaired glucose tolerance: 140-199 mg/dl

- Diabetes mellitus : >=200 mg/dl

#### CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose >=126 mg/dl
- Classical symptoms +Random plasma glucose >=200 mg/dl
- Plasma glucose >=200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin > 6.5%

\*\*\*Any positive criteria should be tested on subsequent day with same or other criteria. **GAMMA GT** 40.0 5 - 55

Result relates to sample tested, Kindly correlate with clinical findings.

**Checked By** SHAISTA Q

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

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## Summary

Ref.By : DR ANANT MUNDE Protocol : BRUCE Objective:

# 386/VAISHALI PRABHU S-1, VEDANT COMPLEX, VARTAK NAGAR, THNAE(W)-400606 SIDDHIVINAYAK HOSPITAL

Date: 17-Feb-2024 10:25:30 AM 30 Yrs/Female 71 Kg/162 Cms

Stage	StageTime	PhaseTime (Min:Sec)	Speed	Grade	METs	H.R.	B.P.	R.P.P.	PVC	Comments
Supine					1.0	124	ot/or!	0	*	
Standing					1.0	134	110/70	147		
H (					1.0	138	110/70	151		
ExStart					1.0	139	110/70	152		
Stage 1	3:01	3:02	1.7	10.0	4.7	156	110/70	171	×	8
Stage 2	3:01	6:02	2.5	12.0	7.1	169	112/72	189		
PeakEx	0:28	6:29	3.4	14.0	7.6	176	114/74	200	•	
Recovery	1:00		0.0	0.0	1.1	150	114/74	171	×	
Recovery	2:00		0.0	0.0	1.0	134	114/74	152		
Recovery	3:00		0.0	0.0	1.0	128	112/72	143	•	
Recovery	4:00		0.0	0.0	1.0	129	110/70	141		

## Medication:

History:

# Test End Reason:

Pressure of 114/74 mmhg. The exercise stress test was stopped due to heart rate of 176 bpm which represents 93% of maximum age predicted heart rate. Resting blood pressure 0/0 mmhg, rose to a maximum blood Findings: The patient exercised according to BRUCE for 6:28, achieving a work level of Max METS:7.6. Resting heart rate initially 124 bpm, rose to a max.

# Parameters:

**Exercise Time** 

Max HR Attained

:176 bpm 93% of Max Predictable HR 190

Max BP: 114/74(mmHg)

Max WorkLoad attained :7.6(Fair Effort Tolerance)

Advice/Comments: The test is negative for inducible ischemia

Dr. Anant Rankishanrao Munde MBBS, DNB, DM (Cardiology) Reg. No. 2005021228

**4**× 1.2 ¥5 53 mS Post J Date: 17-Feb-2024 10:25:30 AM 71 Kg/162 Cms 30 Yrs/Female 386/VAISHALI PRABHU HR: 156 bpm 12 Lead + Median 0.9 BP: 110/70 0.9 avR avL avf ≡ 0.3 0.7 1.7 Grade: 10.0% Speed: 1.7 mph MPHR:82% of 190 SAN YUNG Print Date: 17-Feb-2024 S-1, VEDANT COMPLEX, VARTAK NAGAR, THNAE(W)-400606 1.1 SIDDHIVINAYAK HOSPITAL 0.5 1.7 Raw ECG BRUCE (1.0-100)Hz = 1.5 avR 0.8 2.1 V6 ٧5 V4 ¥3 V2 **Y**1 Notch:On BLC:On Ex Time 03:00 0.1 0.1 1.2 2.1 BRUCE:Stage 1(3:00) 10.0 mm/mV 25 mm/Sec. 1.3 1.5 1.5



Name : Mrs. VAISHALI PRABHU (A) **Collected On** : 17/2/2024 9:23 am

. 17/2/2024 9:33 am Lab ID. Received On : 184004

: 19/2/2024 7:33 pm Reported On Age/Sex : 30 Years / Female

**Report Status** : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

#### **PAP SMEAR REPORT1**

	PAP SME	AK KEPUKII		
TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
CYTO NUMBER	F/54/24			
CLINICAL HISTORY	Routine check up			
NO. OF SMEARS RECEIVED	One			
SPECIMEN ADEQUACY	Adequate			
CELL TYPE	Superficial, interme cells	diate,squamous me	etaplastic and few endocervical	
BACKGROUND	Inflammatory			
ORGANISM	Absent			
EPITHELIAL CELL ABNORMALITY	Nil			
OTHER NON-NEOPLASTIC FINDINGS	Dense neutrophils			
INTERPRETATION/RESULT	Inflammatory smea	rs		
FINAL IMPRESION	Negative for intraep	ithelial lesion or ma	alignancy.	
NOTE		_	d has associated false negative pling and follow up is	
	END C	F REPORT		

**Checked By** 

Dr\_smita.ranveer

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist** 

Page 1 of 1