

DRAWN : 23-03-2024
09:48 Hrs.RECEIVED : 23-03-2024
13:59 Hrs.REPORTED : 23-03-2024
16:33 Hrs.

OPD/IPD DOC NO SD01/OPD/BILL/2023-24/OP40505309

PATIENT CODE SD01.PAT/1000154805



2331469660

REFERRING DOCTOR

ACCESSION NO DHHI-1/2023-24/0009933

AGE 36 Yrs 7 Mths 24 Dys SEX Female

Results relate only to the samples tested

TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - Fasting			
Glucose - Fasting Specimen : Plasma Ficunde Methodology : Hexokinase	78	Adult: 74 - 106 Children 50 - 100	mg/dL
Uric Acid			
Uric Acid Specimen : Serum Methodology : Uricase Peroxidase	3.8	Male : 3.5 - 7.2 Female : 2.5 - 6.0	mg/dL
Creatinine			
Creatinine Specimen : Serum Methodology : Jaffe Method	0.81	Male (<50 years) : 0.84 - 1.25 Male (>50 years) : 0.81 - 1.44 Female : 0.56 - 1.09 Neonate : 0.5 - 1.2 Infant : 0.4 - 0.7 Child : 0.5 - 1.2	mg/dL
LFT (Liver Function Test)			
Total Bilirubin Specimen : Serum Methodology : Diazotization	0.89	Adults: 0.3 - 1.2 Children 0-1 day 1.4 - 8.7 1-2 days 3.4 - 11.5 3-5 days 1.5 - 12.0	mg/dL
Direct Bilirubin Specimen : Serum Methodology : Diazotization	0.19	Adults and Children: < 0.2	mg/dL
Indirect Bilirubin Methodology : Calculated Value	0.70		mg/dL
Total Protein Specimen : Serum Methodology : Biuret	7.4	Adult : 6.6 - 8.3 Children (1 - 18 y) : 5.7 - 8.0 Newborns (1 - 30 d) : 4.1 - 6.3	g/dL
Albumin Specimen : Serum Methodology : Bromocresol Green (BCG)	4.2	Adults: 3.5 - 5.2 Newborn (0 - 4 day) : 2.8 - 4.4	g/dL
Globulin Methodology : Calculated Value	3.2	1.8 - 3.6	g/dL



23032024170658

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 MD (Path), WBM-70606
 Consultant Pathologist

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PATIENT NAME & ADDRESS

MRS. SUCHANDRIMA SENGUPTA

PATHOLOGY



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
LFT (Liver Function Test)			
Aspartate Aminotransferase (SGOT) (AST)	24	Male (Adult): <50 Female (Adult): <35 Newborn: 25 - 75 Infant: 15 - 60	U/L
Specimen : Serum Methodology : IFCC (UV without P5P)			
Alanine Aminotransferase (SGPT) (ALT)	23	Male(Adult): <50 Female(Adult): <35 Newborn/Infant: 13 - 45	U/L
Specimen : Serum Methodology : IFCC (UV without P5P)			
Alkaline Phosphatase (ALP)	54	75 - 316	U/L
Specimen : Serum Methodology : IFCC (PNPP, AMP buffer)			



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Glucose - PP (Post Prandial)			
Glucose - Post Prandial	103	70.0 - 140.0	mg/dL
Specimen : Plasma Flouride			
Methodology : Hexokinase			
** Sample Drawn : 23.03.2024 13:52 Hrs.	Received : 23.03.2024 14:22 Hrs.	Reported : 23.03.2024 16:33 Hr	

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total Specimen : Serum Methodology : CHOD-POD	160	<200 : Desirable 200 - 239 : Borderline High >=240 : High	mg/dL
Cholesterol - HDL Specimen : Serum Methodology : Direct Enzymatic Colorimetric	69	40.0 - 59.0	mg/dL
Cholesterol - LDL Methodology : Calculated Value	72	> 160.0 : High Risk 130.0 - 160.0 : Borderline High <= 130.0 : Desirable	mg/dL
Cholesterol - VLDL Methodology : Calculated Value	19	< 40.0	mg/dL
Triglyceride Specimen : Serum Methodology : GPO POD	95	Normal : <150 Borderline high : 150 - 199 High : 200 - 499 Very high : >=500	mg/dL



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Lipid Profile			
Cholesterol - Total/HDL ratio <i>Methodology : Calculated Value</i>	2.32	3.4 : 1/2 Average Risk 5.0 : Average Risk 9.6 : 2 x Average Risk 23.4 : 3 x Average Risk	ratio
Cholesterol - HDL/LDL ratio <i>Methodology : Calculated Value</i>	0.96		



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
HbA1c (Glycosylated Haemoglobin)			
Glycosylated Haemoglobin (HBA1C)	5.6	4.6 - 6.2	%
Specimen : Methodology : NGSP			
BUN (Blood Urea Nitrogen)			
Blood Urea Nitrogen (BUN)	09	Newborn : 4 - 18 Child : 5 - 18 Adult : 6 - 20	mg/dL
Specimen : Serum Methodology : Urease, GLDH			
LFT (Liver Function Test)			
A/G Ratio	0	1.1 - 2.2	ratio
Specimen : serum Methodology : Calculated Value			
GGT (Gamma-glutamyltransferase)			
Gamma-glutamyltransferase (GGT)	14.0	12 - 122	U/L
Specimen : Serum Methodology :			



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count)			
Haemoglobin (Hb) Specimen : Whole Blood - EDTA Methodology : Colorimetry	12.6	12.0 - 15.0	gm %
RBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	4.83	3.8 - 4.8	million/cmm
Packed Cell Volume (Hematocrit) (PCV) Specimen : Whole Blood - EDTA Methodology : Pulse height detection	39.8	36.0 - 46.0	%
Mean Cell Volume (MCV) Specimen : Whole Blood - EDTA Methodology : Calculated Value	82.3	83 - 101	fL
Mean Cell Haemoglobin (MCH) Specimen : Whole Blood - EDTA Methodology : Calculated Value	26.0	27 - 32	pg
Mean Cell Haemoglobin Concentration (MCHC) Specimen : Whole Blood - EDTA Methodology : Calculated Value	31.7	31.5 - 34.5	g/dL
Platelet Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance	1.87	1.5 - 4.1	lakh/cmm
Total Count			
WBC Count Specimen : Whole Blood - EDTA Methodology : Electrical Impedance * CLINICAL CORRELATION REQUESTED.	* 16.1	4 - 10	thou/cmm
Differential Count (Microscopy)			
Neutrophil	92	40 - 80	%
Lymphocyte	06	20 - 40	%
Monocyte	01	2 - 8	%
Eosinophil	01	1 - 6	%
Basophil	00	<1 - 2	%



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
CBC (Complete Blood Count) Peripheral Blood Smear (Microscopy)			
RBC	Normocytic Normochromic		
WBC	Neutrophilia		
Erythrocyte Sedimentation Rate (ESR) Specimen : Whole Blood - EDTA Methodology : Westergren	30	<=15	mm / hr



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
ABO Group & RH Type			
ABO Blood Group Methodology : Tube Agglutination / Slide method	B		
Rh Typing Specimen : Whole Blood - EDTA Methodology : Tube Agglutination / Slide method	POSITIVE		
<p>Note : Following factors are responsible for discrepancies in ABO Grouping:</p> <ol style="list-style-type: none"> 1. Patients may fail to express ABO antigens on red cells due to diseases like Leukaemia & lymphoma. 2. Acquired B antigen can occur due to Infections; gram negative septicaemia, carcinoma colon, Blood Group chimera i.e. an individual with two population of cells which may occur as a result of either Bone marrow transplantation or Transfusion of group 'O' blood to 'A' or 'B' patient. 3. Rouleaux formation: It occurs in patients with abnormal Albumin/globulin concentration or in cord blood samples due to Whartons Jelly contamination. 4. Acquired antibodies i.e. Anti -A1 in A2 persons Anti -H in Bombay phenotype Cold auto - antibodies Unexpected allo-antibodies. 			



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LABORATORY REPORT

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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Urinalysis			
Physical Examination			
Volume Methodology : By graduated container	25		mL
Colour	Pale Straw		
Appearance Methodology : Visual	Slightly Hazy	Clear	
Specific Gravity Methodology : pKa change	1.015	1.000 - 1.030	ratio
Chemical Examination			
Reaction Methodology : Double indicator (Strip)	Acidic		
Protein Methodology : Protein-error-of-indicators	Absent	Absent	
Glucose Methodology : Glucose oxidase (Strip) Benedict's Test	Absent	Absent	
Ketone Bodies Methodology : Nitroprusside method (Strip)/ Tube	Absent	Absent	
Bile Salt Methodology : Hay's Method	Absent	Absent	
Bile Pigment Methodology : Diazo Method (Strip)	Absent	Absent	
Blood Methodology : Benzidine method (Strip) Microscopy	Absent	Absent	
Microscopic Examination			
Pus Cells	2-4	0 - 5	/hpf
RBC	Not Seen	Nil	/hpf
Epithelial Cells	14-16	0 - 1	/hpf



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
Casts	Not Seen		
Crystals	Not Seen		



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TEST REPORT STATUS	RESULTS	BIOLOGICAL REFERENCE INTERVAL	UNITS
Urinalysis			
<i>Chemical Examination</i>			
Urobilinogen	Absent	Absent	
<i>Methodology : Modified Ehrlich reaction (Strip)</i>			
----- End of Report -----			



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CARDIOLOGY

DESUN
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REPORTED Date: 23/03/2024 Email: desun@desunhospital.com Website: www.desunhospital.com
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PROCEDURE DONE ON : 23.03.2024
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REFERRING DOCTOR :
ACCESSION NO : R/DHHI-1/2023-24/0015472

PATIENT CODE : SD01/PAT/1000164605
AGE : 36 Yrs 7 Mths 24 Dys
SEX : F

REPORT OF ELECTROCARDIOGRAM

Standardization : 10 mm/mv.
Rhythm : Regular/Sinus.
Rate : 91 bpm
QRS Axis : Normal.
QRS : Normal.
QTC : Normal.
'P' Wave : Normal.
P.R : Normal.
QRS Complex : Normal.
'Q' Wave : Absent.
ST Segment : Isoelectric.
'T' Wave : ↓ VI
'U' Wave : Absent.
IMPRESSION : SINUS RHYTHM.



Dr. IMRAN AHMED KHAN

Reg No: 64336, MBBS
Dept. of Cardiac Science

Prepared By : Utpal Checked By : A Esai

IAK

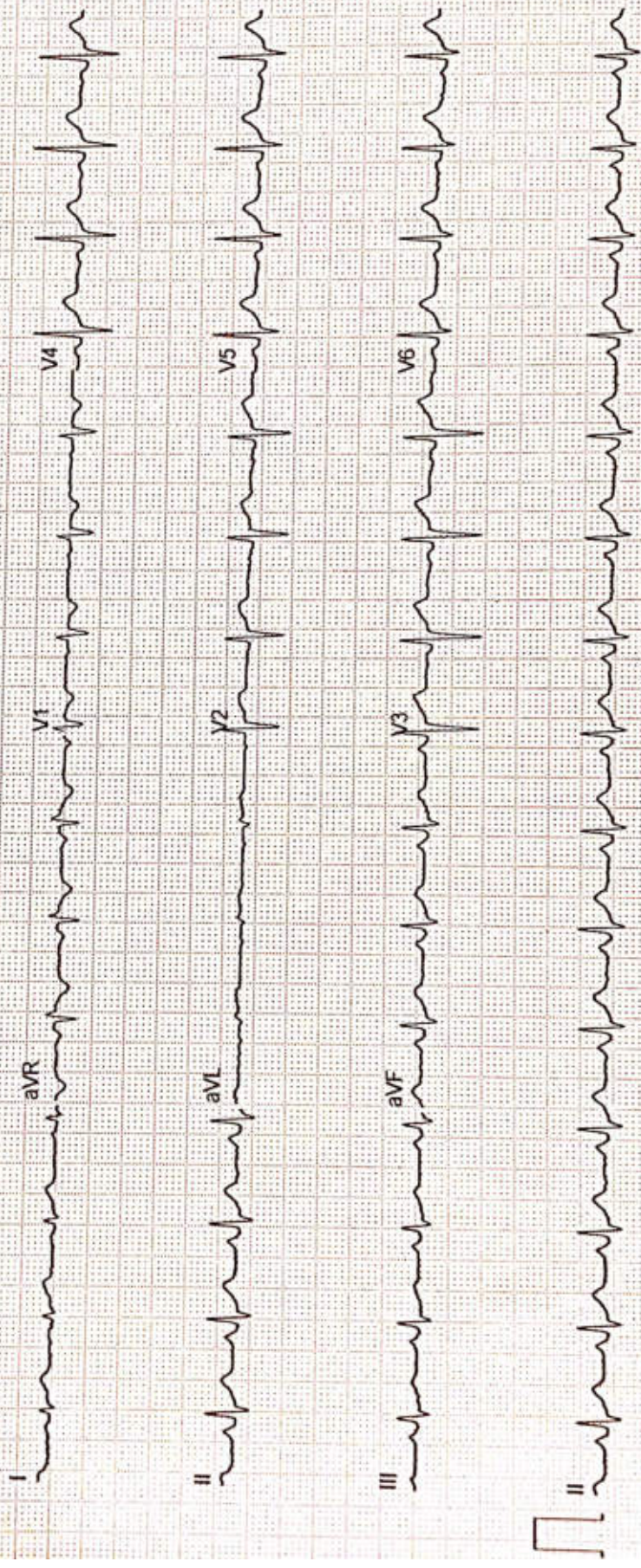
23.03.2024: 9:47:44
DESU HOSPITAL
EM Baidyas Katsiba Golpark
Kolkata - 700107

91 bpm
- / - mmHg

Female

QT / QTcBaz 344 / 423 ms
 PR 132 ms
 P 96 ms
 RR / PP 658 / 659 ms
 P / QRS / T 69 / 69 / 53 degrees
 Normal sinus rhythm
 Normal ECG

Technician:
 Ordering Ph:
 Referring Ph:
 Attending Ph:



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CARDIOLOGY

DESUN
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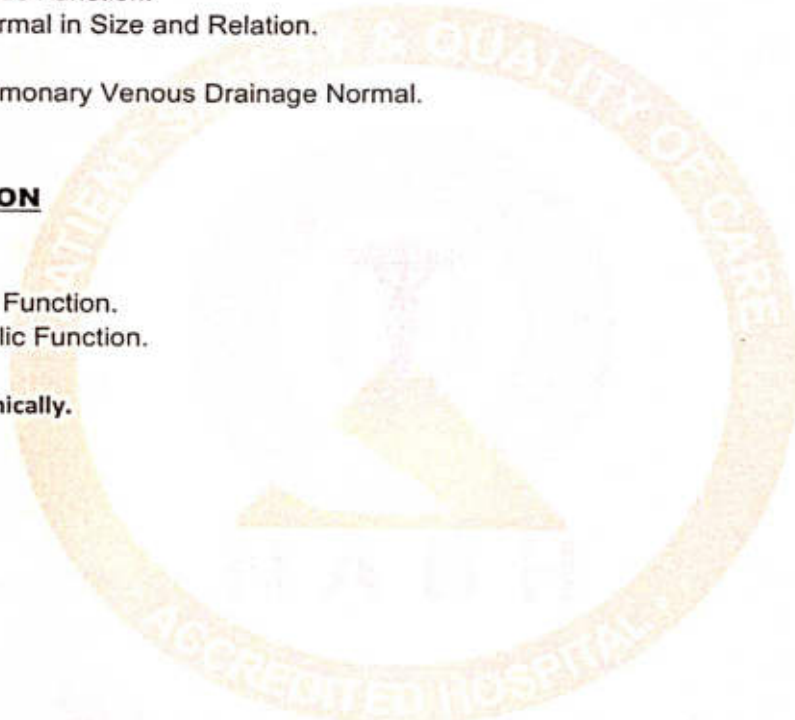
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ECHO CARDIOGRAPHY SCREENING REPORT**ECHO NO : 512****SUMMARY**

- >> Normal LV Cavity.
- >> No RWMA.
- >> Good LV Systolic Function. LVEF = 64 %.
- >> Normal LV Diastolic Function.
- >> Great arteries Normal in Size and Relation.
- >> IAS & IVS Intact.
- >> Systemic and Pulmonary Venous Drainage Normal.
- >> No PE.

FINAL IMPRESSION

- >> No RWMA.
- >> Good LV Systolic Function.
- >> Normal LV Diastolic Function.

****Please Correlate Clinically.**

Sanjib Kumar Patra

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Sutapa Checked By : A Esai

S K P

PATIENT NAME & ADDRESS

CARDIOLOGY

MRS. SUCHANDRIMA SENGUPTA

DESUN
HOSPITAL
A NABH HOSPITAL

Desun More, E.M. Bypass, Kasba Gopark, Kolkata-700 107. Ph: 71 222 000, Fax: 2443 9003
E-mail: desun@desunhospital.com, Website: www.desunhospital.com
(A unit of P. N. Memorial Neurocentre & Research Institute Ltd.)

PROCEDURE DONE ON : 23.03.2024
OPD / IPD DOC NO : SD01/OPD/BILL/2023-24/OP40505309
REFERRING DOCTOR :
ACCESSION NO : R/DHHI-1/2023-24/0015424

REPORTED : 23.03.2024
PATIENT CODE : SD01/PAT/1000164605
AGE : 36 Yrs 7 Mths 24 Dys
SEX : F

M - mode Measurements Valves :-

Aorta - 2.7 cm LV ed - 4.5 cm
LA - 3.2 cm LV es - 2.6 cm
ACS - cm IVS ed - 1.0 cm
RV ed - cm PW (LV) - 1.0 cm
FS - % LVEF - 64 %

CHAMBERS:-

Left Ventricle : Normal in Size. Walls Normal in Thickness and Motion.

Left Atrium : Normal in Size.

Right Atrium : Normal in Size.

Right Ventricle : Normal in Size.

OTHERS :-

GREAT ARTERIES : Normal in Size and Relation.

Sanjib Kumar Patra

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Sutapa Checked By : A Esai

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PERICARDIUM : Normal.

VALVES :-**MITRAL VALVE**

Morphology : Normal
Doppler : Normal

TRICUSPID VALVE

Morphology : Normal
Doppler : Normal

AORTIC VALVE

Morphology : Normal
Doppler : Normal

PULMONARY VALVE

Morphology : Normal
Doppler : Normal



Sanjib Kumar Patra

Dr. SANJIB KUMAR PATRA

Reg No: 53571 (WBMC)
DM CARD
Dept. of Cardiac Science

Prepared By : Sutapa Checked By : A Esai

SKP

PATIENT NAME & ADDRESS

MRS. SUCHANDRIMA SENGUPTA

RADIOLOGY



DESUN
HOSPITAL
A NABH HOSPITAL

PROCEDURE DONE ON : 23.03.2024
 OPD / IPD DOC NO : SD01/OPD/BILL/2023-24/OP40505309
 REFERRING DOCTOR :
 ACCESSION NO : R/DHHI-1/2023-24/0015456

REPORTED : 23.03.2024
 Desun More, E.M. Bypass, Kasba Golpark Kolkata-700 107, Ph: 71 222 000, Fax: 2443 9003
 PATIENT CODE : SD01/PAT/1000164608
 (A unit of P. N. Memorial Neurocentre & Research Institute Ltd.)
 AGE : 36 Yrs 7 Mths 24 Dys
 SEX : F

(US-13129) USG OF WHOLE ABDOMEN**LIVER**

Shows normal homogeneous echotexture. Intrahepatic biliary ducts and hepatic vein tributaries are not dilated. Multiple (at least 4 mm echogenic lesions scattered in both lobes of liver, largest (1.3 x 1.2) cm. in SEGMENT - III

GALL BLADDER

Physiologically distended. Wall thickness is normal. No evidence of any intraluminal lesion seen.

C.B.D.

Normal for age. No obvious intraluminal lesion seen in visible parts.

PORTAL VEIN

Normal for age.

PANCREAS

Normal in size, shape and echotexture. No obvious focal lesion or intraparenchymal calcification seen. Main pancreatic duct is not dilated. No peripancreatic fluid collection seen.

SPLEEN

Spleen is normal in size, shape and echotexture. No focal lesion seen. Spleno-portal axis is normal.

KIDNEYS

Both the kidneys are normal in size, shape and axis. Cortical echotexture and cortico-medullary differentiation are normal in both sides. No evidence of any focal lesion seen in either kidneys. No hydronephrosis detected.

URETERS

Pelvi-ureteric junction and vesico-ureteric junctions are normal. No obvious intraluminal lesion seen in visible part.

URINARY BLADDER

Optimally distended, normal in shape and wall thickness. No evidence of any intraluminal lesion seen.

PATIENT NAME & ADDRESS RADIOLOGY
 MRS. SUCHANDRIMA SENGUPTA

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Desun Moni, E.M. Bypass, Kasta Golpark, Kolkata-700 107, Ph: 71 222 000, Fax: 2443 9003
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UTERUS, anteverted and anteflexed. Endometrial thickness is normal. Myometrial echotexture is homogenous without any focal lesion or abnormal area of focal thickening.

OVARIES

Normal in size, shape and echopattern. No focal cystic or solid lesion seen.

No adnexal or pelvic SOL seen.

Pouch of Douglas - Clear.

RETROPERITONEUM

No obvious sonological evidence of any retroperitoneal mass lesion or lymphadenopathy seen in visible part. Aorta and I.V.C. appear normal.

PERITONEUM

No free fluid seen in the peritoneal cavity. Mesenteric echogenicity appears normal.

LOWER PLEURAL SPACES

No free fluid seen.

R. I. F.

No obvious mass lesion / localised collection seen.

IMPRESSION:

* Multiple echogenic lesions scattered in liver -(?) Hemangioma / (?) Nature.

Suggested TPCT MR/CT if clinically indicated.

Dinesh Jain

Dr. DINESH JAIN
 WBMC-70597
 MD, DNB (Radiology), EDIR, FRCR

Patient Name:	SUCHANDRIMA SENGUPTA 36Y OPD	Study Date/Time:	23-03-2024 09:59 AM
Sex/Age/Modality:	F/36Y/CR	Report Date/Time:	23-03-2024 01:03 PM
Patient ID:	20988	Report:	CHEST PA
Ref. Physician:	DESUN HOSPITAL & HEART INSTITUTE, KOLKATA	Report ID:	1302702D1305

X-RAY REPORT OF CHEST PA VIEW

FINDINGS:

No evidence of any parenchymal lesion is seen in the lung field.

No focal Space occupying lesion is seen.

Mediastinal shadow is appears normal and central in position. Trachea is in midline.

Both domes of diaphragm are smoothly outlined with normal in position.

Both lateral costo-phrenic angles are appears clear.

Hilum appears normal bilaterally.

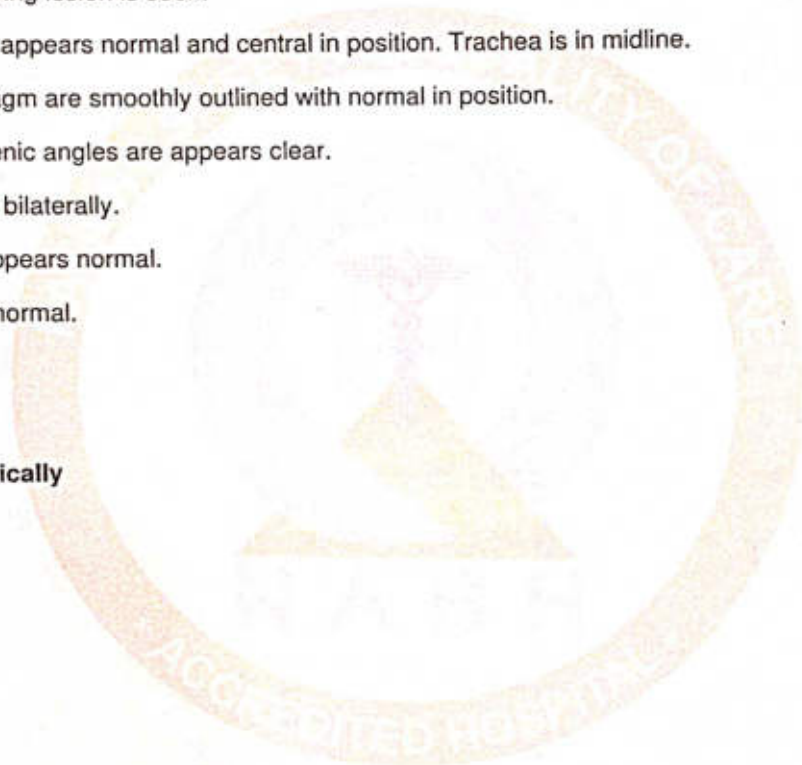
Cardiothoracic ratio appears normal.

Bony thorax appears normal.

IMPRESSION:

Normal Study.

Please correlate clinically



Dr. Tarique Aji
MBBS, MD(Radiology)
Consultant Radiologist
Reg-64888



Disclaimer: The report is prepared based on the image and patient information provided by the origin. In no event shall Radisky Labs Private Limited be liable for any special, direct, indirect, consequential, or any damages, arising out of or in connection with the use of the service. Patient identification in online reporting is not established, so this report cannot be used for any medicolegal purpose/certifications.



NAME - SUCHANDRIMA SENGUPTA
AGE - 36Y, M
DATE - 23/03/24

Refraction Done.
Adv gl.

BE → PLANO, 6/6

VA 36/6
(Un-Aided)

- Patient can read all plates of
ISHIHARA Chart.



Dr. Soumyadeep Majumder

MBBS 18
Reg. No. 68358-WBMC 024

Department of Ophthalmology

DESUN HOSPITAL

(A unit of P N Memorial Neurocentre & Research Institute Ltd.)

CIN - U85110WB2000PLC091118

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Name : Mrs. Suchandrima Sengupta
U/Doctor : Dr. Anish Chakraborty

Date : 23.03.24
Age : 36y Sex : F

Doctor's Prescription

Rx

* Carious 211 ,
adv. - DDPAR 211 -
- LC. Composite Restoration of 211 .
D.

Toothpaste Sensodent KF

Use 2 times after heavy meals
(with Tooth Brush).
for 2 months.

Anish Chakraborty

23/3/24

DR. ANISH CHAKRABORTY
(BDS)
DENTISTRY
REGN. NO. 6648 A
DESUN HOSPITAL



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Website : www.desunhospital.com



Name : Mrs. Suchandrima Sengupta
U / Doctor : Dr. Snehamoni Bag

Date : 03.03.24
Age : 36y Sex : F

Doctor's Prescription

eye throat
pain
mild allergic
stomach
x 1 day
feeling of malaise
No known
allergic
history

Known
allergic
history
None on Rx -
B/L nasal
cystoid
rhinitis

Acute
rhinitis
? acute
laryngitis
Post-nasal
drip

Rx

→ voice rest X 3 days. Adult's
→ Steam inhalation
→ Cap GANATON TOTALY 1 capsule
once daily before breakfast
X 10 days.

→ Tab CLAVAM 625 1 tab twice
daily after meal X 5 days.

→ Cap ENTEROGERMINA 1 tab twice daily
X 5 days (if any antibiotic
associated loose stool)

→ Tab MONTICOPRYL 1 tab once daily
at bedtime X 10 days.

→ Tab ATO 2 1 tab once daily after
lunch X 10 days.

→ RYALTRIS A2 nasal spray 1 puff twice
daily each nasal cavity X 10 days.

→ NASOCLEAR nasal drip drops 5mls daily
each nasal cavity X 10 days.

→ Tab PARIGESIC (16m) 1 tab twice daily after
meal X 2 days / then SOS



1A70

- BETADINE (o.i) eyes (i.i) 2-3 times
times daily after meal X 1 week.
- If symptoms unresolved,
→ FOL
- Review after 10 days or earlier if
→ Monitor temp regularly
- Refer for internal medicine opinion
if persistent rise of temperature.



S. Bag

29-03-24

Dr. Sreemanti Bag
MBBS, MS
Reg. No.- 73883 WBMC
Department of ENT
Desun Hospital

