DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178		**REF. DOCTOR :** DR. DCDC	
	ACCESSION NO : **0707XG000820**	AGE/SEX	:50 Years Male
	PATIENT ID : MDSAM111073707	DRAWN	:14/07/2024 10:03:08
	CLIENT PATIENT ID:	RECEIVED	: 14/07/2024 10:05:16
	ABHA NO :	REPORTED	:14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR			
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	**5.3 C.Low**	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	**2.73 Low**	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT	**11.80 High**	4.0 - 10.0	thou/µL
PLATELET COUNT	259	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	**16.9 Low**	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV)	**62.0 Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**19.5 Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	31.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	**16.6 High**	11.6 - 14.0	%
MENTZER INDEX	22.7		
MEAN PLATELET VOLUME (MPV)	9.6	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	75	40 - 80	%
LYMPHOCYTES	**16 Low**	20 - 40	%
MONOCYTES	06	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	**8.85 High**	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.89	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.71	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.35	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0	0.0 - 0.1	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	4.7		

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178		**REF. DOCTOR :** DR. DCDC	
	ACCESSION NO : **0707XG000820**	AGE/SEX	:50 Years Male
	PATIENT ID : MDSAM111073707	DRAWN	:14/07/2024 10:03:08
	CLIENT PATIENT ID:	RECEIVED	:14/07/2024 10:05:16
	ABHA NO :	REPORTED	:14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY

CBC WITH ESR (CBC+PS+ESR) EDTA WHOLE BLOOD/SMEAR

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD

E.S.R	**146 High**	0 - 14	mm at 1 hr

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION** :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178 **REF. DOCTOR :** DR. DCDC

ACCESSION NO	: **0707XG000820**	AGE/SEX	:50 Years Male
PATIENT ID	: MDSAM111073707	DRAWN	:14/07/2024 10:03:08
CLIENT PATIENT ID:		RECEIVED	:14/07/2024 10:05:16
ABHA NO	:	REPORTED	:14/07/2024 17:02:36

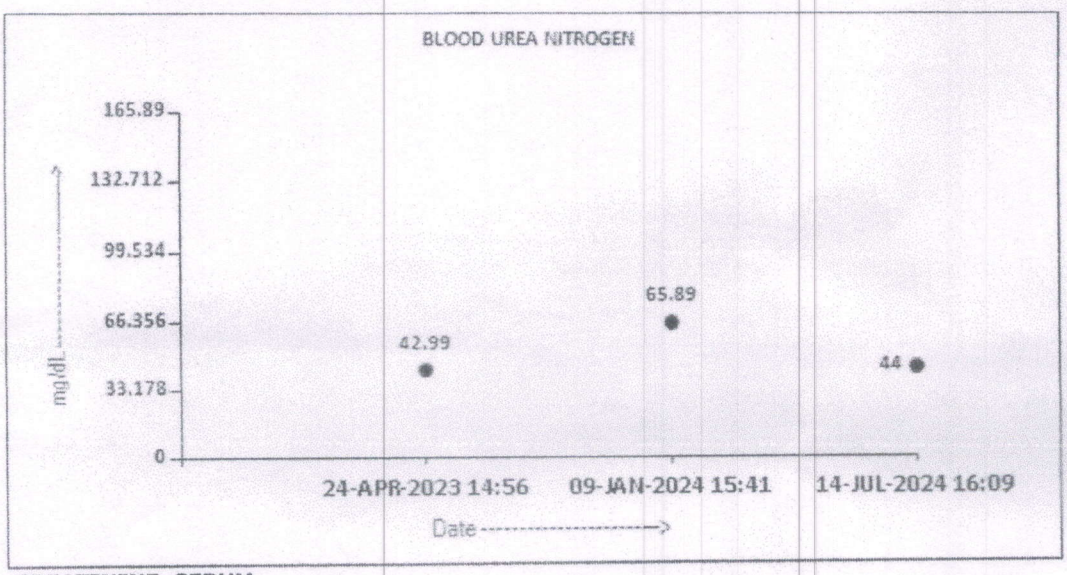
Test Report Status **Final**	Results	Biological Reference Interval	Units

BIOCHEMISTRY

KIDNEY FUNCTION TEST

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	**44 High**	6 - 22	mg/dL



CREATININE, SERUM

CREATININE	**6.09 High**	0.6 - 1.4	mg/dL

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

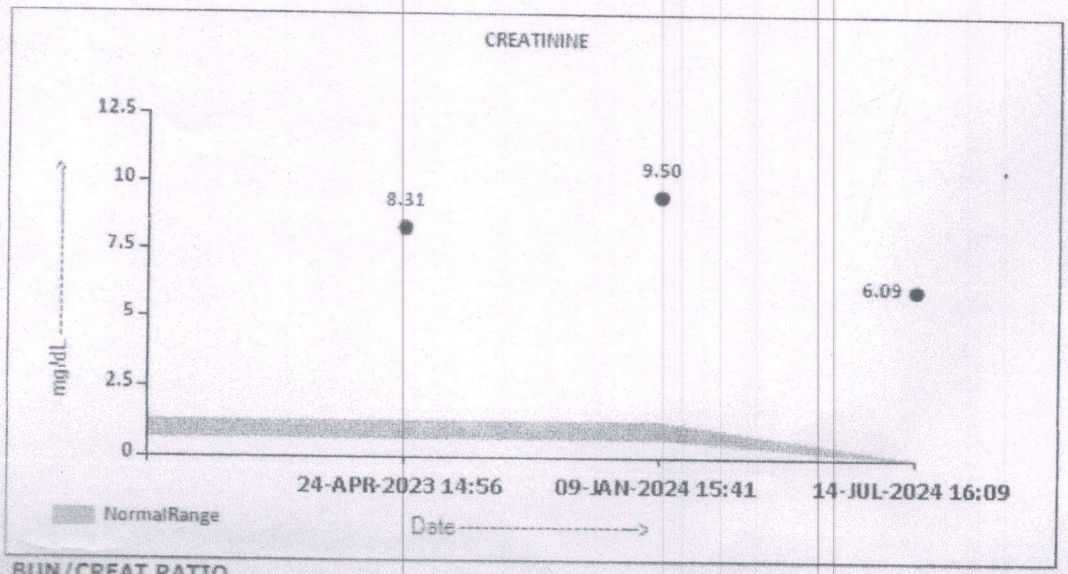
ULR No.775000008397114-0707

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178 | **REF. DOCTOR :** DR. DCDC

ACCESSION NO	: **0707XG000820**	AGE/SEX	:50 Years Male
PATIENT ID	: MDSAM111073707	DRAWN	:14/07/2024 10:03:08
CLIENT PATIENT ID:		RECEIVED	:14/07/2024 10:05:16
ABHA NO	:	REPORTED	:14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units



BUN/CREAT RATIO			
BUN/CREAT RATIO	7.22	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	5.5	3.6 - 7.2	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.3	6.0 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN	**2.7 Low**	3.2 - 5.0	g/dL
GLOBULIN			
GLOBULIN	**4.6 High**	2.0 - 4.1	g/dL

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178 | **REF. DOCTOR :** DR. DCDC

ACCESSION NO	: **0707XG000820**	AGE/SEX	:50 Years Male
PATIENT ID	: MDSAM111073707	DRAWN	:14/07/2024 10:03:08
CLIENT PATIENT ID:		RECEIVED	:14/07/2024 10:05:16
ABHA NO	:	REPORTED	:14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units
CALCIUM, SERUM			
CALCIUM	**7.9 Low**	8.4 - 10.4	mg/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**131.8 Low**	135.0 - 148.0	mmol/L
POTASSIUM, SERUM	4.06	3.5 - 4.8	mmol/L
CHLORIDE, SERUM	98.6	98.0 - 107.0	mmol/L

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in:CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants (SSRI), antipsychotics.	**Decreased in:** Low potassium intake,prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome,osmotic diuresis (e.g., hyperglycemia),alkalosis, familial periodic paralysis,trauma (transient).Drugs: Adrenergic agents, diuretics.	**Decreased in:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.
Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.	**Increased in:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration,renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics,NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	**Increased in:** Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	**Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	**Interferences:**Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

LIVER FUNCTION PROFILE, SERUM

TOTAL PROTEIN	7.3	6.0 - 8.3	g/dL
ALBUMIN	**2.7 Low**	3.2 - 5.0	g/dL

Sanjeew

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178 **REF. DOCTOR :** DR. DCDC

ACCESSION NO	: **0707XG000820**	AGE/SEX	:50 Years Male
PATIENT ID	: MDSAM111073707	DRAWN	:14/07/2024 10:03:08
CLIENT PATIENT ID:		RECEIVED	:14/07/2024 10:05:16
ABHA NO	:	REPORTED	:14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units
GLOBULIN	**4.6 High**	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	**0.6 Low**	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	20	0 - 45	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	12	0 - 45	U/L
ALKALINE PHOSPHATASE	**342 High**	41 - 137	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	**81 High**	0 - 50	U/L
LACTATE DEHYDROGENASE	**629 High**	200 - 450	U/L

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-**Higher than normal level may be due to:**
• Blockage in the urinary tract, Kidney problems, such as kidney damage or failure, infection, or reduced blood flow, Loss of body fluid (dehydration), Muscle problems, such as breakdown of muscle fibers, Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)
Lower than normal level may be due to:• Myasthenia Gravis, Muscuophy
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.
Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. **Low blood albumin levels (hypoalbuminemia) can be caused by:** Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
CALCIUM, SERUM-**Common causes of decreased value of calcium (hypocalcemia)** are chronic renal failure, hypomagnesemia and hypoalbuminemia.
Hypercalcemia (increased value of calcium) can be caused by increased intestinal absorption (vitamin D intoxication), increased skeletal reabsorption (immobilization), or a combination of mechanisms (primary hyperparathyroidism). Primary hyperparathyroidism and malignancy accounts for 90-95% of all cases of hypercalcemia.
Values of total calcium is affected by serum proteins, particularly albumin thus, latter's value should be taken into account when interpreting serum calcium levels. The following regression equation may be helpful.
Corrected total calcium (mg/dl)= total calcium (mg/dl) + 0.8 (4- albumin [g/dl])*
because regression equations vary among group of patients in different physiological and pathological conditions, mathematical corrections are only approximations. The possible mathematical corrections should be replaced by direct determination of free calcium by ISE. A common and important source of preanalytical error in the measurement of calcium is prolonged torniquet application during sampling. Thus, this along with fist clenching should be avoided before phlebotomy.
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**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, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic 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 attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : MD SAKIR REG NO 178 **REF. DOCTOR :** DR. DCDC

ACCESSION NO	: **0707XG000820**	AGE/SEX	: 50 Years Male
PATIENT ID	: MDSAM111073707	DRAWN	: 14/07/2024 10:03:08
CLIENT PATIENT ID	:	RECEIVED	: 14/07/2024 10:05:16
ABHA NO	:	REPORTED	: 14/07/2024 17:02:36

Test Report Status **Final**	Results	Biological Reference Interval	Units

EIA - INFECTIOUS SECTION

HEPATITIS C ANTIBODIES, SERUM

HEPATITIS C ANTIBODIES	NON REACTIVE	NON REACTIVE	

HEPATITIS B SURFACE ANTIGEN, SERUM

HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	NON REACTIVE	

Interpretation(s)

HEPATITIS C ANTIBODIES, SERUM-**Hepatitis C Virus (HCV)** is a blood borne flavivirus. It is one of the most important causes of post-blood transfusion as well as community acquired non-A non-B hepatitis and chronic liver failure. Although the majority of infected individuals may be asymptomatic, HCV infection may develop into chronic hepatitis, cirrhosis and/or increased risk of hepatocellular carcinoma.

Notes & Limitations: HCV antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance of the first biochemical marker of illness) and is almost always detectable by the late convalescent stage of infection. A negative result may also be observed due to loss of HCV antigen, years following resolution of infection. Infants born to hepatitis C infected mothers may have delayed seroconversion to anti-HCV. Hence a negative result should be evaluated cautiously with respect to clinical findings. It is to be noted that absence of HCV antibodies after 14 weeks of exposure is strong evidence against HCV infection.Presence of HCV antibodies does not imply an active Hepatitis C infection but is indicative of both past and/or recent infection .It has been reported that as many as 90% of individuals receiving intravenous commercial immunoglobulin test falsely positive for HCV antibody. Also,patients with autoimmune liver disease may show a false positive HCV antibody result. Hence it is advisable to confirm a positive antibody result with a supplemental test. A positive result when followed by a positive supplemental test (i.e. HCV-RNA-PCR) suggests active hepatitis C infection.

HEPATITIS B SURFACE ANTIGEN, SERUM-**Hepatitis B** is caused by infection with HBV, a enveloped DNA agent that is classified as hepadnavirus. This test detects the presence of viral surface antigen i.e HBsAg also known as "Australia antigen" in serum sample and is indicative of HBV infection, either acute or chronic.

Test Utility: HBsAg is the first serologic marker appearing in the serum 6-16 weeks following hepatitis B viral infection. In typical HBV infection, HBsAg will be detected 2-4 weeks before the liver enzyme levels (ALT) become abnormal and 3-5 weeks before patient develops jaundice. In acute cases HBsAg usually disappears 1-2 months after the onset of symptoms. Persistence of HBsAg for more than 6 months indicates development of either a chronic carrier state or chronic liver disease.The presence of HBsAg is frequently associated with infectivity. HBsAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.

Limitations: For diagnostic purposes, results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute or chronic infection. If the antibody results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.HBsAg detection will only indicate the presence of surface antigens in the serum and should not be used as the sole criteria for diagnosis, staging or monitoring of HBV infection. This test may be negative during "window period" i.e. after disappearance of anti-HBsAg antibody.The current assay being a highly sensitive test may yield a small percentage of false positive reports. Hence all HBsAg positive specimens should be confirmed with an assay based upon Neutralisation of Human anti Hepatitis B Surface antibody.

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

Dr.Sanjeew Kumar
Consultant - Pathologist &
Laboratory Head

View Details View Report

PERFORMED AT :
Agilus Pathlabs Reach Limited
Sadar Hospital,Sector-1, Bokoro Steel City,
Bokoro, 827001
Jharkhand, India
Tel : 7260813496
Email : customercare.bokaro@agilus.in

ULR No.775000008397114-0707

OPD SLIP

मुस्कान
हॉस्पीटल
एण्ड रिसर्च सेन्टर

MUSKAN Hospital &Research Centre

Name : Md. Sakia.

Age/Sex: 50/M

Weight

Date : 20 JUN 2024

CKD on MHD twice weekly

fever x 4 dys
Pain abd.
Vomiting

BP 120/80 mmHg

HR 98/m

Chest B/L RBS
Ronchi ++
Crepts
BSL left base

CVS S1 S2

P/A - Ascites

14.00.00 TA

Adv
CBC 7.2 gm
CXR
USG WLA
CKD
Mod. Ascites
Enlarged Cortex bird

Rx
Mahaflox 400 mg OD
1 ———— x 10 dy

Nebracays 500
1 ———— x 10 dy

Calpol 650 mg SOS

B.T. one unit days
HD

Dr. S. C. Munshi
MBBS, DCH, MD (Paeds)
Consultant Paediatrician & Neonatologist
Time : 9:30 am to 01:30 pm
(Sunday Off)

Dr. Irfan Ansari
MBBS, MS (Gen. Surgery)
Consultant Laparoscopic & Cancer Surgeon
Time : 10:30 am to 02:30 pm
(Friday Evening Off)

Dr. Md. Shahnawaj Anwar
MBBS, MD (Med.)
Consultant Physician
Cardiologist & Diabetologist
Time : 11:00 am to 02:30 pm
07:00 pm to 08:00 pm
(Sunday Evening Off)

Dr. Manoj Kr. Srivastava
MBBS, AFMC (PUNE)
Child Specialist, General Physician & Surgeon
Time : 11:30 am to 02:00 pm

Muskan Ruganalya (P) Ltd.
Undertaking
Muskan SUPERSPECIALITY Centre

Plot No. : S-3, City Centre,
Beside M-Bazar, Sector - IV,
Bokaro Steel City (Jharkhand)
[Near Samarjit Gas Agency]
Ph. : 06542-231335, 08877080738

Facilities Available :

 # Gastroenterology Department :
- Upper GI Endoscopy
- Variceal Band Ligation.
- Sclerotherapy
- Colonoscopy
- ERCP.

 # Eye Department :
- Phaco Surgery & OCT etc.
- Ben Franklin Optical Point

 # Neuro Surgery Deparment :
- OPD.

Report दिखाने का समय
1 : 15 PM to 1 : 45 PM
EXCEPT FRI & SUN

www.muskanhospital.com
e-mail : muskanhospital@yahoo.co.in

8877080718, 9204061814
24 hours service available

राम नगर कॉलोनी, चास, बोकारो, झारखण्ड
06542-236186, 236187 फैक्स - 236457

जहाँ है मुस्कान, वहीं है जिन्दगी आसान।

Not for medico legal purpose