

M.B.B.S., D.G/O

#### BIRTH CERTIFICATE

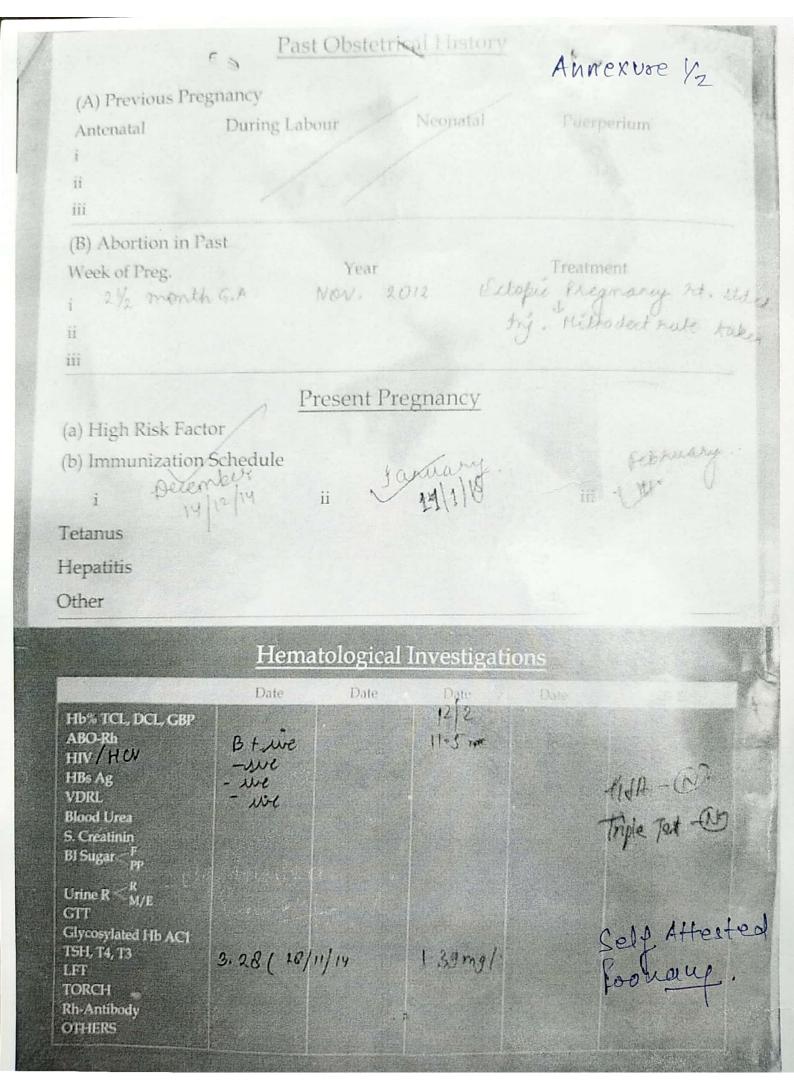
# JAVITRI HOSPITAL & TEST TUBE BABY CENTRE

Telibagh, Lucknow- 226 002 2 : 7800427000, 0522-3218637.

This is to Certify that Mrs. Roopum Miggin
W/o. Mani 8/2 Miggm S/o. Mr.
Resident of 3/310 Vrindo wari 39 heur 9 Plates Jan 4 Kungm Lis
Delivered a Female Child on 18/4/15
At 3:32 Pm. Birth weight 2:300 Kg. Type of delivery
L. S. C. S.
David Tragi

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Self Attesfield frommery.



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PILATE VISIT	$(\hat{\lambda})$	thomblein,		(3/2)	Respitations	Optic/frais	An
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(on & off)				1 1 22 (42)	any		
9. 111 15 Pair in oppor	99/70	106/m.	64kg	91 w	1 (1	de	
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1. 14 2 15 Backache	111111111111111111111111111111111111111	10)/11/	66/9.	26 WIL	>04	3	
Tisking over							
1. odošlo fiditu	16/00	96/m	60 kg 00	98 wk			
Iroligation				27 wk			
				30 wx			
			(9)				
- 21/03/15 Backache.	132/96	2/1	68ky.	81 cok 2	d		
La sile Brancher.	12/30	00/1					
e entute O	122/02	201	15-1	33wk O	F		
· 14/04/15 Bourselo	153/92	92/min	67.0129	3/0084		オン	
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# **Ultrasonology Findings**

	Date ) 11 /17. Date	Date	Date	Date
Placental Position TEST ( Placental Position TIFA  Maturity  Amniotic Fluid  Gestational Age  Fetal Weight  IUGR  Fetal Anomaly	Junitable lie  14 kpm  Tri- anni otic  Jri zygolic  Bi cherionic:  brif let pregmana  3 weeks 3 days  14 weeks 5 days	1	self	Heeted

## Annexure no. 2/1

## IVF RECORD SHEET

INDIRA IVF

DEMOGRAPHICS	5					tion:23
Name	Poor		***			NO. EPODUDY-7
Husband Name	mony	SH A	ge <u> </u>	HIG M3	munto	rdgan
		City	Mid State	J. P.	Contact No. 70	107899031
Height UU)) F	t. Weight					
Infertility 1° / 2		Mar	ried life 104~	• Du	ration of Infertility	syr.
INDICATION						
Female				Male		
1) Unexplained				1) Norma	W 4 1 4 1	
2) Diminished Ovaria	n Reserve / PCOS	/ Endometriosis				spermia, OAS, OATS
3) Tubal Factor				3) Azoos		
4) Uterine Factor (Fib				4) Others	s	
Congenital Malforn	nation etc.)		5) RPL, Genetic			
MENSTRUAL HISTO	DRY Day of Cy	cie 14 da	JS Duration	REG/IRR	NF/SCANTY/F	HEAVY PL/PF ength 28-30
Hysterosalpingogram	~ *	Fino	ings			
OBSTETRIC HISTOR				,		
CNIC	Mode of conception Natural / IUI / IVF	Weeks	outcome-Abortion / Ectopic / Preterm / ND / LSCS	Any Surgical Intervention	Any Complication	Comments
1" Pregnancy	orchina	2806	Rd Ectopic.			
2 Pregnancy	IVA	9 m	Lscs.	16 1 5-	*	Fen-syans
3 <sup>rd</sup> Pregnancy						
4 <sup>th</sup> Pregnancy					(Marie)	
5 <sup>th</sup> Pregnancy						
6 <sup>th</sup> Pregnancy				,		
Past History				moner-	-om.	3
Hospital Admission fo	r any reason.		Bopons	Duy	2015,	approscopy/
		know	J 1 160	1		201
Allergies	/			Th	capicl	
DM / HTN / Thyroid / A	Asthma / Epilepsy /	Skin Disease /	Jaundice / MI / TIA / DVT	<u> </u>	7 /	Call Allooka
MEDICAL HISTORY	(WIFE)					Selfullat
S.No.	Medical Problem		Current Medic	ations	Previous	reatment
1) Lupe	- Granz	lu	the friend	~ 88 no		toona
	Ilan	ue [14.				
	Car	10				
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AKT: Yes/No	yes Month	ns 6 w Date	started 2011.	Indication _	2	t.D.
AND DESCRIPTION OF THE PARTY OF	A					

	L HISTORY (WIFE)		254936	a transfer de	to the the	lút	FERTILITY & IVF CEN	ITRE
S.No.	Surgery Done	if they	Date	Pla	ice	Deta	alls / Findings .	1774
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0	1 eneman	u	20	- 1	OS OW	1 2 00	- Calasia	400
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S.No.	Medical Probler			Certificant	Medications	· · · · · · · · · · · · · · · · · · ·	. High V	
	a . W X.	11 E	-		Wedications		Previous Treatment	-51' y
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URGICA	L HISTORY (HUSBAND	000				1		C
S.No.	Surgery Done		Date	Plac	e	Detail	s / Findings	81.1.
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S.No.	Treatment	Attempt		rug Used	Protocol	Result	Commen	ts
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OOD TES	TS: FEMALE			В	LOOD TESTS	S: MALE		
	TS: FEMALE	45			LOOD TESTS	S: MALE	HBsAg	801
emoglobin	See C	5		Н			HBsAg	80
emoglobin ood Group ndom Bloo	10	).\ ).\		H VI	IV		HBsAg	<b>e</b>
emoglobin ood Group ndom Bloo	(ABO/RH)	<b>3.1</b>		HI VI	DRL		HBsAg J	24.66 4.66
emoglobir	(ABO/RH)	<b>3.1</b>		HI VI HI	DRLCV	BO/RH).	eg D	1935
emoglobin ood Group ndom Bloo /sAg	(ABO/RH)	<b>3.1</b>		HI VI HI	DRLCV		eg D	2001
emoglobin ood Group ndom Bloo /sAgs RLV	(ABO/RH)	<u> </u>		HI VI HI BI	DRLCV	BO/RH)estosterone)	eg	2000
emoglobin ood Group ndom Bloo /sAg RL V	(ABO/RH) B+ od Sugar (RBS) L2C	) ) )		HI VI HI BI	DRL CV ood Group (Al	BO/RH)estosterone)	Motility	ec]
emoglobin ood Group ndom Bloo /sAg RL V	(ABO/RH) 13 + 15 color of Sugar (RBS) 10 color of Suga	)  - T()  - E,		HI VI HI BI	DRLood Group (Al	BO/RH)estosterone)	eg	**************************************
emoglobin ood Group ndom Bloo /	(ABO/RH) 13 + 15 color of Sugar (RBS) 10 color of Suga	) ) )	2 2 2 1 10	HI VI HI BI Ot SE	DRL  CV  cood Group (Al	BO/RH)estosterone)	Motility 55	- %
emoglobin ood Group ndom Bloo /sAg RLV	(ABO/RH) 13 + cod Sugar (RBS) 10 CO	)  - T()  - E,	207 10	HI VI HI BI Ot SE Co Mc	DRL  CV  cood Group (Al thers (FSH, T  EMEN ANALY  bunt  prphology	BO/RH)estosterone)	Motility 55	eg
emoglobin ood Group ndom Bloo /	(ABO/RH) 13 + cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 13	)  - T()  - E,	100	HI VI HI Ot SE CO Mo DN Re	DRL  CV  cood Group (All thers (FSH, T. EMEN ANALY punt	BO/RH)estosterone)	Motility 55	eg La Maria
emoglobin ood Group ndom Bloo / sAg V H yotyping. OT	(ABO/RH) 13 + cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 13	0 		HI VI HI Ot SE CO Mo DN Re	DRL  CV  cood Group (Al thers (FSH, T  EMEN ANALY  bunt  prphology	BO/RH)estosterone)	Motility 55	eg %
emoglobin ood Group ndom Bloo /	(ABO/RH) 13 + cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 12 cod Sugar (RBS) 13	0 	100	HI VI HI Ot SE CO Mo DN Re	DRL  CV  cood Group (All thers (FSH, T. EMEN ANALY punt	BO/RH)estosterone)	Motility 55	eg Ha Maga

	ORT		Date .			OF CENTRE
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Myometriu	m pletou	ognou	3	Adnexa		
Ovaries (R	Tous	3		(L) 120 FV	is wallseg	7
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	GIVEN BEFORE / AT					
	GIVEN BEFORE / AT edication During IVF C		Androgel			
adjuvant Me	edication During IVF C	Cycle	Androgel		•	Others
djuvant Me	edication During IVF C	Cycle	Androgel		•	Others
djuvant Me	edication During IVF C	Cycle	Androgel		•	Others
abergolin .	edication During IVF C	Cycle	Androgel		•	Others
adjuvant Me	edication During IVF C	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	onorm	
cabergolin .	at INDIRA IVF Surgery	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	Procedure	Comments
cabergolin .	at INDIRA IVF Surgery	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	Procedure	Comments
cabergolin .	at INDIRA IVF Surgery	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	Procedure	Comments
cabergolin .	at INDIRA IVF Surgery	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	Procedure	
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cabergolin .	at INDIRA IVF Surgery	CycleMy	Androgel Estrogel o inositol / Astaxanthir	Thyr	Procedure	Comments

	+	Aunexuse no - 21
Patients Name		ATMISH Age 26 Yrs. Reg. No. ETTO UPV- 756
Address :	SUCTANO	PUR 1 12: P. Mobile No. 1007899031
23 2.20		
09 0,00		
WIFE		HUSBAND
Haemoglobin	10:5	· HIV
	Bte	HBsAg
Random Blood Sugar (RBS	s) 1201)	VDRL MES
	NEZ	HCV
HBsAgVDRL		Blood Group (ABO/RH)
HCV		
тsн		Thalassemia screen
PRL		Karyotype
AMH		SEMEN ANALYSIS
SGOT	10	Count
Sr.CREATININE	0.60	Motility%
	16	Remarks FERRETOZOGS OBRANIA WITH
Rubella IgG		
Karyotype		DFI%
PREVIOUS IVE ATT	EMPTS	
7 V F 12015	TO DAY	TRI ELASOTTAC LOCAL SELF (Auc)
Height (1) Ft.	Weight6	2.3. Kg. BMI
Pulse rate	Blood Press	ure 10 Tommhg
	KO.	HOT.B. 9-1.2. 2011 GMONTHS
Galactorrhea	MOT KNOWN	
Diabetes (Yes / No)		Hypertension (Yes / No)
Surgical / Medical History	LARANOCCOF	Typofy (2010) sof sine of 11/2.
Obstetrics History	MAT & WE O	FECTOPIC.
P/S/V 201	- TVG   2m.1	LCCS PCM-SYHIA
	Cely	Partied from y
		Rowelly,



वेटी बवाओ/वेटी पढाओ | SAVE GIRL अभियान में सहयोग करें। CHILD भूग लिंग परिवान करवाना ज्याना अपराध है। Consultant Gynaecologist MBBS MS (OBGY), DNB, FNB

UPMC Reg. No.: 74640

Date: 21-Feb-20

Name: Poonam Manish/36yrs

Day:13 of cycle

Reg. No-EADUPV756

#### TRANSVAGINAL SCAN REPORT

- . Uterus is normal in size measuring 7.0cm X 4.0cm X 4.6cm is anteverted and anteflexed in nature.
- Myometrium is heterogeneous in texture with no evident focal lesion.
  - Endometrium is homogeneous and measures 9.5mm in thickness and is centrally placed.
  - Right ovary measures 1.7cm X 1.4cm X 1.3cm in size with evidence of few small follicles
  - Left ovary not visualised.
  - Left Adnexa normal with no evidence of any abnormality.
  - Right adnexa shows evidence of tubular cystic structure adjacent to the ovary suggestive of hydrosalpinx.
  - · No Free fluid in POD.

# 3 Impression:

1. Adenomyotic Uterus
2. Poor Ovarian Reserve
3. Extractionalised
4. Right hydrosalpinx

PREPARED BY
Noha

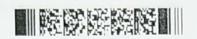
Jab Johnine 5 mg On X 30 day
Jab Jhydronom 12. Spg BBf
Jab Jhydronom 12. Spg BBf
Jab C'blin [0.5] weetly X

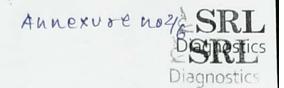
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Scarfned with CamScanner

#### DIAGNOSTIC REPORT

#### DIAGNOSTIC REPORT





CLIENT CODE: C000067890

CLIENT'S NAME AND ADDRESS:

OPD - ALLAHABAD SRL LIMITED INDIRA IVF HOSPITAL PVT. LTD., 41/2, MOHALLA CIVIL STATION, ELGIN

NEAR HANUMAN MANDIR. ALLAHABAD 211001 ITTAR PRADESH INDIA 9956666714

SRL LIMITED

43/1, Sardar Patel Marg, Civil Lines,

Allahabad, 211001 Uttar Pradesh, INDIA

Tel: 0532-2260438,8601433777, Fax: CIN -

U74899PB1995PLC045956

PATIENT NAME: POONAM EADUPV 756

PATIENT ID :

ACCESSION NO:

0201TB004422 AGE:

36 Years

SEX: Female

DATE OF BIRTH:

DRAWN: 21/02/2020 00:00

REFERRING DOCTOR: DR. ANJALI SHARMA

RECEIVED: 21/02/2020 17:54

REPORTED :

CLIENT PATIENT ID :

Test Report Status

Preliminary

Results

**Biological Reference Interval** 

21/02/2020-19:25

Units

INFERTILITY PANEL - F (WITH AMH)

HIV 4TH GEN ASSAY (P24AG + HIV AB), SERUM

HIV 4TH GEN ASSAY (P24AG + HIV AB)

NON REACTIVE

NON REACTIVE

HEPATITIS B SURFACE ANTIGEN, SERUM

HEPATITIS B SURFACE ANTIGEN

NON REACTIVE

NON REACTIVE

0.51

Ref. ranges for Electrochemiluminescence IU/mL

< 0.90 (Non Reactive) > or = 1.00 (Reactive)

VDRL, SERUM

PATIENT VALUE

PATIENT VALUE

VDRL

NONREACTIVE

NONREACTIVE

TITER

IU/mL

MITHOD . NON TREPONEMAL FLOCCULATION TEST

HEPATITIS C ANTIBODIES, SERUM

HEPATITIS C ANTIBODIES

NON REACTIVE

NON REACTIVE

Ref. ranges for Electrochemiluminescence

< 0.90 (Non Reactive) > or = 1.00 (Reactive)

TSH 3RD GENERATION ULTRA( TSH3 - UL), SERUM

TSH 3RD GENERATION

3.700

0.06

0.27 - 4.20

µIU/mL

PROLACTIN, SERUM

PROLACTIN

25.83

High 4.79 - 23.3

ng/mL

GLUCOSE RANDOM, PLASMA

GLUCOSE RANDOM, PLASMA

120.1

Non-Diabetic: < 200 ' Diabetic: > or = 200

mg/dL

"In individuals with symptoms of

hyperglycemia or hyperglycemic crisis.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

**ABO GROUP** 

RH TYPE

TYPE B

POSITIVE

ANTI MULLERIAN HORMONE

ANTI MULLERIAN HORMONE

0.777 - 5.240

ng/ml

1.73

g/dL

**BLOOD COUNTS** 

HEMOGLOBIN

10.5

Low 12.0 - 15.0

METHOD: SPECTROPHOTOMETRY AUTOMATED HEMATOLOGY ANALYSER

Low 3.8 - 4.8

mil/µL

RED BLOOD CELL COUNT WHITE BLOOD CELL COUNT

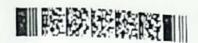
4.0 - 10.0

thou/µL

Page 1 Of 6

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# AGNOSTIC REPORT



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UTAR PRADESH INDIA

SRL LIMITED 43/1, Sardar Patel Marg, Civil Unes, Allahabad, 211001 Uttar Pradesh, INDIA Tel : 0532-2260438,8601433777, Fax : CIN -U74899PB1995PLC045956

POSSESS 114 PATIENT NAME : POONAM EADUPY 756

PATIENT ID :

#TISSION NO: 0201TB004422 AGE: 36 Years SEX: Fernale

DATE OF BIRTH

CREAN 21/02/2020 00:00

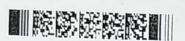
RECEIVED: 21/02/2020 17:54

REPORTED: 21/02/2020 19:25

EFFERING DOCTOR: DR. ANJALI SHARMA Preliminary.	Results		<b>Biological Reference</b>	Interval	Units
est Report Status Preliminary.					
	150		150 - 410		hou/uL
LATELET COUNT	150		150 410		100/56
BEC AND PLATELET INDICES					
	33.2	Low	36 - 46		6
MEMATOCRIT METHOD: CALCULATED (HEMATOLOGY ANALYSER)					-
MEAN CORPUSCULAR VOL	0.88		83 - 101		L
METHOD CALCULATED (HEMATOLOGY ANALYSER)			77.0		
EAN CORPUSCULAR HGB.	28.0		27.0 - 32.0	,	ig
METHOD CALCULATED (HEMATOLOGY ANALYSER)				,	I/dL
MEAN CORPUSCULAR HEMOGLOBIN	31.8		31.5 - 34.5	,	,, 52
TENTE ATION					
METHOD : CALCULATED (HEMATOLOGY ANALYSER)	16.9	High	11.6 - 14.0		1/6
RED CELL DISTRIBUTION WIDTH	10.5				
METHOD CALCULATED (HEMATOLOGY ANALYSER)	11.3	High	6.8 - 10.9		L
MEAN PLATELET VOLUME	11.0				
MITHOL CALCULATED (HEMATOLOGY ANALYSER)					
WBC DIFFERENTIAL COUNT	67		40 - 80	•	%
SEGMENTED NEUTROPHILS			2.0 - 7.0		thou/µL
ABSOLUTE NEUTROPHIL COUNT	4.76		1 - 6		Y <sub>0</sub>
EOSINOPHILS	04		0.02 - 0.50	t	hou/µL
ABSOLUTE EOSINOPHIL COUNT	0.28		20 - 40		16
LYMPHOCYTES	26		1.0 - 3.0	t	hou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.85			d	Va
MONOCYTES	03		2 - 10	t	hou/µL
ABSOLUTE MONOCYTE COUNT	0.21		0.2 - 1.0	q	ío .
BASOPHILS	00		<1-2		hou/µL
ABSOLUTE BASOPHIL COUNT	0	Low	0.02 - 0.10	•	
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR				
METHOD AUTOMATED ANALYZER / MICROSCOPY					
DISCIAIMER THE ABSOLUTE WHITE CELL COUNTS ARE OUT	SIDE THE NABL ACCREDITED S	COPE OF THE	LABORATORY.		
ASPARTATE AMINOTRANSPERASE, SERUM				U	I/L
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	18		0 - 32		
ALANINE AMINOTRANSFERASE, SERUM			0 - 33 U/I	- 1	/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	18		0 - 33		
SERUM BLOOD UREA NITROGEN					ng/dL
BLOOD UREA NITROGEN	16		6 - 20		
CREATININE, SERUM					ng/dL
CREATININE	0.60		0.50 - 0.90		/ dr
		0	olf Alt	ester	ige 2 C

#### DIAGNOSTIC REPORT

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Annexuseno

CLIENT CODE: CD00067890

CLIENT'S NAME AND ADDRESS :

CP ALLAHABAD SRL LIMITED

VI THA IVE HOSPITAL PVT. LTD., 41/2, MOHALLA CIVIL STATION, ELGIN

MANUMAN MANDIR. A) AHABAD 211001 AR PRADESH INDIA 4910666714

SRL LIMITED 43/1, Sardar Patel Marg, Civil Lines, Allahabad, 211001 Uttar Pradesh, INDIA

Tel: 0532-2260438,8601433777, Fax: CIN -

U74899PB1995PLC045956

PATIENT NAME POONAM EADUPY 756

PATIENT ID :

ACCESSION NO :

0201TB004422 AGE: 36 Years

SEX: Female

DATE OF BIRTH :

DRAWN . 21/02/2020 00:00

RECEIVED: 21/02/2020 17:54

REPORTED: 21/02/2020 19:25

REFERRING DOCTOR: DR. ANJALI SHARMA

CLIENT PATIENT ID :

Test Report Status

Preliminary

Results

Biological Reference Interval

Units

LIQUID-BASED CYTOLOGY

LETTER

RESULT PENDING

HEMOGLOBIN VARIANT ANALYSIS, BLOOD

RESULT PENDING RESULT PENDING

RUBELLA IGG & IGM, SERUM

RESULT PENDING

RUBELLA IGG AVIDITY, SERUM

RESULT PENDING

Interpretation(s)

GEN ASSAY (P24AG + HIV AB), SERUM-Acquired immunodeficiency syndrome (AIDS) is caused by 2 types of human immunodeficiency viruses, collectively HIV HIV is transmitted by sexual contact, exposure to blood or blood products, and prenatal infection of a fetus or perinatal infection of a newborn.

analysis classifies HIV-1 into groups M (major), N (non-M, non-O), and O (outlier).HIV-2 is similar to HIV-1 in its structural morphology, genomic organization, in vitro cytopathogenicity, transmission routes, and ability to cause AIDS. However, HIV-2 is less pathogenic than HIV-1.HIV-2 infections have a longer latency slower progression to disease, lower viral titers, and lower rates of vertical and horizontal transmission. HIV-2 is endemic to West Africa but HIV-2 infections, at a compared to HIV-1, have been identified in the USA, Europe, Asia, and other regions of Africa. India predominantly has HIV-1M subtype C.

The test used as an aid in the diagnosis of HIV-1/HIV-2 infection.

If HIV reactive result is obtained, confirmation of HIV antibody status is done using 2 more antibody tests ( as per NACO guidelines-Strategy III algorithm). If indicated HIV serious may be confirmed by repeating antibody test on fresh specimen or HIV-1 Western Blot (Immunobiot) Assay (SRL test code #3012).

Antibody tests may give alse negative during the window period, an interval of 3 weeks to 6 months between the time of HIV infection and the production of measurable antibodies to HIV seroconversion. Most people develop detectable antibodies approximately 30 days after infection, although some seroconvert later. The vast majority of people (97%) have detectable antibodies by three months after HIV infection a 6-month window is extremely rare with modern antibody testing. Party antiretroviral therapy during the window period may alter antibody responses. This does not apply to individuals undergoing treatment with post-exposure prophylaxis

Antibody tests may yield false negative results in patients with X-linked agammaglobulinemia.

Additional HIV result in an infant < 18 months of age may not reflect the infant reflect the infant result in an infant < 18 months of age may not reflect the infant reflect the infant

but a 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 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. HosAg when accompanied by Hepatitis Be antigen and/or hepatitis B viral DNA almost always indicates infectivity.

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.

- rilisAg 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-HBs.

- The surrent 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.

THE OPERATE STRUM.

THE OP

Nontreponemal tests lack sensitivity in primary and late syphilis. False negative reactions can occur in stages of the disease where there is minimal tissue damage,

Nontreponemal tests lack sensitivity in printery and lates syptimized particularly in early infection and in latent stages.

Biologic false positive reactions are common in a variety of other infections (Leprosy, Malaria, Relapsing fever, Infectious mononucleosis, hepatits), Rheumatic diseases and Auto- Immune disorders, More specific Treponemal tests, such as Treponema pallidum Hemagglutination assay (TPHA) test are recommended for confirmation.

Communication of the most important causes of post-blood transfusion as well as community. HE PARTIES 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

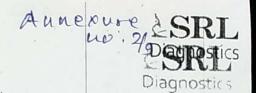
lates & Limitations:

antibody is typically not detected until approximately 14 weeks after infection (or 5 weeks after appearance)

## DIAGNOSTIC REPORT

### DIAGNOSTIC REPORT





CLIENT CODE: C000067890

CLIENT'S NAME AND ADDRESS :

OPD - ALLAHABAD SRL LIMITED INDIRA IVF HOSPITAL PVT. LTD., 41/2, MOHALLA CIVIL STATION, ELGIN

NEAR HANUMAN MANDIR, ALLAHABAD 211001

UTTAR PRADESH INDIA 9956666714

SRL LIMITED

43/1, Sardar Patel Marg, Civil Lines,

Allahabad, 211001 Uttar Pradesh, INDIA

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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-RNA-PCR) suggests active hepatitis C infection.

1SH 3RD GENERATION ULTRA( TSH3 - UL), SERUM-Comment: The Biological Reference Interval of TSH-3rd Generation Ultra [TSH3-UL] is not established for age less than 2 years.

Below mentioned are the guidelines for Pregnancy related reference ranges for TSH.

Levels in Pregnancy

(µIU/mL)

First Immester

0.1 - 2.5

2nd Trimester

0.2 - 3.0

3rd Trimester

PROLACTIN, SERUM-Reference Ranges of Prolactin for Pregnant and Post-Menopausal Females:

PREGNANT

9.7 - 208.5 ng/mL POSTMENOPAUSAL:

1.8 - 20,3 ng/mL GLUCOSE RANDOM, PLASMA-GLUCOSE RANDOM, PLASMA

As per ADA Guidelines 2012

Diabetic- Random plasma glucose = 200 mg/dL in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis.

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of reciblood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to dive A.B.O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same.

The test is performed by both forward as well as reverse grouping methods.

ANTI MULLERIAN HORMONE-

Anti mullerian hormone (AMH) or Mullerian inhibiting substances (MIS) is a glycoprotein dimer composed of two 72 kDa monomers linked by disulfide bonds. AMH belongs to the transforming growth factor B (TGF - B) superfamily. AMH is a hormone marker for quantitative prediction of ovarian reserve, ovarian aging, ovarian dysfunction and ovarian responsiveness. The levels of AMH decrease in pre-menopausal women as the quality and number of ovarian follicles decline with age

Clinical Utility:

- Evaluating Fertility Potential - Serum AMH levels correlate with the number of early antral follicles with greater specificity than Inhibin B, Oestradiol, Follicle Stimulating

Pratinating Fertility Potential – Serum AMH levels correlate with the number of early antral rollicles with greater specificity than Inhibin B, Oestradiol, Follicle Stimulating Hormone on cycle day 3. Thus, Day 3 AMH may reflect ovarian follicular status better than these hormone markers.

 Measuring Ovarian Aging – Diminished ovarian reserve, associated with poor response to IVF, is signaled by reduced baseline serum AMH concentrations. AMH would appear to be a useful marker for predicting ovarian aging and the potential for successful IVF.

 Predicting Onset of Menopause – The duration of the menopausal transition can vary significantly in individuals and reproductive capacity may be seriously compromised prior to clinical diagnosis AMH can predict the occurrence of the menopausal transition.

 Assossing Polycystic Ovary Syndrome – Serum AMH levels are elevated in patients with polycystic ovary syndrome and may be useful as a marker for the extent of the

discase

Interpretation:

AMH levels do not change significantly throughout the menstrual cycle and decrease with age. Healthy women, below 38 years of the menstrual cycle, have AMH levels of 2.0 – 6.8 ng/ml (14.28 – 48.55 pM);

Ovarian Fertility Potentia Optimal Fertility Satisfactory Fertility Low Fertility Very I pw / undetectable

pmol/L 28.6 - 48.5 15.7 - 28.6 2.2 - 15.7 > 48.5

4.0 - 6.8 2.2 - 4.0 0.3 - 2.2 0.0 - 0.3 > 6.8

Self Altested

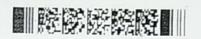
The interpretation guide provided above are only suggestions which are based upon examination of multiple published studies. It is expected in the near future that refinement of these ranges may occur

1. Durlinger ALL, Visser JA, Themmen APN. Regulation of ovarian function: the role of anti-Müllerian hormone. Reproduction 2002 124:601-609.

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#### **D!AGNOSTIC REPORT**

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Annexuse note

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2. Ficidioglu C, Kutlu T, Baglam E, Bakacak Z. Early follicular antimüllerian hormone as an indicator of ovarian reserve. Fertility and Sterility 2006 85:592-6.

3 Human Reproduction 2007 22(9):2414-2421 doi:10.1093/humrep/dem204. Fertil Steril. 2005 83(4):979-87 (ISSN: 1556-5653)

BLOOD COUNTS-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC RBC AND PLATELET INDICES-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

ASPARTATE AMINOTRANSFERASE, SERUM-Aminotransferase (AST) is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, 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 becirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous ALANINE AMINOTRANSFERASE, SERUM-Alanine aminotransferase (ALT) test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, 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 the commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine the commonly measured as a part of a diagnostic evaluation of hepatocellular injury. health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhoss SERUM BLOOD UREA NITROGEN-Causes of Increased levels

Pre renal

· High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal

· Renal Failure Post Renal

· Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

· Liver disease

· STADH

CREATININE, SERUM-Higher than normal level may be due to:

Blockage in the urinary tract
 Kidney problems, such as kidney damage or fallure, 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

· Muscular dystrophy

\*\*End Of Report\*\*

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

Dr. Akanksha Singh

M. D. (PATH)

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