



515, Udyog Vihar, Phase 5, Gurgaon, Haryana
Phones: +91 0124 4833900 Fax: +91-124-4699611-12,4308211,2438276
Toll Free : 1800 102 7477
CIN : U67200DL1993PTC055422

Date: 30-August, 2022

To,

SETHI HOSPITAL

301-302/4, MODEL TOWN, BASAI ROAD

GURGAON

HARYANA

Pin: 122001



Authorisation No :

NIB0823894

File No :

23CB01NIB3266

Policy No :

31040034210400000040

Sub: Cashless Facility for MRS. KIRAN SHARMA

Dear Sir/Madam,

We have been requested for the cashless facility in your hospital for the above captioned patient. You are requested to provide us the following details to enable us process the request.

1.) KINDLY PROVIDE THE INVESTIGATION REPORT SUPPORTING DIAGNOSIS

Thanking You,

for Vidal Health Insurance TPA Private Limited

Authorized Signatory

Claims Department

Printed On :30-Aug, 2022

Kindly correct the Patient
Name - The Patient Name is
KIRTI Pichoria.
Kiran Sharma is not admitted
here.



**REQUEST FOR CASHLESS HOSPITALISATION FOR HEALTH INSURANCE
POLICY PART - C (Revised)**

(TO BE FILLED IN BLOCK LETTERS)

DETAILS OF THE THIRD PARTY ADMINISTRATOR/ INSURER/ HOSPITAL

a. Name of TPA / Insurance company: VIDAL HEALTH INSURANCE TPA PRIVATE LTD.

b. Toll free phone number: _____

c. Toll free fax: _____

d. Name of Hospital: SETHI HOSPITAL PRIVATE LTD.

i. Address: BASIN ROAD, GURGAON

ii. Rohini id: 8900080014046

iii. e-mail id: SETHIHOSPITAL@gmail.com

TO BE FILLED BY INSURED/PATIENT

A. Name of the Patient: KIRTI PIGORIA

B. Gender: ☐ Male ☒ Female ☐ Third Gender

C. Age: 1 9 MONTH (Years) / (Month)

D. Date of Birth: _____ (DD/MM/YYYY)

E. Contact number: 9972300399

F. Contact number of attending Relative: _____

G. Insured Card ID number: 0111360049742405

H. Policy number / Name of Corporate: KINGSPAN JINDAL PRIVATE LTD.

I. Employee ID: KJPL0140

J. Currently do you have any other mediclaim / health insurance: ☐ Yes ☒ No

i. Company Name: No

ii. Give Details: No

K. Do you have a family Physician: ☐ Yes ☒ No

L. Name of the Family Physician: _____

M. Contact number, if any: _____

N. Current Address of Insured patient: GURGAON

O. Occupation of Insured patient: _____

(PLEASE COMPLETE DECLARATION OF THIS FORM)



TO BE FILLED BY TREATING DOCTOR/HOSPITAL

A. Name of the treating Doctor: ADAR DROR

B. Contact number: 9810215055

C. Nature of Illness / Disease with presenting complaint: fever persisting 12 hours / week

D. Relevant Critical Findings: Neutrophilia Hb 140 g/L Tef. 102°F

E. Duration of the present ailment: 3 Days Unresponsive to PM Rx

i. Date of First consultation: _____ (DD/MM/YYYY)

ii. Past history of present ailment, if any _____

F. Provisional diagnosis: Acute febrile illness Hematuria & Dehydration

i. ICD 10 code _____

G. Proposed line of treatment:

i. Medical Management ☒

ii. Surgical Management ☐

iii. Intensive care ☐

iv. Investigation ☒

v. Non-allopathic treatment ☐

H. If investigation and / or Medical Management, provide details As above

i. Route of Drug Administration: I.V

I. If surgical, name of surgery _____

i. ICD 10 PCS code _____

J. If other treatment, provide details _____

K. How did injury occur _____

L. In case of accident

i. Is it RTA: ☐ Yes ☐ No

ii. Date of Injury: _____ (DD/MM/YYYY)

iii. Report to Police ☐ Yes ☐ No

iv. FIR NO: _____

v. Injury / Disease caused due to substance abuse / alcohol consumption ☐ Yes ☐ No

vi. Test conducted to establish this (if yes, attach report) ☐ Yes ☐ No

M. In case of Maternity ☐ G ☐ P ☐ L ☐ A

i. expected date of Delivery _____ (DD/MM/YYYY)



DETAILS OF PATIENT ADMITTED

A.	Date of admission	30/8/2022	(DD/MM/YYYY)
B.	Time of admission	10.20 Am	(HH:MM)
C.	Is this an emergency / planned hospitalization event:	Emergency <input checked="" type="checkbox"/> Planned <input type="checkbox"/>	
D.	Mandatory Past History of any chronic illness	if yes (since ___ / ___) (month/year)	
	i. Diabetes	/	
	ii. Heart disease	/	
	iii. Hypertension	/	
	iv. Hyperlipidemias	/	
	v. Osteoarthritis	/	
	vi. Asthma/COPD/Bronchitis	/	
	vii. Cancer	/	
	viii. Alcohol/Drug abuse	/	
	ix. Any HIV/ or STD Related ailment	/	
	X. Any other ailment, give details	/	
E.	Expected number of Days / stay in hospital	3	Days
F.	Days in ICU		Days
G.	Room Type	Single Room	
H.	Per day room rent+nursing and service charges+ patients diet	9000	
I.	Expected cost of investigation + diagnostic	5000	
J.	ICU charges		
K.	OT charges		
L.	Professional fees Surgeon + Anesthetist Fees + consultation Charges	3000	
M.	Medicines + Consumables + Cost of Implants (if applicable please specify)	5000	
N.	Other hospital expenses if any		
O.	All-inclusive package charges if any applicable		
P.	Sum Total expected cost of hospitalization	22000	

DECLARATION (Please read very carefully)

We confirm having read understood and agreed to the Declarations of this form

a.	Name of the treating doctor	Dr. Arora
b.	Qualification:	MBBS, MD
c.	Registration number with State code	11663



Patient / Insured Name and Sign

[Signature]

DECLARATION BY THE PATIENT / REPRESENTATIVE

- a. I agree to allow the hospital to submit all original documents pertaining to hospitalization to the Insurer / TPA after the discharge. I agree to sign on the Final Bill & the Discharge Summary, before my discharge.
- b. Payment to hospital is governed by the terms and conditions of the policy. In case the Insurer / TPA is not liable to settle the hospital bill, I undertake to settle the bill as per the terms and conditions of the policy.
- c. All non-medical expenses and expenses not relevant to current hospitalization and the amount over & above the limit authorized by the Insurer / T.P.A. not governed by the terms and conditions of the policy will be paid by me.
- d. I hereby declare to abide by the terms and conditions of the policy and if at any facts disclosed by me are found to be false or incorrect I forfeit my claim and agree to indemnify the insurer / T.P.A.
- e. I agree and understand that T.P.A. is in no way warranting the service of the hospital & that the Insurer / TPA is no way guaranteeing that the services provided by the hospital will be of a particular quality or standard.
- f. I hereby warrant the truth of the forgoing particulars in every respect and I agree that if I have made or shall make any false or untrue statement, Suppression or concealment with respect to the claim, my right to claim reimbursement of the said expenses shall be absolutely forfeited.
- g. I agree to indemnify the hospital against all expenses incurred on my behalf, which are not reimbursed by the insurer / TPA.
- h. "I/We authorize Insurance Company / TPA to contact me/us through mobile/email for any update on this claim"

a) Patient's / Insured's Name:

Anuj Peakash Pigeis

b) Contact Number:

9977300399

Email-Id (optional)

anuj.peakash34@yahoo.com

c) Patient's / Insured's Signature:

Anuj

Date: _____ Time: _____

HOSPITAL DECLARATION

- a. We have no objection to any authorized TPA / Insurance Company official verifying documents pertaining to hospitalization.
- b. All valid original documents duly countersigned by the insured / patient as per the checklist below will be sent to TPA / Insurance Company within 7 days of the patient's discharge.
- c. We agree that TPA / Insurance Company will not be liable to make the payment in the event of any discrepancy between the facts in this form and discharge summary or other documents.
- d. The patient declaration has been signed by the patient or by his representative in our presence.
- e. We agree to provide clarifications for the queries raised regarding this hospitalization and we take responsibility the sole for any delay in offering clarifications.
- f. We will abide by the terms and conditions agreed in the MOU.
- g. We confirm that no additional amount would be collected from the insured in excess of Agreed Package Rates except costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
- h. We confirm that no recoveries would be made from the deposit amount collected from the Insured except for costs towards non-admissible amounts (including additional charges due to opting higher room rent than eligibility / choosing separate line of treatment which is not envisaged / considered in package).
- i. In the event of unauthorized recovery of any additional amount from the Insured in excess of Agreed Package Rates, the authorized TPA / Insurance Company reserves the right to recover the same from us (the Network Provider) and / or take necessary action, as provided under the MOU or applicable laws.

Hospital Seal

Date: 20/8/22 Time: _____



Doctor's Signature

[Signature]

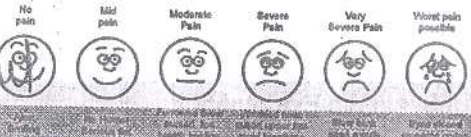
Patient Name Baby - KIRTI Age / Sex 9 months
Date : 30/8/22 Time 10-20 AM
UHID No. 84586 Bed No. / Ward No. 16
Treating Consultant DR. Ajay Arora / Dr. Sumedh

Pediatric Initial Assessment Form (To be filled by Doctor)

1. Provisional Diagnosis

Acute febrile illness &

Gastritis & Dengue



2. Presenting Complaints

Acute febrile illness

H/o - Fever persisting

L Intermittent

fever

Assoc

symptoms

3. History of presenting Complaints

H/o - Rejection for feeds basis

But no retrop

4. Past History / Allergy History

Child born at term - 36 weeks

Weight 3.5 kg, Length 48 cm

Birth weight 3.5 kg, Length 48 cm

5. Diet History

On breast milk

6. Head to Toe Examination

Pallor + Icterus - Cyanosis - Clubbing - Lymphadenopathy - Edema -

Vital HR 140bpm RR 24bpm SpO2 96 BP - Temp. 102F

7. Development History

8. Immunization History

9. Anthropometry

Weight:

9.9 kg

Height:

OFC

10. Systemic Examination

Respiratory System

Rf. Clear

Cardiovascular System

MAD

Abdomen

Soft

Neurological examination

MAD

11. Investigations

CRP LFT RBS
 LFT Typhidot IgM
 CRP WBC

12. Treatment Advice

1. V.I.P. - 0.45 DMS 300mg 8hr
 2. Paracetamol - 0.9 mg/kg stat
 3. Acute N 500mg 10hr
 4. Dexamethasone 135mg 10hr

13. Others

RMO Sign. with Date / Time / Stamp

Consultant Name with Reg. No. Sign. with Date / Time All ord Medic

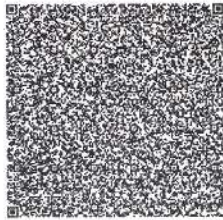


भारतीय विशिष्ट पहचान प्राधिकरण
भारत सरकार
Unique Identification Authority of India
Government of India

नामांकन क्रम/ Enrolment No.: 1508/45087/00169

To
अनुज प्रकाश पिगोरीया
Anuj Prakash Pigoria
S/O O. P. Pigoria
behind indra colony opp grand father school chandra nagar
koteshwar road gali no. 1 house no.1
Gird
Gwalior City
Gwalior Madhya Pradesh - 474003
9977300399

Download Date: 11/11/2019
Generation Date: 22/10/2017



QR Code with Photograph

आपका आधार क्रमांक / Your Aadhaar No. :

7158 4948 8839

VID : 9186 1711 7406 3508

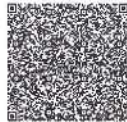
मेरा आधार, मेरी पहचान



भारत सरकार
Government of India



अनुज प्रकाश पिगोरीया
Anuj Prakash Pigoria
जन्म तिथि/DOB: 01/01/1987
पुरुष/ MALE



7158 4948 8839

VID : 9186 1711 7406 3508

मेरा आधार, मेरी पहचान



Government of India



सूचना

- आधार पहचान का प्रमाण है, नागरिकता का नहीं।
- पहचान का प्रमाण ऑनलाइन ऑथेंटिकेशन द्वारा प्राप्त करें।
- यह एक इलेक्ट्रॉनिक प्रक्रिया द्वारा बना हुआ पत्र है।

INFORMATION

- Aadhaar is a proof of identity, not of citizenship.
- To establish identity, authenticate online.
- This is electronically generated letter.

- आधार देश भर में मान्य है।
- आधार भविष्य में सरकारी और गैर-सरकारी सेवाओं का लाभ उठाने में उपयोगी होगा।
- Aadhaar is valid throughout the country.
- Aadhaar will be helpful in availing Government and Non-Government services in future.



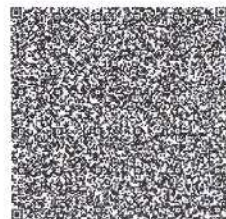
भारतीय विशिष्ट पहचान प्राधिकरण
Unique Identification Authority of India

पता:

S/O ओ. पी. पिगोरीया, बिहाइंड इन्द्रा कॉलोनी ओप ग्रैंड फादर स्कूल चंद्रा नगर, कोटेश्वर रोड गली नं. 1 हाउस नं. 1, गिर्द, ग्वालियर, मध्य प्रदेश - 474003

Address:

S/O O. P. Pigoria, behind indra colony opp grand father school chandra nagar, koteshwar road gali no. 1 house no.1, Gird, Gwalior, Madhya Pradesh - 474003



QR Code with Photograph

7158 4948 8839

VID : 9186 1711 7406 3508

1047

help@uidai.gov.in

www.uidai.gov.in



पृ. 1
NO. 1



मध्य प्रदेश सरकार
GOVERNMENT OF MADHYA PRADESH
प्लानिंग, आर्थिक एवं सांख्यिकी विभाग
DEPARTMENT OF PLANNING, ECONOMICS & STATISTICS
नगर निगम ग्वालियर
MUNICIPAL CORPORATION GWALIOR

फॉर्म-5
FORM-5



जन्म प्रमाण-पत्र
BIRTH CERTIFICATE

(जन्म मृत्यु रजिस्ट्रेशन अधिनियम, 1969 की धारा 12 / 12 तथा मध्य प्रदेश जन्म मृत्यु रजिस्ट्रेशन नियम, 1969 के नियम 5/13 से प्रमाणित जारी किया गया)

ISSUED UNDER SECTION 12(17) OF THE REGISTRATION OF BIRTHS & DEATHS ACT, 1969 AND RULE 5/13 OF THE MADHYA PRADESH REGISTRATION OF BIRTHS & DEATHS RULES 1969)

यह प्रमाणित किया जाता है कि निम्नलिखित सूचना जन्म के मूल अभिलेख से ली गई है जो कि नगर निगम ग्वालियर तहसील/ब्लॉक गिरी के जिला ग्वालियर राज्य/मध्य प्रदेश मध्य प्रदेश भारत के रजिस्टर में दर्जित है।

THIS IS TO CERTIFY THAT THE FOLLOWING INFORMATION HAS BEEN TAKEN FROM THE ORIGINAL RECORD OF BIRTH WHICH IS THE REGISTER FOR MUNICIPAL CORPORATION GWALIOR OF TAHSIL/BLOCK GIRI OF DISTRICT GWALIOR OF STATE/UNION TERRITORY MADHYA PRADESH, INDIA.

नाम / NAME: KIRTI PIGORIA

लिंग / SEX: महिला / FEMALE

जन्म तिथि / DATE OF BIRTH:

20-12-2021

THIRTIETH-DECEMBER-TWO THOUSAND TWENTY ONE

जन्म स्थान / PLACE OF BIRTH:

HANSRAJ MEMORIAL HOSPITAL

माता का नाम / NAME OF MOTHER:

RAJANA PIGORIA

पिता का नाम / NAME OF FATHER:

ANUJ PRAKASH PIGORIA

माता का आधार नंबर / MOTHER'S AADHAAR NO:

पिता का आधार नंबर / FATHER'S AADHAAR NO:

बच्चे के जन्म के समय माता-पिता का पता / ADDRESS OF PARENTS AT THE TIME OF BIRTH OF THE CHILD:
BEHIND INDRA COLONY, OFF. GRAND FATHER SCHOOL CHANDRA NAGAR,
KOTESHWAR ROAD GALI NO-1,
GWALIOR, GIRI, GWALIOR, MADHYA PRADESH

माता-पिता के स्थायी पता / PERMANENT ADDRESS OF PARENTS:
BEHIND INDRA COLONY, OFF. GRAND FATHER SCHOOL
CHANDRA NAGAR, KOTESHWAR ROAD GALI NO-1,
GWALIOR, GIRI, GWALIOR,
MADHYA PRADESH

पंजीकरण नंबर / REGISTRATION NUMBER:

B-2022, 23-90934-006284

पंजीकरण तिथि / DATE OF REGISTRATION:

06-04-2022

टिप्पणी / REMARKS (IF ANY):

जारी करने की तिथि / DATE OF ISSUE:

06-04-2022

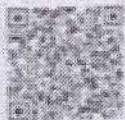
जारी करने का अधिकार / ISSUING AUTHORITY:

रजिस्ट्रार (जन्म एवं मृत्यु)
REGISTRAR (BIRTH & DEATH)

MUNICIPAL CORPORATION GWALIOR




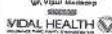

UPDATED ON:
06-04-2022 17:51:58




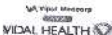

"THIS IS A COMPUTER GENERATED CERTIFICATE."
"THE GOVT. OF INDIA VIDE CIRCULAR NO. 1/12/2014-VS(CRS) DATED 27 JULY 2015 HAS
APPROVED THIS CERTIFICATE AS A VALID LEGAL DOCUMENT FOR ALL OFFICIAL PURPOSES."

"प्रत्येक जन्म एवं मृत्यु का पंजीकरण सुनिश्चित करें" / ENSURE REGISTRATION OF EVERY BIRTH AND DEATH


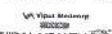



THE NEW INDIA ASSURANCE COMPANY LTD. ID No. 0111360049747426 ANUJ PRAKASH PIGORIA KINGSPAN JINDAL PVT. LTD.		
Age 35 Years Gender MALE		
Emp Code	KJPLD140	Relation EMPLOYEE
Valid From	15/12/2021	
		




Emergency No : 1800-102-7477 Please Quote your card number for HELP - This card is invalid if the policy is cancelled. - Immediate intimation to Vipul MedCorp TPA is a must in case of Hospitalisation. - Cashless Hospitalisation in Network Hospitals can be obtained in conjunction with this card and Authority letter issued by Vipul MedCorp TPA. - Validity of this card is subject to renewal without break in coverage an issuance of policy from the same underwriting office. Vipul MedCorp Insurance TPA Private Limited 515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com Phones : 0124-4827030 Fax No : 0124-2438276,4699611-12 4308211

THE NEW INDIA ASSURANCE COMPANY LTD. ID No. 0111360049747407 SAROJ PIGORIA KINGSPAN JINDAL PVT. LTD.		
Age 53 Years Gender FEMALE		
Emp Code	KJPLD140	Relation MOTHER
Valid From	15/12/2021	
		




Emergency No : 1800-102-7477 Please Quote your card number for HELP - This card is invalid if the policy is cancelled. - Immediate intimation to Vipul MedCorp TPA is a must in case of Hospitalisation. - Cashless Hospitalisation in Network Hospitals can be obtained in conjunction with this card and Authority letter issued by Vipul MedCorp TPA. - Validity of this card is subject to renewal without break in coverage an issuance of policy from the same underwriting office. Vipul MedCorp Insurance TPA Private Limited 515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com Phones : 0124-4827030 Fax No : 0124-2438276,4699611-12 4308211

THE NEW INDIA ASSURANCE COMPANY LTD. ID No. 0111360049747406 OM PRAKASH PIGORIA KINGSPAN JINDAL PVT. LTD.		
Age 71 Years Gender MALE		
Emp Code	KJPLD140	Relation FATHER
Valid From	15/12/2021	
		

Emergency No : 1800-102-7477 Please Quote your card number for HELP - This card is invalid if the policy is cancelled. - Immediate intimation to Vipul MedCorp TPA is a must in case of Hospitalisation. - Cashless Hospitalisation in Network Hospitals can be obtained in conjunction with this card and Authority letter issued by Vipul MedCorp TPA. - Validity of this card is subject to renewal without break in coverage an issuance of policy from the same underwriting office. Vipul MedCorp Insurance TPA Private Limited 515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com Phones : 0124-4827030 Fax No : 0124-2438276,4699611-12 4308211

THE NEW INDIA ASSURANCE COMPANY LTD. ID No. 0111360049747405 KIRTI PIGORIA KINGSPAN JINDAL PVT. LTD.		
Age 0 Years Gender FEMALE		
Emp Code	KJPLD140	Relation DAUGHTER
Valid From	15/12/2021	
		

Emergency No : 1800-102-7477 Please Quote your card number for HELP - This card is invalid if the policy is cancelled. - Immediate intimation to Vipul MedCorp TPA is a must in case of Hospitalisation. - Cashless Hospitalisation in Network Hospitals can be obtained in conjunction with this card and Authority letter issued by Vipul MedCorp TPA. - Validity of this card is subject to renewal without break in coverage an issuance of policy from the same underwriting office. Vipul MedCorp Insurance TPA Private Limited 515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com Phones : 0124-4827030 Fax No : 0124-2438276,4699611-12 4308211

THE NEW INDIA ASSURANCE COMPANY LTD. ID No. 0111360049747403 RANJANA PIGORIA KINGSPAN JINDAL PVT. LTD.		
Age 30 Years Gender FEMALE		
Emp Code	KJPLD140	Relation WIFE
Valid From	15/12/2021	
		

Emergency No : 1800-102-7477 Please Quote your card number for HELP - This card is invalid if the policy is cancelled. - Immediate intimation to Vipul MedCorp TPA is a must in case of Hospitalisation. - Cashless Hospitalisation in Network Hospitals can be obtained in conjunction with this card and Authority letter issued by Vipul MedCorp TPA. - Validity of this card is subject to renewal without break in coverage an issuance of policy from the same underwriting office. Vipul MedCorp Insurance TPA Private Limited 515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com Phones : 0124-4827030 Fax No : 0124-2438276,4699611-12 4308211

515, Udyog Vihar, Phase 5, Gurgaon, Haryana Pin Code: 122 016
 E-Mail : info@vipulmedcorp.com Website: http://www.vipulmedcorp.com
 Phones : 0124-4699600,4833900 Fax No : 0124-2438276,4699611-12 4308211





GIPSA NETWORK-DECLARATION FORM

(To be filled by the Hospitals)

Name of the Hospital: - SETHI HOSPITAL PVT. LTD. Date of Admission... 30/8/22

Address: - 301.302/4 MODEL TOWN BASAI ROAD GURGAON

PATIENT NAME/INSURED NAME: KIRTI PHORIA AGE/SEX 9 months F

(To be filled by the Insured/policy holder/Attendant)

1. Do you have an Insurance policy? YES/NO

If yes, then please select: New India/ United India/ National Insurance/ Oriental Insurance/others

Policy No

TPA Name

TPA card No:

Vipul Medico TPA
011360049242405

2. Have you contacted TPA or Insurance Company for cashless facility? YES/NO

3) Whether patient opted for Eligible Room Category under Policy: YES/NO

If No, then kindly mention the opted room category: Single Ac Room

On my own option, I wish to avail above facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff for the treatment. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff for the treatment and balance amount will be borne by me / patient only.

I have also been explained that when room service of a category other than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me/ patient only

Signature:

Name of the Patient/Patient's attendant:

Mobile No.

E-Mail:

PAN / Form 60:

Aadhar Card Number:

Signature:

Name of the Hospital Representative & Hospital Seal:



84550

Baby kirti | 2 year | Infant

29/08/22

Temp - 100.8°F

Wt - 9.5 kg

210

fever & Cough (Penicillin)

Oral Amoxicillin x 1 day

D

CBC & ESR

Typhoid

m.b. antibody

Reduce Opinion

Rx

Syr Amoxicillin - 4ml - B.D
(Syr 15ml)

Syr Paracetamol DS 120mg/5ml
- 3ml - TDS

Syr Zinc D - 5ml - OD

3x day

Oral Sx 2 Pack

30/8/22

fever persisting

Admit

Dr. Sumeet Kumar



Sanjeevani Path Lab

Sethi Hospital, 301-302/4, Model Town, Basai Road, Gurgaon
Tel: +91-124-4118001-2, M: 9818469653
E-mail : sanjeevanipathlab22@gmail.com



SETHI
HOSPITAL
Caring for Life

Patient Id 2208301074

Name Baby KIRTI PIGORIA

Ref. By Dr. AJAY ARORA

Srl No. 1074

Age 9 Yrs.

Sex F

Date

30/08/2022

R. Printing Date

30/08/2022

Address

IPD

Test Name	Value	Unit	Normal Value
COMPLETE HAEMOGRAM			
HAEMOGLOBIN (Hb)	12.1	gm/dl	12.0 - 15.0
TOTAL LEUCOCYTE COUNT (TLC)	16,800	/cumm	6000 - 15000
DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHIL	70	%	40 - 75
LYMPHOCYTE	26	%	20 - 45
EOSINOPHIL	02	%	01 - 06
MONOCYTE	02	%	02 - 10
BASOPHIL	00	%	0 - 0
ERYTHROCYTE SED.RATE (WIN)	30	mm 1st hr.	0 - 20
PLATELET COUNT	3.30	Lakh/cmm	1.50 - 4.00
R B C COUNT	4.91	Millions/cmm	4.0 - 5.2
P.C.V / HAEMATOCRIT	37.3	%	35 - 45
M C V	76.0	fl.	80 - 100
M C H	24.6	Picogram	27.0 - 31.0
M C H C	32.4	gm/dl	33 - 37
RDW	12.0	%	11.50 - 14.50

**** End Of Report ****

Checked By

Gulshan Yadav

DR. GULSHAN YADAV
MBBS., MD. (Pathologist)

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Test Name	Value	Unit	Normal Value
-----------	-------	------	--------------

BIOCHEMISTRY

BLOOD SUGAR RANDOM	77.00	mg/dl	80 - 170
<u>KIDNEY FUNCTION TEST (RFT)</u>			
BLOOD UREA	37.7	mg /dl	11.0 - 45.0
SERUM CREATININE	0.56	mg%	0.60 - 1.20
SERUM URIC ACID	3.69	mg/dl	2.4 - 5.7
BLOOD UREA NITROGEN (BUN)	17.617	mg%	6.0 - 20.0
SODIUM	144.1	mmol/L	136.0 - 149.0
POTASSIUM	4.50	mmol/L	3.5 - 5.0
CALCIUM	10.1	mg/dl	8.4 - 10.4
INORGANIC PHOSPHORUS	4.63	mg/dl	4.0 - 7.0
<u>LIVER FUNCTION TEST (LFT)</u>			
BILIRUBIN TOTAL	0.37	mg/dl	0.00 - 1.00
CONJUGATED (D. Bilirubin)	0.09	mg/dl	0.00 - 0.25
UNCONJUGATED (I.D. Bilirubin)	0.28	mg/dl	0.00 - 0.70
SGOT	30.9	IU/L	0 - 32
SGPT	17.1	IU/L	0.0 - 33.0
ALKALINE PHOSPHATASE	154.4	IU/L	54 - 369
TOTAL PROTEIN	6.74	gm/dl	6.4 - 8.3
ALBUMIN	3.86	gm/dl	3.5 - 5.0
GLOBULIN	2.88	gm/dl	2.3 - 4.1
A/G RATIO	1.34		1.0 - 2.00
GAMMA GT	12.8	IU/L	0.0 - 38

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Patient Id	2208301074	Srl No.	1074	Date	30/08/2022
Name	Baby KIRTI PIGORIA	Age	9 Yrs.	R. Printing Date	30/08/2022
Ref. By	Dr. AJAY ARORA	Sex	F	Address	IPD

Test Name	Value	Unit	Normal Value
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SEROLOGY

C-REACTIVE PROTEIN:CRP,SERUM
Immunoturbidimetry

59.61

mg/L

0.0 - 6.00

Comments :-

CRP is an acute phase reactant which is used in inflammatory disorders for monitoring course and effect of therapy. It is most useful as an indicator of activity in Rheumatoid arthritis, Rheumatic fever, tissue injury of necrosis and infections. As compared to ESR, CRP shows an earlier rise in inflammatory disorders which begins in 4-6 hrs. the intensity of the rise being higher than ESR and the recovery being earlier than ESR. Unlike ESR, CRP levels are not influenced by hematologic conditions like Anemia, polycythemia etc.]

TYPHIDOT (IgG & IgM)

DOT EIA FOR DETECTION OF IgM AND IgG ANTIBODIES TO SALMONELLA TYPHI:

IgM - NEGATIVE

IgG - NEGATIVE

INTERPRETATION :

- IgM Positive - Acute Typhoid fever.
- Typhi DOT has high sensitivity and specificity (95%) as compared to Blood Culture, Stool Culture and Widal test.
- It is useful for early, definite diagnosis of Typhoid (IgM levels in patient are usually detected by Typhidot at the onset of fever).

Checked By

**** End Of Report ****

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