

Date	20/02/2018	Srl No. 1	Patient Id 1802201
Name	Mrs. PALLAVI LAMBA	Age 29 Yrs.	Sex F
Ref. By	Dr. ARUNA KALRA		

USG SPECIAL

USG LOWER ABD + NT

USG OBSTETRICS:-

LMP:16/11/2017 GA by LMP:13 wks 5 day EDD by LMP:23/08/2018

Maternal:

UTERUS is gravid with a normal appearing gestational sac in the upper uterine segment. The sac shows a single live fetus within it. The internal Os is closed. **The cervix is adequate in length(3.7 cm)**. Both adnexae are clear.

The right uterine artery shows a normal flow pattern with RI = 0.73 and a PI = 1.58.

The left uterine artery shows a normal flow pattern with RI = 0.84 and a PI = 2.05.

The mean pulsatility index of the uterine arteries is 1.81 (within normal range).

Fetal:

Placenta: Forming posteriorly. Extends down towards the internal os, however doesn't span across it. Homogenous echopattern. No R.P. collection. Liquor amnii is normal.

CRL= 62.6 mm corresponding to 12 wks 5 days +/- 3 days. EDD by USG is 30/08/2018

Cardiac activity is visualised and is normal. Approx. = 165 bpm.

Nasal bone is seen and measures 3.4 mm in length and appears normal.

Nuchal Translucency is 0.9 mm thick (within normal range).

Intracranial lucency is within normal range.

Ductus venosus flow is normal.

No tricuspid regurgitation.

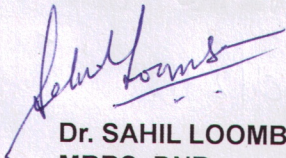
Fetal stomach bubble and fetal urinary bladder are visualised and are normal.

IMPRESSION: Single intrauterine pregnancy, corresponding to a gestational age of 12 wks 5 days +/- 6days.

Normal level 1 scan.

I, Dr. Sahil Loomba, declare that while conducting the ultrasound on Mrs. PALLAVI LAMBA, I have neither detected nor disclosed the sex of her fetus to anybody in any manner. Please note: All congenital anomalies cannot be detected on ultrasound.

**** End Of Report ****


Dr. SAHIL LOOMBA
MBBS, DNB
MNAMS, FRCR 2A(UK)
CONSULTANT RADIOLOGIST



TEST REQUISITION FORM

Patient Details

First Name: Mrs Pallavi Last Name: Lamba

Age: 29 years Gender: Male Female

Address: _____
Contact No. : _____

E-mail ID _____

Referred by _____ Contact No. : _____

For Maternal Screening - Date of Birth :-

Weight : _____ kg. Height : _____ ft _____ inches, LMP _____ Last Ultrasound Report

Billing Information

Client Name : Scanlab Diagnostics.

Client ID : _____

Total Amount : _____

Amount Received : _____ Receipt No. : _____

Amount Balance / Due : _____

Payment via : CASH CHEQUE CREDIT

Specimen Type Received (For MolQ use only)

- | | | |
|--|---|---------------------------------|
| <input checked="" type="checkbox"/> Serum | <input type="checkbox"/> Bone Marrow | <input type="checkbox"/> CSF |
| <input type="checkbox"/> Plasma: EDTA/FL/CIT | <input type="checkbox"/> FN Aspirate | <input type="checkbox"/> Fluid |
| <input type="checkbox"/> SST | <input type="checkbox"/> Tissue Formalin | <input type="checkbox"/> BAL |
| <input type="checkbox"/> W. Blood EDTA | <input type="checkbox"/> Paraffin Block | <input type="checkbox"/> Sputum |
| <input type="checkbox"/> W. Blood Fluoride | <input type="checkbox"/> Smear | <input type="checkbox"/> Urine |
| <input type="checkbox"/> W. Blood Heparin | <input type="checkbox"/> Slide (H&E) | <input type="checkbox"/> Stool |
| <input type="checkbox"/> W. Blood Sodium Citrate | <input type="checkbox"/> Pus | <input type="checkbox"/> Swab |
| | <input type="checkbox"/> Blood Culture Bottle | <input type="checkbox"/> Others |

Other Sample Type / Source : ① ⑧

Received Specimen Information (For MolQ use only)

Temperature : Ambient Refrigerated Frozen

Date: _____ Time : _____

Patient ID _____ No. of vials/container _____

1	2
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Signature of Accessioning Officer(s)

Test Name/Test Code


(Please refer to the Directory of Services for correct name and specimen type)

TSH
FT4
Double Marker

Instructions to Laboratory/Clinical Information

Sent Specimen Information

Temperature : Ambient Refrigerated Frozen

Sample / Vial Type	Vial ID Barcode
<u>Plain</u>	 10210559 F

Total No. of Vials/Container _____

Specimen Collection Information

Date: _____ Time : _____

Fasting : Yes No Fasting Period : _____ Hrs.

Collection by : Go Rey

Urine Volume : _____ ml Hrs. _____

Patient Consent : I hereby authorize MolQ Laboratory to use and share with affiliates my personal information including but not limited to any condition / disease information etc. as may be necessary to perform the test or services etc. Medical records/information, to the extent of the applicable by laws and regulations, will be kept confidential and will not be made publicly available. Further, I authorize the use of the leftover specimens for immediate research and in future research of any kind and at any time in the future. The samples will be coded to maintain confidentiality and will be discarded as per the rules and regulations specified as applicable by law. In the event of any publication by MolQ Laboratory, patient's identity will remain confidential. I agree to this access of my medical records and specimen for diagnostic and research purpose.

Disclaimer : For any test/service related complain/query please contact MolQ Laboratory for resolution. In case of any dispute the jurisdiction will be Head Office, Dehradun, Uttarakhand. The financial liability or compensation of any sort is not more than MRP of the Test requested.

रोगी सहमति : मैं मोल्क्यू प्रयोगशाला को अधिकृत करता हूँ कि मेरी पूर्ण व्यक्तिगत जानकारी अपनी किसी भी शाखा के साथ साझा कर सकती है। मेरी बीमारी की हालत या सूचना का खुलासा अगर परीक्षण के संचालन के लिए आवश्यक है, तो मैं इसकी अनुमति देता हूँ यद्यपि यह जानकारी उस सीमा तक साझा की जाए जो कि कानूनी सीमा के अंतर्गत हो। मेरी इस प्रकार की जानकारी को पूर्ण रूप से गुप्त रखा जाए और सार्वजनिक रूप से उपलब्ध ना कराई जाए। इसके पश्चात मैं प्रयोगशाला को देबारा अधिकृत करता हूँ कि जो नमूना जाँच के लिए उपलब्ध करवाया था, उसमे से बचे हुए नमूने को प्रयोगशाला कभी भी और किसी भी समय किसी भी प्रकार के प्रयोग के लिए उपयोग में ला सकती है। शेष नमूने को पूर्ण रूप से अंकित किया जाए और गुप्त रूप से रखा जाए, जब इसको नष्ट किया जाए तो पूर्ण रूप से नियम और विनियमता का उपयोग किया जाए। किसी भी प्रकार के मोल्क्यू प्रयोगशाला के प्रकाशन में रोगी की निजी जानकारियों को पूर्ण रूप में गुप्त रखा जाएगा। मैं सहमत हूँ कि मेरी मेडिकल रिकॉर्ड और मेरे बचे हुए नमूने को नैदानिक प्रयोग और किसी भी प्रकार के अनुसंधान के लिए उपयोग में लिया जा सकता है।

अस्वीकृति : किसी भी जाँच सम्बन्ध शिकायत या जानकारी हेतु आप मोल्क्यू प्रयोगशाला को सम्पर्क कर सकते हैं, किसी भी प्रकार की कानूनी झगड़े हेतु हमारा मुख्यालय देहरादून, उत्तराखंड है, किसी भी जाँच का मूल्य उसके लिए अधिकतम फुटकर मूल्य से अधिक नहीं होगा।

Aneesha
Patient/Client/Doctor's Signature
Date : 20/12/18

Annexure-III- Dual/ Triple/ Quadruple Marker Tests on Maternal Serum

Sr. No.	Pre-Requisites	Check Mark/ Remark
1	Name	Pallavi Lamba
2	Date of Birth	3/3/1988
3	LMP	16/11/17
4	Maternal Weight(Kg)	72.2 kg.
5	Smoking Status	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
6	Diabetic Status	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
7	History of IVF [if Yes, please provide DOB of Donor]	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
8	Number of Fetus (Single/Twins)	Single.
9	USG Report with radiologist name and degree.	Attached
10	Origin(Asian/ European African)	Asian
11	Dual marker test(from 11 weeks to 13 weeks 6 days)	Dual Marker
12	Triple marker test (from 14 weeks to 21 weeks)	—
13	Quadruple marker test (from 15 weeks to 22 weeks)	—
14	Prev Trisomy Pregnancy	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
15	Missed Abortion	N.A.

Form filled by (Name & Signature) _____

Savitri Lomane

Patients Signature _____

Pallavi

Date _____

20/2/18