



Jan Sanjeevni Trust

Hands to Serve - Heart to Love

Reg. No. 1061

PAN No. AADTJ0816E

Jan Sanjeevni Trust Registration No: 1061/2017

Jan Sanjeevni Trust PAN No: AADTJ0816E

Jan Sanjeevni Trust Website: www.jstngo.org

Jan Sanjeevni Trust E-mail : we@jstngo.org

PATIENT NAME	Rudranil Sinha
GURDIAN	Somnath Sinha
D.O.B/ SEX	2 Years, Male
DISEASE NAME	Hepatoblastoma (liver cancer)
TREATMENT HOSPITAL	AIG Hospital (Hyderabad)
UHID NO	AIGG.21269198
DEPARTMENT NAME	Pediatric Oncology
TREATMENT COST	₹5,60,000/-
GURDIAN's OCCUPATION	Unemployed
ADDRESS	Ichhar, PO: Ichhar, DIST: Puruliya, West Bengal - 723145



@jansanjeevnitrust



Jan Sanjeevni Trust



Jan Sanjeevni Trust

Surgery Estimation

Patient's UHID/ IPNO : AIGG.21269198
 Estimation Amount : 560000
 Estimation Date/Time : 27/08/2026 10:58:37
 Requested Bed Type : Sharing
 Surgeon/Physician Name : Dr. BALACHANDRAN PALAT
 Expected day of stay : 8
 Minimum Deposit : 480000
 Company :

Patient's Name/Age/Sex : Mast. RUDRANIL SINHA/2 Year(s) 4
 Estimation Given by : Month(s)/Male/9002766646
 Billing Counselling done by : Jalleda Asaswini Priyanka
 Billing Counselling done To : PRIYANKA
 Relationship : POOJA SINHA
 Emergency No : Mother
 Expected Date of Admission :
 Estimate Type :

: Initial Pre-Admission Estimate
 : ESTG17591

Diagnosis/Medical Problem : RT HEPATECTOMY

Estimate No.

Estimation Break-Up-

Item Name	Amount
Room Rent Sharing (5X5500)	27500
Investigation Charges	50000
Drug Charges	100000
Consumable Charges	100000
Admission Charges	1500
ICU Charge (3.00X9,000.00)	27000
RT HEPATECTOMY	220000
OTHERS	30000
Total Amount	560000

Remarks : OT-5HRS, BLOOD, VIRALS+VE, EXTRA ICU/ROOM STAY/OPEN SURGERY/CUSA-25K REQUIRED
 CHARGES EXTRA

Note: Hospital Admission Terms & Conditions

• Estimates & Billing

The admission cost estimate is approximate. Final billing reflects actual treatment and services received. Enhanced treatment and extended stay costs will be communicated timely. It is the responsibility of patient attendants to check the bill everyday at Tower A, 5th Floor.

• Advance Payment

Full estimated cost is payable at admission. A minimum positive balance of ₹50,000 must be maintained during the stay.

• Payment Responsibility & Regulations

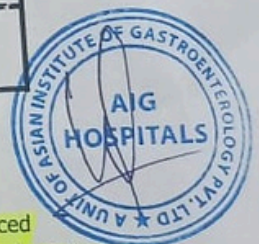
The patient/legal guardian is responsible for full bill settlement. If a nominee/guardian will pay, a signed undertaking is required. PAN card of the patient or attendant is mandatory at admission.

• Payments & Refunds

Payments accepted via cash, card, DD, UPI, or bank transfer. Cheques are not accepted. Refunds up to ₹20,000 will be issued in cash; higher amounts via NEFT within 4-7 working days.

• Admission & Attender Policy

One attender must stay with the patient throughout, except in general wards (no attenders allowed). Admission without an attender is not permitted. If the patient is moved to ICU/HDU/PICU/OT, the attender must vacate the room. No separate



accommodation will be provided.

- Belongings

The hospital is not liable for loss/theft of personal belongings. Patients/attenders must safeguard valuables.

Insurance-Specific Terms

- Role of Hospital

a. The hospital acts solely as a facilitator and is not responsible for insurer decisions. If cashless is denied, hospital cash tariff applies, which differs from insurance rates.

b. The hospital is not liable for insurance denial due to non-disclosure of pre-existing conditions, cosmetic treatments, substance-related ailments, self-harm, or war-related injuries.

- Policy Eligibility

Patients must confirm room eligibility with their insurer. Upgrades may lead to proportionate deductions, and the cost difference must be borne by the patient.

- Copay & Exclusions

Policies may include co-payments or sub-limits for specific conditions, payable by the patient. Non-medical expenses are not covered and must also be paid by the patient. Refer to your policy for details.

Self-Declaration

I agree to all hospital terms on billing, discharge, refunds, insurance, and clinical documentation. I take full responsibility for settling my bill before discharge. I understand the estimate is approximate and final billing will reflect actual services. I consent to clinical photography/videotaping for documentation. I agree to maintain a positive balance, vacate my room if moved to ICU/HDU/QT, and confirm that I was counselled about all investigations, treatments, and consumables in the language Hindi known to me.

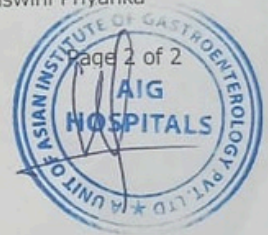
Signature: Somnath Sinha
Relation: Father

Name: _____
Date: 27/8/26

Estimate Given By : Jalleda Asaswini Priyanka

Print DateTime : 27/08/2026 10:58:39

Print By : Jalleda Asaswini Priyanka





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Patient Name: Most Rudramil Senha

UHID No: 21269198

Age & Sex: 24 / (P)

Date & Time: 04.08.26

FABRI - W.B.

Chief Complaints: *AFP > 1000000

Blood group - NA

History of presenting complaints:

No H/O previous Ix

Past Medical / Surgical History:

c/o - Abd distension from 1 week
intermittent fever - 20 days

Diaper MRCP 1) Liver - Enlarged
31.7.26. 2) 4 lesions: largest is
9.1 x 9.8 x 11.6 cm involving
Sag VII, VIII, 0, VI.

Family History/Personal History (Including social and psychological factors):

Medication History:

3) PV - MPD appears stretched with maintained
flow void. => ? Hepatoblastoma

S.No	Medication	Dosage	Route	Frequency
	<u>On 31.07.2026.</u>	<u>OT/PT - 143/27</u>		
	<u>PT/INR - 11.5/0.94</u>	<u>Albu - 4.5</u>	<u>AFP</u>	<u>> 100.000.</u>
	<u>APTT - 28.8</u>	<u>HB - 7.1, TLC - 11830</u>		
	<u>CRP - 67.00</u>	<u>PLT - 367</u>		
	<u>Bill-TID - 0.8/0.2</u>			

General & Systemic examination: CVS:

RS:

G.I:

CNS:

OTHERS:

LOCAL EXAMINATION:

Provisional Diagnosis:

Consultant Review Notes:

Final Diagnosis:

USG :- Liver - widely enlarged.
lobulated heterogeneous mass of liver
109 x 100 mm. - rt lobe.
Not HBD

large SOL
beher

RT PV a RT V enlargement

CON R
Amf

Ans

PET CT Multiphasic Scan
Abdomen

α levels c Reports

CONSULTATION NOTE

MC-3380

UHID	AIGG.21269198	Visit Date	04/08/2026 11:35 AM
Patient Name	Mast. RUDRANIL SINHA	Age / Gender	2 Years / Male
Doctor Name	Dr. ARIF KHAN	Visit ID	1100.OP.2692754
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR , RAGHUNATHPUR - II, WEST BENGAL. 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	T	N	M	Accuracy
C22.2	MALIGNANT NEOPLASM. HE- PATOBLASTOMA					Provisional

Present Complaints:

AFP> 1000000

MRCP:At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma. PRETEXT II (C, F)

Visit Summary:

4.8.26 :

PET CECT (triphasic)

liver transplant opinion

Patient Medical History:

ABDOMINAL DISTENSION FROM 1 WEEK

Fever : 15 days on and off

H/o recurrent fevers every month

No jaundice / vomiting / loose stools / weight loss/ pruritis

Weight < 3rd centile

Height < 3rd centile

Investigations:

PET CT WHOLE BODY WITH CONTRAST - triphasic

UHID	AIGG.21269198	Patient Name	Mast. RUDRANIL SINHA
Doctor Name	Dr. ARIF KHAN	Age / Gender	2 Years / Male
Visit Date	04/08/2026 11:35 AM		

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT)

Medications:

S. No	Name	Frequency	Route	Duration	Start Date	Instructions
1	CROCIN DS 240MG/5ML 60ML SYP (PARACETAMOL(240MG/5ML))	When Necessary Dose: 1	Oral	1 day	04/08/26	3.5ML / SOS for fever , can be give times a day

Referrals:

Doctor	Speciality	Instructions
Dr. SUMANA KOLAR RAMACHANDRA	Liver Transplant & Heptobiliary Suregry	-


DR ARIF KHAN MOHAM
 MBBS | Senior Cons
 MEDICAL ONCO

CONSULTATION NOTE**Dr. Dharani Nagoji**

MBBS, MD

Fellowship in Paediatric Gastroenterology

Hepatology & Nutrition

Consultant Medical Gastroenterology

Reg No : TSMC/FMR/00583

UHID	AIGG.21269198	Visit Date	31/07/2026 04:48 PM
Patient Name	Mast. RUDRANIL SINHA	Age / Gender	2 Years / Male
Doctor Name	Dr. Dharani Nagoji	Visit ID	1100.OP.2682987
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR , RAGHUNATHPUR - II, WEST BENGAL, 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	Accuracy
K76.9	LIVER DISEASE, UNSPECIFIED		Provisional

Present Complaints:

ABDOMINAL DISTENSION FROM 1 WEEK

Fever : 15 days on and off

H/o recurrent fevers every month

No jaundice / vomiting / loose stools / weight loss/ pruritis

Weight < 3rd centile

Height < 3rd centile

Systemic Examination:

P/A: Soft , non tender

Investigations:

CBP (COMPLETE BLOOD PICTURE)

LFT (LIVER FUNCTION TEST)

PT WITH INR AND APTT

AFP

MRCP

CRP

↓ anasthuria

LFT (LIVER FUNCTION TEST) Sample Type - Serum

**BIOCHEMISTRY AND
THERAPEUTIC DRUG
MONITORING**

Test (Method)	Result	Normal Range	Unit
TOTAL BILIRUBIN (Method: DPD)	0.8	0.3 - 1.2	mg/dL
DIRECT BILIRUBIN (Method: DPD)	0.2	0-0.2	mg/dL
INDIRECT BILIRUBIN (Method: Calculated)	0.6	-	mg/dL
S.G.P.T (ALT) (Method: Enzymatic without P5P (Ref IFCC))	27 ▲ (H)	10 - 25	U/L
S.G.O.T (AST) (Method: Enzymatic without P5P (Ref IFCC))	143 ▲ (H)	21 - 44	U/L
ALP (Method: AMP optimised to IFCC)	290	134 - 315	U/L
TOTAL PROTEINS (Method: Biuret)	7.8 ▲ (H)	5.6 - 7.5	g/dl
ALBUMIN(SERUM) (Method: BCG)	4.5	3.8 - 5.4	g/dl
GLOBULIN (Method: Calculated)	3.3	2.3 - 3.5	g/dl
A/G RATIO (Method: Calculated)	1.4	0.9 - 2	

Interpretation: Liver function tests are blood tests used to help diagnose and monitor liver disease or damage. Liver function tests can be used to: Screen for liver infections, such as hepatitis Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working Measure the severity of a disease, particularly scarring of the liver (cirrhosis) Monitor possible side effects of medications.

Report Saved By - V Sekhar (31-07-2026 23:02)


Dr. G. DEEPIKA

Director & HOD - Biochemistry MBBS,
MD

End of Report



View Report

Name : Mast RUDRANIL SINHA
LMD : AIGG.21269198
Gender/Age : M/2 Y
Ref. Phys. : Doctor Dharani Nagoji
Procedure Name : MRCP

Accession No : 10.7182192.33993
Bill Date : 31-Jul-2026 20:04
Reporting Date : 03/08/2026 1:58PM
Modality : MR

Gallbladder is partially distended. No e/o intraluminal sludge / calculi. Wall thickness is normal.
Cystic duct is not well delineated.

PANCREAS:

- Pancreas appears displaced by the mass effect of enlarged liver. Otherwise, normal in bulk and signal intensity. No peripancreatic fluid collection.
- Pancreatic duct: Not dilated.
- Pancreatic divisum could not be commented upon.

Spleen measures 4.9 cm with normal signal intensity.

Both kidneys appear unremarkable.

IMPRESSION:

At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma. PRETEXT II (C, F).

Suggested contrast study for better vascular evaluation.

This examination and reported findings have been reviewed and confirmed.

Approved by:



Dr. Aishvarya Shri Rajasimman
MBBS, MD
Junior Consultant

*****End Of Report*****



Mindspace Road, Gachibowli, Hyderabad,
Telangana - 500032
Tel: 040 4244 4222 | info@aighospitals.com
aighospitals.com

LABORATORY INVESTIGATION REPORT

Patient Name	: Mast. RUDRANIL SINHA	Age/Sex	: 2 Year(s) 3 Month(s) / Male
UHID	: AIGG.21269198	Order Date	: 31/07/2026 20:04
Episode	: OP	Bill No.	: AGOCS260822976
Ref. Doctor	: Dharani Nagoji	Mobile No	: 9002766646
		Facility	: AIG Hospitals, Gachibowli
Sample No	: AGO1944930E	Collec.Date	: 31/07/26 20:07
Ack. Date	: 31/07/2026 22:11	Report Date	: 01/08/26 20:24

Hormones

TEST	RESULT	UNIT	BIOLOGICAL REF. INTERVAL
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AFP

Sample Type- Serum

ALPHA FETOPROTEIN.

Method - ECLIA

> 1000000 ▲ (H)

ng/mL 0-87

Interpretations: AFP produced by the fetus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Dr. Katamareddy Prathyusha (01/08/2026 10:27 AM)

End of Report

Dr.G. DEEPIKA

Director & HOD - Biochemistry
MBBS, MD
RegNo: 54289

Patient Name: Mast. Rudranil Sinha
UHID : AIGG.21269198
Age / Sex: 2 Year(s) / Male
Mobile No: 9002766646
Facility: AIG Hospitals, Gachibowli

Episode: OP
Bill No: AGOC5260822976
Sample No: AGO1944930A
Ref. Doctor: Dr. Dharani Nagaji

Order Date: 31/07/2026 20:04
Collec. Date: 31/07/2026 20:07
Ack. Date: 31/07/2026 23:14
Report Date: 31/07/2026 23:43

PT WITH INR AND APTT Sample Type - Citrated Plasma

Coagulation

Test (Method)	Result	Normal Range	Unit
PROTHROMBIN TIME (Method: Photometric Clotting Assay)	11.3	10.8 - 13.2	Seconds
MEAN NORMAL PROTHROMBIN TIME (Method: Photometric clotting assay)	12.0	-	Seconds
INR	0.94	Normal <1.3 Therapeutic Range 2.0 - 3.5 Critical Alert >4.0	
APTT TEST (Method: Photometric Clotting Assay)	28.8	26.8-41.5	Seconds

Interpretation: Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), tissue factor and proteins of the common pathway (Factors X, V, II & Fibrinogen). Prolonged PT Administration of oral anticoagulant drugs Liver disease, particularly obstructive jaundice Vitamin K deficiency Disseminated intravascular coagulation Inherited deficiency of factors in extrinsic pathway (VII) and common pathway (V, X, prothrombin and fibrinogen) International Normalized Ratio (INR) is used for defining the therapeutic ranges for anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity. Recommended Therapeutic range for Oral Anticoagulant therapy INR 2.0-3.5: Treatment of Venous thrombosis & Pulmonary embolism, Prophylaxis of Venous thrombosis (High risk surgery), Prevention of systemic embolism in tissue heart valves, AMI, Valvular heart disease & Atrial fibrillation, Bileaflet mechanical valve in aortic position
Note : 1. Results should be clinically correlated

2. Test done on citrated plasma. Comments Partial Thromboplastin Time / Activated Partial Thromboplastin Time (PTT / APTT) measures the activity of intrinsic and common pathway of coagulation, which consists of Factor XII, Prekallikrein, High molecular weight kininogen, Factors VIII, IX & XI. It also measures proteins of the common pathway namely factors II, V, X & Fibrinogen. Abnormal Partial Thromboplastin Time Associated with bleeding: Defects of factors VIII, IX & XI Not associated with bleeding: Defects of factor XII, Prekallikrein, High molecular weight kininogen & Lupus anticoagulants Isolated prolonged APTT Undiagnosed haemophilia, Congenital coagulation disorders Moderately prolonged APTT Patients taking oral anticoagulant drugs, Presence of vitamin K deficiency Prolonged PTT/APTT Disseminated intravascular coagulation, Liver disease, Massive transfusion with plasma depleted red blood cells, Administration or contamination with heparin or other anticoagulants, A circulating anticoagulant including lupus anticoagulant, Deficiency of a coagulation factor other than factor VII
Note : 1. Results should be clinically correlated
2. Test done on citrated plasma.

Report Saved By - Rajesh Kumar (31-07-2026 23:43)

End of Report

Dr. MD Shareef Ahmed
MBBS, MD Pathology

Dr. ANURADHA SEKARAN
MD, DNB, MNAMS, DipRCPath (UK)
Director of Pathology & Molecular Pathology



View Report



Patient Name: **Mast. Rudranil Sinha**
 ID: **AIGG.21269198**
 Sex: **2 Year(s) / Male**
 File No: **9002768648**
 City: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOC5260822976**
 Sample No: **AGO1944930C**
 Ref. Doctor: **Dr. Dharani Nagoji**

Order Date: **31/07/2026 20:04**
 Collec. Date: **31/07/2026 20:07**
 Ack. Date: **01/08/2026 01:18**
 Report Date: **01/08/2026 06:18**

CRP Sample Type - Serum

Serology

Test (Method)	Result	Normal Range	Unit
CRP - C Reactive Protein (Method: Sandwich Immunoassay)	67.00 ▲ (H)	Negative <10 mg/L Positive >= 10 mg/L	mg/L

Interpretation:
 C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation. Markedly increased levels are observed, for example, after trauma or a heart attack, with active or uncontrolled autoimmune disorders, and with serious bacterial infections like sepsis.

The test measures the amount of CRP in the blood and can be valuable in detecting inflammation due to acute conditions or in monitoring disease activity in chronic conditions.

CRP is detected in pregnant women after the 1st trimester of pregnancy and persists until delivery. Increased levels are also seen in women who are on Oral Contraceptives.

The CRP test is not diagnostic, but it provides information as to whether inflammation is present

Report Saved By - P Siva Nagaraju (01-08-2026 06:18)

J. Sadhana

Dr. TV. SADHANA
 Sr. Consultant, Microbiologist
 MD, FRCP (UK)

End of Report



View Report



Name	: Mast RUDRANIL SINHA	Accession No	: 10.7182192.33993
UHID	: AIGG.21269198	Bill Date	: 31-Jul-2026 20:04
Gender/Age	: M/2 y	Reporting Date	: 03/08/2026 1:58PM
Ref. Phys.	: Doctor Dharani Nagoji	Modality	: MR
Procedure Name	: MRCP		

DEPARTMENT OF RADIO-DIAGNOSIS
MRCP (NON-CONTRAST)

TECHNIQUE: Thick slab MR Cholangio-Pancreatography. B-TFE Axials, T1, T2-FS Axials, T2 and T2 FAT Coronals, 3D HR MRCP.

CLINICAL DETAILS: Abdominal distention for one week. Fever on and off.

OBSERVATIONS:

Liver is enlarged measuring 15 cm.

No well-defined lesions are seen involving the right lobe of liver as described.

Lesion/multifocal: Four discrete lesions are seen.

Location: Segments VII, VIII, V, VI (PRETEXT II).

Size: Largest measuring 9.1 x 9.8 x 11.6 cm (AP X TR X CC).

Signal: Hypointense with few T1 hyperintense areas showing diffusion restriction, suspicious for hemorrhage / necrosis.

Character: Heterogeneously hyperintense.

VI: Few areas of focal restriction (in T1 hyperintense areas).

Portal Vein: MPD appears stretched with maintained flow void. Right portal vein is encased with attenuated caliber. Left portal vein normal.

Hepatic Veins: Middle and left hepatic veins are normal. Right hepatic vein is faintly visualized - encased with attenuated caliber.

GC: Displaced. Patent with maintained flow void.

Update: Involved.

Signatures of rupture: Absent.

BRD: Absent.

Nodes: No significant adenopathy as per size criteria.

Intrahepatic disease: Absent to the visualized extent.

Scites: Absent.

Common bile duct at porta measures 3 mm. No evidence of intrahepatic biliary dilatation is seen.

IPV at porta measures 5 mm.

CBP (COMPLETE BLOOD PICTURE) Sample Type - EDTA Whole Blood

Haematology

Test (Method)	Result	Normal Range	Unit
HEMOGLOBIN (Method: Colorimetric / Spectrophotometry Non-Cyanide Method)	7.1 ▼ (L)	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	4.11	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	23.6 ▼ (L)	34.0 - 40.0	%
MCV (Method: Derived From RBC Histogram / Numeric Integration)	57.4 ▼ (L)	75.0 - 87.0	fL
MCH (Method: Calculated)	17.3 ▼ (L)	24.0 - 30.0	pg
MCHC (Method: Calculated)	30.1 ▼ (L)	31.0 - 37.0	g/dl
RDW (Method: Derived From RBC Histogram / Calculated)	19.5 ▲ (H)	-	%
TOTAL WBC (Method: Flowcytometry SF CUBE / Flowcytometry DHSS and Impedance)	11830	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	67.7 ▲ (H)	30 - 53	%
LYMPHOCYTES (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	24.3 ▼ (L)	27 - 57	%
EOSINOPHILS (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	0.8 ▼ (L)	2.0 - 7.0	%
MONOCYTES (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	6.9 ▲ (H)	4.0 - 7.0	%
BASOPHILS (Method: SF Cube Method / Impedance/Microscopy)	0.3	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT. (Method: Calculated / Flowcytometry DHSS)	8009 ▲ (H)	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	2875 ▼ (L)	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	95 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	816	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	35	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	2.8	-	
PLATELET COUNT (Method: Electrical Impedance / Impedance)	367	200 - 490	$10^3/mm^3$
MPV (Method: Derived From Platelet Histogram / Electrical Impedance)	11.1 ▲ (H)	7.4-10.4	fL
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisocytosis microcytic hypochromic		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Neutrophilic leucocytosis left shift		
PLATELETS.. (Method: Microscopy/Leishman stain)	Adequate		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts. CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Suligitha Madhubabu (01-08-2026 10:08)

End of Report

CONSULTATION NOTE

Dr. Dharani Nagoji

MBBS, MD

Fellowship in Paediatric Gastroenterology

Hepatology & Nutrition

Consultant Medical Gastroenterology

Reg No : TSMC/FMR/00583

MC-3380

UHID	AIGG.21269198	Visit Date	04/08/2026 08:26 AM
Patient Name	Mast. RUDRANIL SINHA	Age / Gender	2 Years / Male
Doctor Name	Dr. Dharani Nagoji	Visit ID	1100.OP.2691083
Phone No	9002766646		
Address	SANTALDIH, ICHHAR-ICHHAR, RAGHUNATHPUR - II, WEST BENGAL 723145		

Diagnosis:

ICD10	Diagnosis	Additional Info	Accuracy
C22.2	MALIGNANT NEOPLASM HEPATOBLASTOMA		Provisional

Present Complaints:

AFP > 1000000

MRCP: At least 4 well defined heterogeneous lesions involving the right lobe of liver as described with encasement of right portal vein and right hepatic vein- Suggestive of Hepatoblastoma, PRETEXT II (C, F)

Patient Medical History:

ABDOMINAL DISTENSION FROM 1 WEEK

Fever : 15 days on and off

H/o recurrent fevers every month

No jaundice / vomiting / loose stools / weight loss/ pruritis

Weight < 3rd centile

Height < 3rd centile

Medications:

S. No	Name	Frequency	Route	Duration	Start Date	Instructions
1	CRIOCIN DS 240MG/5ML, 60ML SYP (PARACETAMOL (240MG/5ML))	When Necessary Dose: 1	Oral	1 day	04/08/26	3.5 ML / SOS for fever, can be given 4 times a day

Referrals:

Doctor	Speciality	Instructions
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PRE-ANAESTHETIC ASSESSMENT

(Patient Label)

UHHO 2126918

PAC Done by Dr. Hemalatha
Date / Time: 11/08/26

12:30 PM

Problems / Comorbidities:

Blood Group:

Hiv / Hbsag / Anti Hcv:

Allergies: No allergy.

Diagnosis:

Surgery/Procedure: MRCP

Ht / Wt BMI: 1.65 m / 74 kg / 27.1

Surgeon: Dr(s).

Date of Surgery:

Site: Left / Right

MEDICAL HISTORY: Add. discussion - 1st

CVS: Essential HTN/ IHD/ MI/ Valvular Heart disease/ PTCA/ Peripheral Vascular disease

Angina: Y/N syncope: Y/N palpitations: Y/N

RS: Bronchial Asthma/ Exposure to TB/ COPD/ILD/Pulmonary Hypertension

Duration- Recent attack- Treatment-

CNS: Epilepsy/ CVA/ Migraine/ spondylosis/ Koch's spine

Duration- Recent attack-

Musculo-Skeletal: Large Joints/ Rheumatoid Arthritis

Renal: UTI/ Renovascular disease/ Nephropathy / Hemodialysis/CRRT

Duration- Recent attack- Treatment-

GIT: ulcerative colitis/ abdominal Koch's/GERD/Hiatu hernia / Obesity

Duration- Treatment-

Hepato-Biliary / Pancreas

hepatitis/CLD/Acute pancreatitis/Chronic pancreatitis/Cholangitis

ENT / Eye: Sinusitis/ Snoring/ Glaucoma/ Deafness/ Others

Endocrine: Thyroid disorder/ DM/ Cushing's/ PCOD/ steroids / others- specify -

Duration- Disease course-

Autonomic symptoms-

Treatment-

Hematology: h/o blood and blood product transfusion/G6PD deficiency/ sickle cell anemia/Polycythemia/ others -specify -

Malignancy and myeloproliferative disorders & others:

Personal History:

Ethanol/ smoking/CAM/steroids/substance abuse/tobacco chewing/ contraceptive pills/ LMP

Paediatric History: Recurrent fever - 7-8 months

Birth History:

Developmental Milestones: Vaccinated till date

Immunization:

List of all previous surgeries / Perioperative or anaesthesia problems / Past hospitalization / ICU admissions:

CURRENT MEDICATIONS

GENERAL EXAMINATION

Temp: 98.4 F Hydration: Fair Dehydrated

HR: 154/min Peripheral Pulses:

P: NYHA: I II III IV V

R: Bedside Resp Function: N / F / P

pO2: 99 BHT

Heart: S3, Q SMI: PEFR:

Lungs: RMC Hand grip Dynamometry:

CNS: MNC Right:

Pallor: +

Icterus: -

Petechiae: -

Cyanosis: -

Anasarca: -

Spine Gr: I II III IV V VI

AIRWAY ASSESSMENT:

Mouth Opening: cannot be opened

Dentition: (A)

Extension: (A)

Mento-Thyroid distance:

Nostril patency: (A) Crico-Thyroid memb:

Mallampati @ PAC : I II III IV

Diff. Intubation: Less likely / Could be / YES

INVESTIGATIONS 31/07/26

Hb / Hct: 7.1

TLC: 11850

Plt: 367

RBS/HBA1C:

Urea / Creatinine:

Bilirubin: 0.8

AST / ALT: 243/27

GGT:

Se. Ammonia:

Amylase / Lipase

TP / Albumin: 7.8/4.5

PT / INR: 11.3/0.04

APTT: 28.8

Fibrinogen:

TSH

FT3 / FT4:

pH / PFR:

PaCO2 / SBE:

Na+ / K+:

CXR:

ECG / TMT / DSE:

CATH:

e- GFR:

24 Hrs Proteins:

PCR:

24 Hrs UO:

ECHO

MRI / CT: Mild hepatomegaly
Liver mass in (A)
lobe of liver.

CULTURES

blotic	7
NMBA	7
IV	7
gesics	7

10%	spontaneous breathing						
2	100	100	100	100	100	100	100
32							

PaCO ₂
G
Peak / Plateau
EP

220
200
180
160
140
120
100
80
60
40
20
BP

Temp	100 ml
Fluids	NS

Time

INTAKE

Cryst	Colloids	PRBCs	Pit
FFPs	Cryo Ppt	Auto trans	Salvaged Bld

OUTPUT

Balance

Cryst	Colloids	PRBCs	Pit
FFPs	Cryo Ppt	Auto trans	Salvaged Bld

Reversal: Neostigmine + Atro - Glyco - or Suggamadex

RECOVERY:

- ☐ Uneventful - Alert, Sustained head lift, Sedated ☐ Elective Ventilation
☐ Laryngospasm ☐ Re-intubation ☐ Unplanned Ventilation
☐ Unplanned SCCU admission

Shifted to: Recovery HDU / SCCU

Vitals Before Shifting: Temp PR BP SpO₂ RR VAS

Name and Signature of the Anaesthesiologist:

Date & Time

* Dr Ruchi 3/8/26

Special Instructions:

- Deep Breathing & Calf Exercises – Mandatory For all
- Stringent Epidural protocol – If pts are on Epidurals
- PPPC Protocol – For all Major & Bariatric Surgeries
- Early Ambulation Protocol for ALL – If no C/I
- Maintain VAS < 3/10 – All Surgical Patients
- Rest – Follow Surgeons & Anaesthesiologists Instructions

INTRA - OPERATIVE ANAESTHESIA RECORD

Date: 3/3/20

Name of Anaesthesiologist / Tech: Dr. Rishi / Rishma

Consent: Regular / Mod risk / High Risk

Immediate Pre-operative Anaesthesia Assessment (To be done when the patient is on the OT table)

PAC chart reviewed ☒ Yes ☐ No Pre-op instruction followed ☒ Yes ☐ No NBM Status: ☐ Yes

Premedication in pre-OP holding area: ☒ Airway exam MP4 II / III

ASA grading: I ☐ Anaesthesia plan MAC + sedation

I.V. Access (Size & Location): 22G (R) hand CVP / AL (Site) from ICU: TT / ETT from ICU - Size / Cuff Pr:

Surgery Name: MRCP Site: Rt Lt Bilateral

Immediate Preop Vitals: Temp: PR: RR: BP: SPO₂: GCS: Pupils: Rt - Lt -

Equipment Check Before Sign-In: ☐ Anaesthesia work Station & Drugs ☒ Monitor & Defib ☒ Routine & Diff Airway Trolley ☐ Endo

Anes start time: Patient into OT: Surg start time: Surg end time: Patient out of OT: Anes end time

Surgery Proposed: MRCP. Anaesthesia Details

Surgery Done (Reason, if change of tech): Proposed Technique: MAC + sedation

GA Details: INDUCTION: Parenteral / Inhalational; B & MASK VENTILATION: Easy / Difficult; INTUBATION: Oral / Nasal - Easy / Difficult, CL GRADE: I II III

SPECIAL INTUBATING AIDS: Video-Laryngoscope / FOB / Stilette / Bougie PLANNED / RESCUE

ETT: Regular / Reinforced / DLT - Lt / Rt / RAE / Double cuffed / Laser SIZE:

PLMA / ILMA / I-Gel: Size Difficulty in Insertion: Yes / No Planned Insertion / Rescue

NOTES: Ventilatory Settings: Mode: VC / PC / PRVC / SIMV - PS, VT; P.P. / P.Pit: PEEP: RR / MV Low Flows - L/min / Metabolic Flow Gases: O₂ / Air

EPIDURAL / SPINAL / CSEA / LUMBAR DRAIN / PNB USG: Yes / No

Aseptic technique Needle Size / make: DSES: LORA / S / T

Position: Space / Site: Fixed at: N/A

Notes & Unanticipated events, if any:

Medications & Dosages administered & Time: ABG - Time

Drugs: 0.05mg iv, 0.2mg iv, 10mg + 2.5mg iv

MONITORING:

Temp - NP / R / O SPO₂ NI - CO POCT - TEG / ROTEM LABS: o Body warmer

ES 11/12 L CVP Flo Trac / SVV Foleys catheter o Fluid Warmer

NIBP - ABP BIS / Entropy Others o Ryles Tube - O

EtCO₂ PA NMJ Others o Cell salvage

o Rapid infuser

LINES	Size	Site	Site	Size	Site	Size	USG Guided
IV Line 1	22G	R hand	Art line 1		CL - 1		Notes / Signatures
IV Line 2			Art line 2		CL - 2		
IV Line 3					PA		

Patient position: Supine Prone Rt Lat Lt Lat Kidney Lithotomy Sitting O -

Tourniquet Time / Vascular occlusion: Site: Duration:

Pressure points padding: EYES / Superficial Nerves / Soft tissues / Extreme extension

SPECIAL NOTES (CPB / TRANSPLANT) CRITICAL INCIDENTS

PROCEDURE NAME:

M/O Radhoni sirha

CONSENT FOR ANAESTHESIA

MRCP.

(Patient Latent)

I, M/O Radhoni sirha acknowledge, that my doctors, (surgeon & anaesthesiologist) have explained detail about my operation, diagnostic or treatment procedure. My doctor has explained the cost, risks of the procedure, me of alternative and benefits treatments and the risks of not having procedure and told me about the expected outcome what could happen if my condition remains untreated in a **language that I understand.** (Hindi). It has been explained to me that all forms of anaesthesia involve some risks and no guarantees or promises concerning the results of my procedure or treatment. Although rare, unexpected severe complications with anaesthesia occur and include the remote possibility of infection, bleeding, drug reactions, blood clots loss of sensation, loss of function, paralysis, stroke, brain damage, heart attack or death. I understand that these risks apply to all forms of anaesthesia, and that additional or specific risks have been identified below as they may apply to a specific type of anaesthesia. I understand that the type(s) of anaesthesia service checked below will be used for my procedure and that the anaesthetic technique used is determined by many factors including my physical condition, the type of procedure my doctor is to do, his or her experience, as well as my own desire and alternate techniques. It has been explained to me that sometimes an anaesthesia which involves the use of local anaesthetics, with or without sedation, may not succeed completely and therefore another technique may have to be used including general anaesthesia.

Please tick the type of Anaesthesia Planned

☐ General Anaesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe, or other to secure airway.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other route. Examination
	Risks	Possibility of mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anaesthesia, injury to blood vessels, aspiration, pneumonia, vomiting.
☐ Spinal or Epidural Analgesia / Anaesthesia	Expected Result	Temporary decrease or loss of feeling and/or movement to lower part of the body (unilateral/ bilateral)
☐ With Sedation	Technique	Drug injected through a needle/ catheter placed either directly into the spinal canal immediately outside the spinal canal (epidural space).
☐ Without Sedation	Risks	Possibility of headache, backache, buzzing in the ears, convulsions infection, per weakness, numbness, residual pain, injury to blood vessels, arrhythmias.
☐ Major/Minor Nerve Block	Expected Result	Temporary loss of feeling and/ or movement of a specific limb or area
☐ With Sedation	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
☐ Without Sedation	Risks	Infection, swelling, persistent numbness, fits, residual pain, injury to blood vessels, lung injury / collapse, allergic reaction.
☐ Intravenous Regional Anaesthesia	Expected Result	Temporary loss of feeling and/or movement of a limb
☐ With Sedation	Technique	Drug injected into vein of arm or leg while using a tourniquet
☐ Without Sedation	Risks	Infection, fits, weakness, persistent numbness, residual pain, injury to blood vessels, allergic reaction, anaphylaxis, arrhythmias
☒ Monitored Anaesthesia Care (with sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes to a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
☐ Monitored Anaesthesia Care (without sedation)	Expected Result	Measurement of vital signs, availability of anaesthesia provider for further intervention
	Technique	None
	Risks	Increased awareness, anxiety and/ or discomfort
☐ Invasive Monitoring Internal jugular vein/Subclavian vein/Arterial	Risks	Infections, chest drain placement, ischemia of extremities

I hereby consent to the anaesthesia service checked above and authorize that it be administered by anaesthetist Dr. Roohi or his/her associates: Team

I also consent to an alternative type of anesthesia, if necessary as deemed appropriate by them.

I have also been expected about the post operative pain management and others techniques for pain control.

Fitness for surgery: Can be posted / Needs further evaluation & Review / Combined counseling - Anaesthesia-
Surgery team with Patient- Family

ASA Grade: I II III IV V VI E

P-POSUM / Others:

DVT Risk: Mild / Moderate / High

MELD Score:

APACHE II / SOFA:

Discussion of Risk - Benefits:

PONV:

☐ Dental damage ☐ Arterial / CVC☐ Transfusion

ANAESTHESIA PLAN - Pro-con / Alternate methods discussed: Yes / No

GA: ETT / LMA / DLT / Tracheostomy / TIVA / Mask

CNB: SAB / CSEA / CSA / EA

PNBs:

LA / MAC

Combined Techniques:

Post op Analgesia plan: CIVI / PC-IVA / PCEA - PIEB / CEI / Nerve Blocks

BLOOD REQUIREMENTS: PABD / ANH MABL

Component

Reserve

PRBCs - Leucodepleted /
Washed / Regular

FFP

Platelets

Cryo

Factor VIIa / VIII / Prothrombin
Complex Conc. / Fibrinogen Conc.

NUTRITIONAL STATUS: Normal / GLIM criteria

Pre-op Investigations / Cross consults / Adv.:

Review Pt. provisionally fit for procedure.
operation

Hemang
Anaesthetist Sign:
Date & Time: 14/12/26

Post Review Fitness for Surgery: Can be Posted / Needs Further Stabilization / evaluation / Defer Surgery / Combined Counseling

Preoperative instructions:

NPO from: Adult: 6 Hrs for Solids & milk, 4 Hrs - clear liquids Carbohydrate drink

Pre-medication: Tab. Pantaprazole 40mg + Metaclopramide 10mg;
12 & 2 hrs before surgery

DVT Prophylaxis: TED / SCD / LMWH - Time:

Medications to be continued: Thyroid / Epilepsy / BP / Cardiac / Steroids

PPPC Protocol: Spirometry / Nebulization / Physiotherapy consult

Medications to be stopped: ADA / Insulin / Antiplatelets / ACIEs / ARBs / Others:

SSI prophylaxis within 2 hrs before Surgery:

REVIEW PAC - Date:

Time

Anaesthetists Sign

Date & Time

Name : Mast RUDRANIL SINHA
UHID : AIGG.21269198
Gender/Age : M/2 y
Ref. Phys. : Arif khan
Procedure Name : USG ABDOMEN PELVIS

Accession No : 10.7348504.34042
Bill Date : 20-Aug-2026 18:26
Reporting Date : 21/08/2026 9:25AM
Modality :US

ULTRASOUND OF ABDOMEN & PELVIS

LIVER: Measures 16 cm, enlarged in size and shows normal echotexture with smooth contour. Intrahepatic biliary and vascular radicles are normal. Large heterogeneous hyperechoic lesion with few areas of necrosis within measuring ~11.5 x 10.5 cm noted in right lobe of liver.

PORTAL VEIN: Appears encased by the lesion.

CBD: Not visualized.

GALLBLADDER: Well distended. No evidence of wall thickening / calculi.

SPLEEN: Measures 6.8 cm, normal in size with normal echotexture.

PANCREAS: Visualized pancreas appears normal in size and echotexture. No calcifications / calculi. No peripancreatic fluid collection.

No ductal dilatation. No

KIDNEYS: Normal in size, shape with smooth contours. Parenchymal echotexture normal. Corticomedullary differentiation well maintained. No calculi / hydronephrosis. Right kidney measures 73 x 27 mm. Left kidney measures 73 x 31 mm.

URINARY BLADDER: Well distended. No evidence of wall thickening / calculus.

PROSTATE: Normal for age.

Mild free fluid in abdomen.

IMPRESSION: In a k/c/o Hepatoblastoma, present scan shows:

- ☐ Hepatomegaly with large heterogeneous hyperechoic lesion with few areas of necrosis within in right lobe.
- ☐ Mild ascites.

For clinical correlation.
sai

This examination and reported findings have been reviewed and confirmed.

Approved by:



Dr. Uday Krishna

Senior Consultant

*****End Of Report*****

Name	: Mast RUDRANIL SINHA	Accession No	: 10.7209527.33462
UHID	: AIGG.21269198	Bill Date	: 04-Aug-2026 14:45
Gender/Age	: M/2 y	Reporting Date	: 06/08/2026 4:27PM
Ref. Phys.	: Arif khan	Modality	:PT
Procedure Name	: PET CT WHOLE BODY WITH CONTRAST		

NUCLEAR MEDICINE DEPARTMENT

Whole Body PET-CT Scan

Clinical Diagnosis: History of liver lesions. PET-CT for evaluation.

Technique: Whole body PET images were acquired from vertex to mid-thigh using a dedicated PET-CT scanner after intravenous administration of ~ 3.2 mCi of 18F-FDG. Reported fasting blood sugar level at the time of administration was within acceptable limits. Data was reconstructed with CT based attenuation correction in to axial, sagittal and coronal PET sections and interpreted after fusion with triphasic contrast enhanced CT images. FDG uptake is semi quantitatively assessed as SUV max.

Findings:

BRAIN:

- Brain parenchyma appears normal in attenuation.
- No supra / infratentorial focal / diffuse lesion is noted.
- Physiological FDG uptake is noted in the entire brain parenchyma.

NECK:

- Symmetrically increased FDG uptake (SUV max: 3.7) noted in bilateral palatine tonsils - ? Inflammatory.
- Faintly FDG avid bilateral cervical level III lymph nodes noted, largest measuring ~0.5x1.1 cm - ? Inflammatory.
- The upper aero-digestive tract and PNS appears normal.
- Thyroid appears normal with physiological FDG uptake.
- No other significant metabolically active cervical lymphadenopathy is noted.

CHEST:

- Mild right pleural effusion noted with passive collapse of underlying lung parenchyma.
 - Fibrotic changes noted in upper lobe right lung.
-

Name	: Mast RUDRANIL SINHA	Accession No	: 10.7209527.33462
UHID	: AIGG.21269198	Bill Date	: 04-Aug-2026 14:45
Gender/Age	: M/2 y	Reporting Date	: 06/08/2026 4:27PM
Ref. Phys.	: Arif khan	Modality	:PT
Procedure Name	: PET CT WHOLE BODY WITH CONTRAST		

-
- Rest of the bilateral lung parenchyma appears normal in attenuation.
 - Heart and the great vessels appear normal.
 - No significant metabolically active mediastinal / axillary lymphadenopathy is noted.
 - No pericardial effusion seen.

ABDOMEN AND PELVIS:

- FDGavidlargeheterogeneouslyenhancinglesionnotedinvolvingsegmentV,VI,VII,VIII & caudate lobe of liver, showing necrotic areas within, measuring ~ 12.2 x 10.8 x 13.9 cm (SUV max: 6.9). It is causing splaying RPV, RHV & MHV with significant attenuation of RHV and MHV. It is closely abutting and indenting the right hemidiaphragm.
- Also noted multiple FDGavid hypoenhancing lesions in segment VIII/IVa of liver, largest measuring ~ 1.5 x 1.3 cm (SUV max: 7.1).
- Rest of the liver shows physiological FDG uptake.
- Minimal perihepatic free fluid noted.
- Mild bilobar IHBRD noted.
- Faintly FDGavid enhancing mesenteric lymph nodes noted, largest measuring ~ 0.9 x 0.6 cm - ? Nonspecific.
- Spleen, pancreas, bilateral kidneys and adrenals appear normal in attenuation with physiological FDG uptake.
- Rest of the visceral structures appear normal in attenuation with physiological FDG uptake.
- No other significant metabolically active abdominopelvic lymphadenopathy noted.

BONES:

- Diffuse FDG avidity noted in marrow of axial and appendicular skeleton – Reactive.
- Rest of the visualized bones appear normal in attenuation and alignment.

Normal physiological ¹⁸F-FDG tracer uptake is seen in rest of the visualized organs.

Name	: Mast RUDRANIL SINHA	Accession No	: 10.7209527.33462
UHID	: AIGG.21269198	Bill Date	: 04-Aug-2026 14:45
Gender/Age	: M/2 y	Reporting Date	: 06/08/2026 4:27PM
Ref. Phys.	: Arif khan	Modality	:PT
Procedure Name	: PET CT WHOLE BODY WITH CONTRAST		

IMPRESSION:

In a given clinical scenario, the present PET-CT scan findings reveal:

- ☐ FDG avid large heterogeneously enhancing lesion involving segment V, VI, VII, VIII & caudate lobe of liver, showing necrotic areas within, causing splaying RPV, RHV & MHV with significant attenuation of RHV and MHV as described - ? Hepatoblastoma. Suggested AFP & HPE correlation.
- ☐ FDG avid multiple hypoenhancing lesions in segment VIII/ IVa of liver as described - ? Satellite lesions.
- ☐ No other significant metabolically active lesion noted in the rest of the scanned segment of body.

Kindly correlate.

This examination and reported findings have been reviewed and confirmed.

Approved by:



Dr. DAVID JAYA PRAKASH
MBBS, MD (SGPGI, Lucknow)
Junior Consultant

*****End Of Report*****

Name : Mast RUDRANIL SINHA
UHID : AIGG.21269198
Gender/Age : M/2 y
Ref. Phys. : LIVER TRANSPLANT TEAM
Procedure Name : USG ABDOMEN

Accession No : 10.7384911.34041
Bill Date : 25-Aug-2026 12:45
Reporting Date : 25/08/2026 1:43PM
Modality :US

ULTRASOUND ABDOMEN

CLINICAL DETAILS: Follow up case of hepatoblastoma in liver.

LIVER: Enlarged in size (11 mm) and shows normal echotexture with smooth contour. Intrahepatic biliary and vascular radicles are normal. Few heterogeneous lesions with few cystic areas within noted in right lobe of liver largest measuring 12x10.6 cm.
PORTALVEIN: Normal.

GALLBLADDER: Not visualized.

SPLEEN: Measures 72 mm, enlarged in size with normal echopattern.

PANCREAS: Poor window.

KIDNEYS: Normal in size, shape with smooth contours. Parenchymal echotexture normal.
Corticomedullary differentiation well maintained. No calculi / calyectases.

URINARY BLADDER: Well distended. No evidence of wall thickening / calculus.
PROSTATE: Normal for age.

No free fluid in abdomen.

IMPRESSION: Follow up case of hepatoblastoma in liver.

- ☐ Hepatomegaly with few heterogeneous lesions and few cystic areas within in right lobe of liver – Consistent with hepatoblastoma. No rupture / free fluid adjacent to the liver or in the pelvis in present scan.
- ☐ Splenomegaly.

Adv: Clinical correlation and further evaluation.

This examination and reported findings have been reviewed and confirmed.

Approved by:



Dr. ROHAN REDDY P

Consultant Radiologist

*****End Of Report*****

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOC260921086**
 Sample No: **AGO1996163A**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **24/08/2026 08:47**
 Collec. Date: **24/08/2026 08:50**
 Ack. Date: **24/08/2026 10:06**
 Report Date: **24/08/2026 13:59**

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

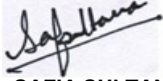
Haematology

Test (Method)	Result	Normal Range	Unit
HEMOGLOBIN (Method:Colorimetric/Spectrophotometry Non-Cyanide Method)	6.7 ▼ (L)	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	2.44 ▼ (L)	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	19.7 ▼ (L)	34.0 - 40.0	%
MCV (Method:DerivedFromRBCHistogram / Numeric Integration)	80.8	75.0 - 87.0	fl
MCH (Method: Calculated)	27.6	24.0 - 30.0	pg
MCHC (Method: Calculated)	34.2	31.0 - 37.0	g/dl
RDW (Method:DerivedFromRBCHistogram / Calculated)	28.2 ▲ (H)	-	%
TOTAL WBC (Method:FlowcytometrySFCUBE / Flowcytometry DHSS and Impedance)	7430	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	33.2	30 - 53	%
LYMPHOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	47.6 ▼ (L)	27 - 57	%
EOSINOPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	0.6 ▼ (L)	2.0 - 7.0	%
MONOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	17.8 ▲ (H)	4.0 - 7.0	%
BASOPHILS (Method:SFCubeMethod / Impedance/Microscopy)	0.8	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	2467	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	3537	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	45 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	1323 ▲ (H)	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	59	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	0.7	-	
PLATELET COUNT (Method:ElectricalImpedance / Impedance)	70 ▼ (L)	200 - 490	10 ³ /mm ³
MPV (Method:DerivedFromPlateletHistogram / Electrical Impedance)	13.5 ▲ (H)	7.4-10.4	fl
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisopoikilocytosis, normocytic hypochromic, microcytes, macrocytes, ovalocytes, tear drop cells, 14-15n RBC/100 WBC		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Within normal limits, reactive lymphocytes		
PLATELETS.. (Method:Microscopy/Leishman stain)	Thrombocytopenia giant platelets		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		
NOTES(CBP)	Platelets count manually checked.		

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts. CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Rajender Reddy Gudi (24-08-2026 13:17)

End of Report

Patient Name: **Mast. Rudranil Sinha**UHID : **AIGG.21269198**Age / Sex: **2 Year(s) / Male**Mobile No: **9002766646**Facility: **AIG Hospitals, Gachibowli**Episode: **OP**Bill No: **AGOCS260921086**Sample No: **AGO1996163A**Ref. Doctor: **Dr. ARIF KHAN**Order Date: **24/08/2026 08:47**Collec. Date: **24/08/2026 08:50**Ack. Date: **24/08/2026 10:06**Report Date: **24/08/2026 13:59****Dr.SAFIA SULTANA****MUSTAFA**

Pathologist, DCP

Dr.ANURADHA SEKARAN

MD,DNB, MNAMS,DipRCPath(UK)

Director of Pathology & Molecular

Pathology

**View Report**

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Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs260822976**
 Sample No: **AGO1944930E**
 Ref. Doctor: **Dr. Dharani Nagoji**

Order Date: **31/07/2026 20:04**
 Collec. Date: **31/07/2026 20:07**
 Ack. Date: **31/07/2026 22:11**
 Report Date: **01/08/2026 20:24**

AFP

Sample Type - Serum

Hormones

Test (Method)	Result	Normal Range	Unit
ALPHA FETOPROTEIN. (Method: ECLIA)	> 1000000 ▲ (H)	0-87	ng/mL

Interpretations: AFP produced by the fetus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Dr. Katamareddy Prathyusha (01-08-2026 10:27)


 Dr.G. DEEPIKA

Director & HOD – Biochemistry MBBS,
 MD

End of Report



View Report

Patient Name: **Mast. Rudranil Sinha**

Episode: **OP**

Order Date: **31/07/2026 20:04**

UHID : **AIGG.21269198**

Bill No: **AGOCs260822976**

Collec. Date: **31/07/2026 20:07**

Age / Sex: **2 Year(s) / Male**

Sample No: **AGO1944930D**

Ack. Date: **31/07/2026 22:11**

Mobile No: **9002766646**

Ref. Doctor: **Dr. Dharani Nagoji**

Report Date: **31/07/2026 23:02**

Facility: **AIG Hospitals, Gachibowli**

LFT (LIVER FUNCTION TEST)

Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
TOTAL BILIRUBIN (Method: DPD)	0.8	0.3 - 1.2	mg/dL
DIRECT BILIRUBIN (Method: DPD)	0.2	0-0.2	mg/dL
INDIRECT BILIRUBIN (Method: Calculated)	0.6	-	mg/dL
S.G.P.T (ALT) (Method: Enzymatic without P5P (Ref IFCC))	27 ▲ (H)	10 - 25	U/L
S.G.O.T (AST) (Method: Enzymatic without P5P (Ref IFCC))	143 ▲ (H)	21 - 44	U/L
ALP (Method: AMP optimised to IFCC)	290	134 - 315	U/L
TOTAL PROTEINS (Method: Biuret)	7.8 ▲ (H)	5.6 - 7.5	g/dl
ALBUMIN(SERUM) (Method: BCG)	4.5	3.8 - 5.4	g/dl
GLOBULIN (Method: Calculated)	3.3	2.3 - 3.5	g/dl
A/G RATIO (Method: Calculated)	1.4	0.9 - 2	

Interpretation: Liver function tests are blood tests used to help diagnose and monitor liver disease or damage. Liver function tests can be used to: Screen for liver infections, such as hepatitis Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working Measure the severity of a disease, particularly scarring of the liver (cirrhosis) Monitor possible side effects of medications.

Report Saved By - V Sekhar (31-07-2026 23:02)


Dr.G. DEEPIKA

Director & HOD – Biochemistry MBBS,
MD

End of Report



View Report

Patient Name: **Mast. Rudranil Sinha**
UHID : **AIGG.21269198**
Age / Sex: **2 Year(s) / Male**
Mobile No: **9002766646**
Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
Bill No: **AGOCs260822976**
Sample No: **AGO1944930C**
Ref. Doctor: **Dr. Dharani Nagoji**

Order Date: **31/07/2026 20:04**
Collec. Date: **31/07/2026 20:07**
Ack. Date: **01/08/2026 01:18**
Report Date: **01/08/2026 06:18**

CRP

Sample Type - Serum

Serology

Test (Method)	Result	Normal Range	Unit
CRP - C Reactive Protein (Method: Sandwich Immunoassay)	67.00 ▲ (H)	Negative <10 mg/L Positive >= 10 mg/L	mg/L

Interpretation:

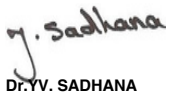
C-reactive protein (CRP) is an acute phase reactant, a protein made by the liver and released into the blood within a few hours after tissue injury, the start of an infection, or other cause of inflammation. Markedly increased levels are observed, for example, after trauma or a heart attack, with active or uncontrolled autoimmune disorders, and with serious bacterial infections like sepsis.

The test measures the amount of CRP in the blood and can be valuable in detecting inflammation due to acute conditions or in monitoring disease activity in chronic conditions.

CRP is detected in pregnant women after the 1st trimester of pregnancy and persists until delivery. Increased levels are also seen in women who are on Oral Contraceptives.

The CRP test is not diagnostic, but it provides information as to whether inflammation is present

Report Saved By - P Siva Nagaraju (01-08-2026 06:18)

**Dr. YV. SADHANA**

Sr.Consultant, Microbiologist
MD,FRCPath(UK)

*****End of Report*******View Report**

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOC260822976**
 Sample No: **AGO1944930A**
 Ref. Doctor: **Dr. Dharani Nagoji**

Order Date: **31/07/2026 20:04**
 Collec. Date: **31/07/2026 20:07**
 Ack. Date: **31/07/2026 23:14**
 Report Date: **31/07/2026 23:43**

PT WITH INR AND APTT

Sample Type - Citrated Plasma

Coagulation

Test (Method)	Result	Normal Range	Unit
PROTHROMBIN TIME (Method: Photometric Clotting Assay)	11.3	10.8 - 13.2	Seconds
MEAN NORMAL PROTHROMBINTIME (Method: Photometric clotting assay)	12.0	-	Seconds
INR	0.94	Normal <1.3 Therapeutic Range 2.0 - 3.5 Critical Alert >4.0	
APTT TEST (Method: Photometric Clotting Assay)	28.8	26.8-41.5	Seconds

Interpretation: Prothrombin time measures the extrinsic coagulation pathway which consists of activated Factor VII (VIIa), tissue factor and proteins of the common pathway (Factors X, V, II & Fibrinogen). Prolonged PT Administration of oral anticoagulant drugs Liver disease, particularly obstructive jaundice Vitamin K deficiency Disseminated intravascular coagulation Inherited deficiency of factors in extrinsic pathway (VII) and common pathway (V, X, prothrombin and fibrinogen) International Normalized Ratio (INR) is used for defining the therapeutic ranges for anticoagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity. Recommended Therapeutic range for Oral Anticoagulant therapy INR 2.0-3.5: Treatment of Venous thrombosis & Pulmonary embolism, Prophylaxis of Venous thrombosis (High risk surgery), Prevention of systemic embolism in tissue heart valves, Atrial fibrillation, Valvular heart disease & Atrial fibrillation, Bileaflet mechanical valve in aortic position
 Note : 1. Results should be clinically correlated

2. Test done on citrated plasma. Comments Partial Thromboplastin Time / Activated Partial Thromboplastin Time (PTT / APTT) measures the activity of intrinsic and common pathway of coagulation, which consists of Factor XII, Prekallikrein, High molecular weight kininogen, Factors VIII, IX & XI. It also measures proteins of the common pathway namely factors II, V, X & Fibrinogen. Abnormal Partial Thromboplastin Time Associated with bleeding: Defects of factors VIII, IX & XI Not associated with bleeding: Defects of factor XII, Prekallikrein, High molecular weight kininogen & Lupus anticoagulants Isolated prolonged APTT Undiagnosed haemophilia, Congenital coagulation disorders Moderately prolonged APTT Patients taking oral anticoagulant drugs, Presence of vitamin K deficiency Prolonged PTT/APTT Disseminated intravascular coagulation, Liver disease, Massive transfusion with plasma depleted red blood cells, Administration or contamination with heparin or other anticoagulants, A circulating anticoagulant including lupus anticoagulant, Deficiency of a coagulation factor other than factor VII
 Note : 1. Results should be clinically correlated
 2. Test done on citrated plasma.

Report Saved By - Rajesh Kumar (31-07-2026 23:43)

End of Report

Dr. MD Shareef Ahmed
 MBBS, MD Pathology

Dr. ANURADHA SEKARAN
 MD, DNB, MNAMS, Dip RCP (UK)
 Director of Pathology & Molecular Pathology



View Report

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCS260837549**
 Sample No: **AGO1952437A**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **04/08/2026 14:45**
 Collec. Date: **04/08/2026 14:48**
 Ack. Date: **04/08/2026 16:21**
 Report Date: **04/08/2026 17:29**

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
BLOOD UREA (Method: UREASE KINETIC)	22	11 - 39	mg/dL
SERUM CREATININE (Method: Kinetic Jaffe's - IDMS Traceable)	0.48	0.260 - 0.770	mg/dL
SODIUM (Method: ISE INDIRECT)	141	138 - 145	mEq/L
POTASSIUM (Method: ISE INDIRECT)	5.5 ▲ (H)	3.400 - 4.700	mEq/L
CHLORIDE (Method: ISE INDIRECT)	104	98 - 107	mEq/L

Interpretations: Aids in diagnosis and management of conditions affecting kidney function. Useful for general health screening, screening patients at risk of developing kidney disease, management of patients with known kidney disease.

Report Saved By - Connectree (04-08-2026 17:25)

End of Report

M. Srihita
Dr. Mahavadi Srihita
 MBBS, MD (Biochem), Consultant
 Biochemistry

Dr. G. DEEPIKA
 Director & HOD - Biochemistry MBBS,
 MD



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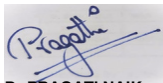
Patient Name: **Mast. Rudranil Sinha**Episode: **IP**Order Date: **07/08/2026 13:15**UHID : **AIGG.21269198**IP / Bed: **5036056 / SW408**Collec. Date: **07/08/2026 13:15**Age / Sex: **2 Year(s) / Male**Sample No: **AGI1959722A**Ack. Date: **07/08/2026 14:55**Mobile No: **9002766646**Ref. Doctor: **Dr. ARIF KHAN**Report Date: **07/08/2026 16:06**Facility: **AIG Hospitals, Gachibowli****BLOOD GROUPING AND RH TYPING**

Sample Type - EDTA Whole Blood

Blood Bank

Test (Method)	Result	Normal Range	Unit
ABO GROUP	O	-	
RH TYPING	POSITIVE	-	
INTERPRETATION (Method: (Method: Forward And Reverse grouping done by column agglutination Technique (CAT)))	O POSITIVE	-	

Report Saved By - Merati Ravi (07-08-2026 16:06)

**Dr. PRAGATI NAIK**

MD Transfusion Medicine, Director &

HOD Department of Transfusion

Medicine

*****End of Report*******View Report**

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs260911267**
 Sample No: **AGO1989696B**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **20/08/2026 18:26**
 Collec. Date: **20/08/2026 18:32**
 Ack. Date: **20/08/2026 20:20**
 Report Date: **20/08/2026 23:35**

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
BLOOD UREA , Serum (Method: UREASE KINETIC)	38	11 - 39	mg/dL
SERUM CREATININE, Serum (Method: Kinetic Jaffe's - IDMS Traceable)	0.47	0.26 - 0.77	mg/dL
SODIUM , Serum (Method: ISE INDIRECT)	132 ▼ (L)	138 - 145	mEq/L
POTASSIUM , Serum (Method: ISE INDIRECT)	4.0	3.4 - 4.7	mEq/L
CHLORIDE , Serum (Method: ISE INDIRECT)	98	98 - 107	mEq/L

Interpretations: Aids in diagnosis and management of conditions affecting kidney function. Useful for general health screening, screening patients at risk of developing kidney disease, management of patients with known kidney disease.

Report Saved By - Tharala Naresh (20-08-2026 23:35)



Dr. G. DEEPIKA

Director & HOD – Biochemistry MBBS,
 MD

End of Report



View Report

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs260921086**
 Sample No: **AGO1996163B**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **24/08/2026 08:47**
 Collec. Date: **24/08/2026 08:50**
 Ack. Date: **24/08/2026 09:58**
 Report Date: **24/08/2026 15:54**

AFP Sample Type - Serum

Hormones

Test (Method)	Result	Normal Range	Unit
ALPHA FETOPROTEIN. (Method: ECLIA)	932000 ▲ (H)	0-87	ng/mL

Interpretations: AFP produced by the fetus is secreted into the fetal serum, reaches a peak at 13 weeks of gestation. Elevated maternal serum AFP levels may indicate open NTD, but are not used to diagnose the defect without additional testing. Elevated maternal serum AFP levels may indicate other forms of fetal distress or malformation, which includes placental malformation, ventral wall defects, fetal kidney function, and fetal death. AFP levels are increased in ataxia telangiectasia, Hereditary tyrosinemia, Primary hepatocellular carcinoma, Teratocarcinoma, Gastrointestinal tract cancers with and without liver metastases.

Report Saved By - Jupalle Balanjaneyulu (24-08-2026 15:53)



Dr. G. DEEPIKA
 Director & HOD – Biochemistry MBBS,
 MD

End of Report



View Report

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOC260921086**
 Sample No: **AGO1996163A**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **24/08/2026 08:47**
 Collec. Date: **24/08/2026 08:50**
 Ack. Date: **24/08/2026 10:06**
 Report Date: **24/08/2026 13:59**

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

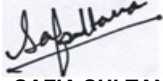
Haematology

Test (Method)	Result	Normal Range	Unit
HEMOGLOBIN (Method:Colorimetric/Spectrophotometry Non-Cyanide Method)	6.7 ▼ (L)	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	2.44 ▼ (L)	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	19.7 ▼ (L)	34.0 - 40.0	%
MCV (Method:DerivedFromRBCHistogram / Numeric Integration)	80.8	75.0 - 87.0	fl
MCH (Method: Calculated)	27.6	24.0 - 30.0	pg
MCHC (Method: Calculated)	34.2	31.0 - 37.0	g/dl
RDW (Method:DerivedFromRBCHistogram / Calculated)	28.2 ▲ (H)	-	%
TOTAL WBC (Method:FlowcytometrySFCUBE / Flowcytometry DHSS and Impedance)	7430	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	33.2	30 - 53	%
LYMPHOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	47.6 ▼ (L)	27 - 57	%
EOSINOPHILS (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	0.6 ▼ (L)	2.0 - 7.0	%
MONOCYTES (Method:SFCubeMethod / Flowcytometry DHSS / Microscopy)	17.8 ▲ (H)	4.0 - 7.0	%
BASOPHILS (Method:SFCubeMethod / Impedance/Microscopy)	0.8	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	2467	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	3537	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	45 ▼ (L)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	1323 ▲ (H)	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	59	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	0.7	-	
PLATELET COUNT (Method:ElectricalImpedance / Impedance)	70 ▼ (L)	200 - 490	10 ³ /mm ³
MPV (Method:DerivedFromPlateletHistogram / Electrical Impedance)	13.5 ▲ (H)	7.4-10.4	fl
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisopoikilocytosis, normocytic hypochromic, microcytes, macrocytes, ovalocytes, tear drop cells, 14-15n RBC/100 WBC		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Within normal limits, reactive lymphocytes		
PLATELETS.. (Method:Microscopy/Leishman stain)	Thrombocytopenia giant platelets		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		
NOTES(CBP)	Platelets count manually checked.		

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts. CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Rajender Reddy Gudi (24-08-2026 13:17)

End of Report

Patient Name: **Mast. Rudranil Sinha**UHID : **AIGG.21269198**Age / Sex: **2 Year(s) / Male**Mobile No: **9002766646**Facility: **AIG Hospitals, Gachibowli**Episode: **OP**Bill No: **AGOCS260921086**Sample No: **AGO1996163A**Ref. Doctor: **Dr. ARIF KHAN**Order Date: **24/08/2026 08:47**Collec. Date: **24/08/2026 08:50**Ack. Date: **24/08/2026 10:06**Report Date: **24/08/2026 13:59****Dr.SAFIA SULTANA****MUSTAFA**

Pathologist, DCP

Dr.ANURADHA SEKARAN

MD,DNB, MNAMS,DipRCPath(UK)

Director of Pathology & Molecular

Pathology

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Discharge Summary



Patient Name : Mast. RUDRANIL SINHA
Age/Sex : 2 Year(s) 4 Month(s) /Male

UHID : AIGG.21269198
Admit Dt : 29/08/2026 08:54 AM

Discharge Date : 31/08/2026 09:50 AM

Doctor Name : Dr. Arif Khan (Medical Oncology)

SUMMARY OF HOSPITAL COURSE:
 NOW ADMITTED IN DAY CARE CHEMOTHERAPY CYCLE 2 AS PER PROTOCOL (SUPERPLADO -CARBOPLATIN + DOXORUBICIN)

PREMEDICATIONS:

INJ. FOSARAN 10 MG (DAY 1)
 INJ. GRANISETRON 0.5 MG (DAY 1 AND DAY 2)
 INJ. DEXA 2 MG (DAY 1 AND DAY 2)
 INJ. PANTOP 10 MG (DAY 1 AND DAY 2)

CHEMO MEDICATIONS:

INJ. CARBOPLATIN 100MG (DAY 1)
 INJ. DOXORUBICIN 5MG (DAY 1 TO DAY 2)

DISCHARGE MEDICATION:

S.NO	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	RELATION TO FOOD	INDICATION
1	TAB. PAN	10 MG	ORALLY	1-0-0	4 DAYS	BEFORE FOOD	
2	TAB. ONDENSETRON	2MG	ORALLY	1-0-1	4 DAYS	BEFORE FOOD	
3	TAB. DEXA	0.5MG	ORALLY	1-0-1	4 DAYS	AFTER FOOD	
4	INJ. FILGRASTIM	50 MCG	SUBCUTANEOUS	1-0-0	5 DAYS		TO BE TAKEN ON 31/08/2026 TO 04/09/2026

RECOMMENDATIONS AT DISCHARGE:

REVIEW ON 18.09.2026 WITH CBP, RFT, LFT AND AFP REPORTS BEFORE 3 PM IN DR. OPD
 READMIT ON 19.09.2026 BY 9 AM IN CHEMOTHERAPY DAYCARE FOR NEXT CYCLE

NOTE: WANTS TO CONTINUE FURTHER CHEMO @ LOCAL PLACE

URGENT CARE:

In case of severe abdominal pain, vomiting blood or coffee-ground-like material, black or tarry stools, right red blood in stool, dizziness, fainting, rapid heartbeat, weakness, fatigue, please visit emergency department in ground floor.

For appointment/ other details contact 040-4244 4222.

For Ambulance contact: 040-4244 4244

For Emergency queries contact. 040-2000 0000

Post discharge follow-up contact: +91 6309031876 (From 9am to 5pm)

For pending reports contact: +91 6309599987, Email. ipreports@aighospitals.com

Verified By:

DR. ARIF KHAN



Discharge Summary

Patient Name : Mast. RUDRANIL SINHA
Age/Sex : 2 Year(s) 5 Month(s) /Male
Discharge Date : 19/09/2026 02:55 PM
Doctor Name : Dr. Arif Khan (Medical Oncology)
Ward/Bed : A- 2-Chemotherapy/Specialty Ward 5 Sw504
UHID : AIGG.21269198
Admit Dt : 19/09/2026 09:06 AM
Company : IP No : 5040598

SUMMARY OF HOSPITAL COURSE:
NOW ADMITTED IN DAY CARE CHEMOTHERAPY CYCLE 3 AS PER PROTOCOL (SUPERPLADO -CISPLATIN)

PREMEDICATIONS:
 INJ. PAN 10MG
 INJ. GRANISETRON 0.5 MG
 INJ. DEXA 2 MG
 HYDRATION

CHEMO MEDICATIONS:
 INJ. CISPLATIN 18MG

HYDRATION

DISCHARGE MEDICATION:

S.NO	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	RELATION TO FOOD	INDICATION
1	TAB. PAN	10 MG	ORALLY	1-0-0	4 DAYS	BEFORE FOOD	
2	TAB. ONDENSETRON	2.5MG	ORALLY	1-0-1	4 DAYS	BEFORE FOOD	
3	TAB. DEXA	0.5MG	ORALLY	1-0-1	4 DAYS	AFTER FOOD	

RECOMMENDATIONS AT DISCHARGE:
 REVIEW ON 28.09.2026 WITH CBP, RFT REPORTS FOR MID CYCLE EVALUATION BEFORE 3 PM IN DR. OPD.

NOTE: WANTS TO CONTINUE FURTHER CHEMO @ LOCAL PLACE

*Tas ondem MD 4mg
1/2 tab BD*

URGENT CARE:

In case of severe abdominal pain, vomiting blood or coffee-ground-like material, black or tarry stools, right red blood in stool, dizziness, fainting, rapid heartbeat, weakness, fatigue, please visit emergency department in ground floor.

For appointment/ other details contact 040-4244 4222.

For Ambulance contact: 040-4244 4244

For Emergency queries contact. 040-2000 0000

Post discharge follow-up contact: +91 6309031876 (From 9am to 5pm)

For pending reports contact: +91 6309599987, Email. ipreports@aighospitals.com

Verified By

Dr. ARIF KHAN



UHID	AIGG.21269198	Patient Name	Mast. RUDRANIL SINHA
Doctor Name	Dr. ARIF KHAN	Age / Gender	2 Years / Male
Visit Date	28/09/2026 03:33 PM		

S. No	Name	Frequency	Route	Duration	Start Date	Instructions
1	CROCIN DS 240MG/5ML 60ML SYP (PARACETAMOL(240MG/5ML))	When Necessary Dose: 1	Oral	1 day	04/08/26	3.5ML / SOS for fever, can be given 4 times a day

Review/Admission:

Review

~~19 Oct 2026~~

Tentative Date

~~19 Oct 2026~~

Remarks

CBC RFT LFT

DR ARIF KHAN MOHAMMED

MBBS | Senior Consultant
MEDICAL ONCOLOGY

CHEMOTHERAPY CARE PATHWAY

Date: 9.10.26

Time: _____

Primary Diagnosis: Hepato Bl carcinoma

Comorbidities if any : _____

Current cycle of chemotherapy : _____

Date: 9.10.26

Laboratory values:

Hb	<u>11.1</u>	Creatinine	<u>0.43</u>
WBC	<u>14630</u>	Bilirubin	<u>0.6</u>
Platelets	<u>3.45</u>	RBS	
Neutrophils	<u>N-3292</u>	Others	

Presenting complaints of: nil

Any toxicities noted in previous cycle : nil
Pre-chemo physician checklist:

Any Drug allergy

☐ Yes

☒ No

Diagnosis confirmed

☒ Yes

☐ No

Imaging done

☒ Yes

☐ No

Tumour Board at Baseline

☒ Yes

☐ No

2D ECHO

Date: NR

EF: _____

Comments: _____

Chemo Protocol written

☒ Yes

☐ No

Dose modification

☐ Yes Remarks if any _____

☒ No

CONSENT

☒ Yes

☐ No

Eastern Cooperative Oncology Group (ECOG) performance status

- 0 Fully active; no performance restrictions.
- 1 Strenuous physical activity restricted; fully ambulatory and able to carry out light work.
- 2 Capable of all self-care but unable to carry out any work activities. Up and about >50% of waking hours.
- 3 Capable of only limited self-care; confined to bed or chair >50% of waking hours.
- 4 Completely disabled; cannot carry out any self-care; totally confined to bed or chair.

Vitals: Time

PR -

BP -

RR -

Temp -

SPO2 -

Anthropometry:

Height - cms

Weight - Kgs

BSA - /m2

Admission criteria

☒ Anti-neoplastic therapy

☐ Blood transfusion

☐ Supportive care

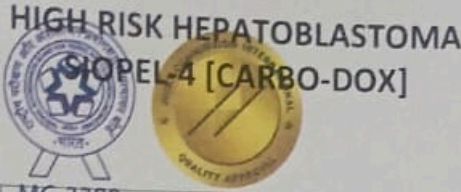
Fit for Anti-Neoplastic therapy

☒ Yes

☐ No

Doctors signature NR

Date & time: 9.10.26



Dr. Arif Mohammed Khan
 MD (Medicine), DM (Oncology), FHM Mumbai
 Senior Consultant Medical & Hemato Oncologist
 Bone Marrow Transplant Physician
 Reg No: DMC/28455

Mr. Rudenil S. K.

MC-3380
Age:

Gender:

Regimen:	Diagnosis & risk:	PreTEXT:
Intent:	Cycle No:	Frequency:
Height: Cm	Emetogenic Risk:	Neutropenic Risk:
Weight: Kg	BSA: Per m2	

PREMEDICATION BEFORE CHEMOTHERAPY

DRUG	DOSE	ADMINISTRATION	DATE & DAY	START TIME	END TIME	NURSE-1	NURSE-2
INJ. GRANISETRON (0.04 MG/KG)	0.5 MG	IN 100 ML OF NS OVER 30 MINUTES	D1				
INJ. PANTOPRAZOLE (1 MG/KG)	10 MG		D2				
INJ. DEXAMETHASONE (10 MG/M ²)	2 MG						

CHEMOTHERAPY

DRUG	DOSE	ADMINISTRATION	DATE & DAY	START TIME	END TIME	NURSE-1	NURSE-2
INJ. CARBOPLATIN (500 MG/M ²)	100 mg	IN 100 ML OF 5% D IV OVER 1 HOUR	D1				
INJ. DOXORUBICIN (20 MG/M ²)	5 mg	IN 100 ML OF NS IV OVER 3 HOURS	D1				
			D2				

INJ. G-CSF 50 mcg SUBCUTANEOUS STAT ON DAY 2 (AFTER CHEMOTHERAPY)

Consultant Sign:

Date & Time: 9.10.20

Clinical Pharmacist Sign:

Date & Time:

Nurse Sign:

Date & Time:

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs261125909**
 Sample No: **AGO2103062B**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **09/10/2026 08:23**
 Collec. Date: **09/10/2026 08:27**
 Ack. Date: **09/10/2026 10:54**
 Report Date: **09/10/2026 15:43**

RFT-RENAL FUNCTION TESTS (UREA, CREAT, ELECT) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
BLOOD UREA , Serum (Method: UREASE KINETIC)	25	11 - 39	mg/dL
SERUM CREATININE, Serum (Method: Kinetic Jaffe's - IDMS Traceable)	0.43	0.26 - 0.77	mg/dL
SODIUM , Serum (Method: ISE INDIRECT)	135 ▼ (L)	138 - 145	mEq/L
POTASSIUM , Serum (Method: ISE INDIRECT)	4.6	3.4 - 4.7	mEq/L
CHLORIDE , Serum (Method: ISE INDIRECT)	100	98 - 107	mEq/L

Interpretations: Aids in diagnosis and management of conditions affecting kidney function. Useful for general health screening, screening patients at risk of developing kidney disease, management of patients with known kidney disease.

Report Saved By - Mohammad Maheboob (09-10-2026 15:43)



Dr. G. DEEPIKA
 Director & HOD – Biochemistry MBBS,
 MD

End of Report



View Report

Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs261125909**
 Sample No: **AGO2103062A**
 Ref. Doctor: **Dr. ARIF KHAN**

Order Date: **09/10/2026 08:23**
 Collec. Date: **09/10/2026 08:27**
 Ack. Date: **09/10/2026 10:44**
 Report Date: **09/10/2026 15:45**

CBP (COMPLETE BLOOD PICTURE)

Sample Type - EDTA Whole Blood

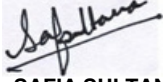
Haematology

Test (Method)	Result	Normal Range	Unit
HEMOGLOBIN (Method: Colorimetric / Spectrophotometry Non-Cyanide Method)	11.1	11.0 - 14.0	g/dl
RBC (Method: Electrical Impedance / Impedance)	4.69	4.0 - 5.2	cells/cumm
PCV (Method: Calculated)	35.0	34.0 - 40.0	%
MCV (Method: Derived From RBC Histogram / Numeric Integration)	74.6	75.0 - 87.0	fl
MCH (Method: Calculated)	23.6 $\downarrow$ (L)	24.0 - 30.0	pg
MCHC (Method: Calculated)	31.6 $\downarrow$ (L)	31.0 - 37.0	g/dl
RDW (Method: Derived From RBC Histogram / Calculated)	20.8 $\uparrow$ (H)	-	%
TOTAL WBC (Method: Flowcytometry SF CUBE / Flowcytometry DHSS and Impedance)	14630	5000 - 15000	cells/cumm
DIFFERENTIAL COUNT			
NEUTROPHILS (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	22.5	30 - 53	%
LYMPHOCYTES (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	57.4 $\downarrow$ (L)	27 - 57	%
EOSINOPHILS (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	8.5 $\uparrow$ (H)	2.0 - 7.0	%
MONOCYTES (Method: SF Cube Method / Flowcytometry DHSS / Microscopy)	11.3 $\uparrow$ (H)	4.0 - 7.0	%
BASOPHILS (Method: SF Cube Method / Impedance/Microscopy)	0.3	0 - 2.0	%
ABSOLUTE LEUCOCYTE COUNT			
ABSOLUTE NEUTROPHIL COUNT. (Method: Calculated / Flowcytometry DHSS)	3292	1500 - 7900	cells/cumm
ABSOLUTE LYMPHOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	8398	1300 - 8500	cells/cumm
ABSOLUTE EOSINOPHIL COUNT (Method: Calculated / Flowcytometry DHSS)	1244 $\uparrow$ (H)	100 - 1000	cells/cumm
ABSOLUTE MONOCYTE COUNT (Method: Calculated / Flowcytometry DHSS)	1653 $\uparrow$ (H)	200 - 1000	cells/cumm
ABSOLUTE BASOPHIL COUNT (Method: Calculated / Impedance)	44	0 - 150	cells/cumm
NEUTROPHIL LYMPHOCYTE RATIO (Method: Calculated)	0.4	-	10 ³ /mm ³
PLATELET COUNT (Method: Electrical Impedance / Impedance)	345	7.4-10.4	fl
MPV (Method: Derived From Platelet Histogram / Electrical Impedance)	11.4 $\uparrow$ (H)		
PERIPHERAL SMEAR (Microscopy)			
RBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Anisocytosis normocytic normochromic to normocytic hypochromic cells		
WBC MORPHOLOGY. (Method: Microscopy/Leishman stain)	Lymphocytosis		
PLATELETS.. (Method: Microscopy/Leishman stain)	Adequate		
ABNORMAL CELLS. (Method: Microscopy/Leishman stain)	Nil		
HEMOPARASITES.. (Method: Microscopy/Leishman stain)	Nil		

Interpretation: A quantitative automated hematology analyser is a screening device used to classify and enumerate the RBC, WBC, Hemoglobin, MCV, MCH, PCV, MPV and Platelet parameters for venous anticoagulated whole blood which are collectively called as complete blood counts. CBP is a screening tool which helps in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders, and infections. This test is also useful in monitoring response to treatment. As results are generated by a fully automated analyser, the differential count is computed from a total of several thousands of cells. The differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

Report Saved By - Siddarth (09-10-2026 15:45)

End of Report

Patient Name: **Mast. Rudranil Sinha**UHID : **AIGG.21269198**Age / Sex: **2 Year(s) / Male**Mobile No: **9002766646**Facility: **AIG Hospitals, Gachibowli**Episode: **OP**Bill No: **AGOCS261125909**Sample No: **AGO2103062A**Ref. Doctor: **Dr. ARIF KHAN**Order Date: **09/10/2026 08:23**Collec. Date: **09/10/2026 08:27**Ack. Date: **09/10/2026 10:44**Report Date: **09/10/2026 15:45****Dr.SAFIA SULTANA****MUSTAFA**

Pathologist, DCP

Dr.ANURADHA SEKARAN

MD,DNB, MNAMS,DipRCPPath(UK)

Director of Pathology & Molecular

Pathology

**View Report**

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Patient Name: **Mast. Rudranil Sinha**
 UHID : **AIGG.21269198**
 Age / Sex: **2 Year(s) / Male**
 Mobile No: **9002766646**
 Facility: **AIG Hospitals, Gachibowli**

Episode: **OP**
 Bill No: **AGOCs261125909**
 Sample No: **AGO2103062B**
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LFT (LIVER FUNCTION TEST) Sample Type - Serum

BIOCHEMISTRY AND THERAPEUTIC DRUG MONITORING

Test (Method)	Result	Normal Range	Unit
TOTAL BILIRUBIN (Method: DPD)	0.6	0.3 - 1.2	mg/dL
DIRECT BILIRUBIN (Method: DPD)	0.1	0-0.2	mg/dL
INDIRECT BILIRUBIN (Method: Calculated)	0.5	-	mg/dL
S.G.P.T (ALT) (Method: Enzymatic without P5P (Ref IFCC))	24	10 - 25	U/L
S.G.O.T (AST) (Method: Enzymatic without P5P (Ref IFCC))	68 ▲ (H)	21 - 44	U/L
ALP (Method: AMP optimised to IFCC)	307	134 - 315	U/L
TOTAL PROTEINS (Method: Biuret)	8.7 ▲ (H)	5.6 - 7.5	g/dl
ALBUMIN(SERUM) (Method: BCG)	4.4	3.8 - 5.4	g/dl
GLOBULIN (Method: Calculated)	4.3 ▲ (H)	2.3 - 3.5	g/dl
A/G RATIO (Method: Calculated)	1.0	0.9 - 2	

Interpretation: Liver function tests are blood tests used to help diagnose and monitor liver disease or damage. Liver function tests can be used to: Screen for liver infections, such as hepatitis Monitor the progression of a disease, such as viral or alcoholic hepatitis, and determine how well a treatment is working Measure the severity of a disease, particularly scarring of the liver (cirrhosis) Monitor possible side effects of medications.

Report Saved By - Mohammad Maheboob (09-10-2026 15:43)


 Dr.G. DEEPIKA

Director & HOD – Biochemistry MBBS,
 MD

End of Report



View Report

Interim Bill



UHID : AIGG.21269198

DC No. : 5042699

Patient Name : Mast. RUDRANIL SINHA
Age/Gender : 2 Year(s) 6 Month(s) 10 Day(s) / Male
Admitted Under Dr. : Dr. ARIF KHAN
Department Name : MEDICAL ONCOLOGY
Date of Admission : 10/10/2026 09:12:26
Date of Discharge : 11/10/2026
Bed No. : SW503 (Day Care)
Address : SANTALDIH, ICHHAR-ICHHAR, RAGHUNATHPUR - II,
 WEST BENGAL, 723145 Raghunathpur-Babugram
 Raghunathpur - II 723133 West Bengal

Patient Category : Cash
Payer : 0

Hospital Pan Card No/Gst No : AABCA7322F /36AABCA7322F1Z1
Mobile No : 9002766646
Patient Pan Card No :

Bed Charges

From Date	Class	Ward	Days	Rate	GST	Total Amount
10/10/2026	Day Care	SW503 / A- 2-CHEMOTHERAPY/SPECIALTY WARD 5	2	1,500.00		3,000.00
Total :						3,000.00

PROCEDURE & THERAPIES

Date	Slip No	ItemCode	Services	Qty	Rate	Total Amount
10/10/2026	0		Chemotherapy (Low Risk)*- (ONCO001)	1	4620	4,620
Total :						4,620

Interim Bill



DC No. : 5042699

UHID : AIGG.21269198

Patient Name : Mast. RUDRANIL SINHA
 Age/Gender : 2 Year(s) 6 Month(s) 10 Day(s) / Male
 Admitted Under Dr. : Dr. ARIF KHAN
 Department Name : MEDICAL ONCOLOGY
 Date of Admission : 10/10/2026 09:12:26
 Date of Discharge : 11/10/2026
 Bed No. : SWS03 (Day Care)
 Address : SANTALDIH, ICHHAR-ICHHAR, RAGHUNATHPUR - II,
 WEST BENGAL, 723145 Raghunathpur-Balogram
 Raghunathpur - II 723133 West Bengal

 Patient Category : Cash
 Payer : 0

 Hospital Pan Card No/Gst No : AABCA7322F /36AABCA7322F1Z1
 Mobile No : 9002766646
 Patient Pan Card No :

Pharmacy Issue

Date	Slip No	Medicine Name	Batch No	Qty	Rate	Total Amt
10/10/2026	AGIPG2437927	ALCOHOL SWABS	26H020247.	3.00	3.00	9.00
10/10/2026	AGIPG2437927	BAND -AID ROUND	08306110M.	1.00	1.87	1.87
10/10/2026	AGIPG2437927	DISPOVAN 50CC SYRINGE LUER LOCK	28504UJR2.	4.00	124.35	497.40
10/10/2026	AGIPG2437927	HALYARD PURPLE NITRILE GLOVES MEDIUM	SM6018ZZZ	12.00	11.34	136.08
10/10/2026	AGIPG2437927	INTRAFOX SAFE SET	26E21K8963	2.00	333.09	666.18
10/10/2026	AGIPG2437927	SYRINGE -10ML -DISPOVAN LUER LOCK	22102UJD2.	6.00	19.95	119.70
10/10/2026	AGIPG2437927	POLYFLUSH PFS 10ML SYRINGE	8509226G	3.00	77.00	231.00
10/10/2026	AGIPG2437927	EEXTRALINE DUO-I.V EXTN LINE	K26F010723	2.00	728.00	1,456.00
10/10/2026	AGIPG2437927	LEUKOMED I.V FILM 7CMX9CM REF:72390-05	53940832.	2.00	241.00	482.00
10/10/2026	AGIPG2437927	VENFLON PRO IV CANNULA 22G	6139942	2.00	318.00	636.00
10/10/2026	AGIPG2437929	IV SETS TRANS FLOW	26C010612.	2.00	246.00	492.00
10/10/2026	AGIPG2437929	NEEDLE DISPOSABLE -16G	30634L.	6.00	5.85	35.10
10/10/2026	AGIPG2437950	D5 DEXTROSE 5% 500ML FREEFLEXBAG FK	2WE706603.	1.00	88.45	88.45
10/10/2026	AGIPG2437950	DEXONA-4MG-INJ	NB00363A	2.00	10.94	21.88
10/10/2026	AGIPG2437950	GRANITERO 3ML INJ	V26DI001	2.00	67.50	135.00
10/10/2026	AGIPG2437950	KEMOCARB 150MG INJ	87260254AB	1.00	1,429.15	1,429.15
10/10/2026	AGIPG2437950	NS 100MLFLEXI DRIP	2261193NG	3.00	44.92	134.76
10/10/2026	AGIPG2437950	PANTOCID -40MG-INJ	NPC00122	2.00	54.24	108.48
10/10/2026	AGIPG2437950	STERILE WATER 10ML	2260014NG	3.00	2.58	7.74
10/10/2026	AGIPG2437957	DOXILYD 10MG INJ	DRI2602AC	2.00	251.60	503.20
11/10/2026	AGIPG2440936	LEUKOMED I.V FILM 7CMX9CM REF:72390-05	53940832.	1.00	241.00	241.00
11/10/2026	AGIPG2440936	VENFLON PRO IV CANNULA 22G	6139942	2.00	318.00	636.00
Total :						8,067.99

Pharmacy-Return

Date	Slip No	Medicine Name	Batch No	Qty	Rate	Total Amt
11/10/2026	3455	DISPOVAN 50CC SYRINGE LUER LOCK	28504UJR2.	-3.00	124.35	-373.05
11/10/2026	3455	SYRINGE -10ML -DISPOVAN LUER LOCK	22102UJD2.	-2.00	19.95	-39.90
Total :						-412.95

Deposit

Date	Slip No	Description	Amount
10-10-2026	AGIDP260102250	OtherPay (OP Deposit Transfer)	5,000.00
Total :			5,000.00

Gross Amount : 15,275.04

Interim Bill



UHID : ATGG.21269198

DC No. : 5042699

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Raghunathpur - II 723133 West Bengal

Patient Category : Cash
Payer : 0

Hospital Pan Card No/Gst No : AABCA7322F /36AABCA7322F1Z1
Mobile No : 9002766646
Patient Pan Card No :

Net Amount : 15,275.00

Deposit / Receipt : 5,000.00

Patient Payable : 10,275.00

Declaration : Any Services not billed by the hospital, I will be liable to pay immediately whenever brought to my notice even after the discharge.

Prepared By : LASKAR SIBIRAL REDDY

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SW
503



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