



MANUSHREE IMAGING CENTRE

Dr. Mayank Ujjaliya
MD Radiodiagnosis

Ex. Consultant Radiologist
Bansal Hospital, Bhopal
Ex. SR. PGIMER Chandigarh
Ex. Consultant Star Hospital, Ahmedabad

| | | | |
|-----------|------------------|----------|-------------------|
| Pt. Name: | MRS. NEVIDA JAIN | Age/Sex: | 35 Years / Female |
| Ref. By: | DR. SAPNA JAIN | Date: | 19/06/2023 |

USG OBSTETRICS NTN/EARLY ANOMALY SCAN

LMP- 15.03.2023 GA LMP- 13w5d.

Findings:

Single intrauterine gestation seen.

Changing lie and presentation.

Placenta -Posterior.

CRL- 68 mm corresponding to 13w1d.

Fetal heart rate 170 b/min.

Internal os is closed.

First trimester anomaly scan

Nasal bone – present

Nuchal translucency (NT) measures – 1.0 mm (normal).

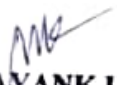
Normal ductus venosus waveform with positive 'a' wave.

Right uterine artery PI-1.27. Left uterine artery PI-2.72. Mean PI-1.99 (83rd centile-normal).

IMPRESSION: Ultrasound findings are suggestive of single live intra-uterine pregnancy. The approximate gestational age is around 13w1d.

EDD by USG-24.12.2023

I, Dr. Mayank Ujjaliya, MD declare that while conducting USG, I have neither declared nor disclosed the sex of her fetus to anybody in any manner.


DR. MAYANK UJJALIYA
MD (MP-16150)

Shop No. 4 CI Square, Kolar Road, Bhopal

Ph.: 0755-3597661, 9303614620



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Timing 9:00 am to 9:00 pm

Test Requisition Form

DIAGNOSTICA SPAN
where quality matters

Executive Name: _____
Signature: _____

Pick-up Date: 20/6/23
Pick-up Time: _____ AM / PM

For Lab use only
Specimen Barcode

Weight - 68

Height - 5.4

DOB - 10/11/1986

PATIENT INFORMATION:

BILL TO:

| | | | |
|--|--|--|--|
| *** PATIENT'S NAME (Block Letters; First Name Mandatory) <u>M S Neri</u> <u>g Jain</u> (First Name) (Middle Name) (Last Name) | | *** Client Code: Name: <u>Dev Pathology</u> Phone No: _____ Email ID: _____ | |
| Patient's Address: _____ Phone No.: _____ Email ID: _____ | | *** Referring Doctor: Doctor's Name: _____ Phone No.: _____ City: _____ Email ID: _____ | |
| *** Date of Birth: <u>35</u> Yrs <u>4</u> Months _____ Days *** Gender: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female Height: _____ cms Weight: _____ kgs | | Specimen Information Date & Time of sample Collection: _____ Time: _____ AM / PM Signature: _____ For Repeat / Add on Test / Follow-up Patient: _____ Old Lab Accession No.: _____ | |
| Test Requirements: Please refer to the Directory of services for correct Test Code *** Test Code: _____ *** Test Name: <u>Double</u> <u>Max 12er</u> | | Essential Clinical Information (Please fill in whatever is relevant) 1) Provisional diagnosis: _____ 2) H/o Medication: _____ (yes / no) if yes, Name & Dose: _____ 3) Status of Medication: Ongoing / Terminated if ongoing, Duration: _____ if terminated, When: _____ 4) LMP (where applicable): _____ 5) Fasting Period: _____ 6) 24 Hour Urine Volume: _____ 7) For Genome studies attach detailed history 8) Attach other relevant information: _____ | |
| *** Temperature Sent Frozen: _____ Refrigerated: _____ Ambient: _____ | | *** Temperature Recd. Frozen: _____ Refrigerated: _____ Ambient: _____ | |
| *** Specimen Type (with Qty) | | | |
| Serum W. Blood ACD W. Blood EDTA W. Blood Flouride Plasma: EDTA/CIT/FL W. Blood Heparin W. Blood Sodium Citrate Slide* Urine (Random/ 1st Morning) Urine (24 Hrs.) Stool (1st/ 2nd/ 3rd) | | Bacter Bottle* Swab* Pus* Body Fluid* BAL CSF Sputum (1st/ 2nd/ 3rd) Tissue* Paraffin Block* Filter Paper Bone Marrow | |
| Any Others* | | Received in Diagnostica Span: Date & Time: _____ Courier Barcode No: _____ No. of Samples received: _____ Any Discrepancy noted (if yes • record details): _____ Initials of Sample Receiving Staff: _____ | |

*Mention Type / Site of Sample Collection

Please Note: After completion of the ordered tests, the remaining sample may be stored and used for research in medical sciences.
 I/ We agree to receive information or to be contacted through mail, telecommunication, electronic & personal means from Diagnostica Span Labs and related group companies, time to time.

I don't agree

Signature / Thumb impression of patient

Signature of Requisitioner

Date:

Date:

*** Mandatory field

IMPORTANT : It is mandatory to provide all the requested information to enable accurate and timely reporting