



**Pragma**

Mother & Child Care Hospital Pvt. Ltd.  
(Ramnagar, Varanasi)

**Pragma**  
**IVF**  
**FERTILITY CENTRE**

02/01/25

मरीज का नाम..... Kavita..... उम्र/लिंग.....

पिता / माता / पति का नाम..... Abhishek.....

पता..... Ahraura, Chunar, M2P.....

9559868132.....

**Dr. Madhukar Pandey**

M.B.B.S., M.D. (Pediatrics) I.M.S., B.H.U.  
Reg. No.: 47311 (UPMC)

**Dr. Pragma Pandey**

M.B.B.S., M.D. (Obstetrics & Gynecology)  
Reg. No.: 59054 (UPMC)

**For Emergency  
& Appointment**

**RAMNAGAR:**  
**0542-2669222**  
**Mob.: 8808541123**

**LANKA:**  
**0542-2367368**  
**Mob.: 8808572123**



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# PRAGYA MOTHER & CHILD CARE IVF CENTER

Sahityanaka More, Ramnagar, Varanasi

PATIENT NAME / AGE Kavita (27y)

HUSBAND NAME / AGE Abhishek (31)

ADDRESS Ahirara, Chunar.

PHONE NO. 9559868132.

HT

WEIGHT

BMI

MARRIED LIFE 1 1/2 years.

OBSTETRIC HISTORY P0+0

MENSTRUAL HISTORY

HSG

A/V, bulley in size  
+ adenomyosis.

ST MEDICAL HISTORY

ST SURGICAL HISTORY

TVS (USG)

PE OF INFERTILITY: Primary.

ROUTINE BLOOD TEST

DATE

BASAL HORMONAL REPORTS

DATE

SAG < H Nf.  
WNL  
H Nf.  
WNL  
ICV < H Nf.  
WNL  
VDRL < H Nf.  
WNL  
BLD GROUP < H  
W B+ve

26/9/24

FSH

LH

E2 379.00

AMH

TSH 3.64

S. PROLACTIN 11.80

27/12/24

26/9/24

2/8/24.

MONTOUX TEST -

SEMEN ALAYSIS -





M PICK UP

ENT NAME & AGE Knvita

TNER NAME & AGE Abhishhek

DRESS Chunar, mzp

PHONE NO. 9559868152.

RE OF INFERTILITY -

RE OF TREATMENT - OPU + ET

SEEN SOURCE — EJACULATED / PESA / TESA / DONEAR

JNT —

MOTALITY —

MULATION PROTOCOL

Gr. Rhlong Protocal / Anta gorist Protocal

TAL GONADOTROPINS USED--

ING FSH

ING HMG

TRIGEER

OF OVUM EXPECTED

RIGHT

LEFT

E<sub>2</sub> on DAY

Of Pickup

RE OF OPU: 5/12/24

NO. OF OOCYTES RETRIVED =

NO. OF OOCYTES FERTILIZED =

3RYO TRANSFER DATE

= 2/12/24

CK ET

POSITION

EASY / DIFFICULT

INTERNAL OS



## EMBRYO TRANSFER DETAILS

PATIENT NAME & AGE Kavita

PARTNER NAME & AGE Abhishek

ADDRESS Ahirara

PHONE NO. 9559868132

EMBRYO TRANSFER DATE - 21/1/25

NO OF EMBRYO TRANSFERRED

CELL STAGE = Blastocyst

GRADE - = 3AA, 4AA

NO. OF EMBRYO CRYO PRESEVED -

CELL STAGE =

GRADE - =

ET PROCEDURE EASY / DIFFICULT

TENACULUM USED / NO

WITH GA / NO

DISTANCE FROM FUNDUS--- CM 1.6 -

ENDOMETRAL THICKNESS--- MM 7.2 mm

POST ET TREATMENT---

UPT/BHCG (DATE) = 14/02/25



भारत सरकार  
Government of India

कुमारी कविता  
Kumari Kavita  
जन्म तिथि / DOB: 04/11/1998  
महिला / Female

9033 7972 1305

आधार - आम आदमी का अधिकार

भारत सरकार  
GOVERNMENT OF INDIA

अभि शेक सिंह  
Abhi Shek Singh  
जन्म तिथि / DOB: 18/07/1993  
पुरुष / MALE

8673 2426 9368

भारतीय विशिष्ट पहचान प्राधिकरण  
Unique Identification Authority of India

पता:  
आत्मजा: राजकुमार सिंह,  
डोहरी(अमरपात),  
पो.ओ. शिवपुर(बबुरी)बहुआर, शिवपुर,  
मिर्जापुर, चुनार, उत्तर प्रदेश,  
231304

Address:  
D/O: Rajkumar Singh,  
dohari(amarpat),  
P.O./shivpur(baburi)bahuar,  
Shivpur, Mirzapur, Chunar, Uttar  
Pradesh, 231304

9033 7972 1305

1847  
1800 300 1947

help@uidai.gov.in

www.uidai.gov.in

भारतीय विशिष्ट पहचान प्राधिकरण  
UNIQUE IDENTIFICATION AUTHORITY OF INDIA

पता:  
आत्मजा: आशाराम सिंह,  
पट्टी कलां, अहरोरा,  
मिर्जापुर,  
उत्तर प्रदेश - 231301

Address:  
S/O: Asharam Singh, patli kalan,  
Ahraura, Mirzapur,  
Uttar Pradesh - 231301

8673 2426 9368

## FORM 6

[See rule 13(f) (i) ]

## Consent Form to be Signed by the Couple or Woman

I/We have requested the clinic Pragya IVF Centre, Ramnagar,  
Kavita, wife of Abhishek (name and address of clinic) to provide us  
 with treatment services to help us bear a child.

We understand and accept (as applicable) that:

1. The drugs that are used to stimulate the ovaries for ovulation induction have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.
2. There is no guarantee that:
  - (i) The oocytes will be retrieved in all cases.
  - (ii) The oocytes will be fertilized.
  - (iii) Even if there were fertilization, the resulting embryos would be of suitable quality to be transferred.

All these unforeseen situations will result in the cancellation of any treatment.
3. I/ We fully consent to these procedures and to the administration of such drugs and anesthetics as may be necessary. We also consent to any other operative measures, which may be found to be necessary in the course of the treatment.
4. I/ We have been told of the risks of ultrasound directed follicle aspiration.
5. I/ We are aware that we are free to withdraw or vary the terms of this consent until the gametes and/ or embryos have been used in accordance with my/ our wishes. I am aware that this will have to be a written request.
6. There is no certainty that a pregnancy will result from these procedures even in cases where good quality embryos are transferred.
7. If a clinical pregnancy does result from assisted conception treatment, I/ we understand there is an accepted risk of multiple pregnancy, an ectopic pregnancy or of a miscarriage. I/ We understand that as in natural conception, there is a small risk of fetal abnormality.
8. Medical and scientific staff can give no assurance that any pregnancy will result in the delivery of a normal living child.
9. The uncertainty of the outcome of the procedure has been fully explained to me/ us.
 

I/ We fully understand the risks of treatment including:

  - (i) it is not possible to guarantee that a follicle will develop in a given cycle and that occasionally cycles have to be abandoned before egg retrieval.
  - (ii) there is a risk that spontaneous ovulation can happen prior to/ or during the egg retrieval.
  - (iii) an egg is not always recovered from a follicle at the time of egg retrieval.
  - (iv) any eggs may be collected and fertilization of any collected eggs will occur
  - (v) is a risk that the cycle will be abandoned before Embryo Transfer if there is failure of fertilization, abnormal fertilization or failure of the embryo to cleave(divide)
  - (vi) a pregnancy may result from treatment.
  - (vii) treatment may be abandoned at any time if there are problems in the laboratory or with the culture system
10. I/ We have been fully informed of all that is involved with the IVF/ICSI technique and have been advised regarding the chances of success, the possibility of multiple pregnancy occurring and other possible complications of treatment by the doctor. I/ We have also received information relating to treatment by these techniques in order to assist us to become more fully aware of what is involved.

*Abhishek Singh*



**Endorsement by the ART clinic**

I/ we have personally explained to \_\_\_\_\_ and \_\_\_\_\_ the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he /she /they understand these details and implications.

This consent would hold good for all the cycles performed at the clinic.

Name and Signature of the couple (husband and wife) or Woman

Name, Address & Signature of the Witness from the Clinic

Name and Signature of the Doctor

Name and Address of the ART Clinic

Dated: .....

**FORM 7**

[See rule 13(f) (ii) ]

**Consent for IVF with Husband's Semen/ Sperm**

Kavita and Abhishek  
Dr. \_\_\_\_\_, being husband and wife and both of legal age, authorize to inseminate the wife intrauterine with the semen / sperm of the husband for achieving conception.

We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

The procedure carried out does not ensure a positive result, nor does it guarantee a mentally and physically normal child. This consent holds good for all the cycles performed at the clinic.

Signature of intending couple

Husband: Abhishek Singh

Wife: Kavita

**Endorsement by the ART Clinic**

I / we have personally explained to ..... and ..... the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

Name, Address and Signature of the Witness from the clinic

Signed: \_\_\_\_\_ (Husband)

\_\_\_\_\_ (Wife)

Name and Signature of the Doctor

Name and Address of the ART clinic

Dated:

**FORM - 8**

[See rule 13 (f) (iii)]

**Consent for Intrauterine Insemination with Donor Semen**

I/We, ..... being of legal age, authorise Dr. .... to inseminate me intrauterine with semen / sperm of a donor Aadhar

no. .... (ART bank's no. ....); obtained from ..... ART bank with valid registration no. ....) for achieving conception.

I/We understand that even though the insemination may be repeated as often as recommended by the doctor, there is no guarantee or assurance that pregnancy or a live birth will result.

I/We have also been told that the outcome of pregnancy may not be the same as those of the general pregnant population, for example in respect of abortion, multiple pregnancies, anomalies or complications of pregnancy or delivery.

I/We declare that we shall not attempt to find out the identity of the donor.

I, the husband, also declare that should my wife bear any child or children as a result of such insemination(s), such child or children shall be as my own and shall be my legal heir(s). (if applicable)

The procedure carried out does not ensure a positive result, nor does it guarantee a mentally and physically normal body. This consent holds good for all the cycles performed at the clinic.

Signature of intending couple/ intending woman

#### Endorsement by the ART clinic

I/we have personally explained to ..... and ..... the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

Name, Address and Signature of  
the Witness from the Clinic

Signed: \_\_\_\_\_ (Husband)

\_\_\_\_\_ (Wife)

Name and Signature of the Doctor

Name and Address of the ART clinic

Dated: .....

**Note:** An appropriate modification of this form may be used for Artificial Insemination or Intrauterine Insemination of a single woman with donor semen.

#### FORM 9

[See rule 13 (f) (iv)]

#### Consent for Freezing of Embryos

I/We, ..... Kavita w/o Abhishek ..... and ..... consent to freezing of the embryos that have resulted out of ART with sperm of ..... & oocyte of ..... I/We understand that the embryos would be normally kept frozen for ..... years. If we wish to extend this period, I/we would let you (the ART clinic) know at least six months ahead of time. If you do not hear from us before that time, you will be free to (a) use them for research purposes; or (b) discard and destroy them off. I/ We also understand that some of the embryos may not survive the subsequent thaw and that frozen embryo-replaced cycles have a lower pregnancy rate than when fresh embryos are transferred.

#### \*Husband

In the unforeseen event of my death, I would like the embryos

To perish

☐

Handed over to my wife

☐

Used for research purposes

☐

Signed:

Abhishek Singh

Dated:



**\*Wife / woman**

In the unforeseen event of my death, I would like the embryos

To perish ☐

To be handed over to my husband / ..... (Specify name and details) ☐

Used for research purposes ☐

Signed: Devi

Dated: \_\_\_\_\_

Name, Address and Signature of the couple/woman

**Endorsement by the ART Clinic**

I/ we have personally explained to ..... and ..... the details and implications of his / her / their signing this consent / approval form, and made sure to the extent humanly possible that he / she / they understand these details and implications.

Name, Address and Signature of the Witness from the Clinic -

Name and Signature of the Doctor

Name and Address of the ART Clinic

Dated: .....

\*The appropriate option may be ticked

\* Strike of which is not applicable

**Terms and Conditions****1. Provision of Information**

As long as I have cryopreserved embryo in storage at clinic mentioned above, I hereby agree to contact the above clinic at least annually to provide current information indicating my address, telephone number, email address and contact details and intention regarding my cryopreserved embryos.

Failure to:

- (i) contact the clinic for a period of twelve months;
- (ii) respond to a request for information from clinic within 90 days of receipt; shall constitute abandonment and signify my desire to terminate storage of Cryopreserved embryos.

In the event of my failure to comply with (i) and (ii) above, I instruct the above-mentioned clinic and hereby consent to my Cryopreserved embryos either being destroyed and discarded or given for research

**2. Payment of Fees**

I understand that I am responsible for the costs of cryopreservation and storage of my Cryopreserved embryos. Cryopreservation and storage fees are due and payable at the time of gamete cryopreservation, and at the beginning of each annual storage interval thereafter. I understand these fees are non-refundable and are not subject to prorated adjustment for partial storage intervals. Should the yearly fee for storage of my Cryopreserved embryos, remain unpaid for a period of one year after the first invoice is forwarded to my address/email/informed to me telephonically the clinic can conclude that I am no longer interested in storing these specimen(s) and I hereby instruct the clinic to destroy of my Cryopreserved embryos or use for research.

**3. Alternate Contact/Responsible Party**

I hereby name ..... as an alternate contact and my representative to assume responsibility for sections 1 and 2 above in the event that I am unable due to illness. I have attached a signed acknowledgement by ..... that they have read this form and will be responsible for its provisions in the event that I cannot.

FORM 12

[See rule 13 (f) (vii)]

Consent for Oocyte Retrieval

Name(s) and address(es) of patient  
Kavita w/o Abhishek

Name and address of the Clinic:  
Pragya IVF Centre, Ramnagar

I have asked the Clinic named above to provide me with treatment services to help me bear a child. I consent to:

1. Being prepared for oocyte retrieval by the administration of hormones and other drugs
2. The removal of oocytes from my ovaries under ultrasound guidance / laparoscopy

I/We had a full discussion with ..... about the above procedures and the risks and complications involved and I have been given oral and written information about them I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

I/We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I/We have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general / regional / sedation) has been discussed in terms which I have understood. Signature of intending couple/ intending woman

Endorsement by the ART Clinic  
*[Signature]*

I / we have personally explained to ..... and ..... the details and implications of her signing this consent / approval form, and made sure to the extent humanly possible that she understands these details and implications.

Signature of woman

Name, address and signature

of the Witness from the clinic

Name and signature of the Doctor

Consent of Husband (as and if applicable)

As the husband/partner, I consent to the course of the treatment outlined above. I understand that I will become the legal parent of any resulting child, and that the child will have all the normal legal rights on me.

Name, address and signature:

(Husband)

Name, address and signature

of the Witness from the clinic:

Name and signature of the Doctor:

Dated

मे Kavita w/o Abhishuk dono अपनी सहमती से  
भ्रूण से IVF की प्रक्रिया करने में समर्थ है।

Husband/Guardian - <sup>9</sup> प्रेम लता <sup>9</sup> देवी

Wife - Kavita  
21/1/25



**FORM 10**  
[See para 13 (e) (v) of the Instructions]

**Consent for Freezing of Gametes/Sperm/Oocytes**

I/We, Kavita and Abhishek  
consent to freezing of the my ..... (sperm/oocyte). We understand that  
the gametes would be normally kept frozen for ten years. In the exceptional circumstances  
If I/we wish to extend this period, we would let the ART clinic .....  
(Name and address) know at least six months ahead of time. If you do not hear from us  
before that time, you will be free to (a) use them for research purposes; or (b) discard and  
destroy them off. We also understand that sometimes the quality of these  
..... sperm or oocytes may decrease on subsequent thaw and that  
frozen gametes may have a lower pregnancy rate than when fresh gametes are transferred.

**\*Husband / Man**

In the unforeseen event of my death, I would like the gametes

To perish

☐

To be handed over to my wife/ .....(specify name and details)

☐

Used for research purposes

☐

Signed: Abhishek Singh

Dated:

**\*Wife / Woman**

In the unforeseen event of my death, I would like the embryos

To perish

☐

To be handed over to my husband/  
.....(specify name and details)

☐

Used for research purposes

☐

Signed: [Signature]

Dated:

Name, Address and Signature of the couple/woman

**FORM 12**  
**[See para 13 (e) (vii) of the Instructions]**

**Consent for Oocyte Retrieval**

Name(s) and address(es) of patient Kavita w/o Abhishek

Name and address of the clinic: Pragya IVF Centre, Ramnagar.

I have asked the clinic named above to provide me with treatment services to help me bear a child. I consent to:

1. Being prepared for oocyte retrieval by the administration of hormones and other drugs
2. The removal of oocytes from my ovaries under ultrasound guidance / laparoscopy

I/We had a full discussion with ..... about the above procedures and the risks and complications involved and I have been given oral and written information about them I understand and accept that the drugs that are used to stimulate the ovaries to raise oocytes have temporary side-effects like nausea, headaches and abdominal bloating. Only in a small proportion of cases, a condition called ovarian hyperstimulation occurs where there is an exaggerated ovarian response. Such cases can be identified ahead of time but only to a limited extent. Further, at times the ovarian response is poor or absent in spite of using a high dose of drugs. Under these circumstances, the treatment cycle will be cancelled.

I/We consent that I/we shall be the legal parent(s) of the child and the child will have all the legal rights on me, in case of anonymous gamete / embryo donation.

I/We have been given a suitable opportunity to take part in counselling about the implications of the proposed treatment.

The type of anaesthetic proposed (general / regional / sedation) has been discussed in terms which I have understood.

Signature of intending couple/ intending woman

Kavita  
~~Abhishek~~ 9559868132  
AB8 → Pattikalan, Aharaura, Chunar Mirzapur  
UP. Pincode - 231301  
Abhishek Singh





**Madhukar Pandey Dr. Pragya Pandey**

(M.D. (Peds.) IMS, B.H.U.

M.B.B.S., M.D. (OBS & GYNE)

**Specialist :**

Specialised in Infertility

Pediatrician & Neonatologist

Laparoscopy Gynae Surgery

Reg. No. - UPMC-47311

Reg. No. - UPMC-59054

Chmi Nagar Colony, Lanka, Varanasi, Phone : 0542-2367368

Na Naka Mor, Ramnagar, Varanasi, Phone : 0542-2669222

Age 27y Sex f

Date 17/12/2024

R<sub>b</sub>

Tab Progynova 16BD020d

Tab Progynova - M 16TD562d

Tab omnacortel 1600620d

Tab Ecosprin 75mg 1600620d

Tab flozita 1600620d

Tab Aliver 26H5610d  
PIV

R<sub>g</sub> R<sub>g</sub> Plus 1600620d

27/12/24

LMP 16/12/24

D12

Ev  
PV

28/12/24  
6 AM  
Zy

Susten 160066d

Timing **Dr. Madhukar & Pragya Pandey**

10.00 am to 02.00 pm

**Dr. Madhukar Pandey**

Evening 07.00 pm to 09.00 pm

Sunday 12.00 to 01.00 noon

Immunization  
Facility Available

Helpline No. :

**8808572123**

Not for medico legal purpose.

Tel: 011-4988-5050, Fax: +91-11-2788-2154, E-mail: customer.care@taipatriads.com



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Name : Ms. KAVITA  
Lab No. : 185736172  
Ref By : DR PRAGYA PANDEY  
Collected : 27/12/2024 12:38:00PM  
Vc Status : P  
Collected at : PRAGYA MOTHER & CHILD CARE HOSPITAL  
Age : 27 Years  
Gender : Female  
Reported : 27/12/2024 3:30:00PM  
Report Status : Final  
Processed at : Dr. Lal Path Labs Ltd  
Lanka, Varanasi 221005

## Test Report

| Test Name                        | Results | Units | Bio. Ref. Interval |
|----------------------------------|---------|-------|--------------------|
| ESTRADIOL (E2), SERUM<br>(ECLIA) |         |       |                    |
| Estradiol                        | 379.00  | pg/mL |                    |

## Interpretation

| MENSTRUAL PHASE            | REFERENCE RANGE IN pg/mL |
|----------------------------|--------------------------|
| Follicular                 | 12.5 - 166               |
| Mid cycle                  | 85.8 - 498               |
| Luteal                     | 43.8 - 211               |
| Pregnancy(First trimester) | 215 - >4300              |
| Post Menopausal            | <5.0 - 54.7              |

## Clinical Use

- Determine estrogen status in women
- Monitor follicular development during induction of ovulation
- Assess estrogen production in males

## Increased Levels

- Precocious puberty (female)
- Male gynecomastia
- Liver disease
- Ovarian tumors
- Adrenal feminizing tumors

## Decreased Level

- Oral contraceptives
- Ovarian failure



# प्रज्ञा मंदर एण्ड चाइल्ड केयर प्रा. लि.

साहित्यनाका मोड़, रामनगर, वाराणसी (उ.प्र.)

ग. मधुकर पाण्डेय

एम.बी.बी.एस. एम.डी. (बाल रोग)  
चिकित्सक - आई.एम.एस., बी.एच.यू.,  
Reg. No.: 47311 (UPMC)



डा. प्रज्ञा पाण्डेय

एम.बी.बी.एस. एम.एस. (आन्तरिक एवं गायत्री)  
स्त्री, प्रसूति एवं बालरोग विशेषज्ञ  
Reg. No.: 59054 (UPMC)

म Kavita उम्र वजन पता

उपलब्ध सुविधाएं

- टीकाकरण
- NICU, PICU
- \*
- वार्मर, फोटोथेरेपी
- सिरिजपम्प
- \*
- धमा, मिर्गी का इलाज
- \*
- नसबन्दी, कॉपर-टी
- र नियोजन की सलाह
- \*
- रियन/नार्मल डिलिवरी
- \*
- दर्द रहित प्रसव
- \*
- II (कृत्रिम गर्भाधान)
- \*
- न विधि से ऑपरेशन
- \*
- वेदानी का ऑपरेशन
- \*
- पन का समुचित इलाज
- \*
- अल्ट्रासाउण्ड
- \*
- ABG
- \*
- आईवीएफ फर्टिलिटी

दूरबीन विधि  
से ऑपरेशन  
वेन्टीलेटर

इमरजेंसी  
सेवा  
उपलब्ध

Rx Pickup Downon 5/12/24

दिनांक 5/12/24

Tab Drotarix-M BD \* 5 day

Tab Delbi-O BD \* 5 day

Tab Fourts BZ plus OD \* 5 day

Cap Cocid DSR OD \* 5 day

Tab Nostra CR 10mg BD \* 8 day

13/12/24 को आना है

By cctmbl 160064d

कृपया फोन पर परामर्श न लें।

कानूनी कार्यवाही के लिए अमान्य

इमरजेंसी सेवा के लिए सम्पर्क करें - 0542-2669222, 8808541123



Scanned with OKEN Scanner

MP - 16/11/24

POTD  
making

(A)

15.20

Center x 50 x 37  
(020)

OT following 201 x 200

23 am

(4-5 Dec)

Pickup 4 ICSI  
femur

(4)

RAL. M. 2024

(14-1500)

LAB 1500 + 200

↓

(Jan / Feb)  
ERT

Timing Dr. Madhukar & Pragya Pandey

10.00 am to 02.00 pm

Dr. Madhukar Pandey

Evening 07.00 pm to 09.00 pm

Sunday 12.00 to 01.00 noon



Immunization  
Facility Available

Helpline No. :

8808572123

Not for medico legal purpose.



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**adhukar Pandey** Dr. Pragma Pandey  
M.B.B.S., M.D. (Obs & GYNE)  
Specialised in Infertility  
Laparoscopy Gynae Surgery  
All OBS & Gynaecological Surgeries  
and Medical Management  
Reg. No. - UPMC-47311 Reg. No. - UPMC-59054

mi Nagar Colony, Lanka, Varanasi, Phone : 0542-2367368  
542-2669222

Age 27y

Date 18/11/24

My is size e  
Adenomyosis.

AFL - 14 to 15

6. Liver/Gallbladder :

7. Kidney / Spleen :

Transvaginal (TVS)

| Date | Date of MC | Right Ovary | Left Ovary | ET |
|------|------------|-------------|------------|----|
|      |            |             |            |    |
|      |            |             |            |    |
|      |            |             |            |    |
|      |            |             |            |    |
|      |            |             |            |    |
|      |            |             |            |    |
|      |            |             |            |    |



Not for Medico - Legal Purpose.



Patient NAME : Mr ABHISHEK SINGH  
DOB/Age/Gender : 31 Y/Male  
Patient ID / UHID : 9431726/OF9431726  
Referred BY : Dr. Pragya Pandey  
Sample Collected : Aug 23, 2024, 01:50 PM

Report STATUS : Final Report  
Barcode NO : YB052138  
Sample Type : Semen  
Report Date : Aug 23, 2024, 03:46 PM.

| Test Description | Value(s) | Unit(s) | Reference Range |
|------------------|----------|---------|-----------------|
|------------------|----------|---------|-----------------|

### men Analysis

|                                         |            |                   |                           |
|-----------------------------------------|------------|-------------------|---------------------------|
| Collection Time                         | 1:46 PM    |                   |                           |
| Examination Time                        | 2:25 PM    |                   |                           |
| Volume (Semen)                          | 5          | mL                | 1.3 - 1.5                 |
| Colour (Semen)                          | Grey white | -                 | Pearly White              |
| Consistence                             | 3          | Days              | 2-7                       |
| Coagulation Time                        | 30         | min               | upto 30 min               |
| Colorator strip                         | 7.0        |                   | 7.0 -8.0                  |
| Fructose (Qualitative)                  | Present    | -                 | Present                   |
| Ranoffs test                            |            |                   |                           |
| Concentration                           | 22         | Millions/mL       | 12 - 16                   |
| Counting Chamber USED: NEUBAUER CHAMBER |            |                   |                           |
| Viscosity                               | Normal     | -                 | Normal                    |
| Sperm Count/ Ejaculate                  | 110        | million/Ejaculate | 35 - 40 million/Ejaculate |
| Normal Motility at 37°C (Total=PR+NP)   | 60         | %                 | 40 - 43                   |
| Counted 200 spermatozoa                 |            |                   |                           |
| Microscopy                              |            |                   |                           |
| Progressive motility (PR)               | 40         | %                 | 29 - 31                   |
| Non Progressive motility (NP)           | 20         | %                 | 0-1                       |
| Immotility                              | 40         | %                 | 19 - 20                   |
| Normal Forms                            | 85         | %                 | 3.9 - 4.0                 |
| Microscopy                              | NIL        | /hpf              |                           |
| Round Cells                             | 5-6        | /hpf              |                           |
| Microscopy                              |            |                   |                           |

station:

The above mentioned ranges are the lower reference interval CRITERIA FOR SEMEN ANALYSIS 2021).

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

For herbarel

Tab utiguand & xoxox 20 dy


Ysabe Dubey


Dr. Usha Dubey  
MBBS, MD

Consultant Pathologist

Booking Centre :- RRL VARANASI, Redcliffe Lifetech Pvt. Ltd., H.No.31/82A-9-B Rashmi Nagar, Near BHU Hospital  
Varanasi-221005

Varanasi-221005  
☎ 928-909-0609

 [ccsupport@redcliffelabs.com](mailto:ccsupport@redcliffelabs.com)

 [www.redcliffelabs.com](http://www.redcliffelabs.com)

Processing Lab :- Redcliffe Lifetech Pvt. Ltd., H.No.31/82A-9-B Rashmi Nagar, Near BHU Hospital, Varanasi-221001  
All Lab results are subject to clinical interpretation by qualified medical professional and this report is not subject to use for any medico-legal pur

Patient Name : MR. ABHISHEK SINGH

Age/ Gender : 31 years / Male

Patient ID : 65833

Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI

Collection Time : Sep 27, 2024, 07:50 p.m.

Reporting Time : Sep 27, 2024, 08:17 p.m.

Sample ID :



004527124

| Test Description        | Value(s) | Reference Range |
|-------------------------|----------|-----------------|
| <b>Hemoglobin (HB%)</b> |          |                 |
| Hemoglobin              | 13.8     | 13-17 gms%      |

**Reference:**

Dacie and Lewis Practical Hematology  
10th edition.

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)

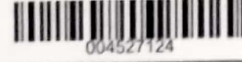


# Accumax Diagnostics

C/o. Visakha Multi Speciality Clinics  
Sarojini Naidu Towers,  
Opp. KGH Clock Tower,  
Maharanipeta, Visakhapatnam-2  
Ph. 0891-2728558

Patient Name : MR. ABHISHEK SINGH  
Age / Gender : 31 years / Male  
Patient ID : 65833  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI  
Collection Time : Sep 27, 2024, 07:50 p.m.  
Reporting Time : Sep 27, 2024, 08:17 p.m.  
Sample ID :



| Test Description            | Value(s) | Reference Range |
|-----------------------------|----------|-----------------|
| <b>Glucose, (RBS)</b>       |          |                 |
| Random Plasma Glucose (RBS) | 90       | 70 - 140 mg/dL  |
| Random urine glucose        | -        | -               |

**Reference:**

American Diabetic Association Guidelines 2016.

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)



Patient Name : MR. ABHISHEK SINGH  
Age / Gender : 31 years / Male  
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Referral : DR.B. SIREESHA RANI  
Collection Time : Sep 27, 2024, 07:50 p.m.  
Reporting Time : Sep 27, 2024, 08:17 p.m.  
Sample ID :



| Test Description                     | Value(s)     | Reference Range |
|--------------------------------------|--------------|-----------------|
| <b>HIV I &amp; II Antibody Rapid</b> |              |                 |
| HIV I Rapid                          | Negative     |                 |
| HIV II Rapid                         | Negative     |                 |
| Method:                              | Tridot Assay |                 |

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)

Ref: MR. ABHISHEK SINGH  
Age: 31 years / Male  
65833  
ZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI  
Collection Time : Sep 27, 2024, 07:50 p.m.  
Reporting Time : Sep 27, 2024, 08:17 p.m.  
Sample ID :



004527124

| Option                                   | Value(s)     | Reference Range |
|------------------------------------------|--------------|-----------------|
| <b>C Virus Antibody (Anti HCV) Rapid</b> |              |                 |
| Virus Rapid                              | Negative     | -               |
|                                          | Tridot Assay |                 |

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)





# Accumax Diagnostics

C/o. Visakha Multi Speciality Clinics  
Sarojini Naidu Towers,  
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Ph. 0891-2728558

Patient Name : MR. ABHISHEK SINGH  
Age / Gender : 31 years / Male  
Patient ID : 65833  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI

Collection Time : Sep 27, 2024, 07:50 p.m.

Reporting Time : Sep 27, 2024, 08:17 p.m.

Sample ID :



004527124

| Test Description                | Value(s)                                                                                                                                                                                                                                                                                                           | Reference Range |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| <b><u>VDRL (RPR), Serum</u></b> |                                                                                                                                                                                                                                                                                                                    |                 |
| VDRL(RPR)                       | Negative                                                                                                                                                                                                                                                                                                           |                 |
| Method                          | Slide Flocculation                                                                                                                                                                                                                                                                                                 |                 |
| Interpretation                  | The Rapid Plasma Reagen (RPR) antigen is a microscopic nontreponemal flocculation test for detection and quantitation of anti lipoidal antibodies. Biological false positive results may be seen in presence of diseases such as, leprosy, malaria, toxoplasmosis, infectious mononucleosis or lupus erythmatosis. |                 |

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)

Page 5 of 6

Home Collection: 9492 84 5959



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# Accumax Diagnostics

C/o. Visakha Multi Speciality Clinics  
Sarojini Naidu Towers,  
Opp. KGH Clock Tower,  
Maharaniapeta, Visakhapatnam-2  
Ph. 0891-2728558

Patient Name : MR. ABHISHEK SINGH  
Age / Gender : 31 years / Male  
Patient ID : 65833  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI  
Collection Time : Sep 27, 2024, 07:50 p.m.  
Reporting Time : Sep 27, 2024, 08:17 p.m.  
Sample ID :



| Test Description | Value(s) | Reference Range |
|------------------|----------|-----------------|
|------------------|----------|-----------------|

**Hepatitis B surface Antigen (HBsAg) Rapid**

Hepatitis B surface Antigen (HBsAg) Rapid      Negative

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)



Patient Name : MRS. KAVITHA SINGH  
Age / Gender : 26 years / Female  
Patient ID : 65787  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI

Collection Time : Sep 26, 2024, 07:33 p.m.

Reporting Time : Sep 26, 2024, 08:10 p.m.

Sample ID :

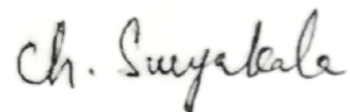


| Test Description                    | Value(s)                                                    | Reference Range |
|-------------------------------------|-------------------------------------------------------------|-----------------|
| <b>Blood Grouping and Rh Typing</b> |                                                             |                 |
| Blood Group (ABO group)             | " B "                                                       |                 |
| Rh Type ( D)                        | POSITIVE                                                    |                 |
| Method :                            | Hemagglutination tube method (Forward and reverse grouping) |                 |

Note:

Records of previous blood grouping / Rh typing not available. Please verify before transfusion.

-----End of Report-----



DR. CH SURYAKALA  
(MD Pathologist)



Patient Name : MRS. KAVITHA SINGH  
Age / Gender : 26 years / Female  
Patient ID : 65787  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI  
Collection Time : Sep 26, 2024, 07:33 p.m.  
Reporting Time : Sep 26, 2024, 08:10 p.m.  
Sample ID :



| Test Description                         | Value(s) | Reference Range      |
|------------------------------------------|----------|----------------------|
| <b>Thyroid Stimulating Hormone (TSH)</b> |          |                      |
| TSH*                                     | 3.64     | 0.38 - 5.6<br>μIU/ml |

**Reference:**

ADVIA Centaur Assay Manual and  
Tietz Fundamentals of Clinical Biochemistry

**Interpretation:**

1. TSH values may be transiently altered because of non thyroidal illness like severe infections, liver disease, renal and heart failure, severe burns, trauma and surgery etc.
2. Drugs that decrease TSH values. e.g:- L-dopa, Glucocorticoids.
3. Drugs that increase TSH values. e.g:- Iodine, Lithium, Amiodarone.

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)

*avg*



Patient Name : MRS. KAVITHA SINGH  
Age / Gender : 26 years / Female  
Patient ID : 65787  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI

Collection Time : Sep 26, 2024, 07:33 p.m.

Reporting Time : Sep 26, 2024, 08:10 p.m.

Sample ID :



003727024

| Test Description                            | Value(s)     | Reference Range |
|---------------------------------------------|--------------|-----------------|
| <b><u>HIV I &amp; II Antibody Rapid</u></b> |              |                 |
| HIV I Rapid                                 | Negative     | -               |
| HIV II Rapid                                | Negative     | -               |
| Method:                                     | Tridot Assay |                 |

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)

# Accumax Diagnostics

C/o. Visakha Multi Speciality Clinics  
Sarojini Naidu Towers,  
Opp. KGH Clock Tower,  
Maharanipeta, Visakhapatnam-2  
Ph. 0891-2728558

Patient Name : MRS. KAVITHA SINGH  
Age / Gender : 26 years / Female  
Patient ID : 65787  
Source : VIZAG IVF CENTER GAJUWAKA

Referral : DR.B. SIREESHA RANI

Collection Time : Sep 26, 2024, 07:33 p.m.

Reporting Time : Sep 26, 2024, 08:10 p.m.

Sample ID :



003727024

| Test Description                                   | Value(s)     | Reference Range |
|----------------------------------------------------|--------------|-----------------|
| <b>Hepatitis C Virus Antibody (Anti HCV) Rapid</b> |              |                 |
| Hepatitis C Virus Rapid                            | Negative     |                 |
| Method:                                            | Tridot Assay |                 |

-----End of Report-----

*Ch. Suryakala*

DR. CH SURYAKALA  
(MD Pathologist)







# Pragya

MOTHER & CHILD CARE HOSPITAL

**Dr. Madhukar Pandey**

M.B.B.S., K.G.M.C. (Lko.), M.D. (Peds.) (MS, B.H.U.)

Specialist :  
Pediatrician & Neonatologist

Reg. No. - UPMC-47311

**Dr. Pragya Pandey**

M.B.B.S., M.D. (OBS & GYNE)

Specialised in Infertility  
Laparoscopy Gynaec Surgery

Reg. No. - UPMC-59054

Plat No. 9, Rashmi Nagar Colony, Lanka, Varanasi, Phone : 0542-234  
Branch : Sahitya Naka Mor, Ramnagar, Varanasi, Phone : 0542-26692

Pt. Name Kavita Age 26y Sex F  
Address Doharai Jamalpur Date 21.8.20.

LMP 1/8/24  
D2

BP 126/88  
C/o Primi 2<sup>nd</sup> fertility

MC 5 day  
30

ML 1y  
Bto

① Tab Letroz 2-5mg x B

② Tab Folkin x ODX 3  
Abi F.

12/Aug  
- TUS USG

Sr. TSH  
Sr. Prolactin

Semen test

ing **Dr. Madhukar & Pragya Pandey**  
10.00 am to 02.00 pm  
ing **Dr. Madhukar Pandey**  
07.00 pm to 09.00 pm  
ay 12.00 to 01.00 noon



Immunization  
Facility Available

Helpline No. :  
**8808572123**

Not for medico legal purpos



12/8/14

(DIT - 18)

LMP - 1/8/14

(Day 12)

✓ CW 1° fertility

Potomacy

~~PR1 - 25.10~~  
PR1 - 11.80  
TSH - 35

4  
+ 1 Tab Thyrox  
(50 mg 200)

TUS - VS4 (FM)

20.18  
Belchard  
197

Parent 3rd

① 10 6/24/2015

② 10 1/2/20

(OIL  
1/2/20)

Processed By  
Varanasi, Pathkind Diagnostic Pvt. Ltd., D63/8-1, Krishna  
Complex, Mahmoorganj, Varanasi-221010, - 221010  
Contact No. -7827949764

1 Mrs. KAVITA  
2 26 Yrs/Female  
3 1208C002202480215  
4 1208C00220248020004  
5 DR PRAGYA PANDEY

Billing Date : 02/08/2024 12:01:06 PM  
Sample Collected on : 02/08/2024 12:01:47 PM  
Sample Received on : 02/08/2024 03:25:08 PM  
Report Released on : 02/08/2024 05:24:33 PM

Report Status -Final

| Result | Biological Ref. Interval | Unit |
|--------|--------------------------|------|
|--------|--------------------------|------|

|       |       |              |       |
|-------|-------|--------------|-------|
| (PRL) | 11.80 | 4.79 - 23.30 | ng/mL |
|-------|-------|--------------|-------|

icated By

Pathology  
read



1208C00220248020004



सही तो इलाज सही



Page 1 of 3



