

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. SARANYA PRAKASH	Order No : 1000119810
UHID : UHJ A24012945	Registered On : 08/03/2025 07:47:35 AM
Age/Sex : 35/Years Female	Collected On : 08/03/2025 07:55:58 AM
Ward / Bed No :	Reported On : 08/03/2025 11:48:27 AM
Reference : Dr. Ashmitha Padma	Bill No : OPBJ A240018239
Station : At Hospital	Mobile No : 8940940879
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	93	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	91	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	5.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	100	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.03	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.25	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.34	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	193	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	109	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.4	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	127.80	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	21.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.45		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.94		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	149.60	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	2.0	mg/dL	2.6-6.0
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	6	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.53	mg/dL	0.6-1.1
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.37	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.07	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.30	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.6	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.40	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.20	g/dL	2.3-3.5

Sample: Serum

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AG RATIO (Method: Calculated)	1.38		2:1
SERUM SGOT (Method:IFCC without P5P)	20	U/L	< 35
SERUM SGPT (Method:IFCC without P5P)	13	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	46	U/L	46-122
GGT (Method:IFCC)	12	U/L	< 38



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	9.83	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	31.1	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4950	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.01	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	24.94	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.42	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.37	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.26	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.95	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	62.8	fL	78-100
MCH (Method: Calculated)	19.9	pg	27-31
MCHC (Method: Calculated)	31.6	g/dL	31-37
RDW - CV (Method: Calculated)	19.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	3.38	Lakhs/Cum	1.5-4.5


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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	6.92	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	46.2	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3270	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	70	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1230	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	360	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	10	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	18	mm/hour	1-20
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Method)	B		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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<u>CLINICAL PATHOLOGY</u>			
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Turbid		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.005		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN	Absent		Absent
<small>(Method:Protein Error of pH Indicator)</small>			
GLUCOSE	Absent		Absent
<small>(Method:GOD-POD)</small>			
KETONE BODIES	Absent		Absent
<small>(Method:Nitroprusside method/ Rothera's test)</small>			
BILIRUBIN	Negative		Negative
<small>(Method:DIAZO/FOUCHET'S TEST)</small>			
BILE SALT	Absent		Absent
<small>(Method:Hay's sulfur test)</small>			
NITRITE	Negative		Negative
<small>(Method:Griess method)</small>			
UROBILINOGEN	Normal		
<small>(Method:Azo coupling method)</small>			
LEUKOCYTE ESTERASE	Present (++)		Negative
<small>(Method:Leukocyte Esterase activity)</small>			
BLOOD	Present (+)		Negative
<small>(Method:Peroxidase Reaction)</small>			
MICROSCOPIC EXAMINATION			

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EPITHELIAL CELLS	4-6	/HPF	0-5
PUS CELLS	8-10	/HPF	0-5
RBCs	4-6	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Dr Varsha Shree R

---End of Report---



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567



NABH



No.1



Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mrs.SARANYA PRAKASH UHID : UHJA24012945
Age / Sex : 44 Years / Female OP NO/Reg Dt : 08-03-2025 07:47 AM
Spouse / Father Name : N PRAKASH Department :
Address : , , Bengaluru Urban, Karnataka, INDIA, Referred By :
Consultant : Dr.Ashmitha Padma MBBS, MD
KMC No. (GENERAL MEDICINE), PGDCC,FEM : 02M1087

Complaints / Findings / Observations :

HTE 163 cm
Wt 65.2 kg
BPs 93/70 mmHg
SpO₂ 99.1
PR 84 bpm

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



NABH



No.1

PATIENT NAME :	Mrs. SARANYA PRAKASH	DATE :	07/03/25
AGE :	44 years	GENDER: FEMALE	PATIENT ID :
REF BY :	CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY
M - MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 3.7 (3.5-5.5)	MV EV : 92.6	AV : 75.7	MR : NORMAL
LA : 2.9 (1.9-4.0)	LVIDS : 2.5 (2.4-4.2)	AV : 141		AR : NORMAL
RA : 2.5 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 103		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : -----	AV : ----	TR : NORMAL
TAPSE: 2.0 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.0 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis:	NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
 NORMAL LV SYSTOLIC FUNCTION EF : 60%
 NORMAL LV DIASTOLIC FUNCTION
 NO PULMONARY ARTERY HYPERTENSION
 NO REGIONAL WALL MOTION ABNORMALITIES
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION


DR. RAHUL PATIL
 CONSULTANT CARDIOLOGIST



NABH



No.1



UNITED
HOSPITAL

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Saranya Prakash	Date	08/03/25
Age	44 years	Hospital ID	UHJA24012945
Sex	Female	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and *shows mildly increased echopattern*. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No evidence of mass or focal lesions.

Right Kidney is normal in size (11.0 x 3.5 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Left Kidney is normal in size (10.6 x 4.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No evidence of calculi or hydronephrosis.

Retroperitoneum- Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is minimally distended.

Uterus is anteverted and normal in size, measures 7.8 x 2.8 x 4.3 cms. Myometrial echoes are normal. Endometrium measures 4.8 mm. *Intrauterine device is seen in the lower uterine cavity.*

Right ovary is normal in size and echopattern, measures 3.6 cc.

Left ovary is normal in size and echopattern, measures 7.2 cc.

Both adnexa: Normal. No mass is seen.

There is no ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Intrauterine device in the lower uterine cavity.**
- **Mild fatty infiltration of liver (Grade I).**

Dr. Elluru Santosh Kumar
Consultant Radiologist



NABH



No.1



DEPARTMENT OF RADIODIAGNOSIS

Name	Saranya Prakash	Date	08/03/25
Age	44 years	Hospital ID	UHJA24012945
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA - VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- No radiographic abnormality.

Dr. Elluru Santosh Kumar
Consultant Radiologist

Name: nr s saranya

Sex: F Birth date: / /

35 years

1100 Sinus rhythm

9110 xx normal ECG xx

Indication:
Symptoms:
History:

lent. rate

77 bpm

IR int

156 ms

RS dur

76 ms

IT/OTc(E) int

356/387 ms

I/QRST axis

40/79/47 °

IV5/SV1 amp

1.02/0.52 mV

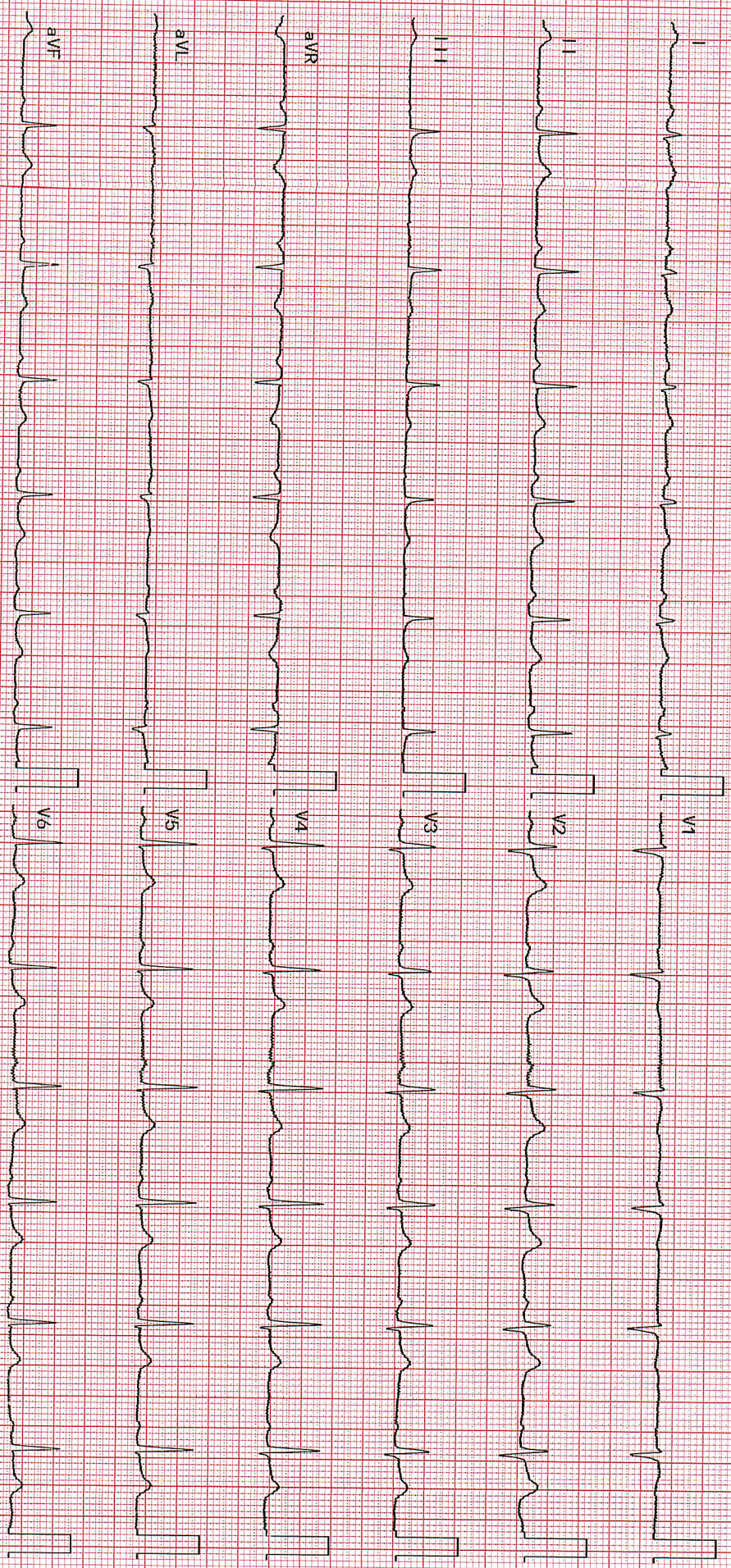
IV5-SV1 amp

1.54 mV

10 mm/mV 25 mm/s Filter: H60 D 35 Hz

10 mm/mV

Unconfirmed Report
Reviewed by:



2350K 03-08 07-01

Dept.:

Exam: UNITED HOSPITAL