

**TEST REPORT**

Reg. No : 2503100104 **UHID :** UHID29983 **Reg. Date :** 08-Mar-2025
Name : TEJAS RAMAN PATEL **Collected On :** 08-Mar-2025 08:49
Age/Sex : 34 Years / Male **Report Date :** 08-Mar-2025
Ref. By : MEDIWHEEL

Parameter	Result	Unit	Reference Interval
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COMPLETE BLOOD COUNT (CBC)

Hemoglobin (SLS method)	13.7	g/dL	13.0 - 17.0
Hematocrit (Electrical Impedance)	43.0	%	40 - 54
RBC Count (Electrical Impedance)	6.05	million/cmm	4.5 - 5.5
WBC Count (Flowcytometry)	7090	/cmm	4000 - 10000
Platelet Count (Electrical Impedance)	209000	/cmm	150000 - 410000
MCV (Calculated)	71.1	fL	83 - 101
MCH (Calculated)	22.7	Pg	27 - 32
MCHC (Calculated)	31.9	%	31.5 - 34.5
RDW (Calculated)	13.4	%	11.5 - 14.5

DIFFERENTIAL WBC COUNT

Neutrophils (%)	53	%	38 - 70
Lymphocytes (%)	42	%	20 - 45
Monocytes (%)	03	%	2 - 8
Eosinophils (%)	02	%	1 - 4
Basophils (%)	00	%	0 - 1
Neutrophils (Absolute)	3758	/cmm	1800 - 7700
Lymphocytes (Absolute)	2978	/cmm	1000 - 3900
Monocytes (Absolute)	213	/cmm	200 - 800
Eosinophils (Absolute)	142	/cmm	20 - 500
Basophils (Absolute)	0	/cmm	0 - 100
Neutrophil-Lymphocyte Ratio(NLR)	1.27	/cmm	0.7 - 4.0

PERIPHERAL SMEAR EXAMINATION

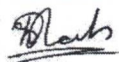
RBC Morphology	RBCs are Normochromic Normocytic.
WBC Morphology	Total WBC and differential count is within normal.
Platelets	Platelets are adequate with normal morphology.
Parasites	Malarial parasite is not detected.

ERYTHROCYTE SEDIMENTATION RATE

ESR (After 1 hour)	12	mm/hr	0 - 14
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----- End Of Report -----

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(MD.Pathology)
Mr. Akshay Parmar
M.Sc(Biochemistry)

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Parameter	Result	Unit	Reference Interval
FBS Fasting Blood Sugar (FBS) Glucose Oxidase-Peroxidase	134.2	mg/dL	70 - 110
PPBS Post Prandial Blood Sugar (PPBS) Glucose Oxidase-Peroxidase	150.3	mg/dL	110 - 140

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HEMOGLOBIN A1 C ESTIMATION

Specimen: Blood EDTA

Hb A1C <i>HPLC, NGSP Certified</i>	6.0	%	>8 : Action Suggested , 7-8 : Good Control , <7 : Goal , 6-7 : Near Normal Glycemia, <6 : Non-diabetic Level
Mean Blood Glucose <i>Calculated</i>	125.50	mg/dL	

Criteria for the diagnosis of diabetes:

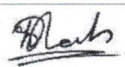
- HbA1c ≥ 6.5 *Or
 - Fasting plasma glucose >126 gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.Or
 - Two hour plasma glucose ≥ 200 mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucosedissolved in water.Or
 - In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose ≥ 200 mg/dL.
- *In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing. American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

Importance of HbA1C (Glycated Hb.) in Diabetes Mellitus:

- HbA1C, also known as glycated heamoglobin, is the most important test for the assessment of long term blood glucose control(also called glyemic control).
- HbA1C reflects mean glucose concentration over pas 6-8 weeks and provides a much better indication of longterm glyemic control than blood glucose determination.
- HbA1c is formed by non-enzymatic reaction between glucose and Hb. This reaction is irreversible and therefore remains unaffected by short term fluctuations in blood glucose levels.
- Long term complications of diabetes such as retinopathy (Eye-complications), nephropathy (kidney-complications) and neuropathy (nerve complications), are potentially serious and can lead to blindness, kidney failure, etc.- Glyemic control monitored by HbA1c measurement using HPLC method (GOLD STANDARD) is considered most important. (Ref. National Glycohaemoglobin Standardization Program - NGSP).

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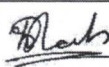
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LIVER FUNCTION TEST			
SGPT <i>Optimized UV-IFCC</i>	32.2	U/L	1 - 45
SGOT <i>Optimized UV-IFCC</i>	21.6	U/L	1 - 35
Total Bilirubin <i>DCA method</i>	0.35	mg/dL	0 - 2.0
Direct Bilirubin <i>DCA method</i>	0.25	mg/dL	0.0 - 0.4
INDIRECT BILIRUBIN <i>Calculated</i>	0.10	mg/dL	0.0 - 1.6
Alkaline Phosphatase <i>PNP-AMP Buffer, Multiple-point rate</i>	54	U/L	53 - 128
Total Protein	6.60	g/dL	6.4 - 8.2
Albumin <i>By Bromocresol Green</i>	3.78	g/dL	3.5 - 5.2
Globulin <i>Calculated</i>	2.82	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	1.34		0.8 - 2.0

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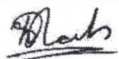
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RENAL FUNCTION TEST			
Creatinine	0.82	mg/dL	0.7 - 1.3
<i>Enzymatic ,IDMS Traceable</i>			
Urea	25.3	mg/dL	19.0 - 45.0
<i>Urease-GLDH, enzymatic UV</i>			
BUN	11.82	mg/dL	7 - 18
<i>Calculated</i>			
Uric Acid	4.21	mg/dL	3.5 - 7.2
<i>Enzymatic using TBHBA</i>			
Sodium	140.3	mmol/L	137 - 145
<i>Direct ISE</i>			
Potassium	4.87	mmol/L	3.6 - 5.1
<i>Direct ISE</i>			
Chloride	95.3	mmol/L	94 - 110
<i>Direct ISE</i>			
Ionized Calcium	4.98	mg/dL	4.4 - 5.4
<i>Direct ISE</i>			

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LIPID PROFILE

Cholesterol <i>CHOD-PAP method</i>	261	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>Enzymatic with GPO method</i>	374.4	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	74.88	mg/dL	15 - 35
LDL CHOLESTEROL	144.42	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Magnetic Cholesterol Oxidase</i>	41.7	mg/dL	Low : < 40 High : > 60
Cholesterol /HDL Ratio <i>Calculated</i>	6.26		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	3.46		0 - 3.5
Total Lipids <i>Calculated</i>	1230.80		400 - 1000

- Pre-analytical requirements for given tests are -Fasting status anywhere between 10-12 hours before collection. Avoid alcohol beverages before lipid panel - minimum 24 hrs.
- Lipid profile results can be erroneous if pre-analytical requirements are not met properly.
- Any medical decision based on test results is to be taken with 2 or more consecutive results suggesting pattern.
- Please note that any lipid lowering drug may interfere in results estimation.
- Sudden commencement or sudden withdrawal of Lipid lowering drug will interfere with test result.

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THYROID FUNCTION TEST

T3 (Triiodothyronine) CMIA	0.84	ng/mL	0.6 - 1.81
T4 (Thyroxine) CMIA	6.31	µg/dL	4.5 - 12.5
TSH ELFA-Enzyme Linked Fluorescent Assay	0.739	µIU/ml	0.35 - 4.94

Thyroid stimulating hormone (TSH) is synthesized and secreted by the anterior pituitary in response to a negative feedback mechanism involving concentrations of FT3 (free T3) and FT4 (free T4). Additionally, the hypothalamic tripeptide, thyrotropin-releasing hormone (TRH), directly stimulates TSH production. TSH stimulates thyroid cell production and hypertrophy, also stimulate the thyroid gland to synthesize and secrete T3 and T4. Quantification of TSH is significant to differentiate primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

TSH levels During Pregnancy :

First Trimester : 0.1 to 2.5 µIU/mL

Second Trimester : 0.2 to 3.0 µIU/mL

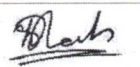
Third trimester : 0.3 to 3.0 µIU/mL

Reference : Carl A. Burtis, Edward R. Ashwood, David E. Bruns. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics. 5th Edition.

Philadelphia: WB Saunders, 2012:2170

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BLOOD GROUP & RH

SPECIMEN: EDTA AND SERUM; METHOD: HAEMAGGLUTINATION

ABO	'A'
Rh (D)	Positive

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TEJAS PATEL

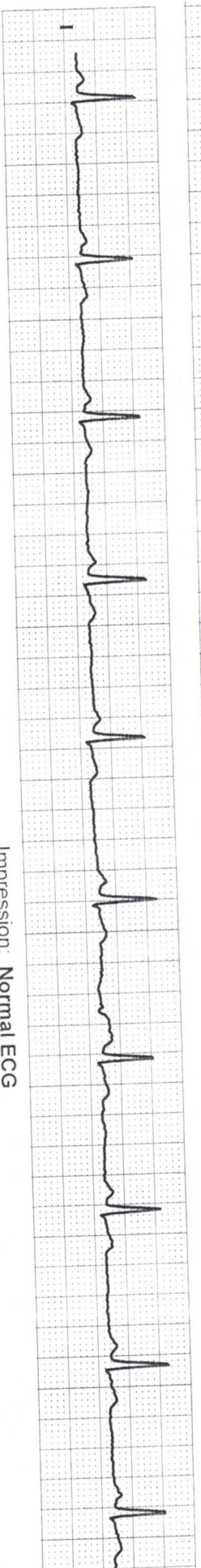
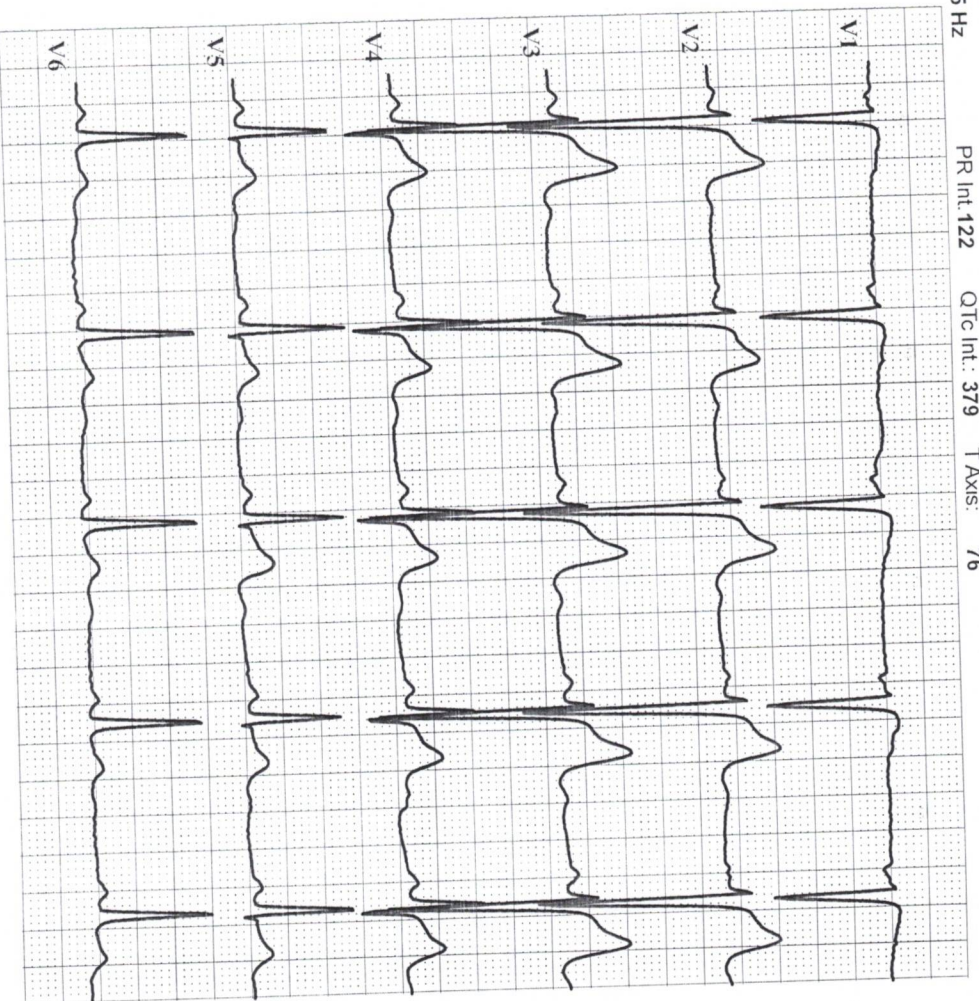
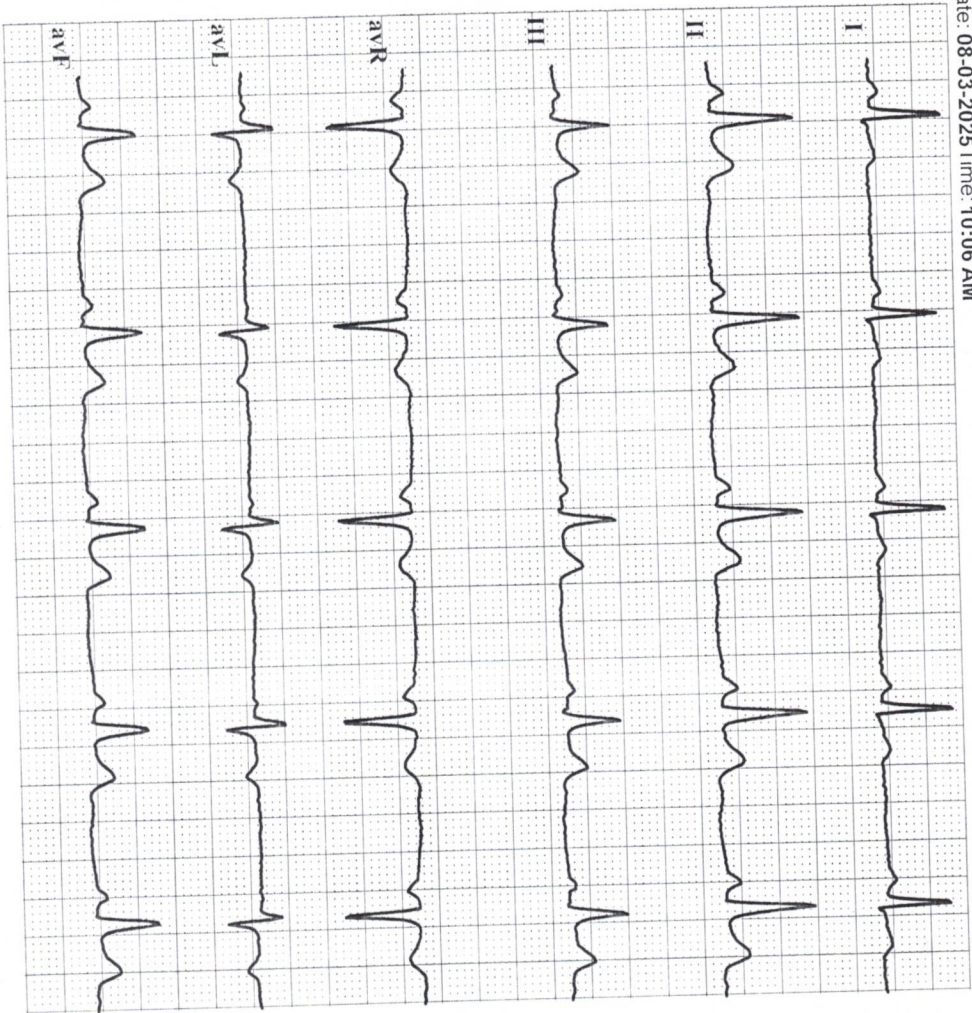
Ref. No.:

421
34 Yrs/M
Date: 08-03-2025 Time: 10:06 AM

Gain: 10 mm/mV
Sweep: 25 mm/s
Notch: On
BP: -/- mmHg
Filter: 0.1 - 35 Hz

Hr: 59
P Int: 88
PR Int: 122
QRS Int: 128
QT Int: 382
QTc Int: 379
P Axis: 56
QRS Axis: 37
T Axis: 76

Ref. By:
Tech.:



Comments: Sinus Bradycardia

Impression: Normal ECG

Patient Name	TEJAS R PATEL	Patient ID	UHID29983
Age/Gender	34 Years / M	Study Date	08-Mar-2025
Referred By		Reported Date	08-Mar-2025

X – RAY CHEST PA VIEW:

Both lung fields under vision appear normal.
Cardiac size appears normal.
Both costophrenic angles are clear.
Hilar regions are normal.
Both domes appear normal in position.
Bony thorax under vision appears normal.



Dr. Sunny Shrivani
MD Radiology REG G-33548

Date Reported: 08-Mar-2025

This Report is done and digitally signed via Tele Radiology Done at Radiscan Diagnostic Ahmedabad. For any clinical discrepancy, please discuss with the Radiologist. This report is not valid for any medico-legal purposes

PATIENT NAME**MR. TEJAS PATEL****AGE / SEX****34YRS/MALE****REF. DOCTOR****DR. DHS DOCTOR TEAM****DATE****08/03/2025**

2D ECHO CARDIOGRAPHY REPORT

Observation:

1. Normal size LV size with normal LV systolic function. LVEF: 65%.
2. No RWMA.
3. Normal LV compliance.
4. Normal sized LA, RA and RV. Normal RV function.
5. All valves are normal in structure.
6. IAS and IVS are intact.
7. No PAH.
8. No clot/ vegetation / pericardial effusion.
9. Doppler: Mild MR, Mild TR, No AR, No PR.
10. IVC is normal in size and well collapse on inspiration.

Conclusion:

**Normal LV systolic function.
No RWMA.
No PAH.**

Measurements :

LVIDD	46.0 mm	AO	29.0mm
LVIDS	36.0 mm	LA	36.0mm
LVEF	65%		
IVSD/LVPWD	09.0mm/09.0mm		

DOPPLER STUDY:

Valves	velocity	Max gradient	Mean gradient	Area	Regurgitation
Aortic	1.5	4.2			No AR
Mitral	E:0.5 A: 0.2				Mild MR
Pulmonary	0.4	2.3			No PR
Tricuspid	0.3	1.5			Mild TR

Dr.ARCHIT PARIKH

PATIENT NAME **TEJAS PATEL**
AGE / SEX **34 Y/ M**
REF. DOCTOR **HEALTH CHECK UP**
DATE **8-Mar-25**

ULTRASOUND WHOLE ABDOMEN - PELVIS

LIVER : Liver is normal in size and shows **grade 3 fatty changes**.
No focal lesion is seen. Intra-hepatic biliary radicals are not dilated.
PORTAL VEIN: appears normal in course and caliber. PV- 9 mm

GALL BLADDER : is distended and appears normal. No calculus or mass lesion seen.
CBD: appears normal, 4mm.

PANCREAS : Pancreas is normal.

SPLEEN : Spleen is normal in size and shows normal echo pattern.

KIDNEYS : Both kidneys are normal in size, shape & echotexture.
No calculus or hydronephrosis seen in either kidney.

URINARY BLADDER : is full & normal.

PROSTATE: normal in size.

Bowel loops appear normal. No any inflammatory wall thickening or mass lesion is seen.
No lymphadenopathy seen. Reactive looking mesenteric lymph nodes noted.
No evidence of collection or mass lesion seen in RIF.
No free fluid.

IMPRESSION :
Grade 3 fatty liver.
No other significant abnormality.


DR. JAY THAKKAR, MD