Patient Name	**:** Gaurav Gupta	**Episode No.**	**:** 0
UHID	**:** 12765982	**Sample ID**	**:** FHM25-R03478
Age / Gender	**:** 34 Year / Male	**Sample Drawn**	**:**
Ward	**:**	**Sample Received**	**:** 08/Mar/2025 02:32 PM
Diagnosis / Clinical Information	**:**		

Blood Group Report

Final Report

Referred By	**:**	**Reported**	**:08/Mar/2025 04:02 PM**
Sample Type	**: EDTA**		
Method	**: AUTOMATION**		
Forward Blood Group	**: B Rh Positive**		
Reverse Blood Group	**: B**		
Final Blood Group	**: B Rh Positive**		
Remark	**:**		

Tested By : bipasha .

Verified By : bipasha .

Approved By :

Dr. APRA KALRA
Addl. Director and
Head-Transfusion Medicine
Fortis Hospital, Mohali (Pb.)
Phone:0172-5021222 (Extn.6723)

Note : Blood group is identified by ABO antigens (forward grouping) present on red cell membrane And anti-ABO antibodies (reverse grouping) present in the plasma. A grouping discrepancy is when there is a mismatch in forward and reverse Blood grouping. Special methods need to be Performed to solve such discrepancies.

In case of Newborn/cord blood grouping, only forward blood grouping would be done as the anti-ABO antibodies (for reverse grouping) Are not present till 4 to 6 months of age. Thus new born grouping should be considered as provisional report and should be supplemented by re-blood grouping after 4 to 6 months of age/ or by more sensitive tests like molecular blood grouping.

“Blood grouping is done on the received sample. In case of any suspected discrepancy, Blood centre should be contacted , 1724692270"

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

Reference:

Method section 2: Red cell typing; AABB technical manual 19th Ed
Wong ECC, Punzalan RC. Neonatal and Pediatric
Transfusion practice. Technical Manual,
AABB, 19th Ed; p613-640

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : GAURAV GUPTA **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL – MOHALI, MOHALI 160062 7087030817	ACCESSION NO : **0006YC008024** PATIENT ID : FH.12765982 CLIENT PATIENT ID: UID:12765982 ABHA NO :	AGE/SEX : 34 Years Male DRAWN : 08/03/2025 09:25:00 RECEIVED : 08/03/2025 14:03:12 REPORTED : 08/03/2025 16:21:43

CLINICAL INFORMATION :

UID:12765982 REQNO-1834401
CORP-OPD
BILLNO-1002125OPCS004046
BILLNO-1002125OPCS004046

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	09	0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	14.8	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.92	4.5 - 5.5	mil/µL
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	5.77	4.0 - 10.0	thou/µL
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	**115 Low**	150 - 410	thou/µL
METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY			
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	47.9	40.0 - 50.0	%
METHOD : HYDRODYNAMIC FOCUSING			
MEAN CORPUSCULAR VOLUME (MCV)	97.4	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	30.1	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	**30.9 Low**	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	**14.7 High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	47	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
LYMPHOCYTES	**43 High**	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
MONOCYTES	6	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			

Dr. Subhijit kaur (MD, Pathology)
Senior Resident, 49300

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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ULR No.6000003687260-0006

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MC-2559

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BILLNO-1002125OPCS004046
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Test Report Status **Final**	Results	Biological Reference Interval	Units
EOSINOPHILS	4	1 - 6	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
BASOPHILS	0	0 - 2	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	2.71	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	2.48	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.35	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.23	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-**TEST DESCRIPTION** :- Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.
- ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION : **Increase** in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia
LIMITATIONS : **False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)
REFERENCE : Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease. (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

Dr. Subhijit kaur (MD, Pathology)
Senior Resident, 49300

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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ULR No.6000003687260-0006

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

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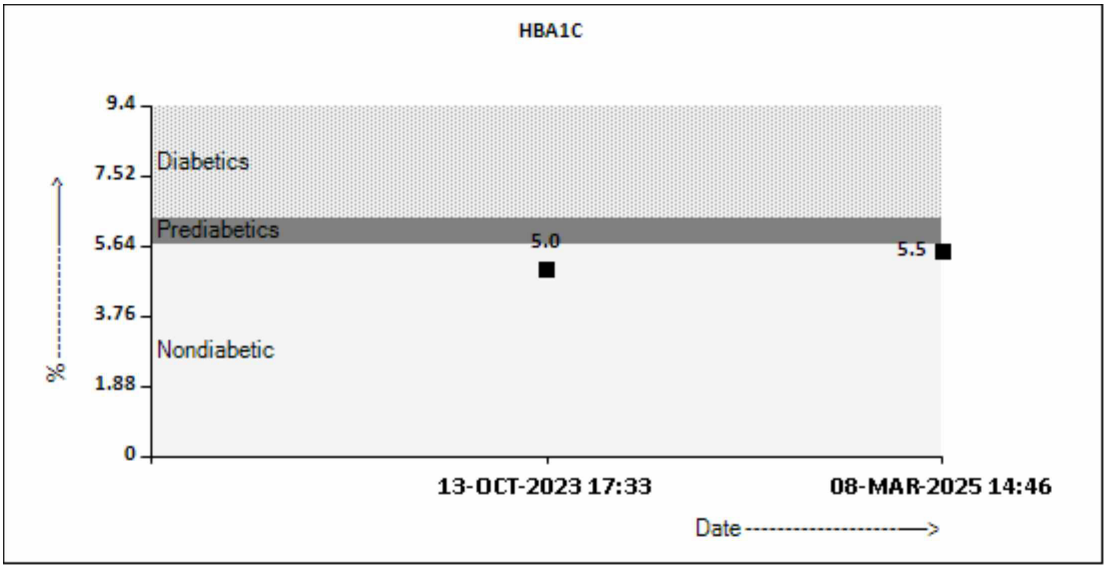
Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			



Interpretation(s)
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

Dr. Subhijit kaur (MD, Pathology)
Senior Resident, 49300

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

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1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.98	Upto 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.22	< or = 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	**0.76 High**	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.6 - 8.7	g/dL
METHOD : BIURET			
ALBUMIN	**5.0 High**	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN	2.5	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	2.0	1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**49 High**	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**109 High**	0 - 41	U/L
METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE			
ALKALINE PHOSPHATASE	**137 High**	40 - 129	U/L
METHOD : PNPP - AMP BUFFER			
GAMMA GLUTAMYL TRANSFERASE (GGT)	**474 High**	8 - 61	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	**241 High**	135 - 225	U/L
METHOD : LACTATE -PYRUVATE UV			
GLUCOSE FASTING,FLUORIDE PLASMA			

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Additional Director, 30897

Ms. Hardeep Kaur(Reviewed by) M.Sc.
Biochemistry

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

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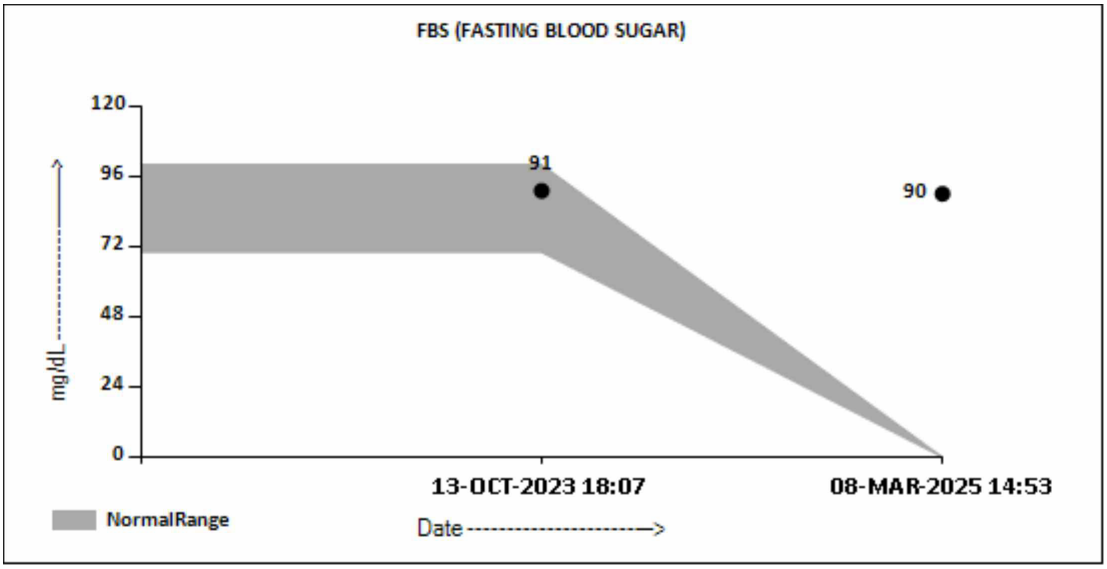
Test Report Status **Final**	Results	Biological Reference Interval	Units
FBS (FASTING BLOOD SUGAR)	90	(Normal <100,Impaired fasting glucose:100 to 125,Diabetes mellitus:>=126(on more than 1 occasion)(ADA guidelines 2024)	mg/dL

METHOD : HEXOKINASE



BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	**5 Low**	6 - 20	mg/dL

METHOD : UREASE - UV

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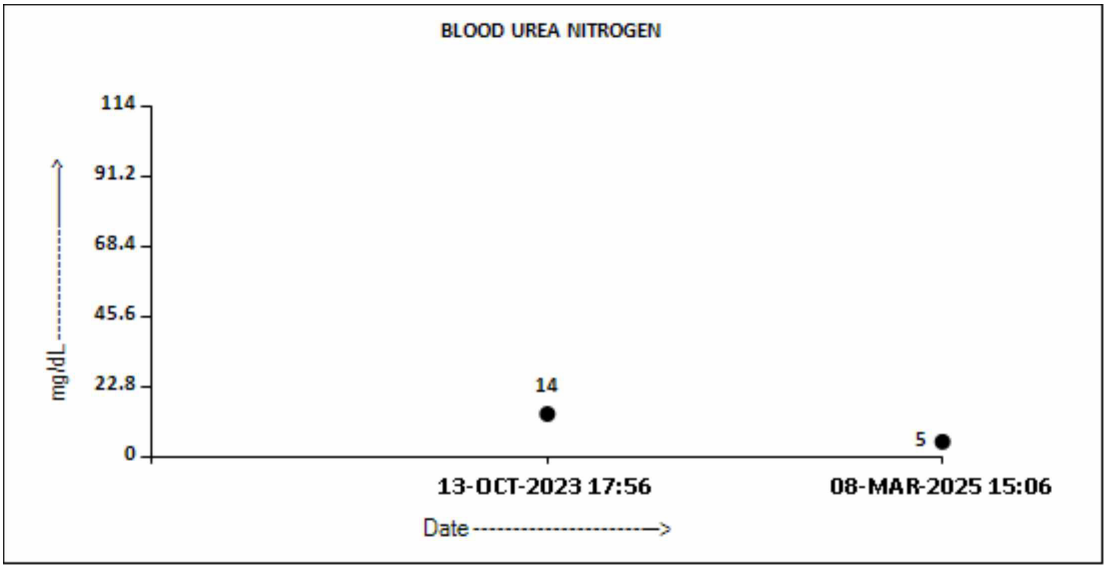

URIC ACID, SERUM

URIC ACID	6.7	3.4 - 7.0	mg/dL

METHOD : URICASE, COLORIMETRIC

CREATININE EGFR

CREATININE	0.90	0.90 - 1.30	mg/dL

METHOD : ALKALINE PICRATE-KINETIC

AGE	34		years

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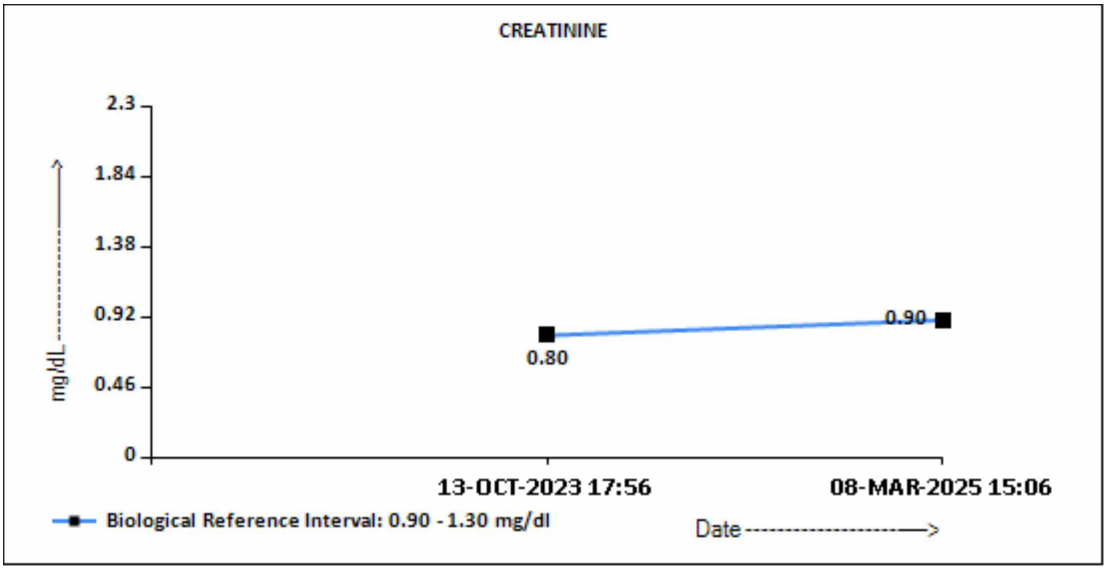
Test Report Status **Final**	Results	Biological Reference Interval	Units
GLOMERULAR FILTRATION RATE (MALE)	115	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure	mL/min/1.73mSq



Interpretation(s)

eGFR (ml/min/1.73 sq.meters)	Interpretation
>or= 90	Normal

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60 - 89	Mild Decrease in GFR
30 – 59	Moderate Decrease in GFR
15 - 29	Severe Decrease in GFR
<15	End stage renal failure

- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.
- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.
- The GFR is a calculation based on serum creatinine test.
- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.
- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.
- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- This equation takes into account several factors that impact creatinine production, including age, gender, and race.
- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:
National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation https://testguide.labmed.uw.edu/guideline/egfr
Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325
Harrison Principle of Internal Medicine, 21st ed. pg 62 and 334

GLUCOSE POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	83	Non-Diabetes 70 - 140	mg/dL

METHOD : HEXOKINASE

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

Ms. Hardeep Kaur(Reviewed by) M.Sc.
Biochemistry

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

View Details View Report

PERFORMED AT :
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Fortis Hospital, Sector 62,Phase Viii,
Mohali, 160062
Punjab, India
Tel : 0172-469-2222 Extn. 6726, 6727), Fax : 0172-469-2221 - CIN - L85110DL1996PLC076704
Email : lab.mohali@fortishealthcare.com

ULR No.6000003687260-0006

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

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CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL – MOHALI, MOHALI 160062 7087030817	ACCESSION NO : **0006YC008024** PATIENT ID : FH.12765982 CLIENT PATIENT ID: UID:12765982 ABHA NO :	AGE/SEX : 34 Years Male DRAWN : 08/03/2025 09:25:00 RECEIVED : 08/03/2025 14:03:12 REPORTED : 08/03/2025 16:21:43

CLINICAL INFORMATION :

UID:12765982 REQNO-1834401
CORP-OPD
BILLNO-1002125OPCS004046
BILLNO-1002125OPCS004046

Test Report Status **Final**	Results	Biological Reference Interval	Units

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.

Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.

Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc

GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.

Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.

Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.

BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis

GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

Ms. Hardeep Kaur(Reviewed by) M.Sc.
Biochemistry

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

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BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	**255 High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	147	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	55	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	**177 High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	**200 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	29.4	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**4.6 High**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

Ms. Hardeep Kaur(Reviewed by) M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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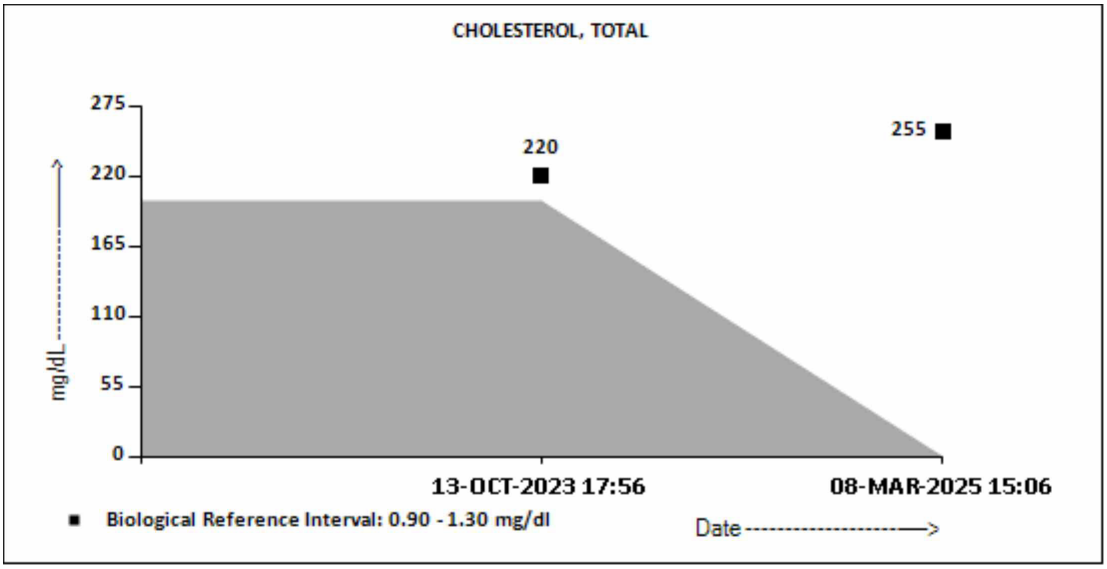
LDL/HDL RATIO	**3.2 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER



Ms. Hardeep Kaur(Reviewed by)
M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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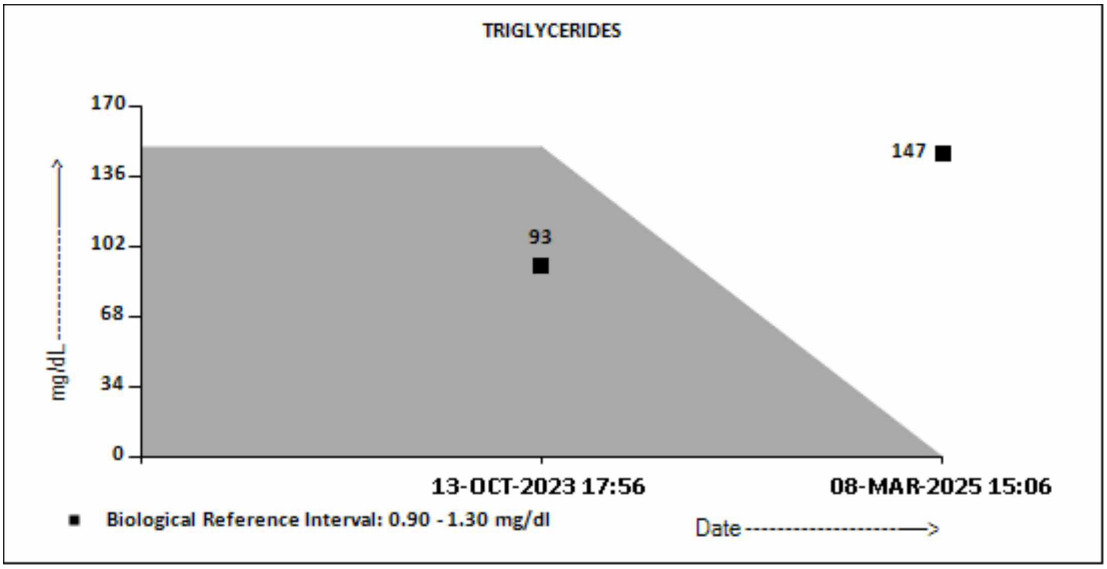

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M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
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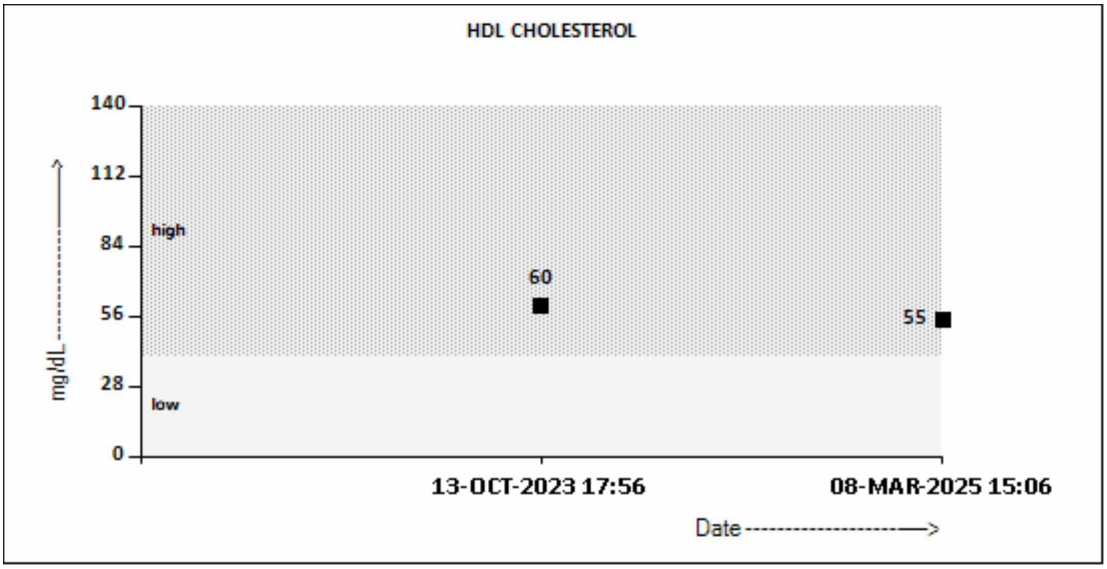

Ms. Hardeep Kaur(Reviewed by)
M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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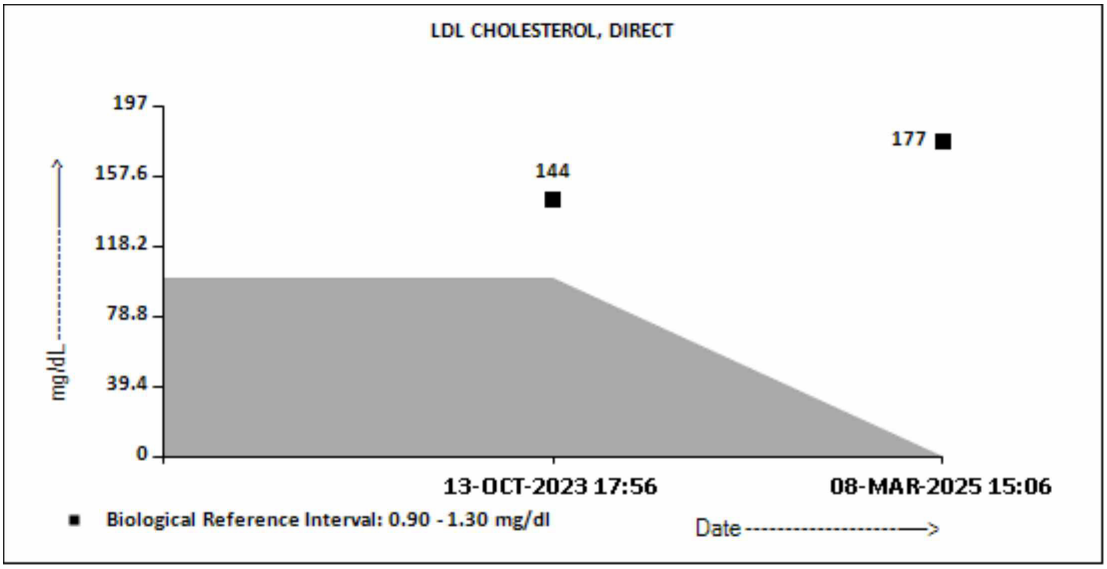

Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

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Biochemistry

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Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

Ms. Hardeep Kaur(Reviewed by)
M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	LT. YELLOW		
METHOD : MANUAL EXAMINATION			
APPEARANCE	CLEAR		
METHOD : MANUAL EXAMINATION			

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE PHOTOMETRY (EHRLICH'S REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBCS)	NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS	NOT DETECTED	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

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BILLNO-1002125OPCS004046

Test Report Status **Final**	Results	Biological Reference Interval	Units
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY			
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

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CLINICAL LABORATORY
Fortis Hospital, Sector 62,Phase Viii,
Mohali, 160062
Punjab, India
Tel : 0172-469-2222 Extn. 6726, 6727), Fax : 0172-469-2221 - CIN - L85110DL1996PLC076704
Email : lab.mohali@fortishealthcare.com

ULR No.6000003687260-0006

MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : GAURAV GUPTA **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL – MOHALI, MOHALI 160062 7087030817	ACCESSION NO : **0006YC008024** PATIENT ID : FH.12765982 CLIENT PATIENT ID: UID:12765982 ABHA NO :	AGE/SEX : 34 Years Male DRAWN : 08/03/2025 09:25:00 RECEIVED : 08/03/2025 14:03:12 REPORTED : 08/03/2025 16:21:43

CLINICAL INFORMATION :

UID:12765982 REQNO-1834401
CORP-OPD
BILLNO-1002125OPCS004046
BILLNO-1002125OPCS004046

Test Report Status **Final**	**Results**	**Biological Reference Interval**	**Units**

Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

Dr. Meenakshi Malhotra (MD, Pathology)
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DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : GAURAV GUPTA **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL – MOHALI, MOHALI 160062 7087030817	ACCESSION NO : **0006YC008024** PATIENT ID : FH.12765982 CLIENT PATIENT ID: UID:12765982 ABHA NO :	AGE/SEX : 34 Years Male DRAWN : 08/03/2025 09:25:00 RECEIVED : 08/03/2025 14:03:12 REPORTED : 08/03/2025 16:21:43

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BILLNO-1002125OPCS004046
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Test Report Status **Final**	Results	Biological Reference Interval	Units

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	133.3	80.00 - 200.00	ng/dL
METHOD : SANDWICH (ECLIA)			
T4	8.87	5.10 - 14.10	µg/dL
METHOD : SANDWICH (ECLIA)			
TSH (ULTRASENSITIVE)	2.270	0.270 - 4.200	µIU/mL
METHOD : SANDWICH (ECLIA)			

Interpretation(s)

Triiodothyronine T3 , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4**.**

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy

Meenakshi Malhotra

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Ritu Pankaj

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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MC-2559

Fortis HOSPITAL Mohali

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BILLNO-1002125OPCS004046
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Test Report Status **Final**	Results	Biological Reference Interval	Units

5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.

TSH in pregnancy

There's reduction in both the lower and the upper limit of maternal TSH relative to the non-pregnant TSH reference range. This is because of elevated levels of serum hCG that directly stimulates the TSH receptor, thereby increasing thyroid hormone production. The largest decrease in serum TSH is observed during the first trimester. Thereafter, serum TSH and its reference range gradually increases in the second and third trimesters, but nonetheless remains lower than in non-pregnant women.

NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

Meenakshi Malhotra

Ritu Pankaj

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

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DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

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CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL – MOHALI, MOHALI 160062 7087030817	ACCESSION NO : **0006YC008024** PATIENT ID : FH.12765982 CLIENT PATIENT ID: UID:12765982 ABHA NO :	AGE/SEX : 34 Years Male DRAWN : 08/03/2025 09:25:00 RECEIVED : 08/03/2025 14:03:12 REPORTED : 08/03/2025 16:21:43

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Test Report Status **Final**	Results	Biological Reference Interval	Units

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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Agilus Diagnostics Limited
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

Meenakshi Malhotra

Dr. Meenakshi Malhotra (MD, Pathology)
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ULR No.6000003687260-0006

Fortis MEDCENTRE
CHANDIGARH
(A unit of Fortis Hospital Mohali)
SCO 11, Sector 11-D, Chandigarh - 160011

Name Mr. Gaurav Gupta
UHID : 12765982 Date : 8/3/25
Age : — Gender : M

Nursing Assessment

Profile	
Height (cm) : 165cm	Waist Circumference (cm) : 33 inches
Weight (Kg.) : 79kg	Body Mass Index : 29 kg/m²
Occupation :	Marital Status ☐ Single ☐ Married

Vital Signs	
Spo2 - 98%	
Pulse Rate (/min) : 82 b/min	Respiratory Rate (/min) : 22/r
Blood Pressure (mmHg) : 120/80 mm Hg	Temperature (if febrile) : Afebrile

Past History	
☐ Hypertension :	☐ Diabetes :
☐ Heart disease :	☐ Dyslipidemia :
☐ Asthma :	☐ Tuberculosis :
☐ Allergies :	
☐ Others :	

For Women	
LMP:	Last Pap smear done in
Menopause ☐ Yes ☐ No	Last Mammography done in
Consent for X-ray & Mammography	

Current Medications

Signature, Name and Emp. ID of the Nurse : Sunny

Fortis MEDCENTRE
CHANDIGARH
(A unit of Fortis Hospital Mohali)
SCO 11, Sector 11-D, Chandigarh - 160011

Name : Mr. Gaurav Gupta
UHID : 1276598 Date : 8/3/22
Age : Gender : M

Internal Medicine Consultation

Relevant History:

Diagnosis:

Examination Findings:

Advice / Treatment Plan:

Investigations:

Signature and stamp of the Consultant :

Fortis MEDCENTRE
CHANDIGARH
(A unit of Fortis Hospital Mohali)
SCO 11, Sector 11-D, Chandigarh - 160011

Name: Mr. Gaurav Gupta
UHID : 12765982
Date : 8/3/25
Age :
Gender : M

Ophthalmology Consultation

History: NIL

Examination findings:

Visual acuity R 6/6, L 6/6
Visual acuity with glasses R, L
Colour Vision R WNL, L WNL

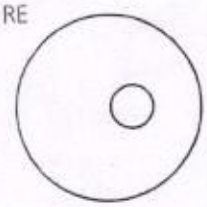
Slit Lamp Examination

RE

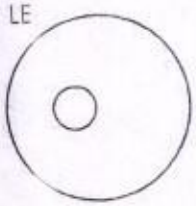
LE

Fundus Examination

RE



LE



Diagnosis: NADBE

Treatment"

Spectacle prescription:

Right eye

	SPH	CYL	AXIS	VA
Distance	Plano			6/6
Near				N.6

Left eye

	SPH	CYL	VA
Distance	Plano		6/6
Near			N.6

Signature and stamp of the Ophthalmologist :

,Mr.gaurav
ID: 12765982

Male

08.03.2025 9:47:07
Fortis Med Centre
sector 11
Chandgarh

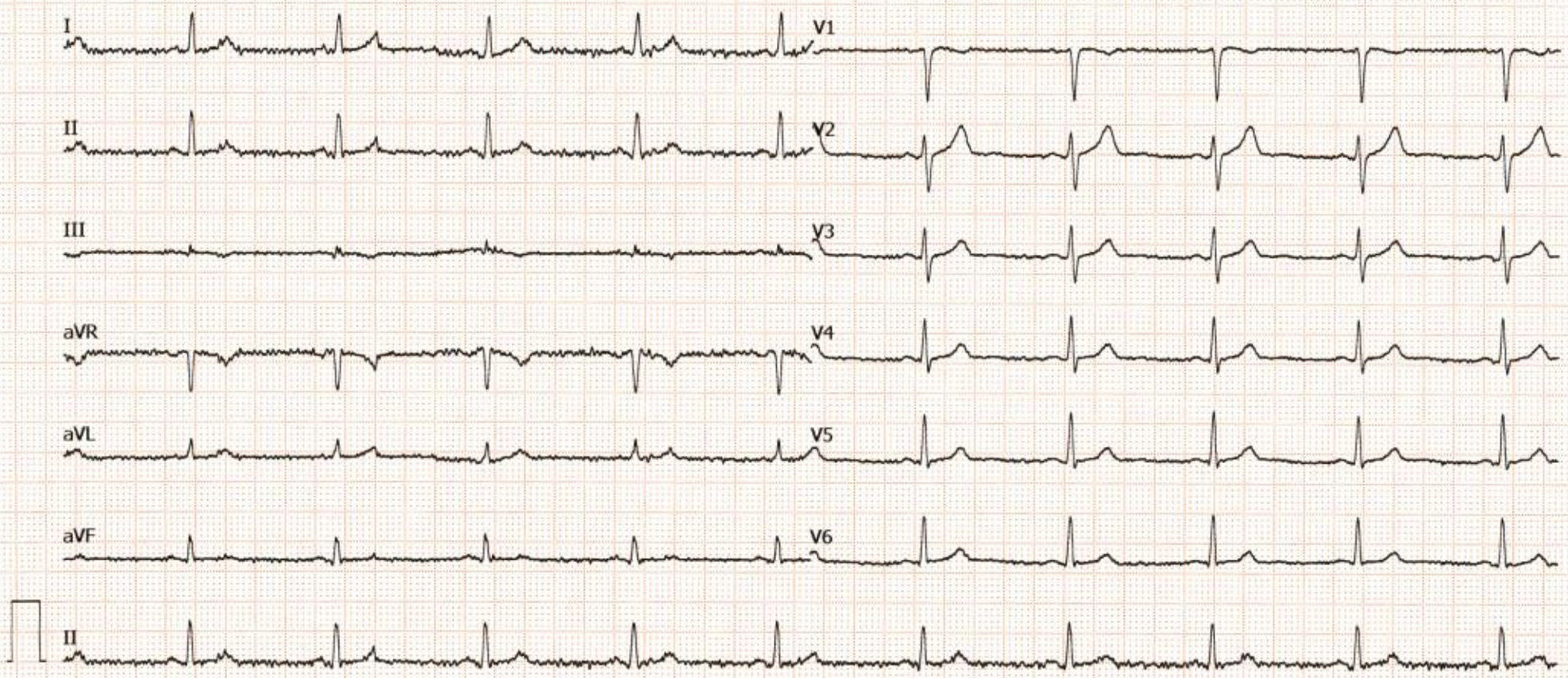
Location:
Order Number:
Visit:
Indication:
Medication 1:
Medication 2:
Medication 3:

Room:

62 bpm
-- / -- mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS :	78 ms	Normal sinus rhythm
QT / QTcBaz :	362 / 367 ms	Normal ECG
PR :	122 ms	
P :	90 ms	
RR / PP :	974 / 967 ms	
P / QRS / T :	42 / 37 / 25 degrees	



GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-40 Hz 50 Hz

Unconfirmed
2x5x6_25_R1 1/1

Fortis MEDCENTRE
CHANDIGARH

Fortis Medcentre
SCO-11, Sector-11-D,
Chandigarh - 160 011 (India)
Telephone : 0172 506 1222 / 505 5441
Fax : 0172-5055440
E-mail : contactus.fmc@fortishealthcare.com
Website : www.fortishealthcare.com

DEPARTMENT OF FMC-RADIOLOGY LAB

Date: 08/Mar/2025

Name: Mr. Gaurav Gupta
Age | Sex: 34 YEAR(S) | Male
Order Station : FRONTOFFICE-FMC
Bed Name :

UHID | Episode No : 12765982 | 3237/25/10021
Order No | Order Date: 10021/PN/OP/2503/8355 | 08-Mar-2025
Admitted On | Reporting Date : 08-Mar-2025 09:34:33
Order Doctor Name : Dr.SELF .

CHEST X-RAY (PA VIEW)

Both the domes of diaphragm are normal.

Both costophrenic angles are normal.

Both lung fields are clear.

Cardiac size and silhouette are normal.

Both hila and mediastinum are normal.

Bony cage and soft tissues are normal.

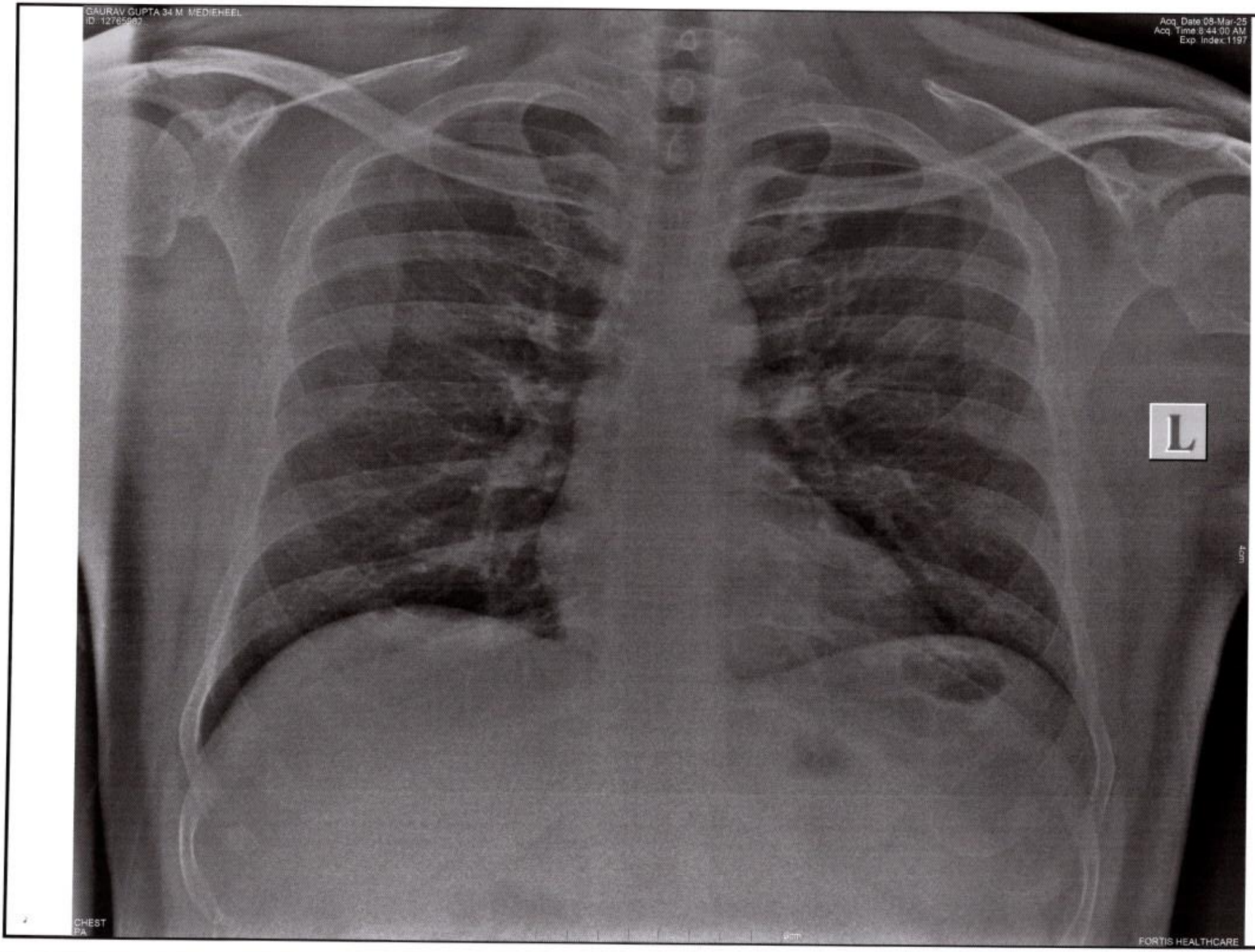
IMPRESSION: NORMAL STUDY.

Please correlate clinically and with other relevant investigations.

Dr. ADITI PANWAR

PMC - 41230

Consultant Radiologist


GAURAV GUPTA 34 M MEDIHEEL
ID: 12765987
Acq. Date:08-Mar-25
Acq. Time:8:44:00 AM
Exp. Index:1197
L
CHEST
PA
FORTIS HEALTHCARE

Fortis MEDCENTRE
CHANDIGARH

Fortis Medcentre
SCO-11, Sector-11-D,
Chandigarh - 160 011 (India)
Telephone : 0172 506 1222 / 505 5441
Fax : 0172-5055440
E-mail : contactus.fmc@fortishealthcare.com
Website : www.fortishealthcare.com

NAME: Mr. GAURAV GUPTA
AGE AND SEX: 34 Y/M
UHID NO: 12765982
DATE: 08/03/2025
ROI: WHOLE ABDOMEN

Liver is normal in size, outline and echogenicity. No focal lesion seen. IHBR's are not dilated. Portal vein and hepatic veins are normal.

Gall bladder is normally distended with anechoic lumen. Wall thickness is normal. No calculus / focal lesion seen. No pericholecystic fluid / collection seen. CBD is normal.

Pancreas is visualized in region of head and proximal body and is normal in size, shape, outline and echotexture. No focal lesion seen. Distal body and tail are obscured by bowel gases.

Spleen is normal in size, outline and echotexture. No focal lesion seen.

Right kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Left kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Retroperitoneum is normal.

The urinary bladder is fully distended and is normal in outline and wall thickness. No calculi or growth seen.

Prostate is normal in size and shows normal outline and echo pattern. No focal lesion seen.

No free fluid is seen.

Opinion: Normal study

Suggested clinical correlation.

Dr. ADITI PANWAR
PMC - 41230
Consultant Radiologist

Patient Demographics

GAURAV GUPTA 34/M **Study Date: 08/03/2025**

Patient ID: 12765982 Accession #: Alt ID:

DOB: Age: Gender: M Ht: Wt: BSA:

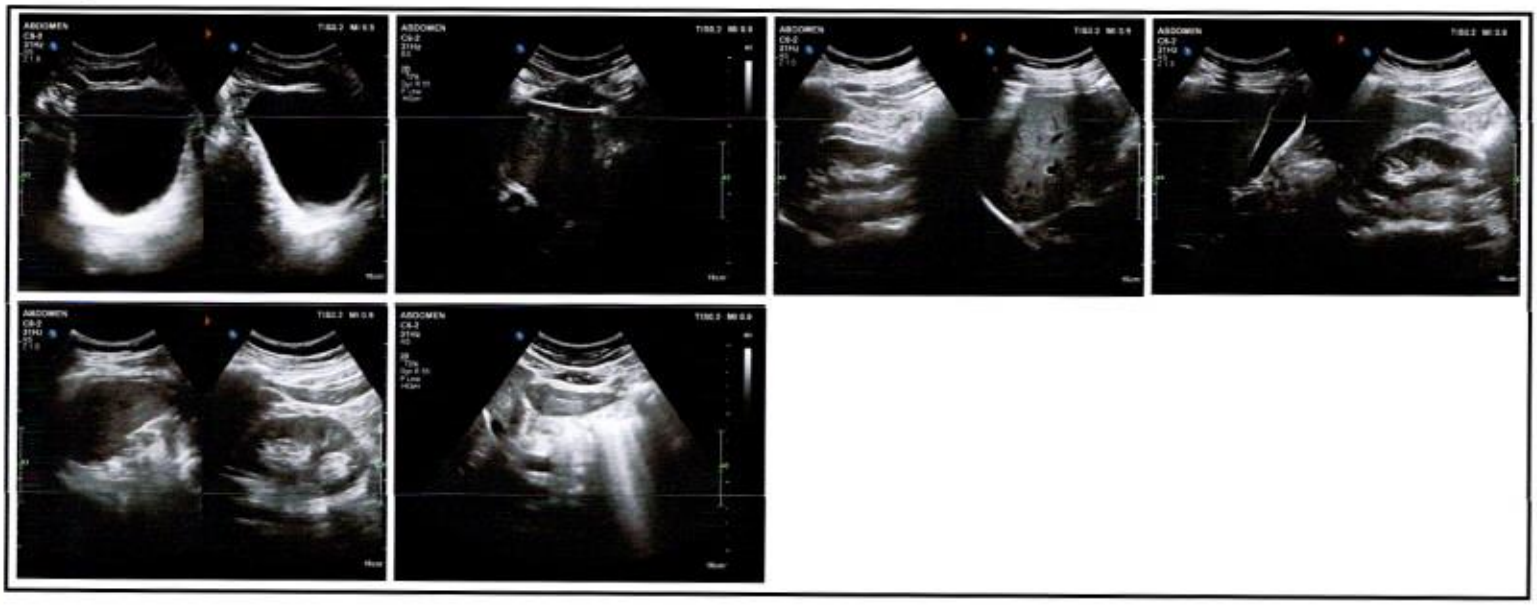
Institution: Fortis MEDCENTRE, Chandigarh

Referring Physician:

Physician of Record: Performed By:

Comments:

Images



Signature

Signature:

Name(Print): Date:

Fortis MECENTRE
SCO 11, Sector 11 D
Chandigarh

Station
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: GUPTA, GAURAV
Patient ID: 12765982
Height: 165 cm
Weight: 79 kg

DOB: 29.09.1990
Age: 34yrs
Gender: Male
Race: Indian

Study Date: 08.03.2025
Test Type: --
Protocol: BRUCE

Referring Physician: --
Attending Physician: DR MANJEET/DR VIJAY HARJAI

Medications:
--

Medical History:
--

Reason for Exercise Test:

--

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (km/h)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:01					
	STANDING	00:19	0.00	0.00	105	120/80	
	HYPERV.	00:16	0.00	0.00	113		
	WARM-UP	01:01	1.60	0.00	118		
EXERCISE	STAGE 1	03:00	4.00	10.00	133	120/80	
	STAGE 2	03:00	5.50	12.00	160	140/80	
	STAGE 3	00:25	6.80	14.00	169	150/80	
RECOVERY		02:18	0.00	8.90	117	110/80	

The patient exercised according to the BRUCE for 6:25 min:s, achieving a work level of Max. METS: 10.40. The resting heart rate of 110 bpm rose to a maximal heart rate of 169 bpm. This value represents 90 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg , rose to a maximum blood pressure of 150/80 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.

Conclusions

--

Physician_____

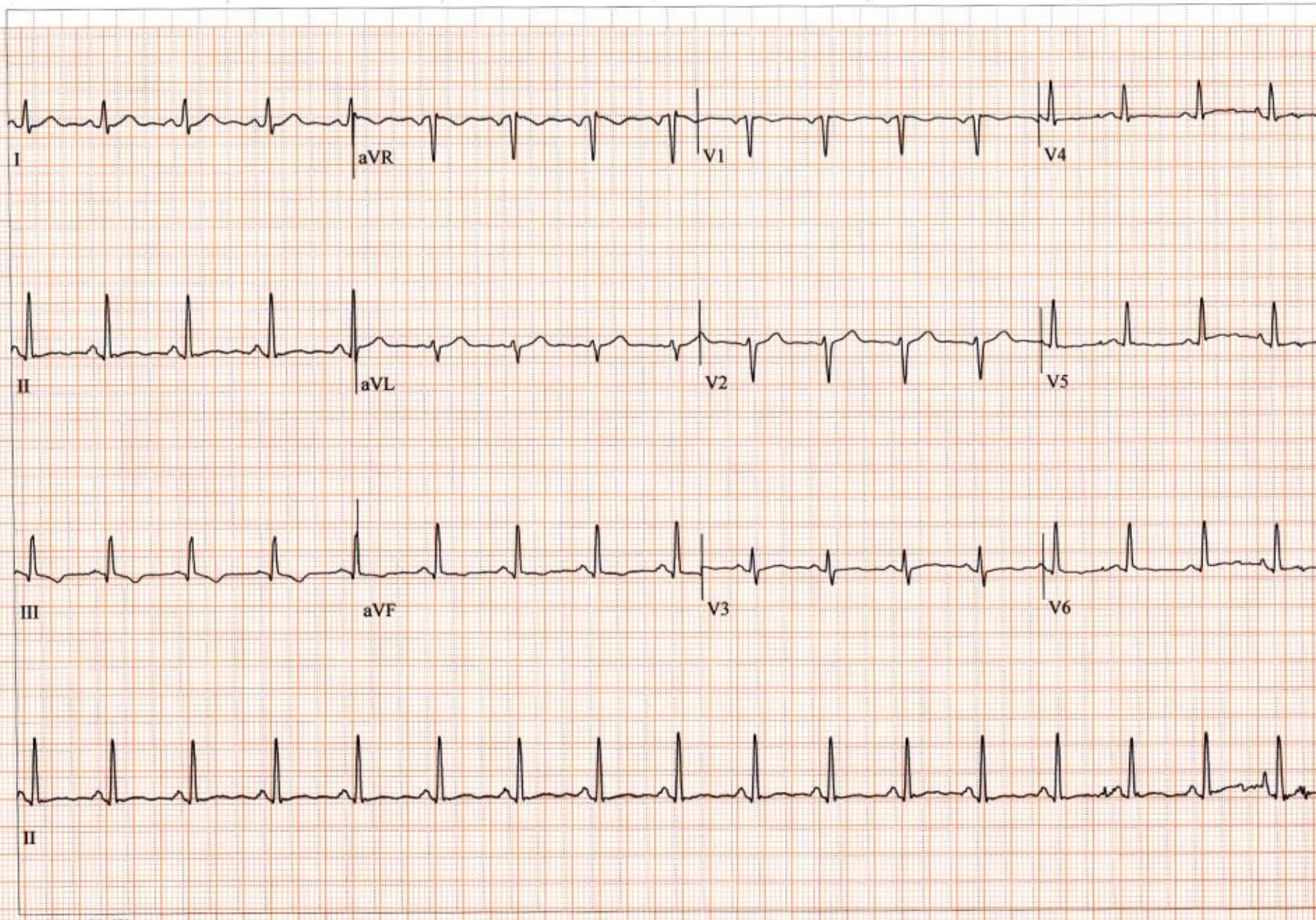
GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:10:52pm

107 bpm
120/80 mmHg

12-Lead Report
PRETEST
STANDING
00:16

BRUCE
0.0 km/h
0.0 %

Fortis MECE



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

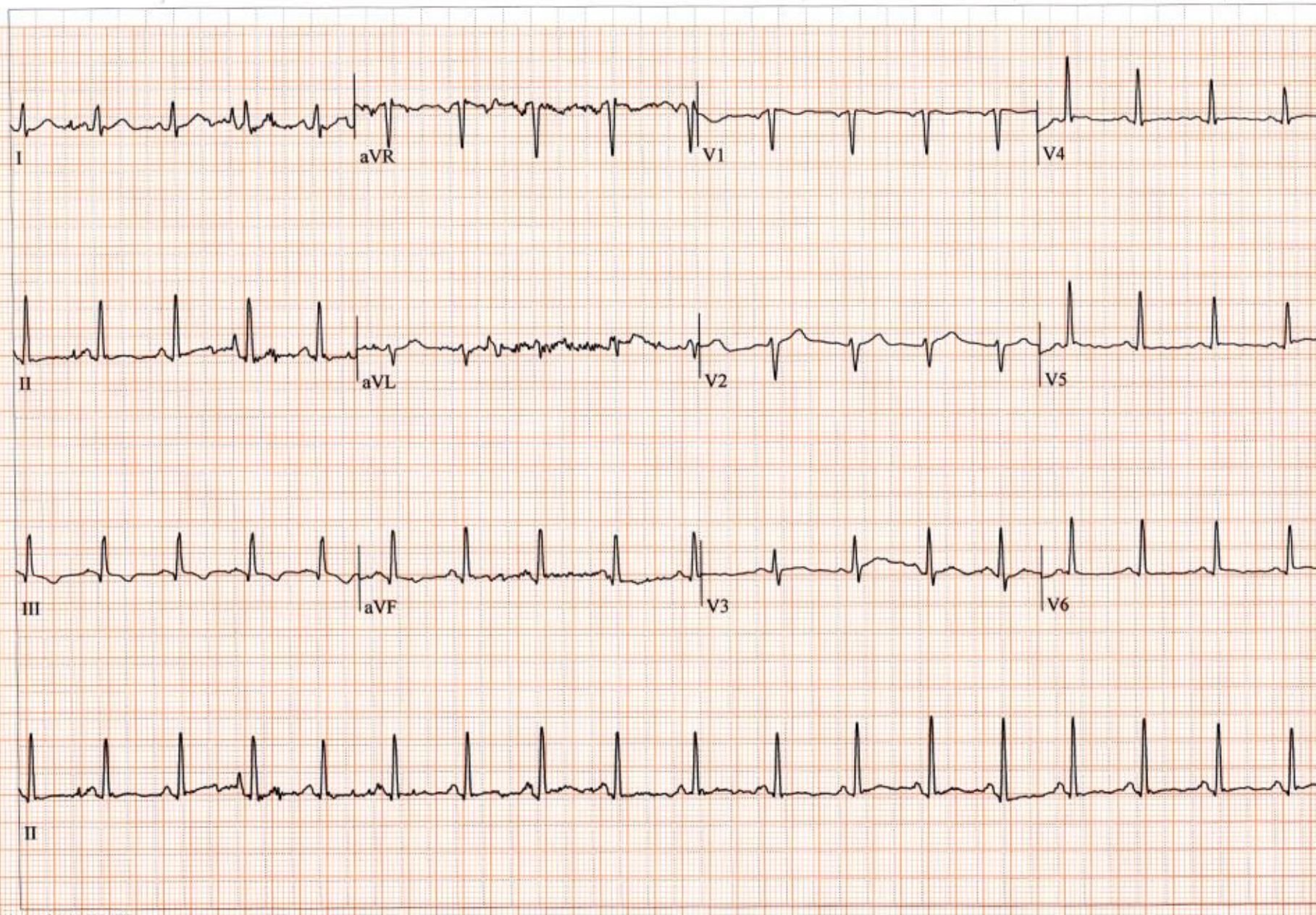
GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:11:00pm

109 bpm
120/80 mmHg

12-Lead Report
PRETEST
HYPERV.
00:24

BRUCE
0.0 km/h
0.0 %

Fortis MECE



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 40Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

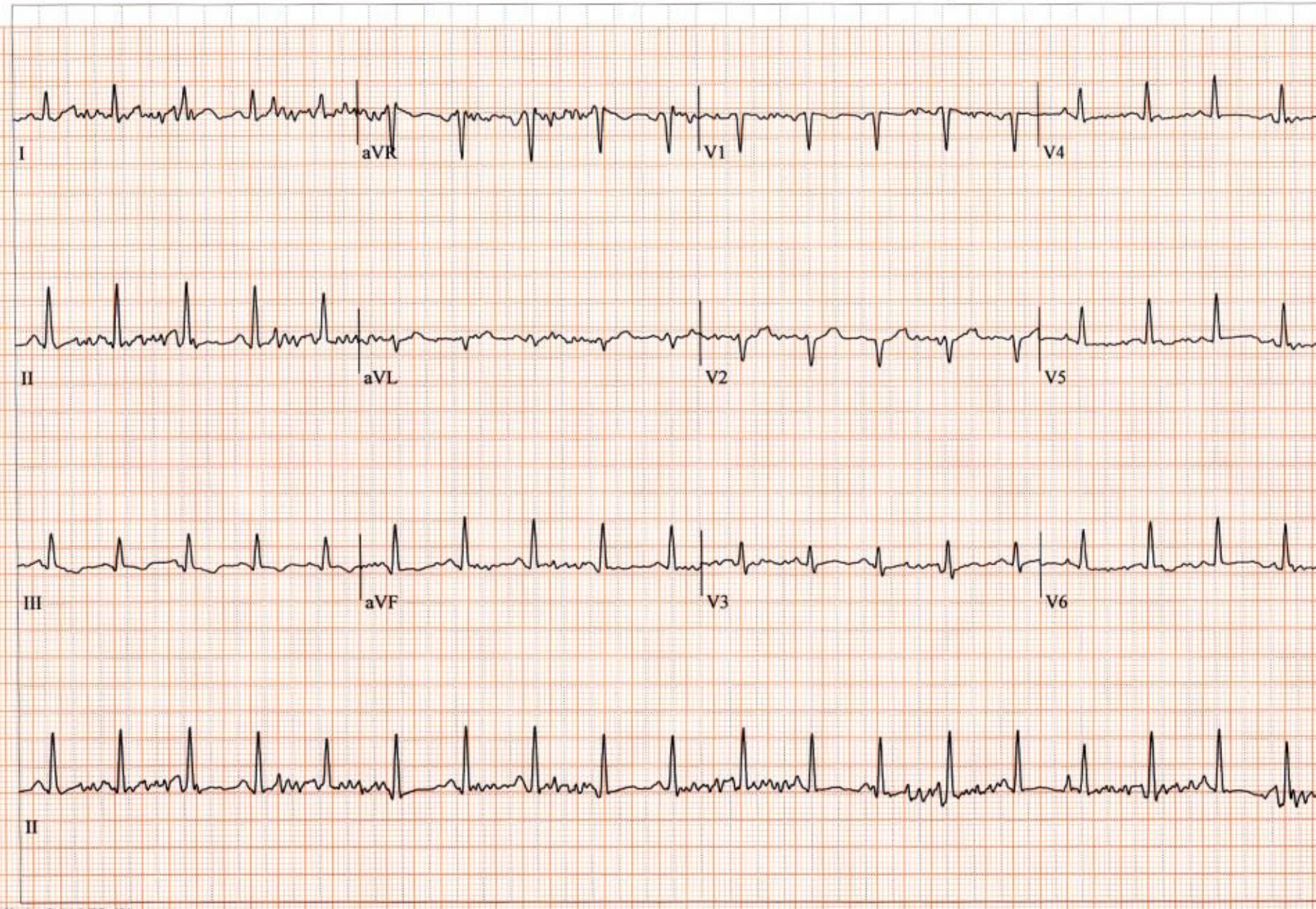
GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:12:12pm

120 bpm

12-Lead Report
PRETEST
WARM-UP
01:35

BRUCE
1.6 km/h
0.0 %

Fortis MECE



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

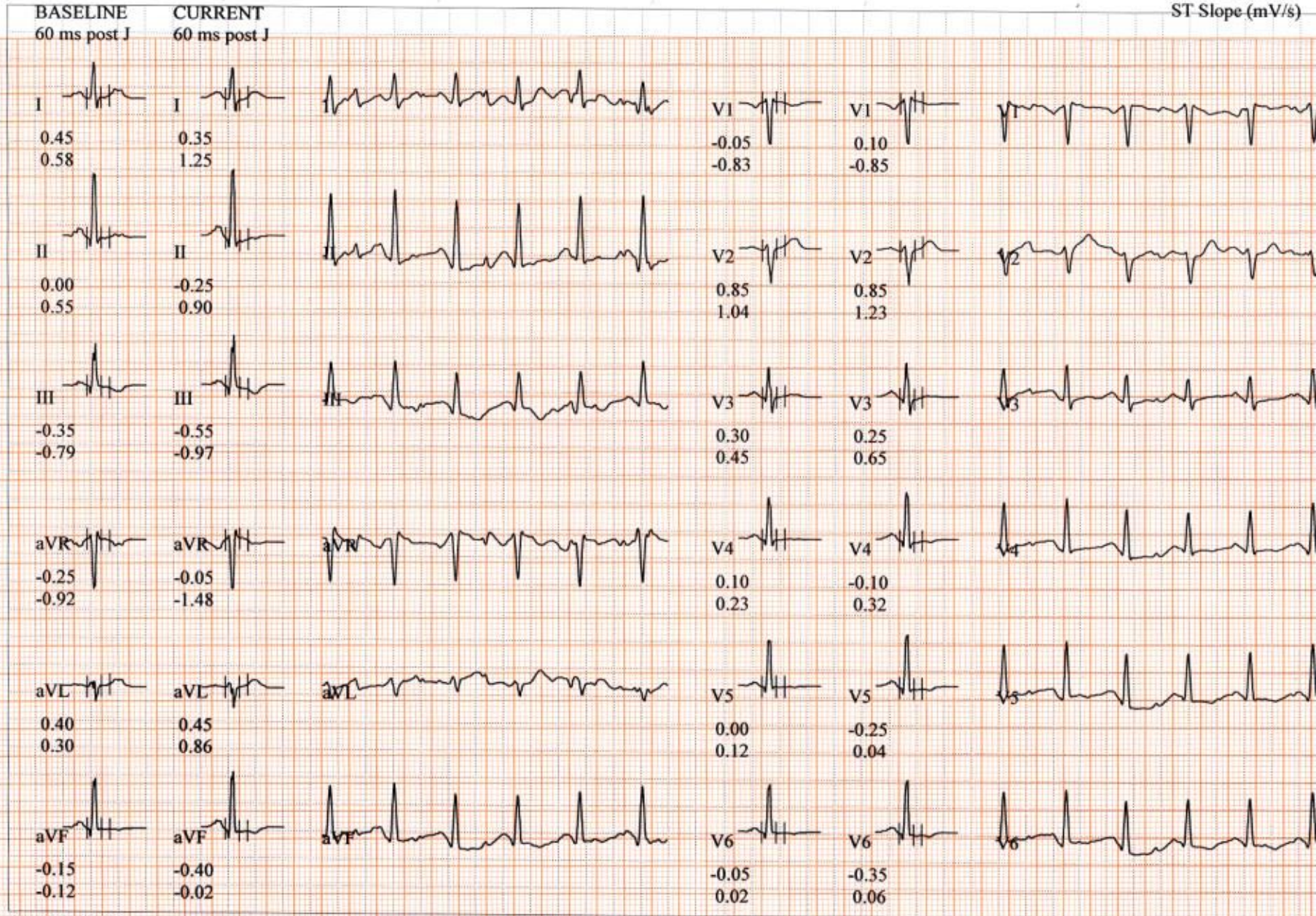
GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:14:58pm

133 bpm
120/80 mmHg

Comparative Medians Report
EXERCISE
STAGE 1
02:50

BRUCE
4.0 km/h
10.0 %

Fortis MEC



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:17:58pm

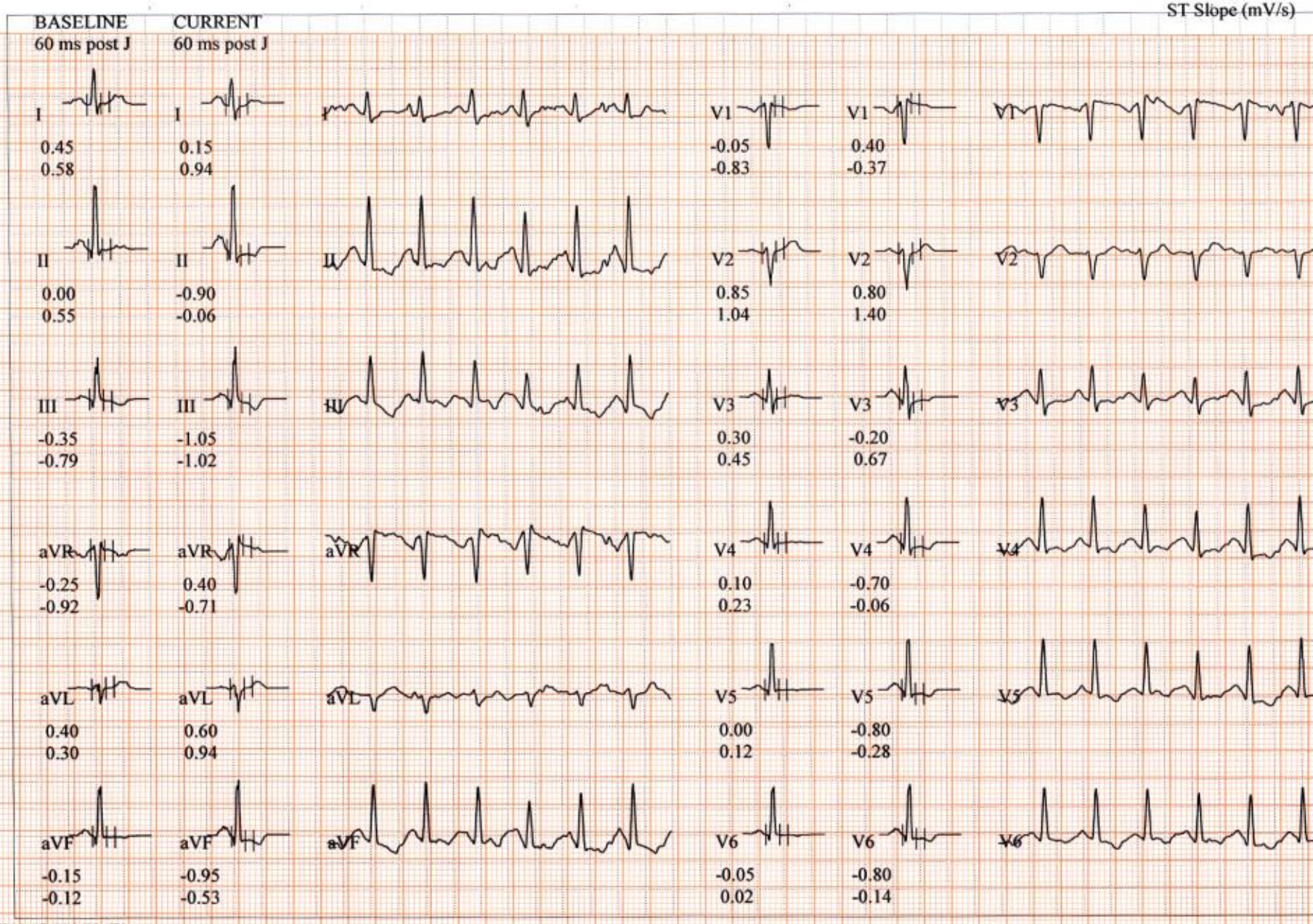
160 bpm
140/80 mmHg

Comparative Medians Report
EXERCISE
STAGE 2
05:50

BRUCE
5.5 km/h
12.0 %

Fortis MECI

Lead
ST Level (mm)
ST Slope (mV/s)



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:18:33pm

169 bpm
150/80 mmHg

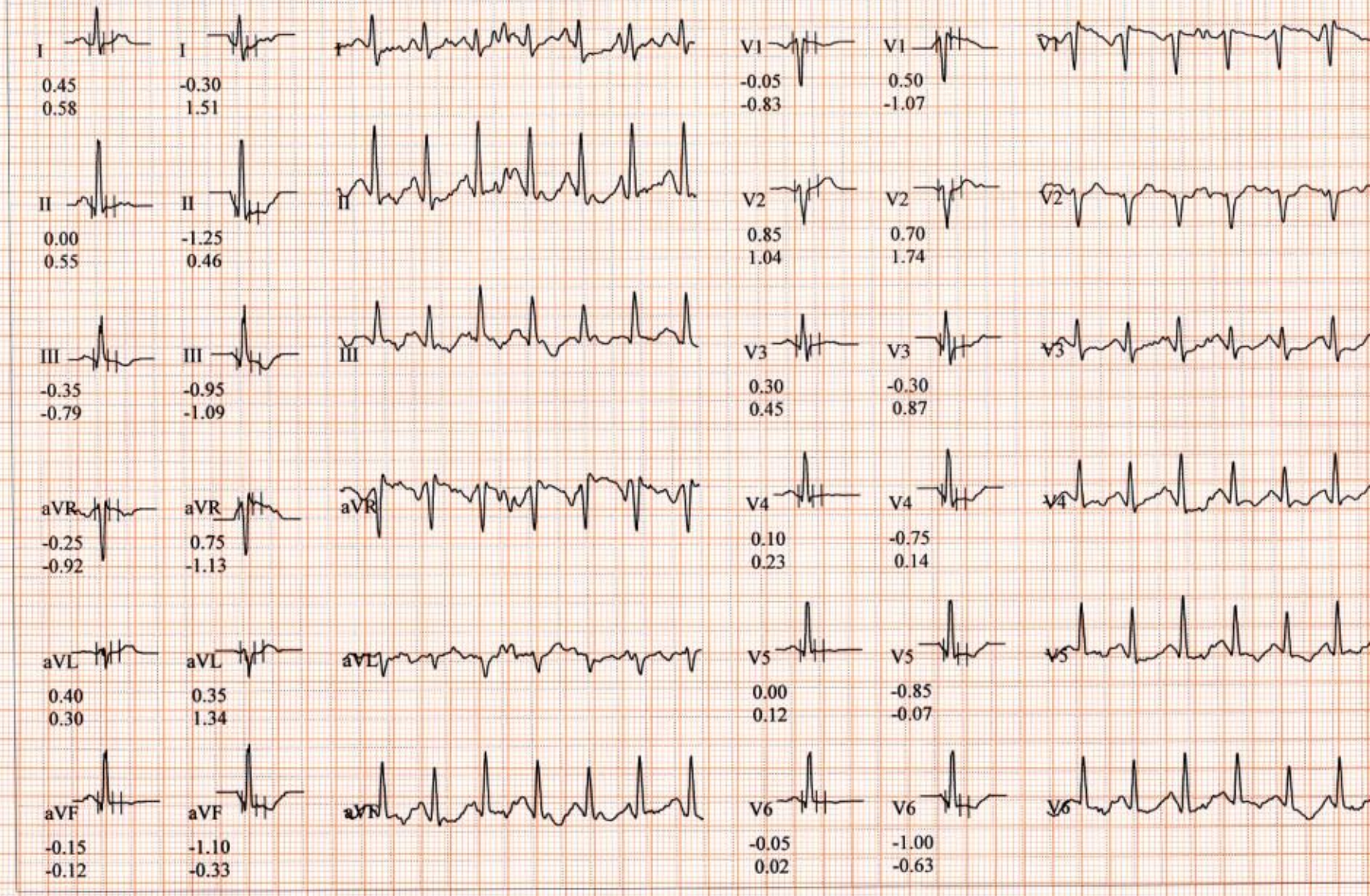
Comparative Medians Report (PEAK EXERCISE)

EXERCISE	BRUCE
STAGE 3	6.8 km/h
06:25	14.0 %

Fortis MECI

Lead	BASELINE 60 ms post J	CURRENT 60 ms post J
I	0.45	-0.30
	0.58	1.51
II	0.00	-1.25
	0.55	0.46
III	-0.35	-0.95
	-0.79	-1.09
aVR	-0.25	0.75
	-0.92	-1.13
aVL	0.40	0.35
	0.30	1.34
aVF	-0.15	-1.10
	-0.12	-0.33
V1	-0.05	0.50
	-0.83	-1.07
V2	0.85	0.70
	1.04	1.74
V3	0.30	-0.30
	0.45	0.87
V4	0.10	-0.75
	0.23	0.14
V5	0.00	-0.85
	0.12	-0.07
V6	-0.05	-1.00
	0.02	-0.63

ST Level (mm)
ST Slope (mV/s)



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:19:23pm

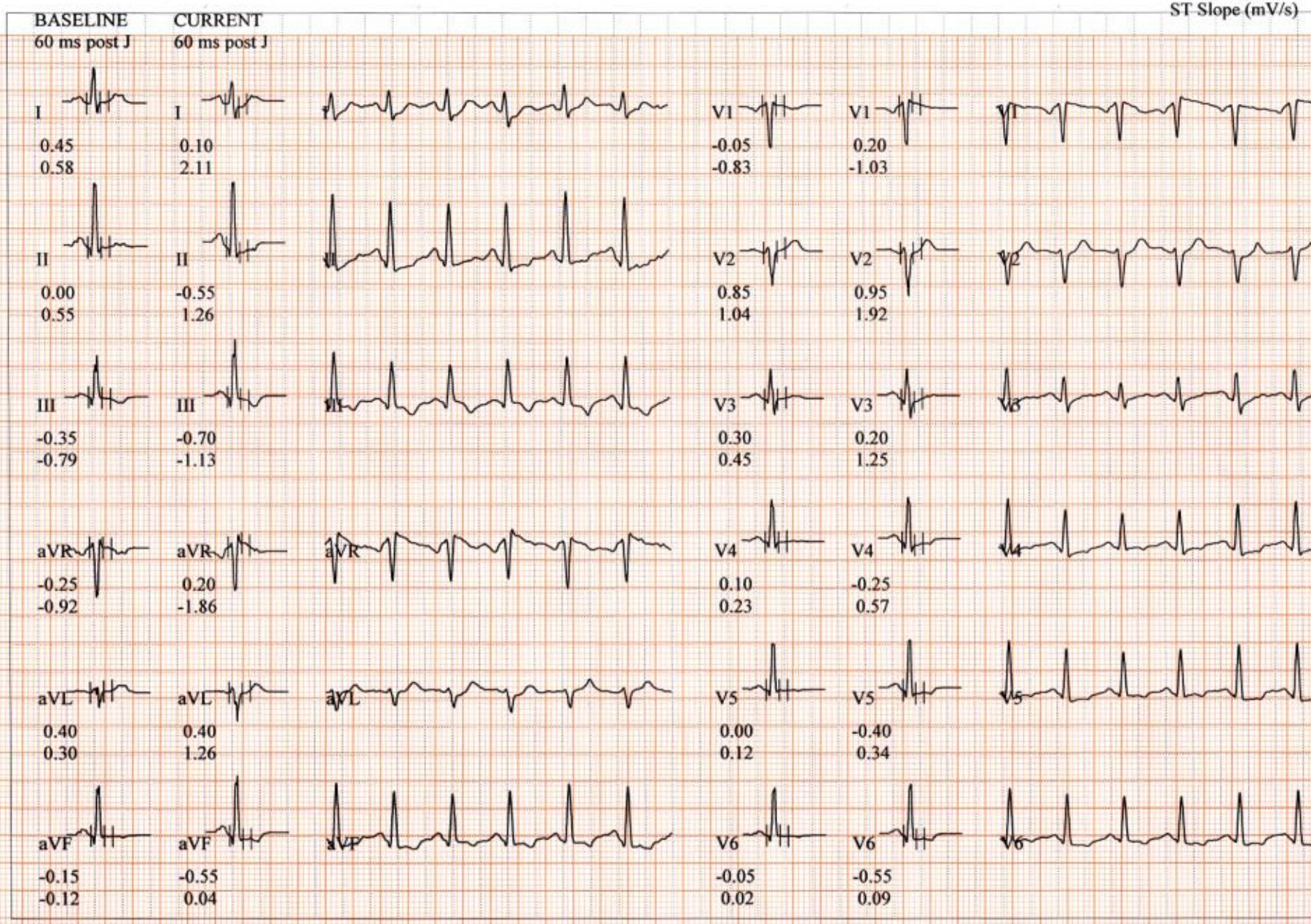
Comparative Medians Report

142 bpm
150/80 mmHg

RECOVERY
#1
00:50

BRUCE
2.4 km/h
8.9 %

Fortis MEC



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm

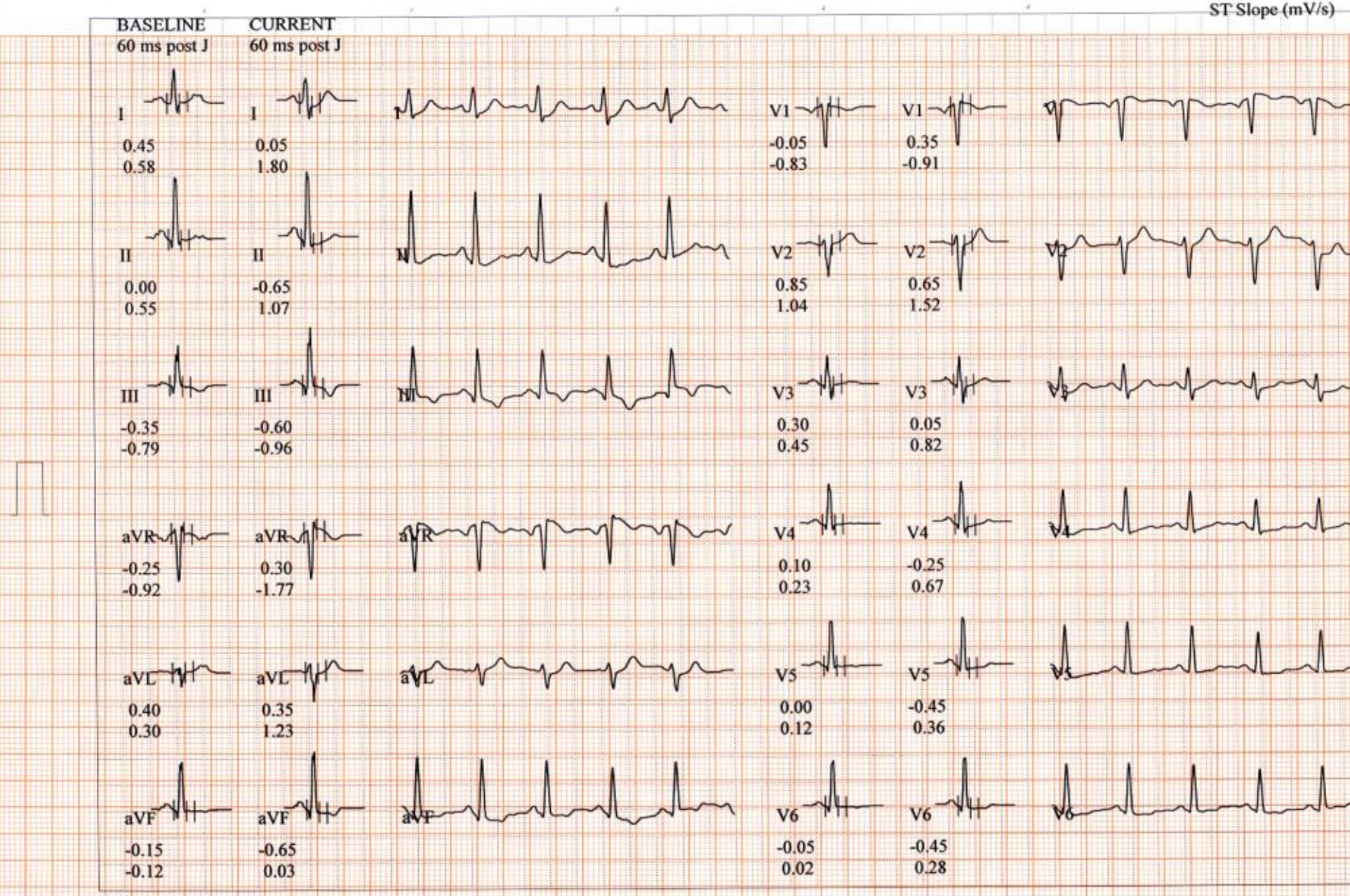
GUPTA, GAURAV
Patient ID 12765982
08.03.2025
12:20:23pm

126 bpm
150/80 mmHg

Comparative Medians Report
RECOVERY
#1
01:50

BRUCE
0.0 km/h
8.9 %

Fortis MEC



GE CardioSoft V6.73 (2)
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V1)

Start of Test: 12:10:30pm