UNITED HOSPITAL
Care Par Excellence

NABH CERTIFIED

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. SHARIL HEGDE P	Order No	: 1000120050
UHID	: UHJA24013008	Registered On	: 09/03/2025 08:09:48 AM
Age/Sex	: 48/Years Male	Collected On	: 09/03/2025 08:14:31 AM
Ward / Bed No	:	Reported On	: 09/03/2025 01:02:28 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240018328
Station	: At Hospital	Mobile No	: 9741542946
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
BIOCHEMISTRY			
FASTING GLUCOSE (Method: Hexokinase)	100	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	84	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C) — Sample: Whole blood (EDTA)			
HBAIC (Method: HPLC)	5.7	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	117	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH) — Sample: Serum			
TOTAL T3 (Method:CLIA)	1.42	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.70	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.29	ı IU/mL	0.34-5.60
LIPID PROFILE — Sample: Serum			
TOTAL CHOLESTEROL (Method:CHOD-POD)	230	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	79	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	42.8	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method: Calculated)	171.40	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	15.80	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.37		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	4.00		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	187.20	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	6.6	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	15	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	1.00	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	15		12¯20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.55	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.11	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.44	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.8	g/dL	6.6-8.3

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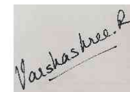
Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.33	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.47	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.25		2:1
SERUM SGOT (Method:IFCC without P5P)	21	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	22	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	78	U/L	50-116
GGT (Method:IFCC)	21	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	2.41	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	33.0	mg/dL	17-43



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)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.68	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	47.9	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	9430	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.00	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	22.24	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.59	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.90	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.27	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.72	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	83.8	fL	78-100
MCH (Method: Calculated)	27.4	pg	27-31
MCHC (Method: Calculated)	32.7	g/dL	31-37
RDW - CV (Method: Calculated)	14.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.69	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.62	fl	7-11
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.2	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	6220	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	430	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	2100	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	650	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	30	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	28	mm/hour	1-15

BLOOD GROUPING & RH TYPING

Sample: Whole blood (EDTA)

Test Name	Result
ABO Group (Method:Agglutination Method)	A
Rh Factor (Method:Agglutination Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.005		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative

MICROSCOPIC EXAMINATION

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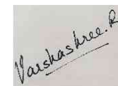
Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		



Verified By
Sridhar Kandukuri

---End of Report---

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

NABH No.1

Out Patient Record

Patient Name	**: Mr.SHARIL HEGDE P**	**UHID**	**: UHJA24013008**
Age / Sex	: 48 Years / Male	OP NO/Reg Dt	: 09-03-2025 08:09 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht - 171 cm
Wt - 60.7kg
Bp - 124/84mmHg
SpO2 - 98%
PR - 100/mts.

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

PATIENT NAME:	Mr. SHARIL HEGDE P	DATE:	09/03/25
AGE :	48 Years Sex: MALE	UHID :	24013008
REF BY :	CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.5 (2.5-3.7)	LVIDD : 4.1 (3.5-5.5)	MV EV : 73.2	AV : 59.2	MR : TRIVIAL MR
LA : 3.1 (1.9-4.0)	LVIDS : 2.4 (2.4-4.2)	AV : 97.7		AR : NORMAL
RA : 2.7 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 67.9		PR : NORMAL
RV : 1.5 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : ---	AV : ---	TR : TRIVIAL TR, PASP-30mmHg
TAPSE:1.9 (>1.6)	LVPWD :0.8 (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	:MILDLY DILATED AORTIC ROOT (3.9cms)
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

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

DEPARTMENT OF RADIODIAGNOSIS

Name	Sharil Hegde P	Date	09/03/25
Age	48 years	Hospital ID	UHJA24013008
Sex	Male	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. Varun
Consultant Radiologist

NABH

No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Sharil Hegde P	Date	09/03/25
Age	48 years	Hospital ID	UHJA24013008
Sex	Male	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 ***shows multiple polyps, largest measures 4.8 x 3.4 mm.*** There is no 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 focal lesion.

Right Kidney is normal in size (10.8 x 3.6 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (10.4 x 4.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

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

Urinary Bladder is normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 14 cc.

Long segment wall thickening of distal ileum and ceacum, measuring about 6 mm in maximum and multiple enlarged lymphnodes are noted in the right iliac and lumbar region.

No ascites.

IMPRESSION:

- **Long segment wall thickening of distal ileum and ceacum with regional lymphadenitis as described above - likely infective / inflammatory etiology.**
- **Multiple small gall bladder polyps.**
- **Mild fatty infiltration of liver (Grade I).**

Dr. Varun
Consultant Radiologist

ID: 24013008 Part No.2.157017M

Name: mr sharil

9-Mar-2025 AM9:16:12

SCHILLER

lex: M Birth date: 48 years

cm kg / mmHg

ledication:

lymptoms:

listory:

1100 Sinus rhythm

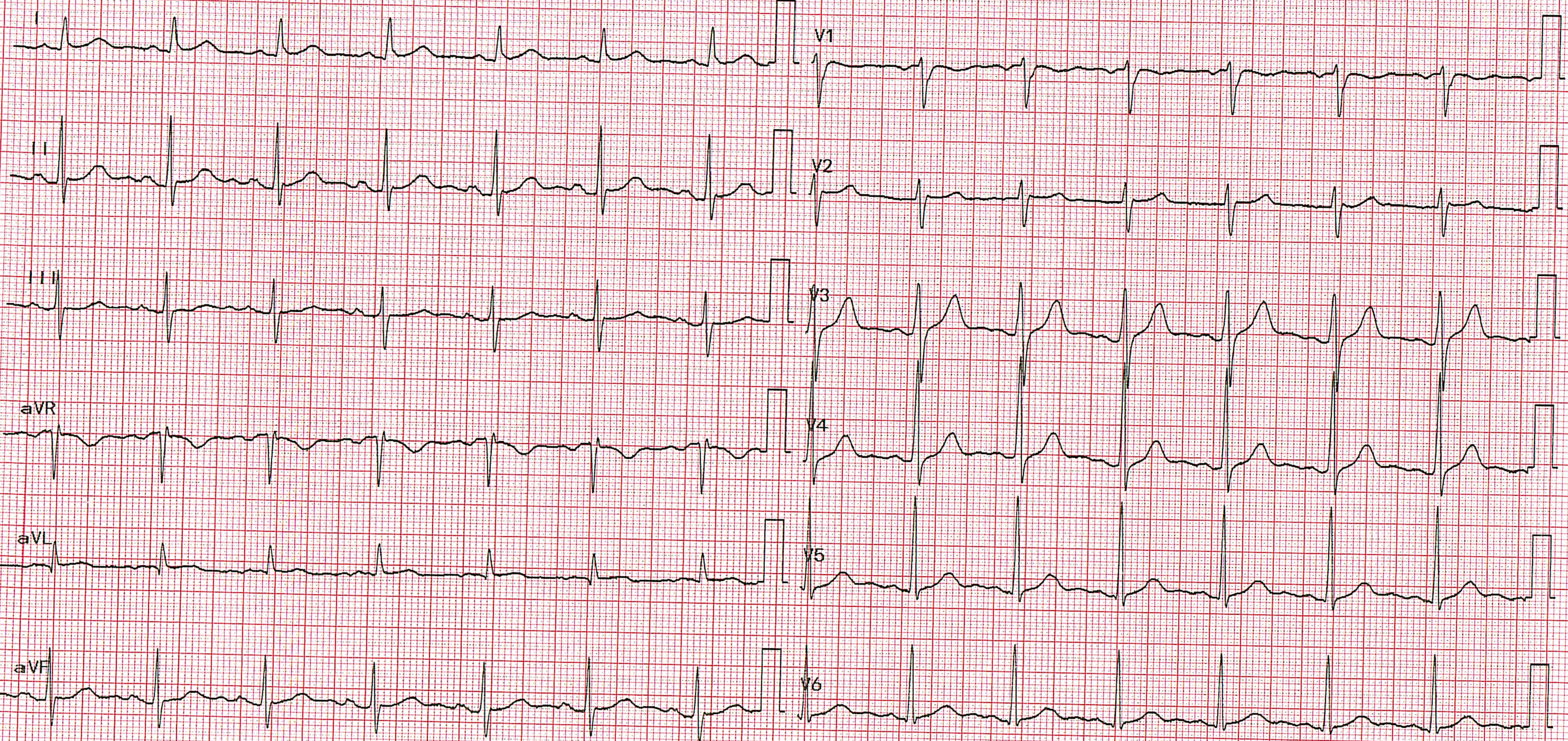
9110 ** normal ECG **

lent. rate	87	bpm
R int	158	ms
RS dur	92	ms
T/QTc(E) int	352/ 397	ms
/QRS/T axis	53/ 45/ 50	°
V5/SV1 amp	1.66/ 0.80	mV
V5+SV1 amp	2.46	mV

Unconfirmed Report

Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz 10 mm/mV



2350K 03-08 07-01 Dept.:

Exam: UNITED HOSPITAL