



**BMI CHART**

Date: 7/3/24

Name: Sandhya Raut Age: 45 yrs

Sex: M/F

BP: 190/90 mmHg Height (cms): 160.5 cm Weight(kgs): 61.3 kg BMI: \_\_\_\_\_

SpO2: 99%  
Pulse: 94 bpm

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215		
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7		
HEIGHT in/cm	<input type="checkbox"/> Underweight <input type="checkbox"/> Healthy <input type="checkbox"/> Overweight <input type="checkbox"/> Obese <input type="checkbox"/> Extremely Obese																									
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42		
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40			
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39				
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39			
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39			
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38			
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38			
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37			
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37			
5'9" - 176.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'11" - 180.3	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
6'1" - 185.4	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
6'4" - 193.0	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			

Doctors Notes:

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Signature



UHID	2904834	Date	06/03/2024		
Name	Mrs Sandhya Raut	Sex	F	Age	45
OPD	PAP	Health Check-Up			

Drug allergy:  
 Sys illness:

Pap smear to be repeated  
 every 3 years only

- Pap done last year

UMP - 12/02/2024.

3d

Irregular X 5-6 months  
 28 d?

Obs - PRL - USG ← 21  
 17 } TR done

Part - NO med / Allergy

Mh - Mother - DM

- Father - Thyroid

Adv

to keep & USG report

Pap to be done in 2025

!



UHID	2904834	Date	06/03/2024		
Name	Mrs Sandhya Raut	Sex	F	Age	45
OPD	Dental	Health Check-Up			

O/E - Stains +  
 Calculus +

Drug allergy:  
 Sys illness:

- Impacted  $\bar{c}$   $\frac{8}{8}$

Treatment

1) Scaling

2) OPG (d-ray)

3) Extraction  $\bar{c}$   $\frac{8}{8}$

Dr. Jyoti

To pay,

Scaling (made I = Rs 2420/-)  
 (Cleaning)



<b>UHID</b>	<b>2904834</b>	<b>Date</b>	<b>06/03/2024</b>	
<b>Name</b>	<b>Mrs Sandhya Raut</b>	<b>Sex</b>	<b>F</b>	<b>Age</b> <b>45</b>
<b>OPD</b>	<b>Ophthal</b>	<b>Health Check-Up</b>		

Clas. No. , wafers .

Drug allergy: → Not know .

Sys illness: → No

Height: → No

+16s No

$\begin{matrix} \nearrow \text{RG} & 6/6^{-1} \\ \searrow \text{LG} & 6/6^{-2} \end{matrix}$ 
}
Bly

$\begin{matrix} \nearrow \text{RG} & +0.25 & @ & 6/6 \\ \searrow \text{LG} & +0.25 & @ & 6/6 \end{matrix}$

Add → +1.50  $\begin{matrix} \nearrow \text{WG} \\ \searrow \text{WG} \end{matrix}$

$\begin{matrix} \nearrow \text{RG} & \rightarrow & 15.5 \\ \searrow \text{LG} & & 15.3 \end{matrix}$ 
}

*[Handwritten signature]*



<b>PATIENT NAME : MRS.SANDHYA GAJANAN RAUT</b>		<b>REF. DOCTOR :</b>	
<b>CODE/NAME &amp; ADDRESS : C000045507</b>		<b>ACCESSION NO : 0022XC001283</b>	<b>AGE/SEX : 45 Years Female</b>
FORTIS VASHI-CHC -SPLZD		<b>PATIENT ID : FH.2904834</b>	<b>DRAWN : 07/03/2024 08:51:00</b>
FORTIS HOSPITAL # VASHI,		<b>CLIENT PATIENT ID: UID:2904834</b>	<b>RECEIVED : 07/03/2024 08:51:45</b>
MUMBAI 440001		<b>ABHA NO :</b>	<b>REPORTED : 07/03/2024 14:05:21</b>

**CLINICAL INFORMATION :**  
 UID:2904834 REQNO-1672472  
 CORP-OPD  
 BILLNO-150124OPCR013300  
 BILLNO-150124OPCR013300

Test Report Status	Final	Results	Biological Reference Interval	Units
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**HAEMATOLOGY - CBC**

**CBC-5, EDTA WHOLE BLOOD**

**BLOOD COUNTS, EDTA WHOLE BLOOD**

<b>HEMOGLOBIN (HB)</b> METHOD : SLS METHOD	<b>11.6 Low</b>	12.0 - 15.0	g/dL
<b>RED BLOOD CELL (RBC) COUNT</b> METHOD : HYDRODYNAMIC FOCUSING	<b>5.29 High</b>	3.8 - 4.8	mil/ $\mu$ L
<b>WHITE BLOOD CELL (WBC) COUNT</b> METHOD : FLUORESCENCE FLOW CYTOMETRY	5.76	4.0 - 10.0	thou/ $\mu$ L
<b>PLATELET COUNT</b> METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	314	150 - 410	thou/ $\mu$ L

**RBC AND PLATELET INDICES**

<b>HEMATOCRIT (PCV)</b> METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	38.1	36.0 - 46.0	%
<b>MEAN CORPUSCULAR VOLUME (MCV)</b> METHOD : CALCULATED PARAMETER	<b>72.0 Low</b>	83.0 - 101.0	fL
<b>MEAN CORPUSCULAR HEMOGLOBIN (MCH)</b> METHOD : CALCULATED PARAMETER	<b>21.9 Low</b>	27.0 - 32.0	pg
<b>MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)</b> METHOD : CALCULATED PARAMETER	<b>30.4 Low</b>	31.5 - 34.5	g/dL
<b>RED CELL DISTRIBUTION WIDTH (RDW)</b> METHOD : CALCULATED PARAMETER	<b>15.6 High</b>	11.6 - 14.0	%
<b>MENTZER INDEX</b> METHOD : CALCULATED PARAMETER	13.6		
<b>MEAN PLATELET VOLUME (MPV)</b> METHOD : CALCULATED PARAMETER	10.3	6.8 - 10.9	fL

**WBC DIFFERENTIAL COUNT**

**Dr. Akshay Dhotre, MD**  
 (Reg.no. MMC 2019/09/6377)  
 Consultant Pathologist



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Patient Ref. No. 22000000907190

**PATIENT NAME : MRS.SANDHYA GAJANAN RAUT**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

**ACCESSION NO : 0022XC001283**

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NEUTROPHILS		68	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		24	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		5	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.92	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.38	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.29	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.17	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.8		
METHOD : CALCULATED				

**MORPHOLOGY**

**RBC**

METHOD : MICROSCOPIC EXAMINATION

MILD HYPOCHROMASIA, MILD MICROCYTOSIS, MILD ANISOCYTOSIS

**WBC**

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

**PLATELETS**

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE

**Dr. Akshay Dhotre, MD**  
**(Reg,no. MMC 2019/09/6377)**  
**Consultant Pathologist**



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Patient Ref. No. 22000000907190

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FORTIS VASHI-CHC -SPLZD

FORTIS HOSPITAL # VASHI,

MUMBAI 440001

ACCESSION NO : **0022XC001283**

PATIENT ID : FH.2904834

CLIENT PATIENT ID: UID:2904834

ABHA NO :

AGE/SEX :45 Years Female

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**Interpretation(s)**

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.



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**HAEMATOLOGY**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD**

<b>E.S.R</b>	<b>22 High</b>	<b>0 - 20</b>	<b>mm at 1 hr</b>
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METHOD : WESTERGREN METHOD

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

<b>HBA1C</b>	<b>5.8 High</b>	<b>Non-diabetic: &lt; 5.7</b>	<b>%</b>
		<b>Pre-diabetics: 5.7 - 6.4</b>	
		<b>Diabetics: &gt; or = 6.5</b>	
		<b>Therapeutic goals: &lt; 7.0</b>	
		<b>Action suggested : &gt; 8.0</b>	
		<b>(ADA Guideline 2021)</b>	

METHOD : HB VARIANT (HPLC)

<b>ESTIMATED AVERAGE GLUCOSE(EAG)</b>	<b>119.8 High</b>	<b>&lt; 116.0</b>	<b>mg/dL</b>
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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, Vasculitides, 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:** Polycythemia 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)

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## REFERENCE :

1. 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.

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

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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 &amp; HbC trait.)

c) HbF &gt; 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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**IMMUNOHAEMATOLOGY****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD****ABO GROUP**

METHOD : TUBE AGGLUTINATION

TYPE B

**RH TYPE**

METHOD : TUBE AGGLUTINATION

POSITIVE

**Interpretation(s)**

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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**BIOCHEMISTRY**

**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.39	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.11	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.28	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.2	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.7	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.5	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	19	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	21	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	55	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	53	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	153	81 - 234	U/L

**GLUCOSE FASTING, FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	95	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
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**Dr. Akshay Dhotre, MD**  
**(Reg, no. MMC 2019/09/6377)**  
**Consultant Pathologist**



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CIN - U74899PB1995PLC045956  
Email : -



**Patient Ref. No. 22000000907190**



PATIENT NAME : MRS.SANDHYA GAJANAN RAUT

REF. DOCTOR :

CODE/NAME &amp; ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : 0022XC001283

PATIENT ID : FH.2904834

CLIENT PATIENT ID: UID:2904834

ABHA NO :

AGE/SEX : 45 Years Female

DRAWN : 07/03/2024 08:51:00

RECEIVED : 07/03/2024 08:51:45

REPORTED : 07/03/2024 14:05:21

## CLINICAL INFORMATION :

UID:2904834 REQNO-1672472  
CORP-OPD  
BILLNO-150124OPCR013300  
BILLNO-150124OPCR013300

Test Report Status	Final	Results	Biological Reference Interval	Units
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## KIDNEY PANEL - 1

## BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN

8

6 - 20

mg/dL

METHOD : UREASE - UV

## CREATININE EGFR- EPI

CREATININE

0.58 Low

0.60 - 1.10

mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

45

years

GLOMERULAR FILTRATION RATE (FEMALE)

113.66

Refer Interpretation Below

mL/min/1.73m<sup>2</sup>

METHOD : CALCULATED PARAMETER

## BUN/CREAT RATIO

BUN/CREAT RATIO

13.79

5.00 - 15.00

METHOD : CALCULATED PARAMETER

## URIC ACID, SERUM

URIC ACID

1.9 Low

2.6 - 6.0

mg/dL

METHOD : URICASE UV

## TOTAL PROTEIN, SERUM

TOTAL PROTEIN

7.2

6.4 - 8.2

g/dL

METHOD : BIURET



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## ALBUMIN, SERUM

ALBUMIN

3.7

3.4 - 5.0

g/dL

METHOD : BCP DYE BINDING

## GLOBULIN

GLOBULIN

3.5

2.0 - 4.1

g/dL

METHOD : CALCULATED PARAMETER

## ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM

136

136 - 145

mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM

4.98

3.50 - 5.10

mmol/L

METHOD : ISE INDIRECT

CHLORIDE, SERUM

103

98 - 107

mmol/L

METHOD : ISE INDIRECT

## Interpretation(s)

## 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.



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**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 so that 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, sulfonyleureas, 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 Glycosuria, 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.

**CREATININE EGFR- EPI--** 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/guide/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's Principle of Internal Medicine, 21st ed. pg 62 and 334  
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  
TOTAL PROTEIN, SERUM-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.

**Dr. Akshay Dhotre, MD**  
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Consultant Pathologist



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Patient Ref. No. 2200000907190





MC-5837

**PATIENT NAME :** MRS.SANDHYA GAJANAN RAUT

**REF. DOCTOR :**

**CODE/NAME & ADDRESS :** C000045507

FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

**ACCESSION NO :** 0022XC001283

**PATIENT ID :** FH.2904834

**CLIENT PATIENT ID:** UID:2904834

**ABHA NO :**

**AGE/SEX :** 45 Years Female

**DRAWN :** 07/03/2024 08:51:00

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**CLINICAL INFORMATION :**

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CORP-OPD

BILLNO-150124OPCR013300

BILLNO-150124OPCR013300

Test Report Status	Final	Results	Biological Reference Interval	Units
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**Lower-than-normal levels may be due to:** Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.  
**ALBUMIN, SERUM-** Human serum 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.

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**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

<b>CHOLESTEROL, TOTAL</b>	<b>219 High</b>	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
<b>TRIGLYCERIDES</b>	<b>45</b>	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
<b>HDL CHOLESTEROL</b>	<b>79 High</b>	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
<b>LDL CHOLESTEROL, DIRECT</b>	<b>120</b>	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
<b>NON HDL CHOLESTEROL</b>	<b>140 High</b>	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
<b>VERY LOW DENSITY LIPOPROTEIN</b>	<b>9</b>	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
<b>CHOL/HDL RATIO</b>	<b>2.8 Low</b>	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			

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LDL/HDL RATIO

1.5

0.5 - 3.0 Desirable/Low Risk  
 3.1 - 6.0 Borderline/Moderate Risk  
 >6.0 High Risk

METHOD : CALCULATED PARAMETER

**Interpretation(s)**

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**CLINICAL PATH - URINALYSIS**

**KIDNEY PANEL - 1**

**PHYSICAL EXAMINATION, URINE**

<b>COLOR</b> METHOD : PHYSICAL	PALE YELLOW
<b>APPEARANCE</b> METHOD : VISUAL	CLEAR

**CHEMICAL EXAMINATION, URINE**

<b>PH</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5
<b>SPECIFIC GRAVITY</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	1.025	1.003 - 1.035
<b>PROTEIN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED
<b>GLUCOSE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED
<b>KETONES</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED
<b>BLOOD</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	<b>DETECTED (TRACE)</b>	NOT DETECTED
<b>BILIRUBIN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED
<b>UROBILINOGEN</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)	NORMAL	NORMAL
<b>NITRITE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED
<b>LEUKOCYTE ESTERASE</b> METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED

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**Dr. Rekha Nair, MD**  
(Reg No. MMC 2001/06/2354)  
Microbiologist



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Test Report Status **Final**

Results

Biological Reference Interval Units

## MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS

DETECTED  
(OCCASIONAL)

NOT DETECTED

/HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S)

1-2

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS

0-1

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

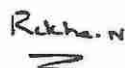
REMARKS

URINARY MICROSCOPIC EXAMINATION DONE ON URINARY  
CENTRIFUGED SEDIMENT

## Interpretation(s)



Dr. Akshay Dhotre, MD  
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Microbiologist

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## PERFORMED AT :

Agilus Diagnostics Ltd.  
Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,  
Navi Mumbai, 400703  
Maharashtra, India  
Tel : 022-39199222, 022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



Patient Ref. No. 22000000907190

**PATIENT NAME : MRS.SANDHYA GAJANAN RAUT**

**REF. DOCTOR :**

**CODE/NAME & ADDRESS : C000045507**

FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

**ACCESSION NO : 0022XC001283**

**PATIENT ID : FH,2904834**

**CLIENT PATIENT ID: UID:2904834**

**ABHA NO :**

**AGE/SEX :45 Years Female**

**DRAWN :07/03/2024 08:51:00**

**RECEIVED :07/03/2024 08:51:45**

**REPORTED :07/03/2024 14:05:21**

**CLINICAL INFORMATION :**

UID:2904834 REQNO-1672472  
CORP-OPD  
BILLNO-150124OPCR013300  
BILLNO-150124OPCR013300

Test Report Status	Final	Results	Biological Reference Interval	Units
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**SPECIALISED CHEMISTRY - HORMONE**

**THYROID PANEL, SERUM**

T3	146.7	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	9.95	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.510	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

**Interpretation(s)**

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

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

**Dr. Akshay Dhotre, MD**  
**(Reg.no. MMC 2019/09/6377)**  
**Consultant Pathologist**



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Patient Ref. No. 22000000907190



PATIENT NAME : MRS.SANDHYA GAJANAN RAUT

REF. DOCTOR :

CODE/NAME &amp; ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

ACCESSION NO : 0022XC001330

PATIENT ID : FH.2904834

CLIENT PATIENT ID: UID:2904834

ABHA NO :

AGE/SEX :45 Years Female

DRAWN :07/03/2024 11:50:00

RECEIVED :07/03/2024 11:50:14

REPORTED :07/03/2024 13:48:57

## CLINICAL INFORMATION :

UID:2904834 REQNO-1672472  
 CORP-OPD  
 BILLNO-150124OPCR013300  
 BILLNO-150124OPCR013300

Test Report Status	Final	Results	Biological Reference Interval	Units
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## BIOCHEMISTRY

## GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	73	70 - 140	mg/dL
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METHOD : HEXOKINASE

## Comments

NOTE: - RECHECKED FOR POST PRANDIAL PLASMA GLUCOSE VALUES, TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

## Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

\*\*End Of Report\*\*

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Dr. Akshay Dhotre, MD  
 (Reg.no. MMC 2019/09/6377)  
 Consultant Pathologist

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 Email :-



Patient Ref. No. 22000000907237



3/7/2024 9:34:55 AM

sandhya raut  
Female

He

Normal

2904834  
45 Years

Rate 87 . Sinus rhythm.....normal P axis, V-rate 50- 99  
PR 169 . Baseline wander in lead(s) I,II,aVR,aVL,V6

QRSD 91  
QT 359  
QTc 432

--AXIS--  
P 76  
QRS 55  
T 36

-- NORMAL ECG --

Unconfirmed Diagnosis

12 Lead; Standard Placement



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?



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www.fortishealthcare.com | vashi@fortishealthcare.com  
CIN: U85100MH2005PTC 154823  
GST IN : 27AABCH5894D1ZG  
PAN NO : AABCH5894D



Date: 07/Mar/2024

DEPARTMENT OF NIC

Name: Mrs. Sandhya Gajanan Raut  
Age | Sex: 45 YEAR(S) | Female  
Order Station : FO-OPD  
Bed Name :

UHID | Episode No : 2904834 | 13615/24/1501  
Order No | Order Date: 1501/PN/OP/2403/28260 | 07-Mar-2024  
Admitted On | Reporting Date : 07-Mar-2024 11:45:54  
Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- Grade I left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 15 mm with normal inspiratory collapse.

M-MODE MEASUREMENTS:

LA	24	mm
AO Root	17	mm
AO CUSP SEP	13	mm
LVID (s)	20	mm
LVID (d)	44	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	24	mm
RA	26	mm
LVEF	60	%



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Date: 07/Mar/2024

**DEPARTMENT OF NIC**

Name: Mrs. Sandhya Gajanan Raut  
Age | Sex: 45 YEAR(S) | Female  
Order Station : FO-OPD  
Bed Name :

UHID | Episode No : 2904834 | 13615/24/1501  
Order No | Order Date: 1501/PN/OP/2403/28260 | 07-Mar-2024  
Admitted On | Reporting Date : 07-Mar-2024 11:45:54  
Order Doctor Name : Dr.SELF .

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.7 m/sec.  
A WAVE VELOCITY: 0.8 m/sec  
E/A RATIO: 0.9

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	08			Nil
TRICUSPID VALVE	N			Trivial
PULMONARY VALVE	04			Nil

**Final Impression :**

- No RWMA.
- Trivial MR and TR .No PH .
- Grade I LV diastolic dysfunction.
- Normal LV and RV systolic function.

  
DR. PRASHANT PAWAR  
DNB(MED), DNB (CARD)

DR.AMIT SINGH,  
MD(MED),DM(CARD)

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



**DEPARTMENT OF RADIOLOGY**

Date: 07/Mar/2024

Name: Mrs. Sandhya Gajanan Raut

Age | Sex: 45 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 2904834 | 13615/24/1501

Order No | Order Date: 1501/PN/OP/2403/28260 | 07-Mar-2024

Admitted On | Reporting Date : 07-Mar-2024 10:12:12

Order Doctor Name : Dr.SELF .

**X-RAY-CHEST- PA**

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. YOGINI SHAH**  
DMRD., DNB. (Radiologist)



Patient Name	: Sandhya Gajanan Raut	Patient ID	: 2904834
Sex / Age	: F / 45Y 3M 25D	Accession No.	: PHC.7626587
Modality	: US	Scan DateTime	: 07-03-2024 11:37:26
IPID No	: 13615/24/1501	ReportDatetime	: 07-03-2024 11:49:22

### USG – WHOLE ABDOMEN

**LIVER** is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

**GALL BLADDER** is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

**CBD** appears normal in caliber.

**SPLEEN** is normal in size and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 9.7 x 5.1 cm. Left kidney measures 9.7 x 4.7 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

**UTERUS** is normal in size, measuring 9.0 x 5.3 x 4.1 cm.

Endometrium measures 10.7 mm in thickness.

Both ovaries are normal.

Right ovary measures 2.5 x 2.4 x 1.7 cm, volume 5.3 cc.

Left ovary measures 2.6 x 2.2 x 1.8 cm, volume 5.7 cc.

No evidence of ascites.

### Impression:

- No significant abnormality is detected.

**DR. CHETAN KHADKE**

**M.D. (Radiologist)**



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CIN: U85100MH2005PTC 154823

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Patient Name	:	Sandhya Gajanan Raut	Patient ID	:	2904834
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IPID No	:	13615/24/1501	ReportDatetime	:	07-03-2024 11:49:22

**USG - BREAST**

**Findings:**

Bilateral breast parenchyma appears normal.

No evidence of solid or cystic lesion.

No dilated ducts are noted.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

**Impression:**

- No significant abnormality detected.

**DR. YOGINI SHAH**

**DMRD., DNB. (Radiologist)**