



Patient Ref. No. 251000000162847



CLIENT CODE : C000049066

Cert. No. MC-5333

## CLIENT'S NAME AND ADDRESS :

SRL JAIPUR WELLNESS CORPORATE WALK IN (CASH)  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG

SRL Ltd

C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg, Gandhi Nagar Mod,  
Tonk Road  
JAIPUR, 302015  
Rajasthan, INDIAJAIPUR 302017  
RAJASTHAN INDIA  
9314660100

PATIENT NAME : PRADEEP SINGH SHEKHAWAT

PATIENT ID : PRADM221087251

ACCESSION NO : 0251VJ002103 AGE : 35 Years SEX : Male

ABHA NO :

DRAWN : 22/10/2022 09:59:00

RECEIVED : 22/10/2022 11:37:18

REPORTED : 23/10/2022 15:14:05

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CLIENT PATIENT ID : 012210220021

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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	16.1	13.0 - 17.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL COUNT	4.95	4.5 - 5.5	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL COUNT	5.00	4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	176	150 - 410	thou/ $\mu$ L
METHOD : ELECTRONIC IMPEDANCE			

**RBC AND PLATELET INDICES**

HEMATOCRIT	46.8	40 - 50	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOL	94.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HGB.	<b>32.5</b>	<b>High</b> 27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.4	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	19.0		
RED CELL DISTRIBUTION WIDTH	11.9	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME	10.4	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

**WBC DIFFERENTIAL COUNT - NLR**

NEUTROPHILS	53	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	2.65	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
LYMPHOCYTES	40	20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
ABSOLUTE LYMPHOCYTE COUNT	2	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3		
EOSINOPHILS	01	1 - 6	%



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METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY

ABSOLUTE EOSINOPHIL COUNT	0.05	0.02 - 0.50	thou/ $\mu$ L
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METHOD : CALCULATED PARAMETER

MONOCYTES	06	2 - 10	%
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METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY

ABSOLUTE MONOCYTE COUNT	0.3	0.2 - 1.0	thou/ $\mu$ L
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METHOD : CALCULATED PARAMETER

BASOPHILS	00	0 - 2	%
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METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY

ABSOLUTE BASOPHIL COUNT	0	Low 0.02 - 0.10	thou/ $\mu$ L
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DIFFERENTIAL COUNT PERFORMED ON: EDTA SMEAR

## \* ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	02	0 - 14	mm at 1 hr
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METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

## GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	97	74 - 99	mg/dL
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METHOD : GLUCOSE OXIDASE

## GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD

HBA1C	4.9	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
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METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

ESTIMATED AVERAGE GLUCOSE (EAG)	93.9	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

## GLUCOSE, POST-PRANDIAL, PLASMA

PPBS (POST PRANDIAL BLOOD SUGAR)	90	70 - 140	mg/dL
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METHOD : GLUCOSE OXIDASE

## CORONARY RISK PROFILE, SERUM

CHOLESTEROL, TOTAL	231	High < 200 Desirable 200 - 239 Borderline High > / = 240 High	mg/dL
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METHOD : CHOLESTEROL OXIDASE



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TRIGLYCERIDES		109	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : LIPASE/GPO-PAP NO CORRECTION				
HDL CHOLESTEROL		47	< 40 Low >=60 High	mg/dL
METHOD : DIRECT CLEARANCE METHOD				
CHOLESTEROL LDL		162	High < 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
NON HDL CHOLESTEROL		184	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO		4.9	High 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO		3.4	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		21.8	</= 30.0	mg/dL
<b>LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.71	0 - 1	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID				
BILIRUBIN, DIRECT		0.20	0.00 - 0.25	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID				
BILIRUBIN, INDIRECT		0.51	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN		7.3	6.4 - 8.2	g/dL
METHOD : BIURET REACTION, END POINT				



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ALBUMIN	<b>4.6</b>	<b>High</b>	3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN	2.7		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.7		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	<b>48</b>	<b>High</b>	0 - 37	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	<b>93</b>	<b>High</b>	0 - 40	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALKALINE PHOSPHATASE	82		39 - 117	U/L
METHOD : AMP OPTIMISED TO IFCC 37° C				
GAMMA GLUTAMYL TRANSFERASE (GGT)	<b>60</b>	<b>High</b>	11 - 50	U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
LACTATE DEHYDROGENASE	319		230 - 460	U/L
METHOD : GERMAN METHODS 37° C				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN	7		5.0 - 18.0	mg/dL
METHOD : UREASE KINETIC				
<b>CREATININE, SERUM</b>				
CREATININE	1.04		0.8 - 1.3	mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO	6.73			
METHOD : CALCULATED PARAMETER				
<b>URIC ACID, SERUM</b>				
URIC ACID	5.8		3.4 - 7.0	mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN	7.3		6.4 - 8.3	g/dL
METHOD : BIURET REACTION, END POINT				
<b>ALBUMIN, SERUM</b>				
ALBUMIN	<b>4.6</b>	<b>High</b>	3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
<b>GLOBULIN</b>				



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GLOBULIN	2.7	2.0 - 4.1	g/dL
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METHOD : CALCULATED PARAMETER

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

SODIUM	135.5	Low 137 - 145	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

POTASSIUM	4.04	3.6 - 5.0	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

CHLORIDE	99.4	98 - 107	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

## PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
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METHOD : GROSS EXAMINATION

APPEARANCE	CLEAR		
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METHOD : GROSS EXAMINATION

SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
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METHOD : IONIC CONCENTRATION METHOD

## CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
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METHOD : DOUBLE INDICATOR PRINCIPLE

PROTEIN	NOT DETECTED	NOT DETECTED	
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METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE

GLUCOSE	NOT DETECTED	NOT DETECTED	
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METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS

KETONES	NOT DETECTED	NOT DETECTED	
---------	--------------	--------------	--

METHOD : SODIUM NITROPRUSSIDE REACTION

BLOOD	NOT DETECTED	NOT DETECTED	
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METHOD : PEROXIDASE ANTI PEROXIDASE

BILIRUBIN	NOT DETECTED	NOT DETECTED	
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METHOD : DIPSTICK

UROBILINOGEN	NORMAL	NORMAL	
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METHOD : EHRlich REACTION REFLECTANCE

NITRITE	NOT DETECTED	NOT DETECTED	
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METHOD : NITRATE TO NITRITE CONVERSION METHOD

LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
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## MICROSCOPIC EXAMINATION, URINE

PUS CELL (WBC'S)	1-2	0-5	/HPF
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METHOD : DIPSTICK, MICROSCOPY

EPITHELIAL CELLS

0-1

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

ERYTHROCYTES (RBC'S)

NOT DETECTED

NOT DETECTED

/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

## THYROID PANEL, SERUM

T3

74.7

60.0 - 181.0

ng/dL

METHOD : CHEMILUMINESCENCE

T4

7.90

4.5 - 10.9

µg/dL

METHOD : CHEMILUMINESCENCE

TSH 3RD GENERATION

2.020

0.550 - 4.780

µIU/mL

METHOD : CHEMILUMINESCENCE

## STOOL: OVA &amp; PARASITE

COLOUR

SAMPLE NOT RECEIVED

METHOD : GROSS EXAMINATION

## \* ABO GROUP &amp; RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE O

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

## Interpretation(s)

BLOOD COUNTS, EDTA WHOLE BLOOD-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-

Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (&gt;13) from Beta thalassaemia trait (&lt;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 - NLR-

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 &lt; 49.5 years old and NLR &lt; 3.3, COVID-19 patients tend to



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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.

## ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE 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 (&gt;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, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)

## 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.

## 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:**

Hypoglycemia is defined as a glucose of &lt; 50 mg/dL in men and &lt; 40 mg/dL in women.

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 &amp; Insulin treatment, Renal Glycosuria, Glycaemic index &amp; response to food consumed, Alimentary Hypoglycemia, Increased insulin response &amp; sensitivity etc.

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 :**

I. 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.

II. Vitamin C &amp; E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).

III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates &amp; opiates addition are reported to interfere with some assay methods, falsely increasing results.

IV. 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

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics &amp; Insulin



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treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c  
LIVER FUNCTION PROFILE, SERUM-  
LIVER FUNCTION PROFILE

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 result 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.

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, Paget's disease, rickets, sarcoidosis etc. Lower-than-normal ALP levels are seen in hypophosphatemia, malnutrition, protein deficiency, Wilson's 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. Serum 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, Waldenström's disease. Lower-than-normal levels may be due to: agammaglobulinemia, bleeding (hemorrhage), burns, glomerulonephritis, liver disease, malabsorption, malnutrition, nephrotic syndrome, protein-losing enteropathy etc. 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.

BLOOD UREA NITROGEN (BUN), SERUM- Causes of increased levels include pre-renal (high protein diet, increased protein catabolism, GI hemorrhage, cortisol, dehydration, CHF renal), renal failure, post-renal (malignancy, nephrolithiasis, prostatism)

Causes of decreased level include liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

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's
- Multiple Sclerosis

Nutritional tips to manage increased uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High fibre foods
- Vit C Intake
- Antioxidant rich foods

TOTAL PROTEIN, SERUM-



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**CLIENT CODE :** C000049066

Cert. No. MC-5333

**CLIENT'S NAME AND ADDRESS :**

SRL JAIPUR WELLNESS CORPORATE WALK IN (CASH)  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG

SRL Ltd  
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg, Gandhi Nagar Mod,  
Tonk Road  
JAIPUR, 302015  
Rajasthan, INDIA

JAIPUR 302017  
RAJASTHAN INDIA  
9314660100

**PATIENT NAME : PRADEEP SINGH SHEKHAWAT**

**PATIENT ID : PRADM221087251**

**ACCESSION NO : 0251VJ002103**    **AGE :** 35 Years    **SEX :** Male

**ABHA NO :**

**DRAWN :** 22/10/2022 09:59:00

**RECEIVED :** 22/10/2022 11:37:18

**REPORTED :** 23/10/2022 15:14:05

**REFERRING DOCTOR :** SELF

**CLIENT PATIENT ID :** 012210220021

Test Report Status	Final	Results	Biological Reference Interval	Units
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Serum 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, Waldenstrom's 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, 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.

**ELECTROLYTES (NA/K/CL), SERUM-**

Sodium levels are increased in dehydration, Cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism, liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion. Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfunction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,

**MICROSCOPIC EXAMINATION, URINE-**

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

**THYROID PANEL, SERUM-Triiodothyronine T3**, is a thyroid hormone. It affects 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.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy			
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.

Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

**Reference:**

- Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
  - Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
  - Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
- STOOL: OVA & PARASITE-



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Patient Ref. No. 251000000162847



CLIENT CODE : C000049066

Cert. No. MC-5333

## CLIENT'S NAME AND ADDRESS :

SRL JAIPUR WELLNESS CORPORATE WALK IN (CASH)  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARGSRL Ltd  
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg, Gandhi Nagar Mod,  
Tonk Road  
JAIPUR, 302015  
Rajasthan, INDIAJAIPUR 302017  
RAJASTHAN INDIA  
9314660100

PATIENT NAME : PRADEEP SINGH SHEKHAWAT

PATIENT ID : PRADM221087251

ACCESSION NO : 0251VJ002103 AGE : 35 Years SEX : Male

ABHA NO :

DRAWN : 22/10/2022 09:59:00

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Test Report Status	Final	Results	Biological Reference Interval	Units
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Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc

ABO GROUP &amp; 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.

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

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession  
TEST MARKED WITH '\*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

**Dr. Abhishek Sharma**  
Consultant Microbiologist

**Dr. Akansha Jain**  
Consultant Pathologist



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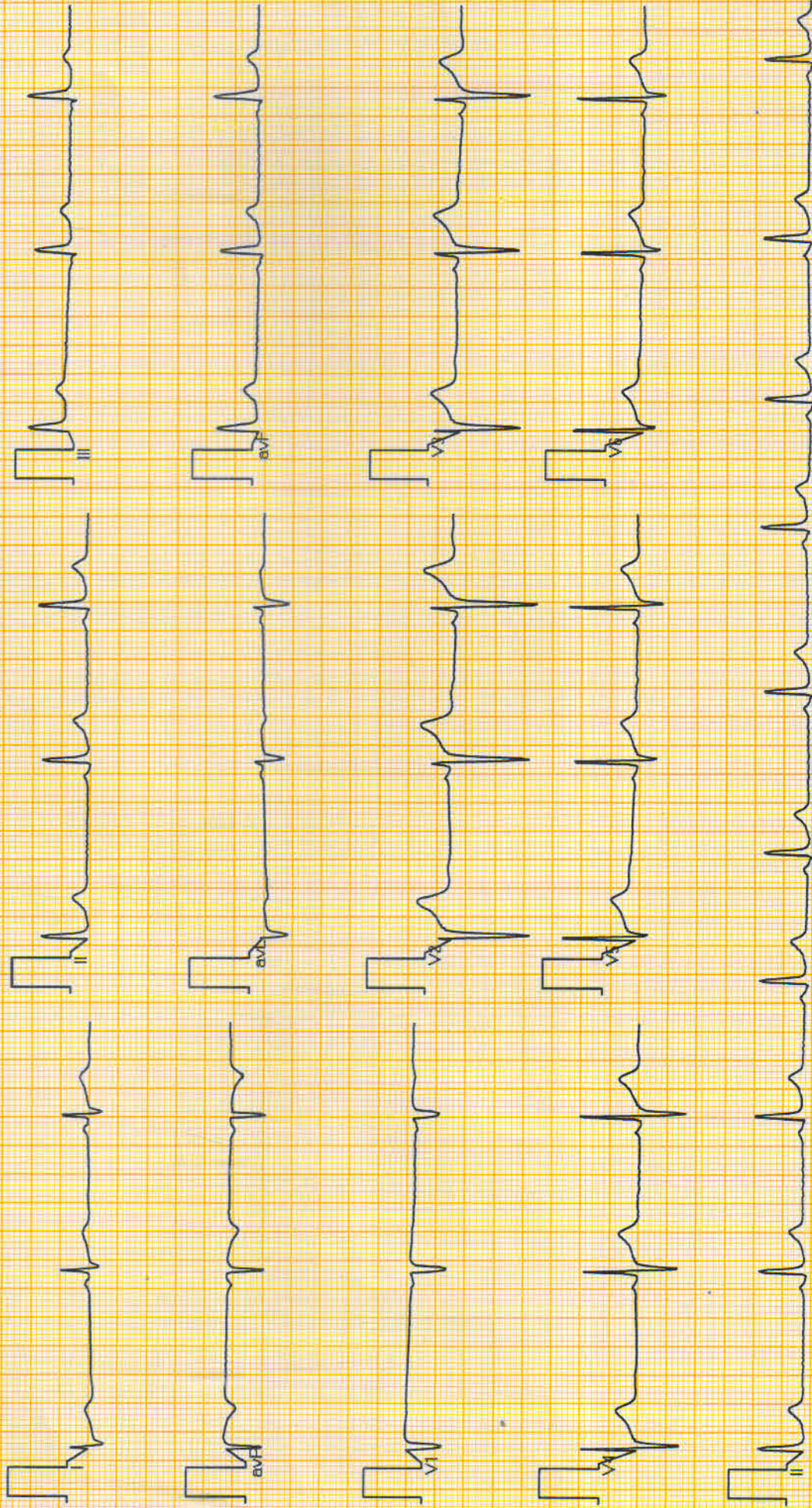
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**AAKRITI LABS PVT.LTD JAIPUR**

19740 / MR. PRADEEP SINGH SHEKHAWAT / 35 Yrs / M / Non Smoker

Heart Rate : 58 bpm / Tested On : 22-Oct-22 10:27:37 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s / Refd By : MEDIL WHEEL

**ECG**



Vent Rate : 58 bpm  
 PR Interval : 120 ms  
 QRS Duration: 90 ms  
 QT/QTc Int : 394/387 ms  
 P-QRS-T axis: 34.00 • 71.00 • 64.00 •

Allergens ECG (PIS215190517)

*SINUS BRADYCARDIA*

**DR. NITIZ GOYAL**  
 M.B.B.S., MD

Reported By: DR. NITIZ GOYAL RMC - 0233310

*DR*

NAME	MR PRADEEP SINGH SHEKHAWAT	AGE	35Y	SEX	MALE
REF BY	MEDIWHEEL	DATE	22/10/2022	REG NO	

## ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

### 2D/M-MOD

IVSD mm	8.8	IVSS mm	13.5	AORTA mm	24.0
LVID mm	40.6	LVIS mm	27.4	LA mm	28.4
LVPWD mm	9.8	LVPWS mm	14.5	EF%	60%

### CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

### DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	0.66/0.66	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANIMETERY)		MVA cm2 (PHT)	
MR			

### AORTIC

PEAK VELOCITY m/s	1.48	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

### TRICUSPID

PEAK VELOCITY m/s	0.54	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR	TRACE	PASP mmHg	

### PULMONARY

PEAK VELOCITY m/s	1.61	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

### IMPRESSION

- LV DIASTOLIC DYSFUNCTION GRADE -1
- NORMAL LV SYSTOLIC FUNCTION
- NO RWMA LVEF 60%
- NORMAL RV FUNCTION
- TRACE TR
- NORMAL CHAMBER DIMENSIONS
- NORMAL VALVULAR ECHO
- INTACT IAS / IVS
- NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.
- IVC NORMAL

**CONCLUSION : DIASTOLIC DYSFUNCTION, FAIR LV FUNCTION.**

Cardiologist



# Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod  
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661  
www.aakritilabs.com  
CIN NO.: U85195RJ2004PTC019563



Name : **Mr. PRADEEP SINGH SHEKHAWAT**  
Age/Gender: 35 Y/Male  
Patient ID : 012210220021  
BarcodeNo : 10065247  
Referred By : Self

Registration No: 44869  
Registered : 22/Oct/2022 09:59AM  
Analysed : 22/Oct/2022 10:36AM  
Reported : 22/Oct/2022 10:36AM  
Panel : Medi Wheel (ArcoFemi  
Healthcare Ltd)

## DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.  
Trachea is central.  
Bilateral lung field and both CP angle are clear.  
Domes of diaphragm are normally placed.  
Transverse diameter of heart appears with normal limits.

**IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.**

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

Page 1 of 1

**Dr. Neera Mehta**  
M.B.B.S.,D.M.R.D.  
RMCNO.005807/14853





Name : **Mr. PRADEEP SINGH SHEKHAWAT**

Age/Gender: 35 Y/Male

Patient ID : 012210220021

BarcodeNo : 10065247

Referred By : Self

Registration No: 44869

Registered : 22/Oct/2022 09:59AM

Analysed : 22/Oct/2022 11:12AM

Reported : 22/Oct/2022 11:13AM

Panel : Medi Wheel (ArcoFemi  
Healthcare Ltd)

## USG: WHOLE ABDOMEN (Male)

**LIVER** : Is normal in size, shape and echogenecity.  
The IHBR and hepatic radicals are not dilated.  
No evidence of focal echopoor/echorich lesion seen.  
Portal vein diameter and common bile duct appear normal.

**GALL** : Is normal in size, shape and echotexture. Walls are smooth and  
**BLADDER** regular with normal thickness. There is no evidence of cholelithiasis.

**PANCREAS** : Is normal in size, shape and echotexture. Pancreatic duct is not dilated.

**SPLEEN** : Is normal in size, shape and echogenecity. Splenic hilum is not dilated.

**KIDNEYS** : **Right Kidney is not seen in its fossa, seen lower down in the pelvis. Size: 91 x 49 mm**

Left Kidney:-Size: 96 x 52 mm.

Left Kidney is normal in size, shape and echotexture,

corticomedullary differentiation is fair and ratio appears normal.

Pelvi calyceal system is normal. No evidence of hydronephrosis/ nephrolithiasis.

**URINARY** : Bladder walls are smooth, regular and normal thickness.

**BLADDER** : No evidence of mass or stone in bladder lumen.

**PROSTATE**: Is normal in size, shape and echotexture,  
measures: 35 x 27 x 22 mm, wt: 11 gms.  
Its capsule is intact and no evidence of focal lesion.


**SPECIFIC** : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.  
No evidence of lymphadenopathy or mass lesion in retroperitoneum.  
Visualized bowel loop appear normal. Great vessels appear normal.

**IMPRESSION** :- Ectopic right kidney

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

Page 1 of 1



  
**Dr. Neera Mehta**  
**M.B.B.S., D.M.R.D.**  
**RMCNO.005807/14853**