



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 11/11/23

Name: Mrs Nisha shirsat Age: 30 yrs Sex: M/F ✓

BP: 110/80 Height (cms): cm Weight (kgs): 66 kg BMI: _____

SPO2 100% P - 80 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	
kg	45.4	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	88.7	90.9	93.2	95.5	97.7	
HEIGHT In/cm	Underweight					Healthy					Overweight					Obese					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	40		
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" - 175.2	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		

Doctor's Initials:

Signature



UHID	12814871	Date	11/11/2023		
Name	Mrs Nisha Shirsat	Sex	F	Age	30
OPD	PAP	Health Check-up			

30yrs F, Married : 13yrs, came

Drug allergy:
 Sys illness:

to do - No complaints

LMP - 8/11/23

ULMP - 1/10/23

DIH - P₁ L₁ - 11yrs | ♂ | FTND | uneventful
 P₂ L₂ - 9yrs | ♀ | FTND

MIH - Reg, Moderate, Pain ⊕

MedIH - Nil

SH - Nil

No HIV DM | HTN | Thyroid (Hypo)

Pap smear done in 10/2020

- Neg

Relv

P₃ - ex - mild inflammation

- Flu & Reports

Vg - ⊕

- HPV vaccine counselling done

Hiranandani Healthcare Pvt. Ltd.
 Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
 Board Line: 022 - 39199222 | Fax: 022 - 39199220
 Emergency: 022 - 39199100 | Ambulance: 1255
 For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
 www.fortishhealthcare.com |
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 GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



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UHID	12814871	Date	11/11/2023
Name	Mrs Nisha Shirsat	Sex	F
OPD	Dental	Age	30
		Health Check-up	

O/R Missing

Shirsat, Nisha
 ————
 6

Drug allergy:
 Sys illness:

Prd

Angela / prastha c/o to

[Signature]



UHID	12814871	Date	11/11/2023
Name	Mrs Nisha Shirsat	Sex	F
OPD	Ophthal	Age	30
		Health Check-up	

As. No (Pari)
 NY NO

Drug allergy: → Not known
 Sys illness: →

Habit: → NO

U.V. → 6/6
 → 6/6

Reflex → 6/6
 → 6/6

→ 6/6
 → 6/6

→ 14-3
 → 15-8

[Handwritten signature]

* PEG - Tany ———— (1) ———— (1) ———— (1)
 (6 weeks)

PATIENT NAME : MRS.NISHA RAJU SHIRSAT	REF. DOCTOR :	AGE/SEX : 30 Yrs / Female
CODE NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WK002207 PATIENT ID : FH.12814871 CLIENT PATIENT ID : UID:12814871 ABHA NO :	DRAWN : 11/11/2023 10:16:00 RECEIVED : 11/11/2023 10:23:06 REPORTED : 11/11/2023 14:11:03

CLINICAL INFORMATION :

UID:12814871 REQNO-1605163
CORP-OPD
BILLNO-150123OPCR064296
BILLNO-150123OPCR064296

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**

HEMOGLOBIN (HB) METHOD : SLS METHOD	10.3 Low	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.67	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	10.28 High	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	383	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	34.5 Low	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	73.9 Low	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	22.1 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	29.9 Low	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	14.7 High	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	15.8		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.2	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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(Reg.no. MMC 2019/09/6377)
Consultant Pathologist



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CIN - U74899PB1995PLC045956
Email : -

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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FORTIS HOSPITAL # VASHI,

MUMBAI 440001

ACCESSION NO : 0022WK002207

PATIENT ID : FH.12814871

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NEUTROPHILS		64	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		29	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		4	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		6.58	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.98	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.41	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.31	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.2		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

MILD HYPOCHROMASIA, MILD MICROCYTOSIS, MILD ANISOCYTOSIS

WBC

METHOD : MICROSCOPIC EXAMINATION

LEUCOCYTOSIS

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE



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Patient Ref. No. 2200000884350

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

ACCESSION NO : 0022WK002207

AGE/SEX : 30 Years Female

FORTIS VASHI-CHC -SPLZD

PATIENT ID : FH.12814871

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FORTIS HOSPITAL # VASHI,

CLIENT PATIENT ID: UID:12814871

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MUMBAI 440001

ABHA NO :

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BTLNO-150123OPCR064296

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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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Patient Ref. No. 22000000889359

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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MUMBAI 440001

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	25 High	0 - 20	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	6.0 High	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)	%
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METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	125.5 High	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

Interpretation(s)

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, Vasculitis, 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 ESR in first trimester is 0-48 mm/hr(52 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 : Polikocytosis,(Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)



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PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals, AMCC Press, 7th edition, Edited by S. Soñin; 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 likely 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 & opines addition 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 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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Patient Ref. No. 2200000884390

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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ACCESSION NO : 0022WK002207

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE O
METHOD : TUBE AGGLUTINATION	
RH TYPE	POSITIVE
METHOD : TUBE AGGLUTINATION	

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."

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



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BIOCHEMISTRY
LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.51	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.11	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.40	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.6	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.8	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.0	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	15	15 - 37	U/L
METHOD : UV WITH PSP			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	22	< 34.0	U/L
METHOD : UV WITH PSP			
ALKALINE PHOSPHATASE	115	30 - 120	U/L
METHOD : PNPP-AMP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	26	5 - 55	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE	162	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	115 High	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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METHOD : HEXOKINASE
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REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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

ACCESSION NO : 0022WK002207

PATIENT ID : FH.12814871

CLIENT PATIENT ID: UID:12814871

ABHA NO :

AGE/SEX : 30 Years Female

DRAWN : 11/11/2023 10:16:00

RECEIVED : 11/11/2023 10:23:06

REPORTED : 11/11/2023 14:11:03

CLINICAL INFORMATION :

UID:12814871 REQNO-1605163

CORP-OPD

BILLNO-1501230PCR064296

BILLNO-1501230PCR064296

Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN

4 Low

6 - 20

mg/dL

METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE

0.63

0.60 - 1.10

mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

30

years

GLOMERULAR FILTRATION RATE (FEMALE)

122.31

Refer Interpretation Below

mL/min/1.73m²

METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO

6.35

5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID

4.5

2.6 - 6.0

mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN

7.6

6.4 - 8.2

g/dL

METHOD : BIURET



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




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Patient Ref. No. 22000000884350

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD

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ALBUMIN, SERUM

ALBUMIN

3.8

3.4 - 5.0

g/dL

METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN

3.8

2.0 - 4.1

g/dL

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM

139

136 - 145

mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM

4.60

3.50 - 5.10

mmol/L

METHOD : ISE INDIRECT

CHLORIDE, SERUM

104

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 blocking of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or perniciou 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, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels 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.

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.

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, hemodialysis, 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%), Drug-corticosteroid, 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 glycaemic 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 (Hypertension, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE GFR- EPI-- Kidney disease outcomes quality initiative (KDIGO) 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://nephguide.ahmed.uw.edu/guideline/gfr/>

Ghuran 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- Dietery (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Leach 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, Waldenström's disease.



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Email : -



Patient Ref. No. 2200000884350

PATIENT NAME : MRS.NISHA RAJU SHIRSAT

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

ACCESSION NO : 0022WK002207

AGE/SEX : 30 Years Female

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PATIENT ID : FH.12814871

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CORP-OPD

BILLNO-150123OPCR064296

BILLNO-150123OPCR064296

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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, hemodialysis, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.



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Patient Ref. No. 22000000884350

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	156	< 200 Desirable 200 - 239 Borderline High ≥ 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	88	< 150 Normal 150 - 199 Borderline High 200 - 499 High ≥ 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	38 Low	< 40 Low ≥ 60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	100	< 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			
NON HDL CHOLESTEROL	118	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	17.6	< / = 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.1	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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 CORP-OPD
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Test Report Status	Final	Results	Biological Reference Interval	Units
LDL/HDL RATIO		2.6	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

COLOR	PALE YELLOW
METHOD : PHYSICAL	
APPEARANCE	CLEAR
METHOD : VISUAL	

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY - DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	<=1.005	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOO/POD		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

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MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		3-5	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)



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SPECIALISED CHEMISTRY - HORMONE
THYROID PANEL, SERUM

T3	127.8	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	9.80	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)


2.230

 Non Pregnant Women
0.27 - 4.20
Pregnant Women
1st Trimester: 0.33 - 4.59
2nd Trimester: 0.35 - 4.10
3rd Trimester: 0.21 - 3.15

METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY

Interpretation(s)
****End Of Report****

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 Patient Ref. No. 22000000894350

MC

Rate 67 . Sinus rhythm.....normal P axis, V-rate 50-99
 . Probable left atrial enlargement.....P >50ms, <-0.10mV V1
 PR 147 . Low voltage, precordial leads.....precordial leads <1.0mV
 QRS 95 . RSR' in V1 or V2, right VCD or RVH.....QRS area positive & R' V1/V2
 QT 407
 QTc 430

--AXIS--

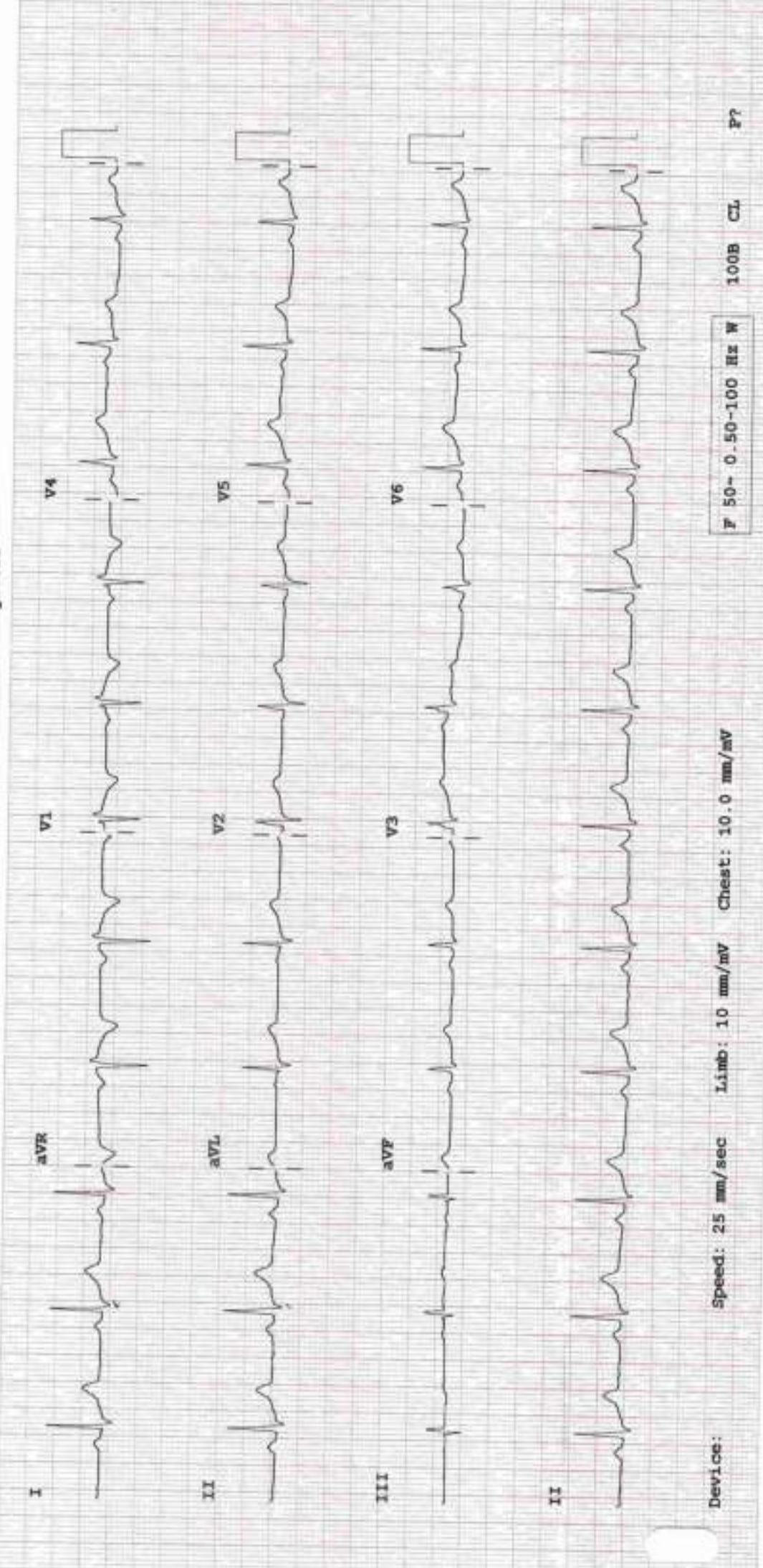
P 35
 QRS 39
 T 28

12 Lead; Standard Placement

-- BORDERLINE ECG --

Unconfirmed Diagnosis

- sinus rhythm
 - the complete RBBB is 0° ST-T changes (V1)
 Atrial



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50- 0.50-100 Hz W

100B CL P?

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani
HOSPITAL
A Fortis Healthcare Hospital

DEPARTMENT OF RADIOLOGY

Date: 11/Nov/2023

Name: Mrs. Nisha Raju Shirsat

Age | Sex: 30 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12814871 | 65309/23/1501

Order No | Order Date: 1501/PN/OP/2311/135820 | 11-Nov-2023

Admitted On | Reporting Date : 11-Nov-2023 15:10:30

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	: Nisha Raju Shirsat	Patient ID	: 12814871
Sex / Age	: F / 30Y 9D	Accession No.	: PHC.6919895
Modality	: US	Scan DateTime	: 11-11-2023 11:19:57
IPID No	: 65309/23/1501	ReportDatetime	: 11-11-2023 13:16:12

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 mildly enlarged in size (13.1 cm) and normal in echogenicity.

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

Right kidney measures 9.9 x 3.4 cm.

Left kidney measures 10.5 x 4.4 cm.

PANCREAS: Visualised head and body of pancreas appears normal. Rest of the pancreas is obscured due to bowel gas.

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 9.5 x 6.0 x 4.2 cm.

Endometrium measures 8.7 mm in thickness.

Both ovaries are normal.


Right ovary measures 3.7 x 1.4 cm.

Left ovary measures 3.2 x 1.4 cm.

No evidence of ascites.

Impression:

- Mild splenomegaly.


DR. KUNAL NIGAM
 M.D. (Radiologist)