DIAGNOSTIC REPORT

Patient Ref. No. 666000003184452

Cert. No. MC-2812

DDRC SRL Diagnostic Services

CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

DDRC SRL DIAGNOSTICS
ASTER SQUARE BUILDING, ULLOOR,
MEDICAL COLLEGE P.O
TRIVANDRUM, 695011
KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@srl.in

PATIENT NAME : MR RIYAS SYED HUSSAIN PATIENT ID : **MRRIM2801734182**

ACCESSION NO : **4182WA013102** AGE : 50 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 28/01/2023 07:50 REPORTED : 30/01/2023 08:18

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

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

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

*** TREADMILL TEST**

TREADMILL TEST	REPORT ATTACHED

*** PHYSICAL EXAMINATION**

PHYSICAL EXAMINATION	REPORT ATTACHED

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Test Report Status **Preliminary**	Results		Units
MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT			
*** BLOOD UREA NITROGEN (BUN), SERUM**			
BLOOD UREA NITROGEN	11	Adult(<60 yrs) : 6 to 20	mg/dL
*** BUN/CREAT RATIO**			
BUN/CREAT RATIO	9.3		
CREATININE, SERUM			
CREATININE	1.18	18 - 60 yrs : 0.9 - 1.3	mg/dL
*** GLUCOSE, POST-PRANDIAL, PLASMA**			
GLUCOSE, POST-PRANDIAL, PLASMA	80	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE FASTING,FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA	90	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
*** GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	4.8	Normal : 4.0 - 5.6%. Non-diabetic level : < 5.7%. Diabetic : >6.5% Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%. Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	%
MEAN PLASMA GLUCOSE	91.1		mg/dL
*** LIPID PROFILE, SERUM**			
CHOLESTEROL	209	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	100	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	47	General range : 40-60	mg/dL

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Test Report Status **Preliminary**	Results			Units
DIRECT LDL CHOLESTEROL	**163**	**High**	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	**162**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	20.0		Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	**4.5**	**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	**3.5**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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Interpretation(s)

1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.

2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3)HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL

4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis.The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.

5)Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

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

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

Risk Category		
Extreme risk group	A.CAD with > 1 feature of high risk group	
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease	
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia	
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque	
Moderate Risk	2 major ASCVD risk factors	
Low Risk	0-1 major ASCVD risk factors	
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors		
1. Age > or = 45 years in males and > or = 55 years in females		3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD		4. High blood pressure
5. Low HDL		

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

Risk Group	**Treatment Goals**		**Consider Drug Therapy**	
	LDL-C (mg/dl)	**Non-HDL (mg/dl)**	**LDL-C (mg/dl)**	**Non-HDL (mg/dl)**

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Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

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

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

*** LIVER FUNCTION TEST WITH GGT**

BILIRUBIN, TOTAL	1.06		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.31		General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	**0.75**	**High**	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.4		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.7		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.6		General Range : 1.1 - 2.5	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	19		Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	18		Adults : < 45	U/L
ALKALINE PHOSPHATASE	74		Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	12		Adult (Male) : < 60	U/L

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL

URIC ACID, SERUM

URIC ACID	6.7		Adults : 3.4-7	mg/dL

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE A
RH TYPE	POSITIVE

METHOD : COLUMN AGGLUTINATION TECHOLOGY

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BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN METHOD : SPECTROPHOTOMETRIC	16.8		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT METHOD : IMPEDANCE VARIATION	5.44		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	6.07		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : IMPEDANCE VARIATION	240		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT METHOD : CALCULATED PARAMETER	49.4		40 - 50	%
MEAN CORPUSCULAR VOL	90.9		83 - 101	fL
MEAN CORPUSCULAR HGB. METHOD : CALCULATED PARAMETER	30.8		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.9		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	15.3		12.0 - 18.0	%
MENTZER INDEX	16.7			
MEAN PLATELET VOLUME	7.3		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
SEGMENTED NEUTROPHILS	53		40 - 80	%
LYMPHOCYTES	29		20 - 40	%
MONOCYTES	8		2 - 10	%
EOSINOPHILS	**9**	**High**	1 - 6	%
BASOPHILS	1		0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	3.22		2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.76		1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT	0.49		0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT	**0.55**	**High**	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0.0			thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.0			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
SEDIMENTATION RATE (ESR)	3		0 - 14	mm at 1 hr
*** SUGAR URINE - POST PRANDIAL**				
SUGAR URINE - POST PRANDIAL	NOT DETECTED		NOT DETECTED	

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PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN	0.745	Age Specific :- <49yrs : <2.5 50-59yrs : <3.5 60-69yrs : <4.5 >70yrs : <6.5	ng/mL
*** THYROID PANEL, SERUM**			
T3	123.90	80 - 200	ng/dL
T4	8.02	5.1 - 14.1	µg/dl
TSH 3RD GENERATION	1.220	21-50 yrs : 0.4 - 4.2	µIU/mL

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Interpretation(s)

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

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

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW	
APPEARANCE	CLEAR	

CHEMICAL EXAMINATION, URINE

PH	7.0	4.7 - 7.5
SPECIFIC GRAVITY	1.004	1.003 - 1.035

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PROTEIN	NEGATIVE	NOT DETECTED	
GLUCOSE	NEGATIVE	NOT DETECTED	
KETONES	NEGATIVE	NOT DETECTED	
BLOOD	NEGATIVE	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
METHOD : DIPSTICK			
NITRITE	NEGATIVE	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NEGATIVE		
CRYSTALS	NEGATIVE		
REMARKS	NIL		
METHOD : AUTOMATED ANALYSER, MICROSCOPY			

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Test Report Status **Preliminary**	Results	Units

Interpretation(s)

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

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

*** SUGAR URINE - FASTING**

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED
*** PHYSICAL EXAMINATION,STOOL**	RESULT PENDING	
*** CHEMICAL EXAMINATION,STOOL**	RESULT PENDING	
*** MICROSCOPIC EXAMINATION,STOOL**	RESULT PENDING	

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CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

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ASTER SQUARE BUILDING, ULLOOR,
MEDICAL COLLEGE P.O
TRIVANDRUM, 695011
KERALA, INDIA
Tel : 93334 93334, Fax : CIN - U85190MH2006PTC161480
Email : customercare.ddrc@srl.in

PATIENT NAME : MR RIYAS SYED HUSSAIN PATIENT ID : **MRRIM2801734182**

ACCESSION NO : **4182WA013102** AGE : 50 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 28/01/2023 07:50 REPORTED : 30/01/2023 08:18

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Units

Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointentestinal tract like infection, malabsorption, etc.The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days.Stool specimens for parasitic examination should be collected before initiation of antidiarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects& reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

1. **Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
2. **Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
3. **Fecal Occult Blood Test(FOBT):** This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
4. **Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or waterydiarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
5. **Biofire (Film Array) GI PANEL:** In patients of Diarrhoea, Dysentry, Rice watery Stool, FDA approved, Biofire Film Array Test,(Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria,fungi,virus ,parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
6. **Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomitting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

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Test Report Status	Preliminary	Results	Units

Interpretation(s)
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, 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
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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
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 patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
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 & 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 & opiates addiction 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 & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

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Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
TOTAL PROTEIN, SERUM-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.
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
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.
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(>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.
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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

DIAGNOSTIC REPORT

Patient Ref. No. 666000003184452

Cert. No. MC-2812

DDRC SRL Diagnostic Services

CLIENT CODE : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

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8800465156

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PATIENT NAME : MR RIYAS SYED HUSSAIN PATIENT ID : **MRRIM2801734182**

ACCESSION NO : **4182WA013102** AGE : 50 Years SEX : Male ABHA NO :

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Test Report Status	**Preliminary**	**Results**	**Units**

Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
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.
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT''S TEST
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

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DIAGNOSTIC REPORT

Patient Ref. No. 666000003184452

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

*** ECG WITH REPORT**

REPORT

REPORT GIVEN

*** USG ABDOMEN AND PELVIS**

REPORT

REPORT GIVEN

*** CHEST X-RAY WITH REPORT**

REPORT

REPORT GIVEN

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

BABU K MATHEW
HOD -BIOCHEMISTRY

DR.VAISHALI RAJAN, MBBS
DCP(Pathology)
(Reg No - TCC 27150)
HOD - HAEMATOLOGY

DR. ASTHA YADAV, MD
Biochemistry
(Reg No - DMC/R/20690)
CONSULTANT BIOCHEMIST

DR NISHA UNNI, MBBS,MD
(RD),DNB (Reg.No:50162)
Consultant Radiologist

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MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. Riyas Syed Hussain
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	50/M - Gender: F/M
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height 175 (cms) b. Weight 82 (Kgs) c. Girth of Abdomen 81 (cms)

d. Pulse Rate ..... (/Min) e. Blood Pressure:

	Systolic	Diastolic
1st Reading	150	100
2nd Reading		

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father			
Mother			
Brother(s)			
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
-	-	-

PERSONAL HISTORY

a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. Y/N

b. Have you undergone/been advised any surgical procedure? Y/N

c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? Y/N

d. Have you lost or gained weight in past 12 months? Y/N

Have you ever suffered from any of the following?

- Psychological Disorders or any kind of disorders of the Nervous System? Y/N
- Any disorders of Respiratory system? Y/N
- Any Cardiac or Circulatory Disorders? Y/N
- Enlarged glands or any form of Cancer/Tumour? Y/N
- Any Musculoskeletal disorder? Y/N
- Any disorder of Gastrointestinal System? Y/N
- Unexplained recurrent or persistent fever, and/or weight loss Y/N
- Have you been tested for HIV/HBsAg / HCV before? If yes attach reports Y/N
- Are you presently taking medication of any kind? Y/N

- Any disorders of Urinary System? Y/N
- Any disorder of the Eyes, Ears Nose, Throat or Mouth & Skin Y/N

FOR FEMALE CANDIDATES ONLY

a. Is there any history of diseases of breast/genital organs? Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports) Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries? Y/N

d. Do you have any history of miscarriage/ abortion or MTP Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc Y/N

f. Are you now pregnant? If yes, how many months? Y/N

CONFIDENTAIL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? Y/N
- Is there anything about the examine's health, lifestyle that might affect him/her in the near future with regard to his/her job? Y/N
- Are there any points on which you suggest further information be obtained? Y/N
- Based on your clinical impression, please provide your suggestions and recommendations below;

Grade I Fatty Liver.

- Do you think he/she is MEDICALLY FIT or UNFIT for employment.

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

Seal of Medical Examiner :

Dr. SERIN LOPEZ. MBBS
MEDICAL OFFICER
DDRC SRL Diagnostics Ltd.
Aster Square, Medical College P.O., TVM
Reg. No. 7656

Name & Seal of DDRC SRL Branch :

DDRC SRL Diagnostics Pvt Ltd MEDICAL COLLEGE

Date & Time : 28/01/2023.

DDRC SRL Diagnostics Private Limited

Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai – 400062.

V1	V2	V3	V4

ID: 013102

Diagnosis Information:

Male / mmHg
50Years
cm kg

Mr. Rajas Syed Hassan

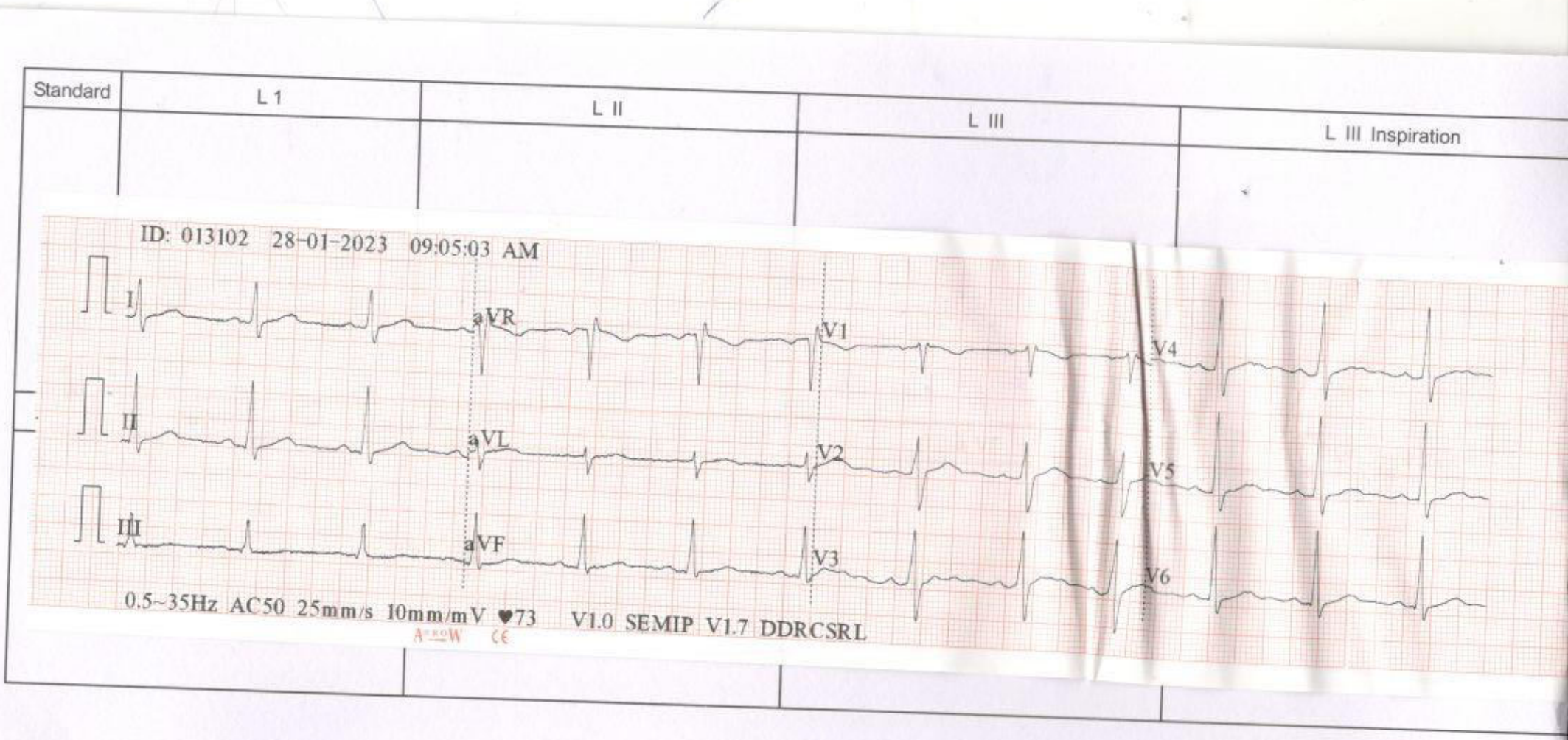
Dr. SERIN LOPEZ. MBBS
MEDICAL OFFICER
DDRC SRL Diagnostics Ltd.
Aster Square, Medical College P.O., TVM
Reg. No. 77656

Standard

HR	: 76	bpm
P	: 115	ms
PR	: 172	ms
QRS	: 101	ms
QT/QTc	: 379/427	ms
P/QRS/T	: 57/71/38	°
RV5/SV1	: 1.413/0.468	mV

Report Confirmed by:

DDRC SRL Diagnostics Pvt. Ltd. MEDICAL COLLEGE


Standard
L 1
L II
L III
L III Inspiration
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I
II
III
aVR
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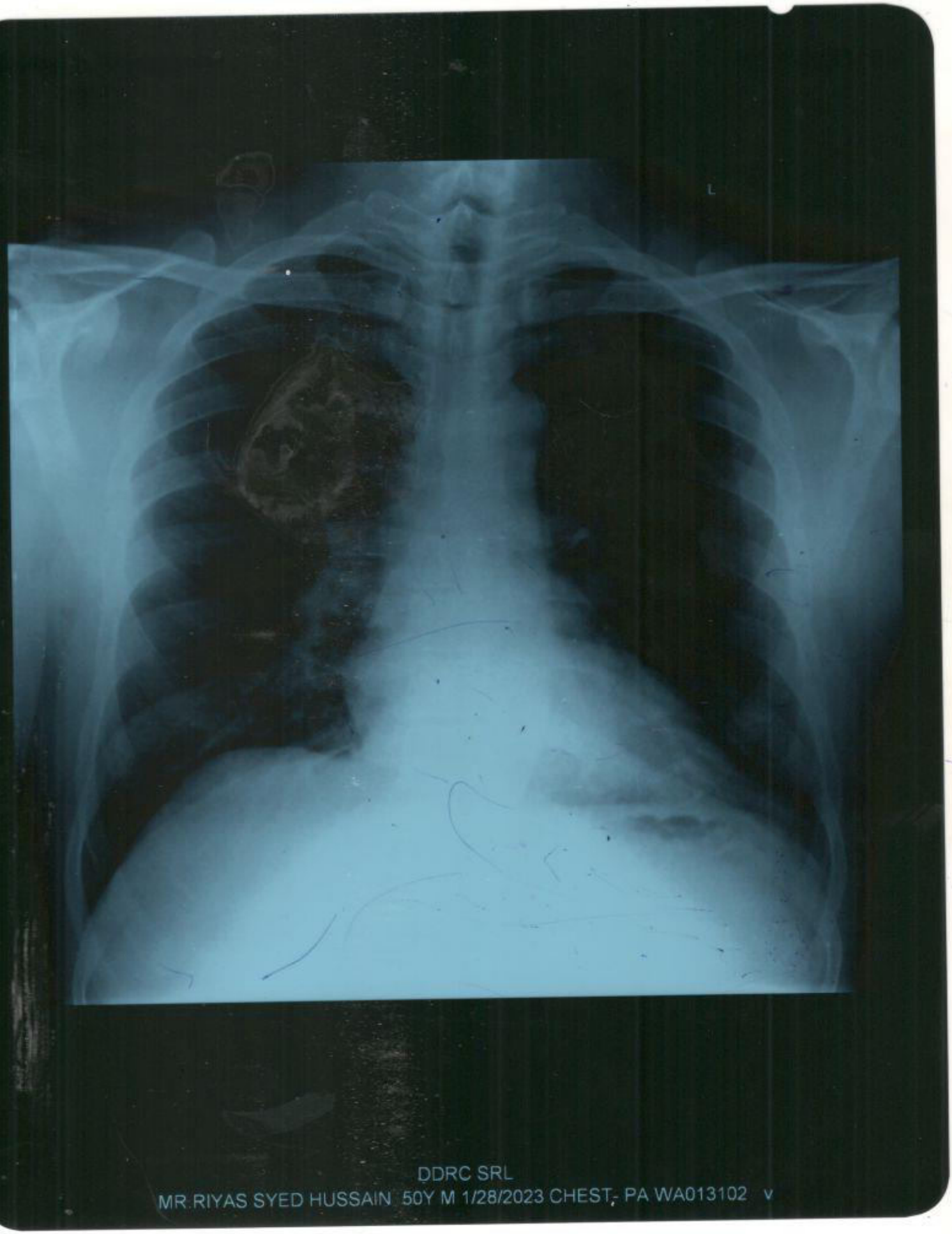
aVF
V1
V2
V3
V4
V5
V6
0.5~35Hz AC50 25mm/s 10mm/mV ♥73 V1.0 SEMIP V1.7 DDRCSRL


L
DDRC SRL
MR RIYAS SYED HUSSAIN 50Y M 1/28/2023 CHEST, PA WA013102 v

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

NAME : MR: RIYAS SYED HUSSAIN	AGE:50/M	DATE:28/01/2023

CHEST X-RAY REPORT

CHEST X-RAY PA VIEW : Trachea central
No cardiomegaly
Normal vascularity
No parenchymal lesion.
Costophrenic and cardiophrenic angles clear

➢ **IMPRESSION** **: Normal Chest Xray**

ELECTRO CARDIOGRAM : NSR:76/minute
No evidence of ischaemia.

➢ **IMPRESSION** **: Normal Ecg.**

Dr. SERIN LOPEZ. MBBS
MEDICAL OFFICER
DDRC SRL Diagnostics Ltd.
Aster Square, Medical College P.O., TVM
Reg. No. 77656

DDRC SRL Diagnostics Ltd. MEDICAL COLLEGE

Company name: BOB

DR SERIN LOPEZ MBBS
Reg No 77656
DDRC SRL DIAGNOSTICS LTD

COLOUR DOPPLER
ULTRASOUND SCANNING
ECHO

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS - WORK
RADIOLOGY DIVISION

Acc no:4182WA013102	Name:Mr. Riyas Syed Hussain	Age: 50 y	Sex: Male	Date: 28.01.23

US SCAN WHOLE ABDOMEN

LIVER is normal in size (13.1 cm). Margins are regular. **Hepatic parenchyma shows increased echogenicity**. No focal lesions seen. No dilatation of intrahepatic biliary radicles. CBD is not dilated. Portal vein is normal in caliber (11.6 mm).

GALL BLADDER is minimally distended. No pericholecystic fluid seen.

SPLEEN is normal in size (10.9 cm) and parenchymal echotexture. No focal lesion seen.

PANCREAS Head and body visualized, appears normal in size and parenchymal echotexture. Pancreatic duct is not dilated.

RIGHT KIDNEY is normal in size (9.6 x 3.2 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

LEFT KIDNEY is normal in size (10.6 x 4.2 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

PARAAORTIC AREA Obscured by bowel air.

URINARY BLADDER is distended, normal in wall thickness, lumen clear.

PROSTATE is normal in size (vol - 18.4 cc) and shows normal echotexture. No focal lesion seen.

No ascites or pleural effusion.

CONCLUSION:-

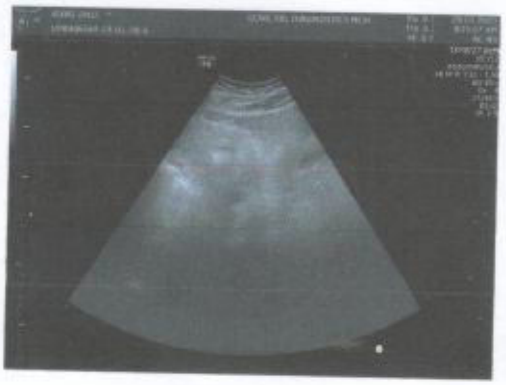
- **Grade I / II fatty liver** - *suggest LFT correlation.*

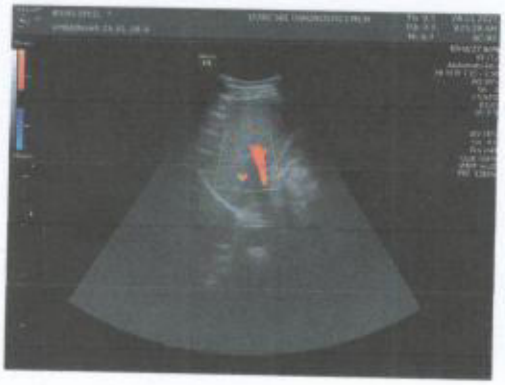
Dr. Nisha Unni MD , DNB (RD)
Consultant radiologist.

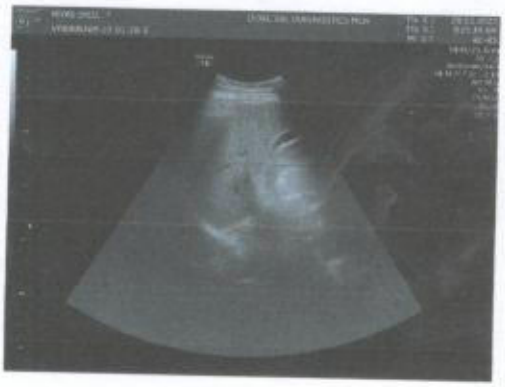
Thanks, your feedback will be appreciated.
(Please bring relevant investigation reports during all visits).
Because of technical and technological limitations complete accuracy cannot be assured on imaging.
Suggested correlation with clinical findings and other relevant investigations consultations , and if required repeat imaging recommended in the event of controversities.

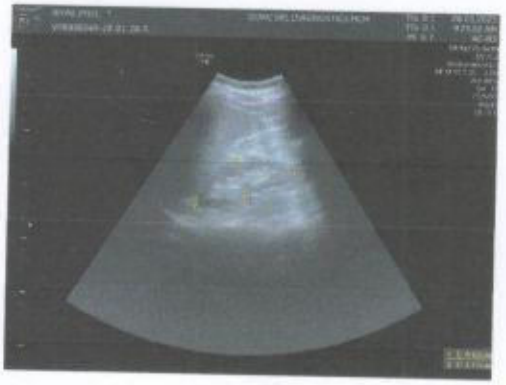
(For appointments please contact 9496005190 between 9 am – 5.30 pm).

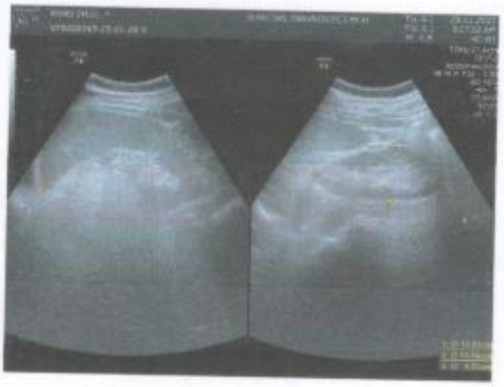
COMPLETE IMAGING SOLUTIONS

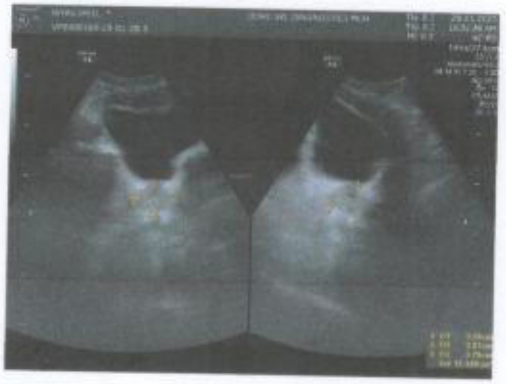












DDRC SRL

Patient Details **Date: 28-Jan-23** **Time: 2:16:29 PM**

Name: RIYAS SYED HUSSAIN **ID: 4182WA013102**

Age: 50 y **Sex: M** **Height: 175 cms** **Weight: 82 Kgs**

Clinical History: HTN

Medications: MEDICATION ON HTN

Test Details

Protocol: Bruce **Pr.MHR:** 170 bpm **THR:** 153 (90 % of Pr.MHR) bpm

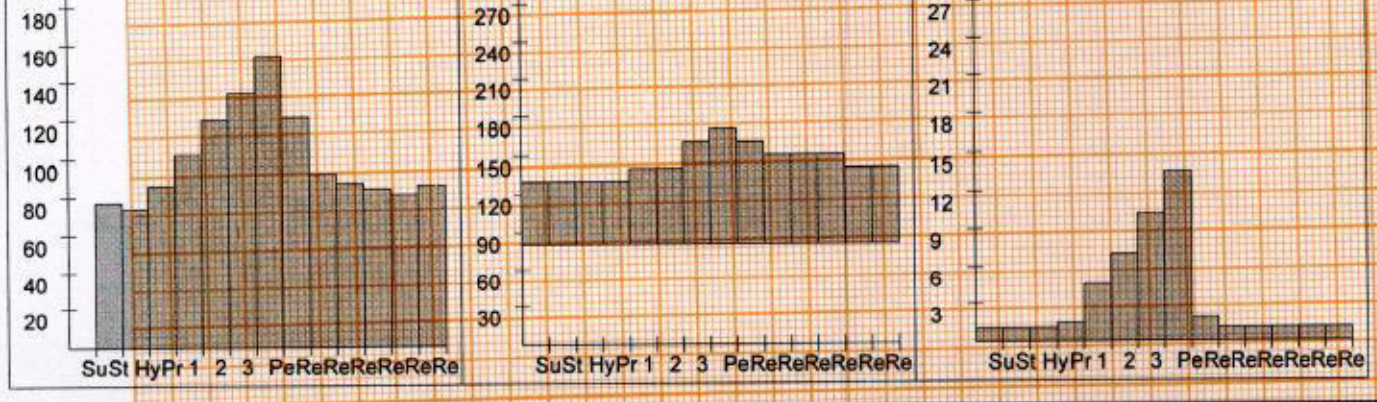
Total Exec. Time: 10 m 35 s **Max. HR:** 154 (91% of Pr.MHR)bpm **Max. Mets:** 13.50

Max. BP: 170 / 80 mmHg **Max. BP x HR:** 26180 mmHg/min **Min. BP x HR:** 5920 mmHg/min

Test Termination Criteria: THR ATTAINED

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 : 11	1.0	0	0	0	130 / 80	0.00 I	0.00 II
Standing	0 : 2	1.0	0	0	77	130 / 80	-1.06 aVR	1.42 II
Hyperventilation	0 : 34	1.0	0	0	74	130 / 80	-1.06 aVR	1.42 II
1	3 : 0	4.6	1.7	10	102	140 / 80	-1.91 aVR	2.48 II
2	3 : 0	7.0	2.5	12	120	140 / 80	-1.27 aVR	2.83 II
3	3 : 0	10.2	3.4	14	134	160 / 80	-2.97 V1	5.66 V5
Peak Ex	1 : 35	13.5	4.2	16	154	170 / 80	-2.97 V2	5.66 V3
Recovery(1)	1 : 0	1.8	1	0	121	160 / 80	-1.49 aVR	5.66 II
Recovery(2)	1 : 0	1.0	0	0	92	150 / 80	-1.49 aVR	5.66 V4
Recovery(3)	1 : 0	1.0	0	0	87	150 / 80	-0.64 aVR	3.18 II
Recovery(4)	1 : 0	1.0	0	0	84	150 / 80	-0.42 aVR	2.12 II
Recovery(5)	1 : 0	1.0	0	0	81	140 / 80	-0.42 aVR	1.42 II
Recovery(6)	0 : 13	1.0	0	0	86	140 / 80	-0.21 aVR	1.06 I



DDRC SRL

Patient Details **Date:** 28-Jan-23 **Time:** 2:16:29 PM

Name: RIYAS SYED HUSSAIN **ID:** 4182WA013102

Age: 50 y **Sex:** M **Height:** 175 cms **Weight:** 82 Kgs

Interpretation

The patient exercised according to the Bruce protocol for 10 m 35 s achieving a work level of Max. METS : 13.50. Resting heart rate initially 0 bpm, rose to a max. heart rate of 154 (91% of Pr.MHR) bpm. Resting blood Pressure 130 / 80 mmHg, rose to a maximum blood pressure of 170 / 80 mmHg.
NO ANGINA/ARRHYTHMIAS/SOB
GOOD EFFORT TOLERANCE
NO SIGNIFICANT ST CHANGES
TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Ref. Doctor: MEDIWHEEL

Doctor: DR.SHASHIKANTH.Y.S

Dr SHASHIKANTH Y.S
MBBS,MD,DM(Cardiology)
Consultant Cardiologist
TCMC Reg No: 73538

(Summary Report edited by user)

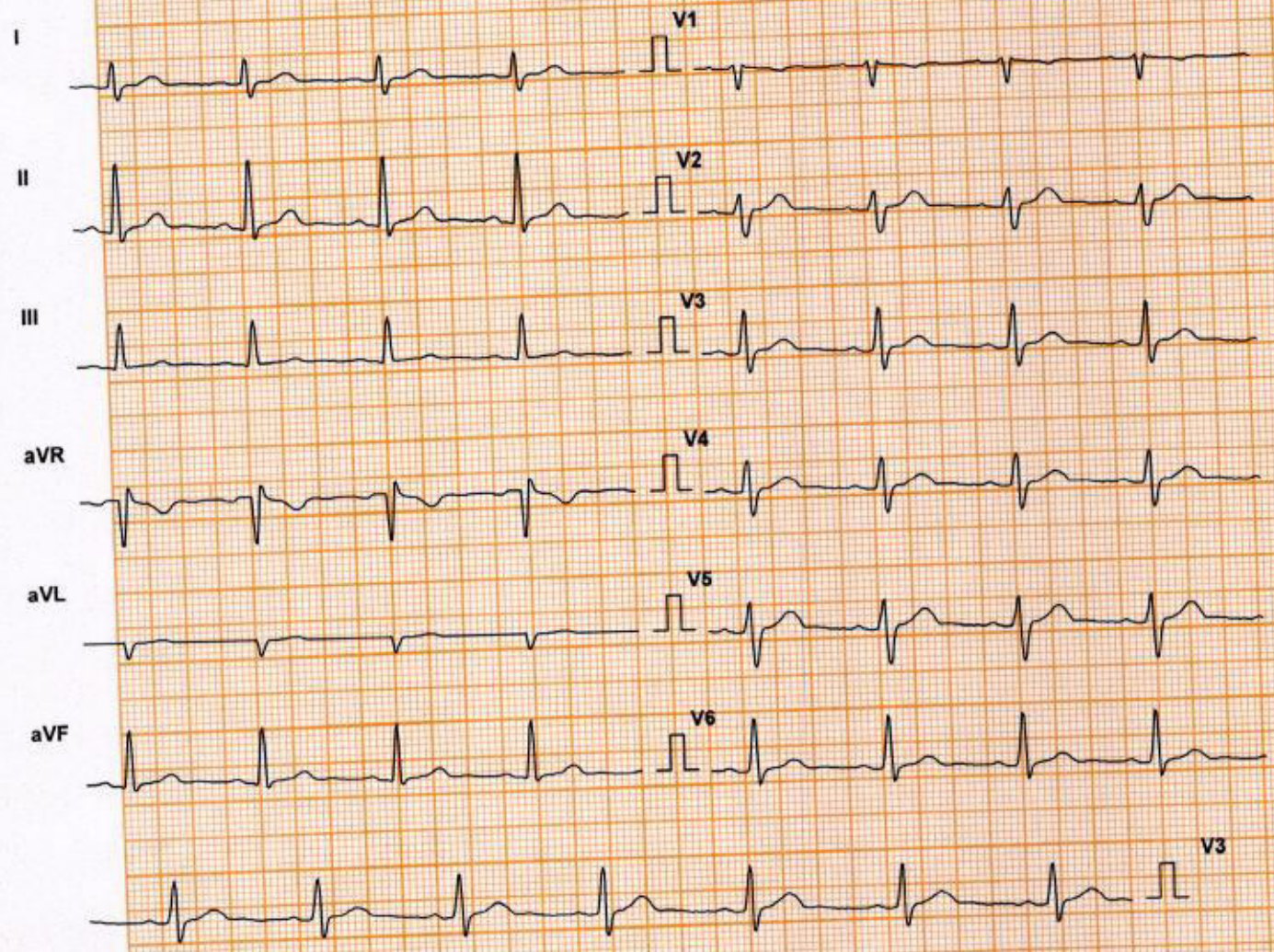
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 0 m 0 s

ID: 4182WA013102
Stage: Supine
Stage Time : 0 m 5 s

Date: 28-Jan-23
Speed: 0 mph
HR: 77 bpm

B.P: 130 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.6	aVR	-1.1	V1	0.0	V4	1.3	ST Level (mm)
	0.4		-1.1		-0.7		1.1	ST Slope (mV / s)
II	1.5	aVL	0.2	V2	1.3	V5	1.5	
	1.4		0.4		0.7		1.1	
III	0.4	aVF	0.8	V3	1.3	V6	1.1	
	0.7		1.1		0.7		0.7	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms *J = R + 60 ms*

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

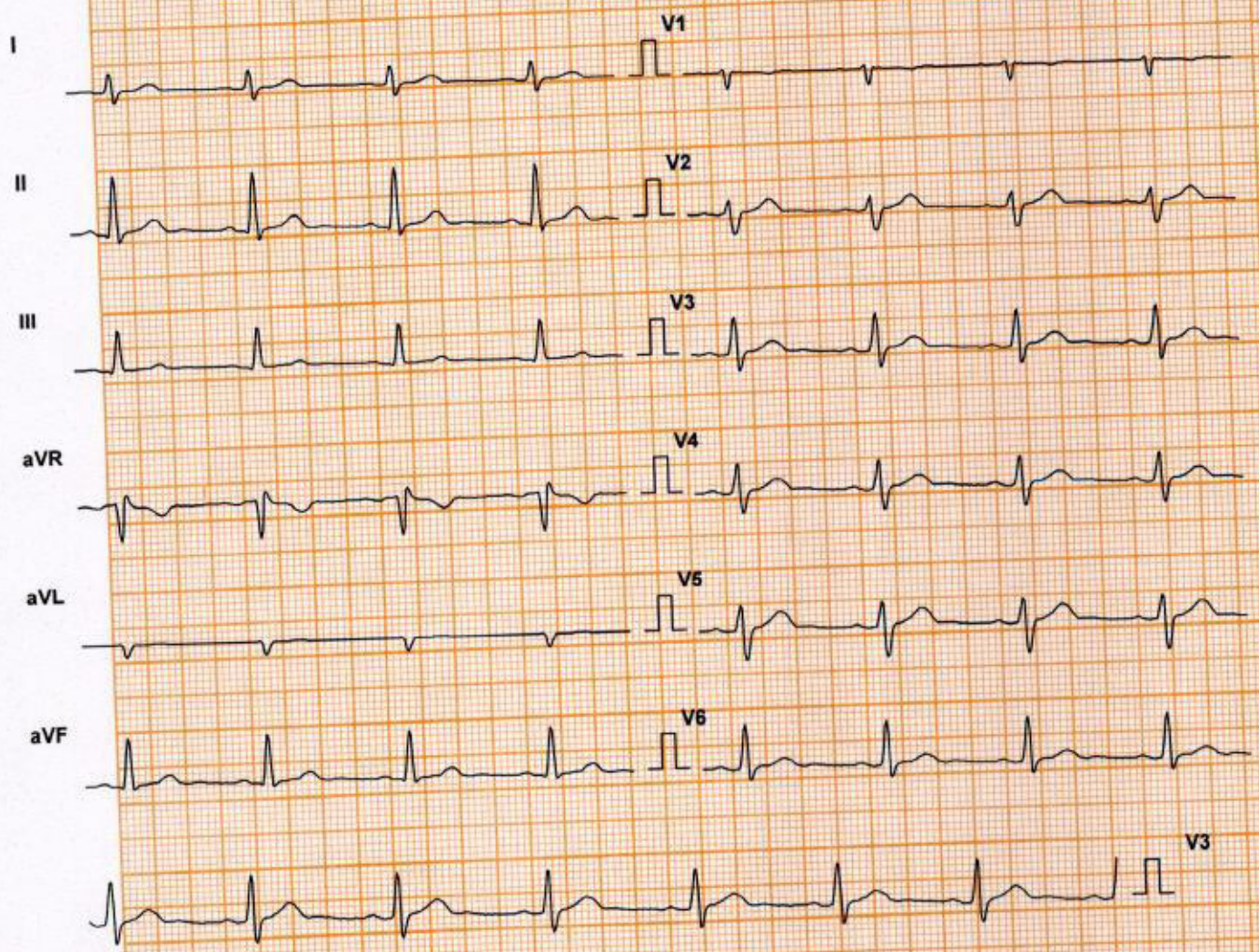
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 0 m 0 s

ID: 4182WA013102
Stage: Standing
Stage Time : 0 m 7 s

Date: 28-Jan-23
Speed: 0 mph
HR: 71 bpm

B.P: 130 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.4	aVR	-0.8	V1	0.0	V4	1.1	ST Level (mm)
	0.4		-0.7		-0.4		0.7	ST Slope (mV / s)
II	1.1	aVL	0.0	V2	0.8	V5	1.5	
	1.1		0.0		0.7		1.1	
III	0.4	aVF	0.6	V3	1.1	V6	0.8	
	0.4		0.7		0.7		0.7	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

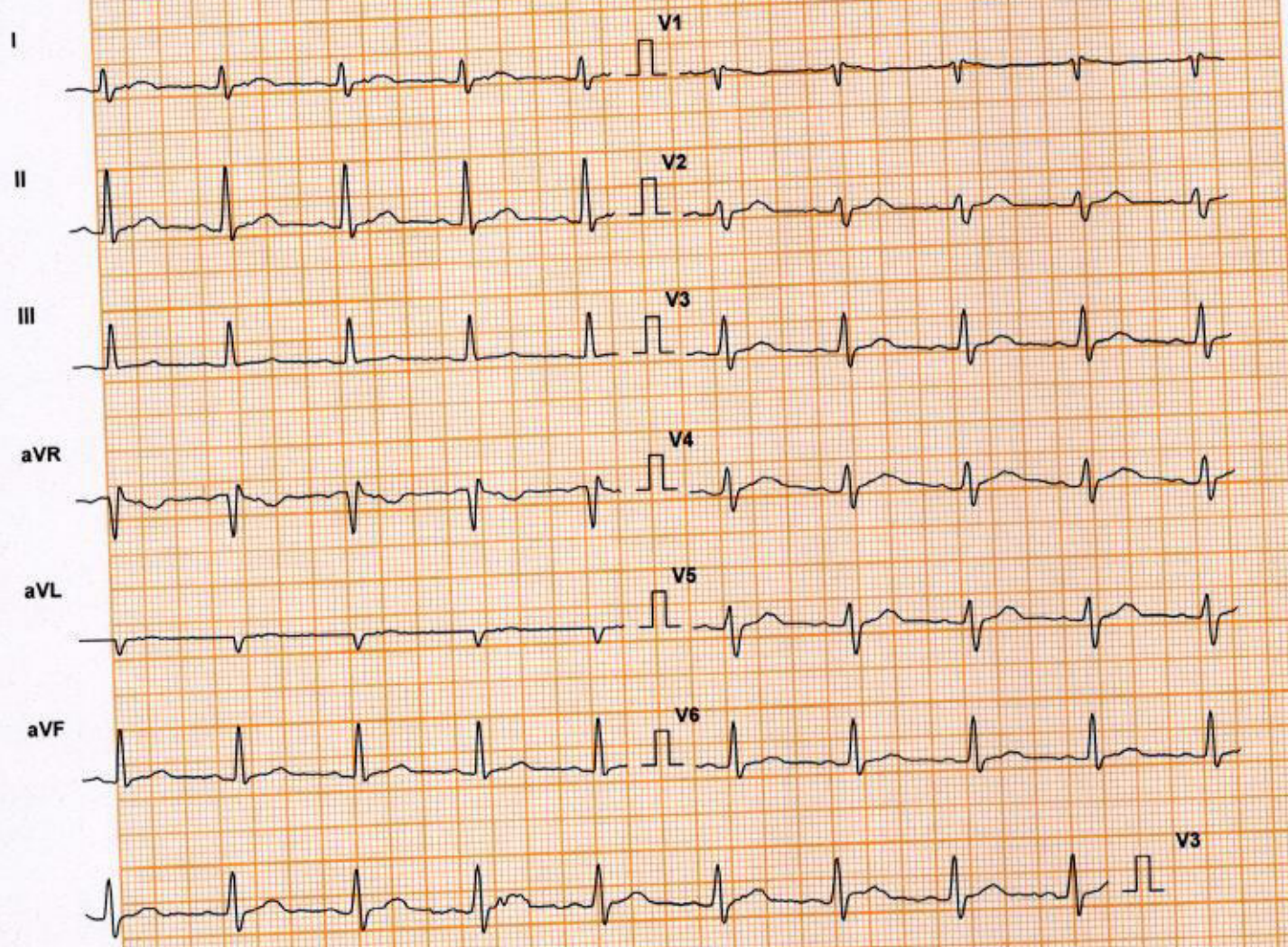
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 0 m 0 s

ID: 4182WA013102
Stage: Hyperventilation
Stage Time : 0 m 28 s

Date: 28-Jan-23
Speed: 0 mph
HR: 85 bpm

B.P: 130 / 80
Grade: 0 %
(THR: 153 bpm)



I	1.1	aVR	-1.7	V1	0.4	V4	2.8	ST Level (mm)
	1.1		-1.8		-0.4		2.1	ST Slope (mV / s)
II	1.9	aVL	0.2	V2	1.1	V5	1.5	
	2.1		0.4		0.7		1.1	
III	0.6	aVF	1.3	V3	1.5	V6	1.3	
	0.7		1.4		1.1		1.1	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

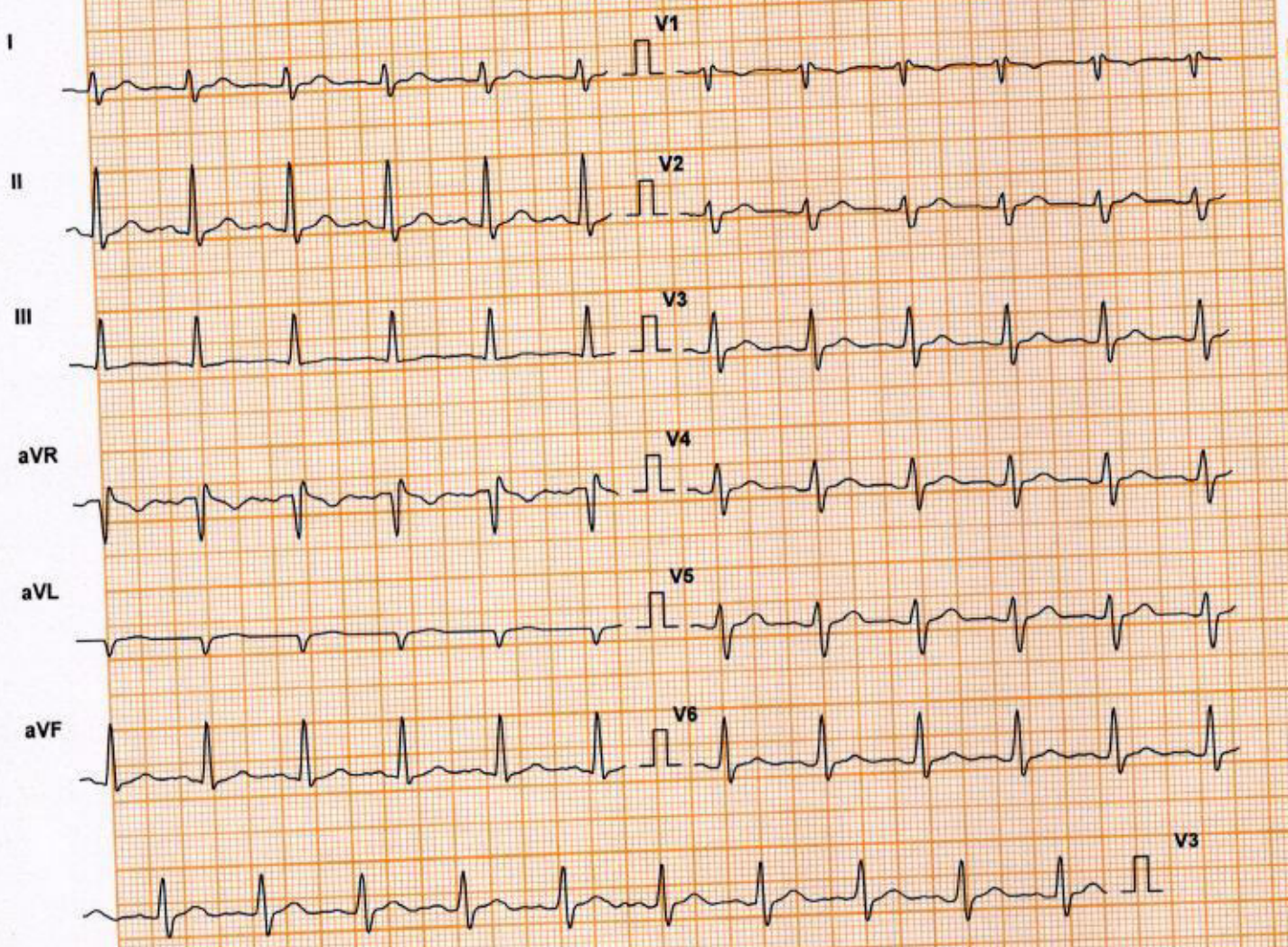
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 2 m 54 s

ID: 4182WA013102
Stage: 1
Stage Time : 2 m 54 s

Date: 28-Jan-23
Speed: 1.7 mph
HR: 103 bpm

B.P: 140 / 80
Grade: 10 %
(THR: 153 bpm)



I	0.6	aVR	-1.1	V1	0.0	V4	1.1	ST Level (mm)
	0.7		-1.8		-0.4		0.7	ST Slope (mV / s)
II	1.1	aVL	0.4	V2	0.8	V5	1.1	
	1.8		0.7		0.7		1.1	
III	-0.2	aVF	0.4	V3	1.1	V6	1.1	
	0.4		1.4		1.1		1.1	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms *J = R + 60 ms*

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

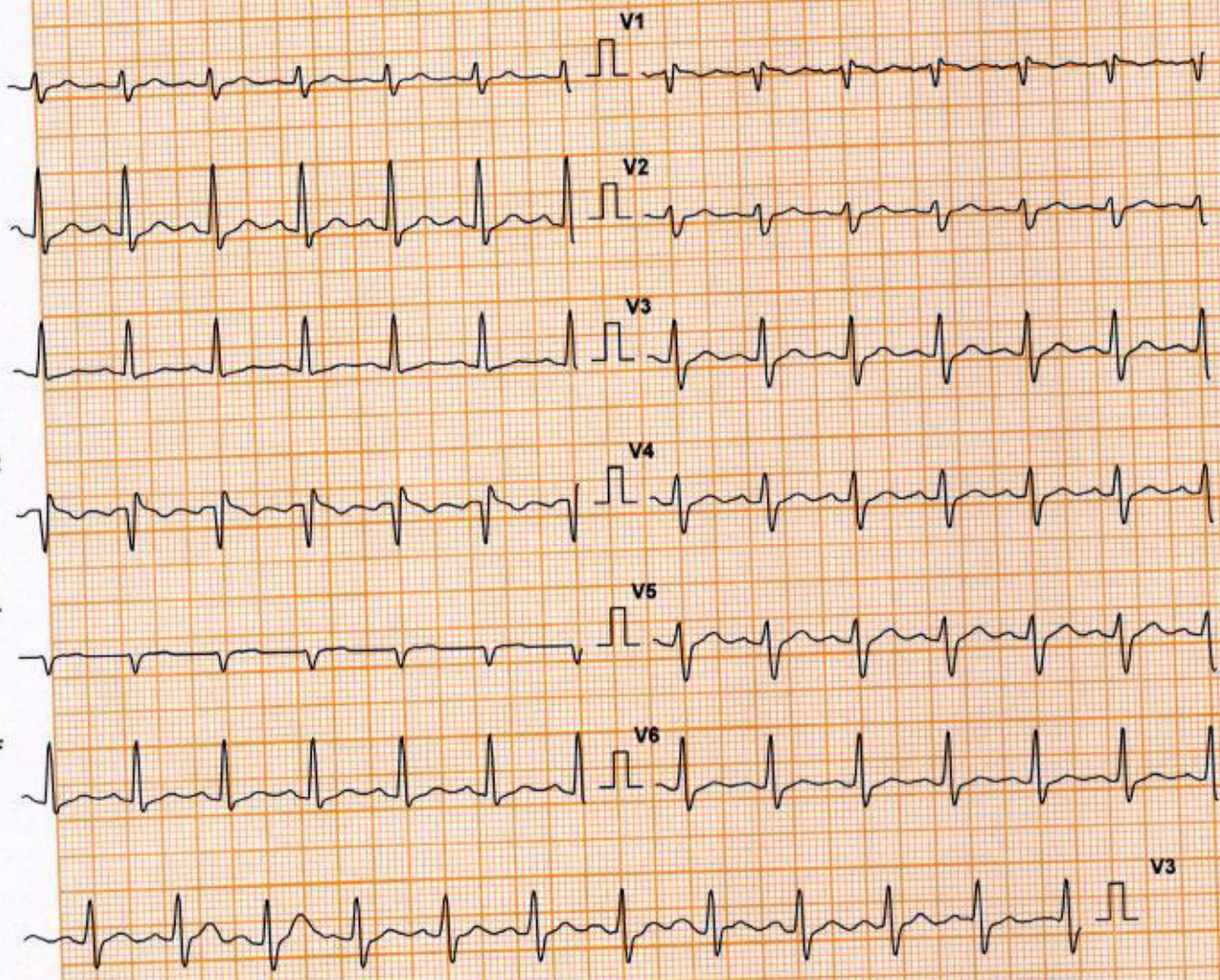
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 5 m 54 s

ID: 4182WA013102
Stage: 2
Stage Time : 2 m 54 s

Date: 28-Jan-23
Speed: 2.5 mph
HR: 119 bpm

B.P: 140 / 80
Grade: 12 %
(THR: 153 bpm)



I	0.4	aVR	-0.8	V1	0.2	V4	0.6	ST Level (mm)
	0.7		-2.1		-0.7		1.8	ST Slope (mV / s)
II	0.6	aVL	0.4	V2	0.6	V5	1.3	
	2.8		0.4		0.7		2.5	
III	0.0	aVF	0.4	V3	0.8	V6	0.8	
	1.4		1.8		2.1		2.1	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

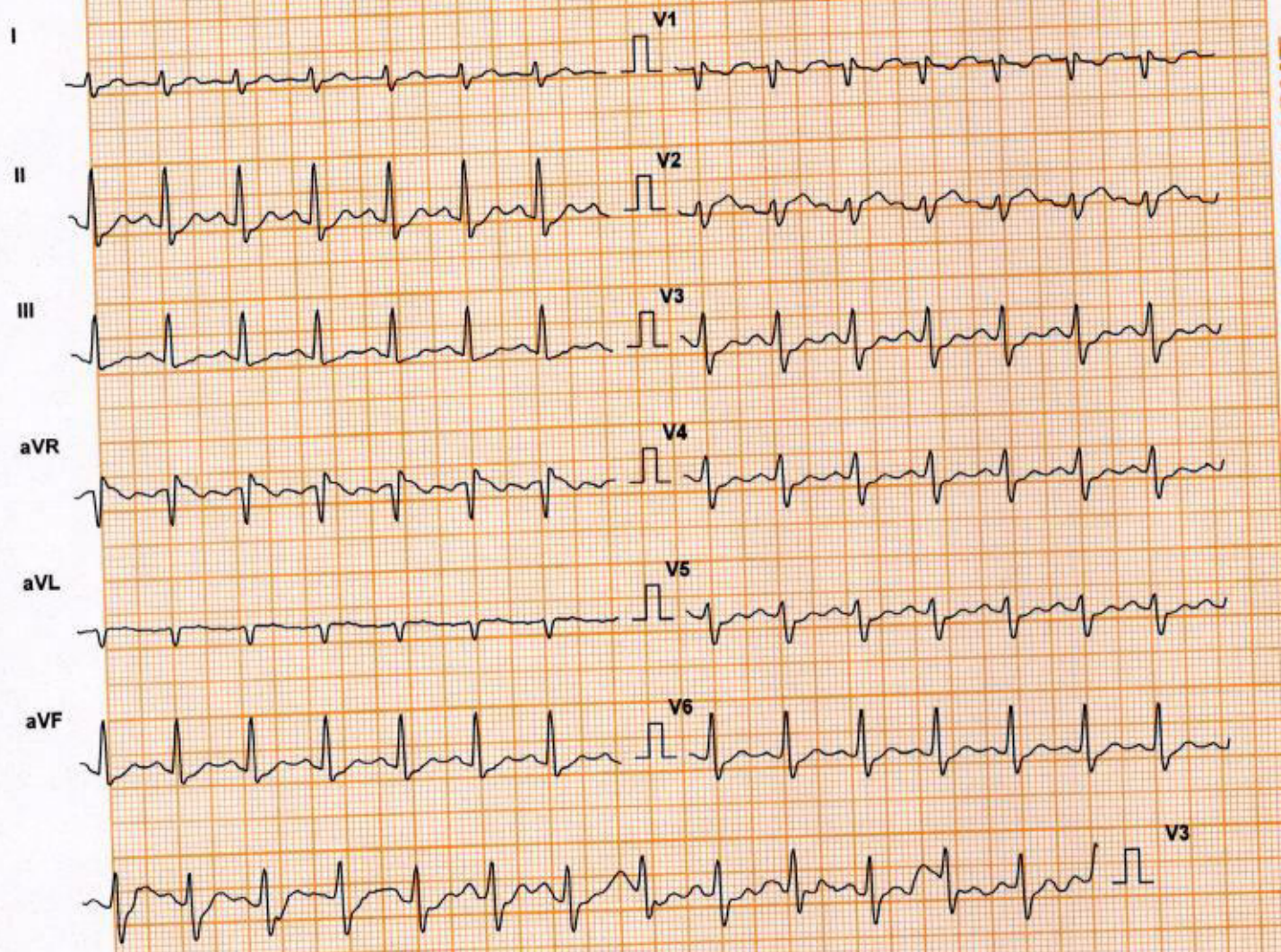
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 8 m 54 s

ID: 4182WA013102
Stage: 3
Stage Time : 2 m 54 s

Date: 28-Jan-23
Speed: 3.4 mph
HR: 134 bpm

B.P: 160 / 80
Grade: 14 %
(THR: 153 bpm)



I	0.2	aVR	-0.4	V1	-0.8	V4	-0.4	ST Level (mm)
	0.7		-2.1		-1.1		2.1	ST Slope (mV / s)
II	0.0	aVL	0.4	V2	4.0	V5	-0.4	
	3.2		-0.7		2.8		1.4	
III	-0.6	aVF	-0.4	V3	-0.6	V6	0.6	
	2.1		2.5		2.5		3.2	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms *J = R + 60 ms*

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

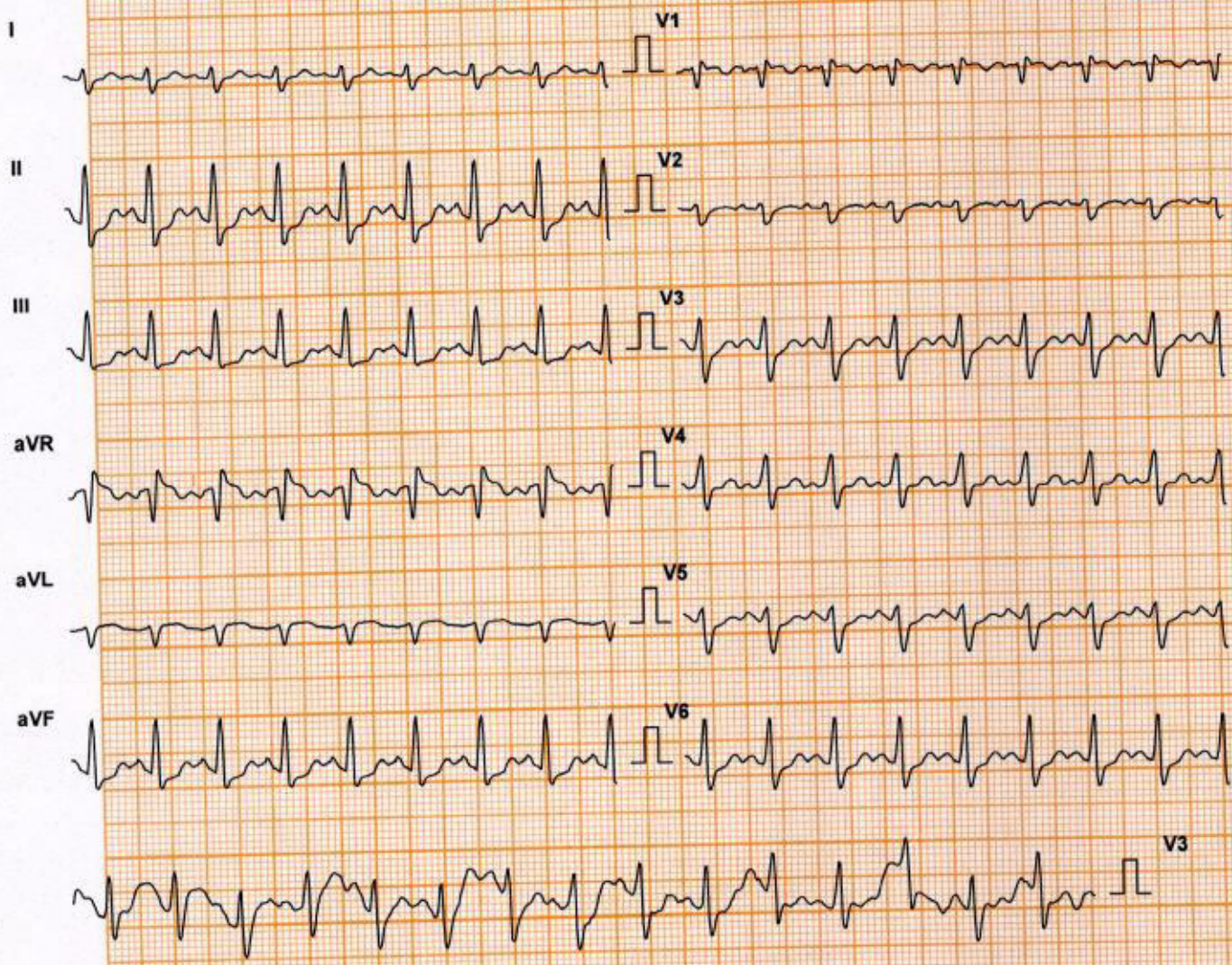
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 29 s

ID: 4182WA013102
Stage: Peak Ex
Stage Time : 1 m 29 s

Date: 28-Jan-23
Speed: 4.2 mph
HR: 154 bpm

B.P: 170 / 80
Grade: 16 %
(THR: 153 bpm)



I	0.2	aVR	0.4	V1	0.4	V4	0.2	ST Level (mm)
	1.4		-2.5		0.0		1.1	ST Slope (mV / s)
II	-1.3	aVL	1.3	V2	0.6	V5	0.0	
	3.2		0.7		1.8		2.5	
III	-1.9	aVF	-1.7	V3	0.2	V6	-0.2	
	0.7		2.1		3.9		2.8	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

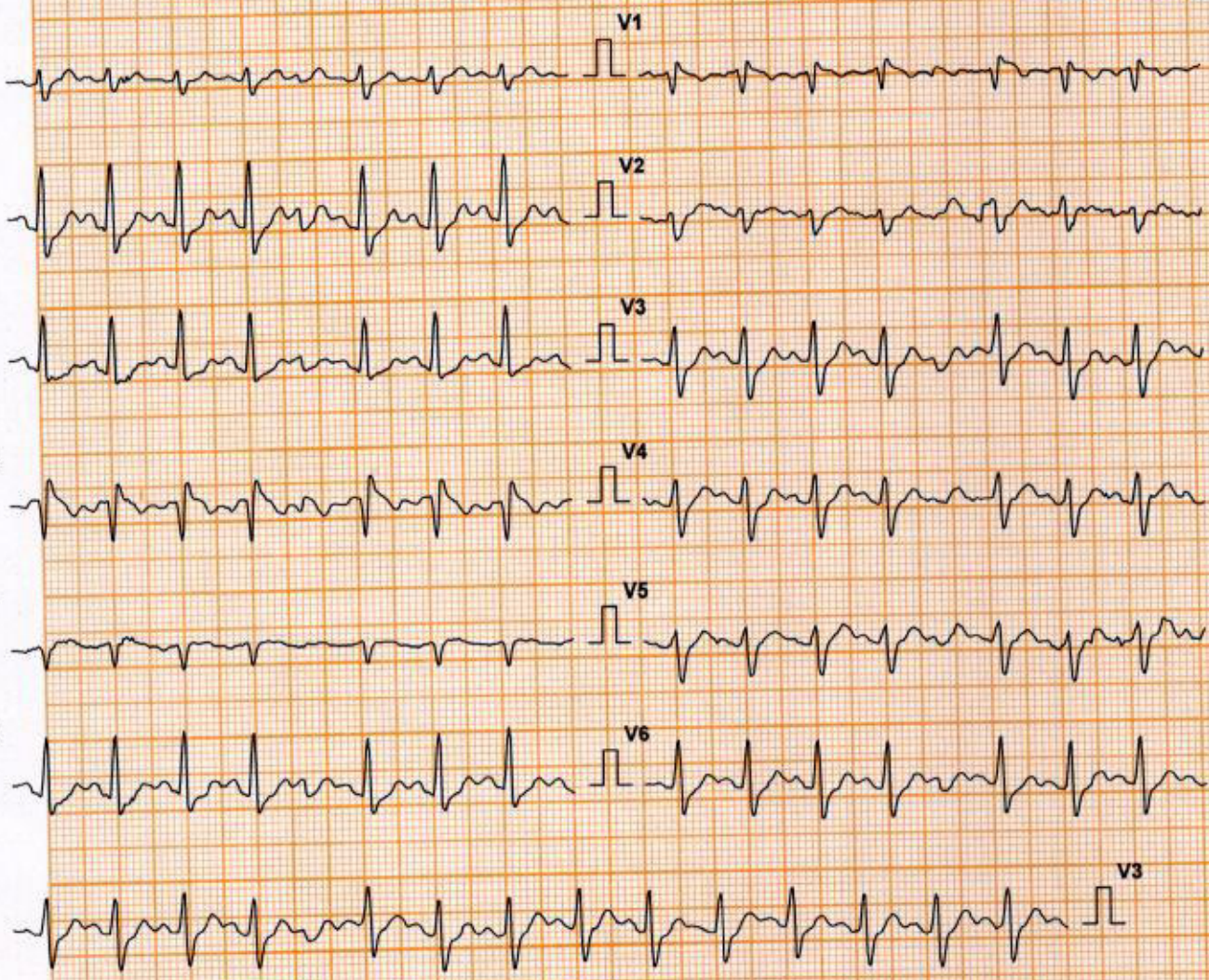
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(1)
Stage Time : 0 m 17 s

Date: 28-Jan-23
Speed: 0 mph
HR: 156 bpm

B.P: 160 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.8	2.1	aVR	-0.8	-3.2	V1	-0.2	-1.4	V4	2.5	5.0	ST Level (mm) / ST Slope (mV / s)
II	0.4	3.9	aVL	1.1	1.1	V2	1.5	1.4	V5	2.5	2.8	
III	-0.8	1.1	aVF	-0.2	2.1	V3	1.7	3.9	V6	0.8	3.9	

Chart Speed: 25 mm/sec
Filter: 35 Hz
Mains Filt: ON
Amp: 5 mm

Schiller Spandan V 4.7
Iso = R - 60 ms *J = R + 60 ms* *Post J = J + 60 ms*

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM. KOTTAYAM. COCHIN. CALICUT.

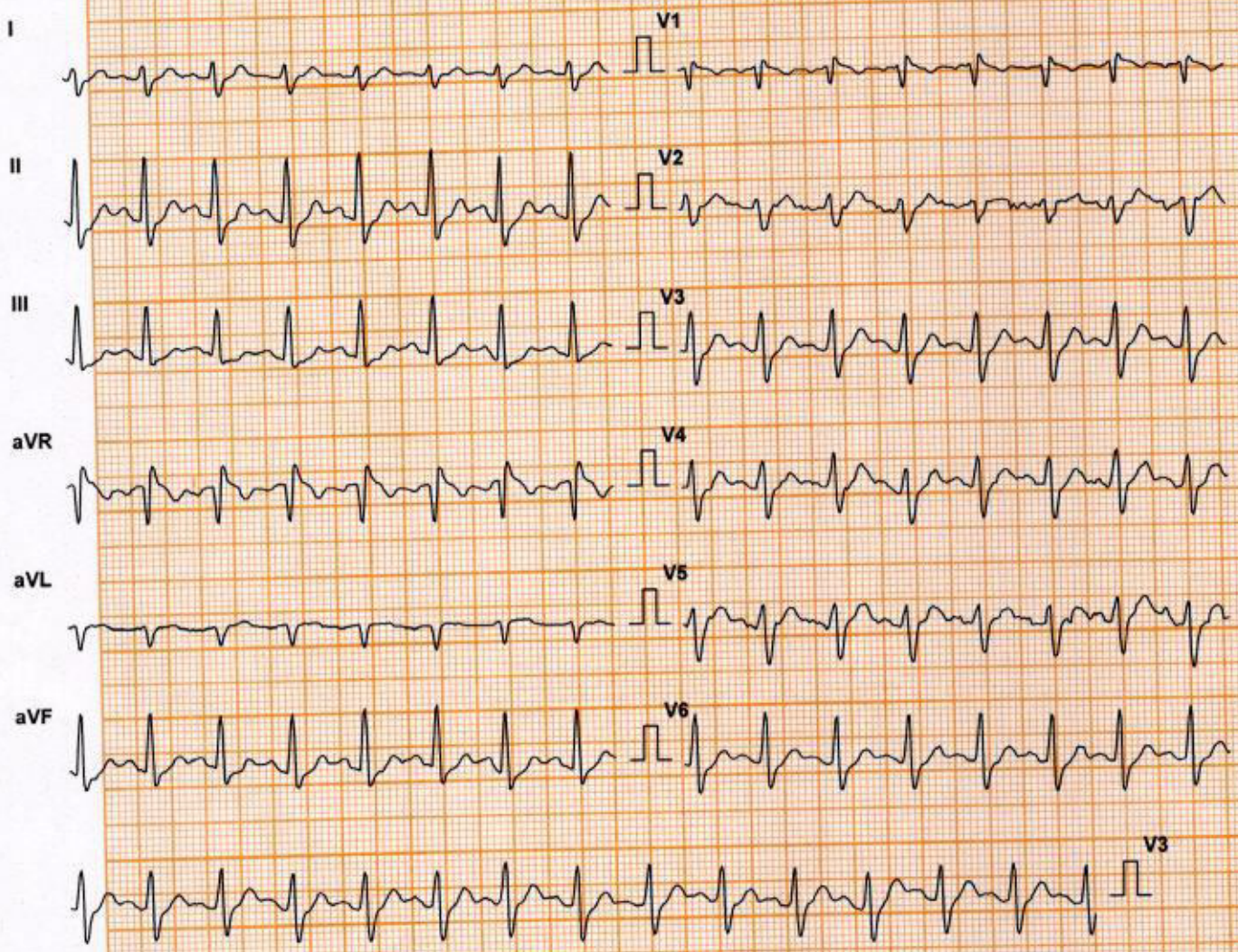
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(1)
Stage Time : 0 m 23 s

Date: 28-Jan-23
Speed: 0 mph
HR: 142 bpm

B.P: 160 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.8	1.8	aVR	-1.1	-3.5	V1	-0.2	-1.4	V4	2.3	4.6	ST Level (mm) / ST Slope (mV / s)
II	1.1	4.6	aVL	0.8	0.4	V2	1.3	2.5	V5	2.8	4.2	
III	-0.4	2.1	aVF	0.4	3.5	V3	1.7	5.0	V6	1.1	3.9	

Chart Speed: 25 mm/sec
Filter: 35 Hz
Mains Filt: ON
Amp: 5 mm

Schiller Spandan V 4.7
Iso = R - 60 ms J = R + 60 ms Post J = J + 60 ms

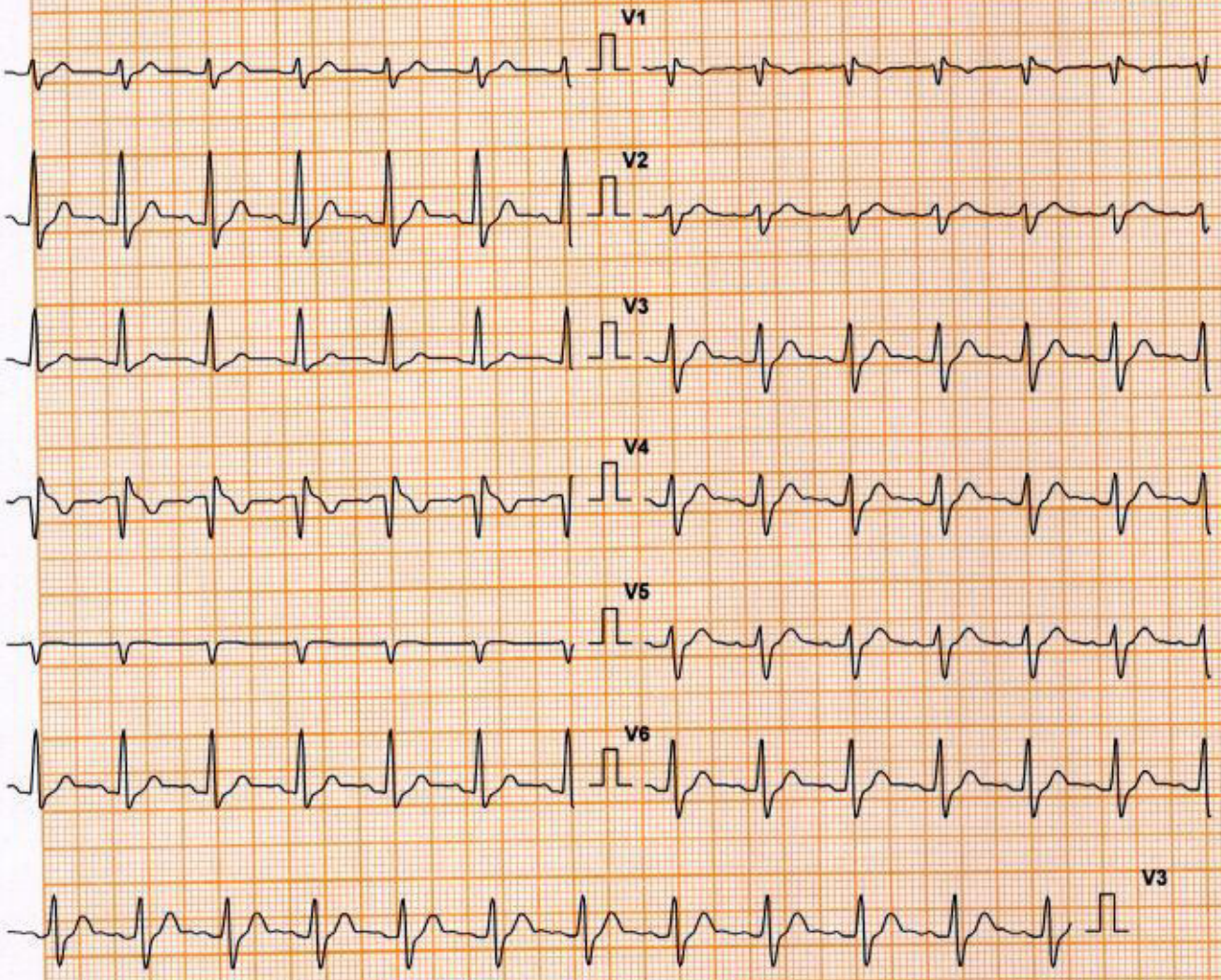
DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

DDRC SRL

RIYAS SYED HUSSAIN (50 M) | ID: 4182WA013102 | Date: 28-Jan-23 | B.P: 160 / 80

Protocol: Bruce | Stage: Recovery(1) | Speed: 1 mph | Grade: 0 %

Exec Time : 10 m 35 s | Stage Time : 0 m 54 s | ***HR: 118 bpm*** | (THR: 153 bpm)



I	0.8	aVR	-1.3	V1	-0.2	V4	3.0	ST Level (mm)
	1.4		-3.2		-1.1		5.0	ST Slope (mV / s)
II	2.1	aVL	0.4	V2	1.7	V5	2.8	
	5.3		0.0		2.5		4.2	
III	0.4	aVF	1.1	V3	2.8	V6	2.1	
	2.5		3.9		5.3		4.6	

Chart Speed: 25 mm/sec | Filter: 35 Hz | Mains Filt: ON | Amp: 5 mm

Schiller Spandan V 4.7 | *Iso = R - 60 ms* | *J = R + 60 ms* | *Post J = J + 60 ms* | Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM. KOTTAYAM. COCHIN. CALICUT.

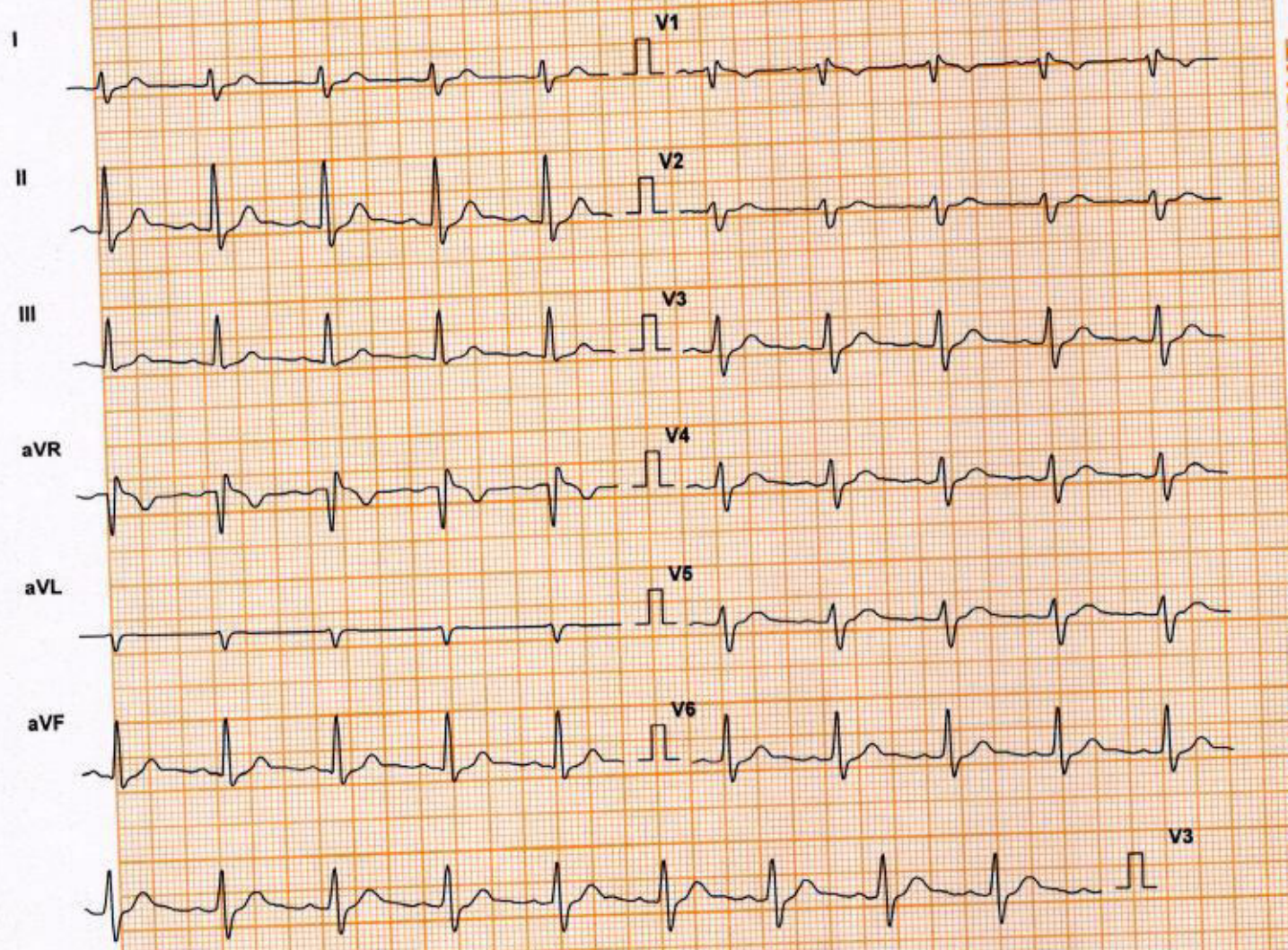
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(2)
Stage Time : 0 m 54 s

Date: 28-Jan-23
Speed: 0 mph
HR: 91 bpm

B.P: 150 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.4	aVR	-0.6	V1	-0.2	V4	0.8	ST Level (mm)
	1.4		-2.1		-1.1		1.8	ST Slope (mV / s)
II	0.6	aVL	0.2	V2	0.4	V5	1.1	
	2.8		0.0		0.4		1.4	
III	0.2	aVF	0.4	V3	1.1	V6	0.6	
	1.1		2.1		2.5		2.1	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms *J = R + 60 ms*

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

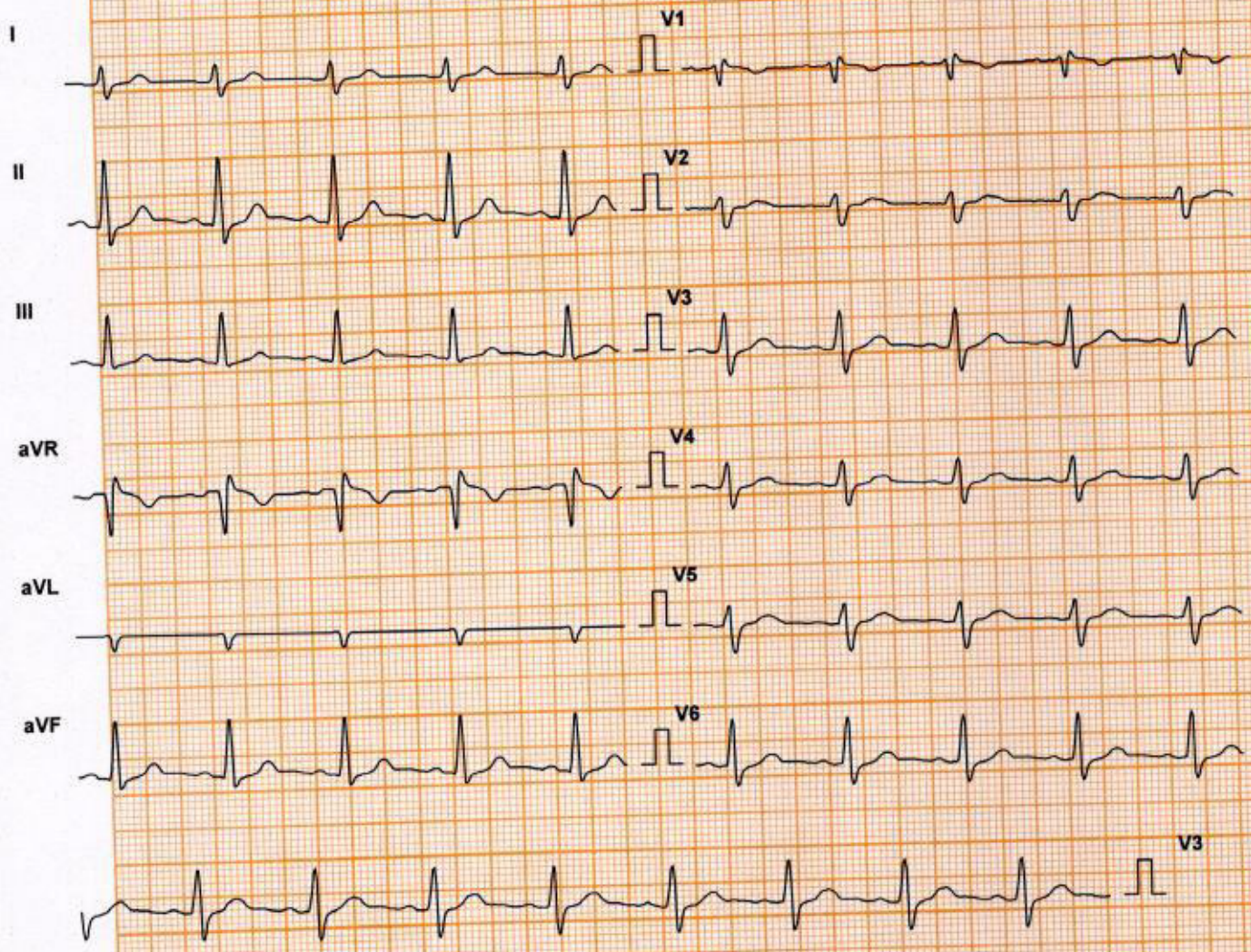
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(3)
Stage Time : 0 m 54 s

Date: 28-Jan-23
Speed: 0 mph
HR: 88 bpm

B.P: 150 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.2	aVR	-0.4	V1	0.0	V4	0.4	ST Level (mm)
	1.1		-1.8		-0.7		1.4	ST Slope (mV / s)
II	0.2	aVL	0.0	V2	0.0	V5	0.4	
	2.1		0.0		0.4		1.1	
III	0.4	aVF	0.2	V3	0.4	V6	0.0	
	1.1		1.4		1.8		1.4	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms *J = R + 60 ms*

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

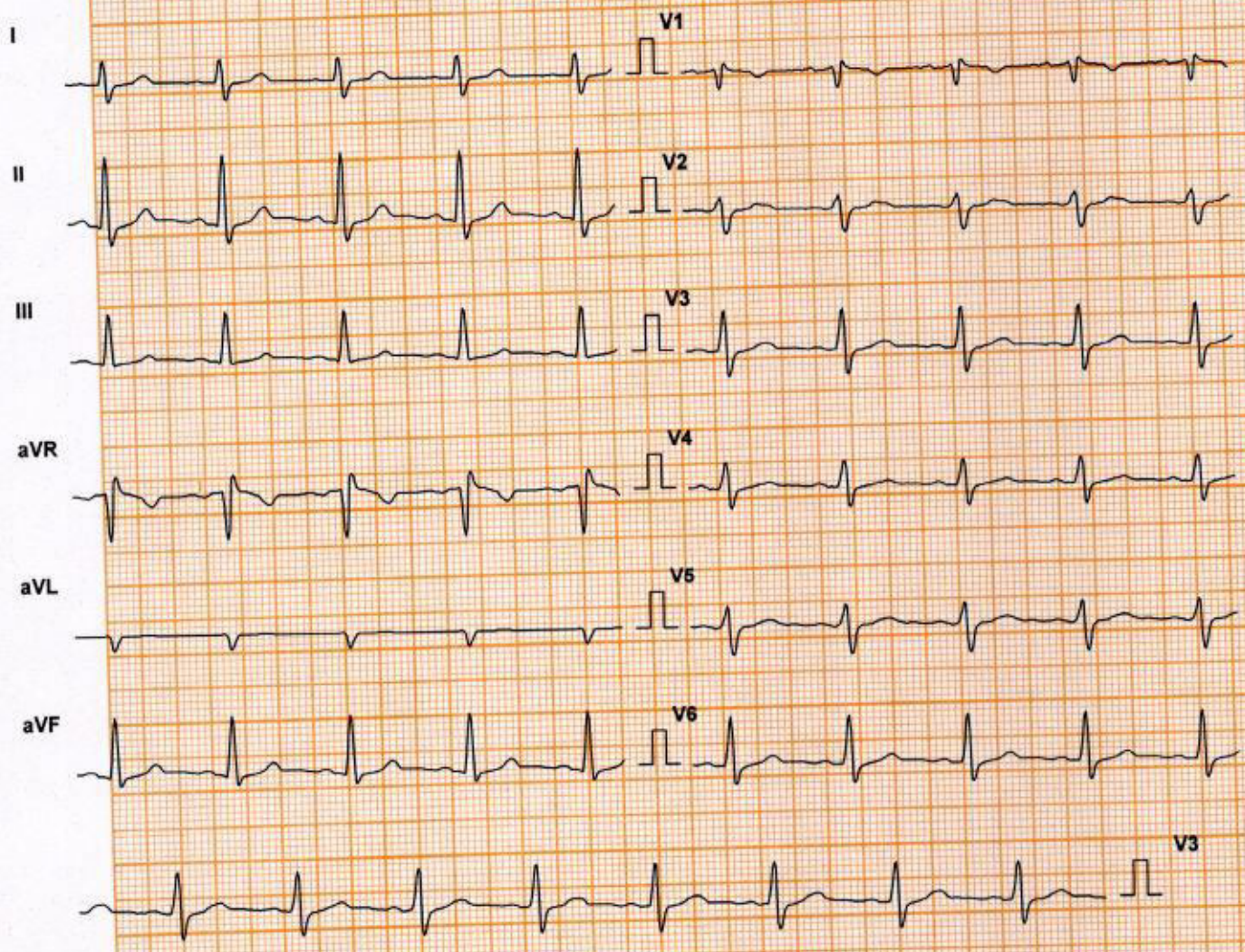
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(4)
Stage Time : 0 m 54 s

Date: 28-Jan-23
Speed: 0 mph
HR: 85 bpm

B.P: 150 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.0	aVR	-0.2	V1	0.2	V4	0.4	ST Level (mm)
	0.7		-1.4		-0.4		1.4	ST Slope (mV / s)
II	0.2	aVL	0.0	V2	0.0	V5	0.2	
	1.4		0.0		0.7		1.4	
III	0.0	aVF	0.2	V3	0.2	V6	0.2	
	0.7		1.1		1.8		1.4	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

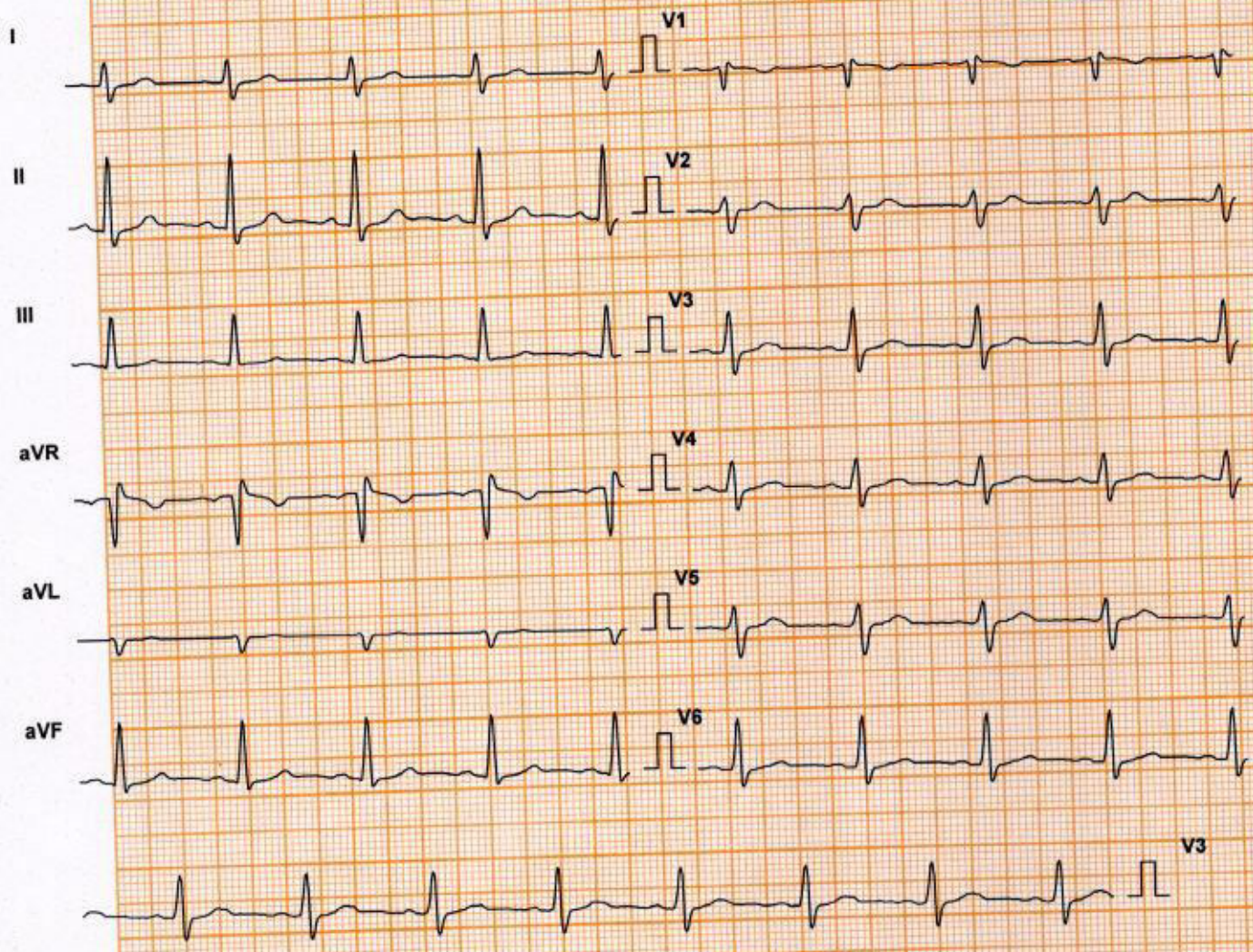
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(5)
Stage Time : 0 m 54 s

Date: 28-Jan-23
Speed: 0 mph
HR: 82 bpm

B.P: 140 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.0	aVR	-0.2	V1	0.0	V4	0.4	ST Level (mm)
	0.7		-1.1		0.0		1.1	ST Slope (mV / s)
II	0.0	aVL	0.0	V2	0.2	V5	0.2	
	1.1		0.0		0.0		0.7	
III	-0.2	aVF	0.0	V3	0.4	V6	0.2	
	0.4		0.7		1.1		0.7	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.

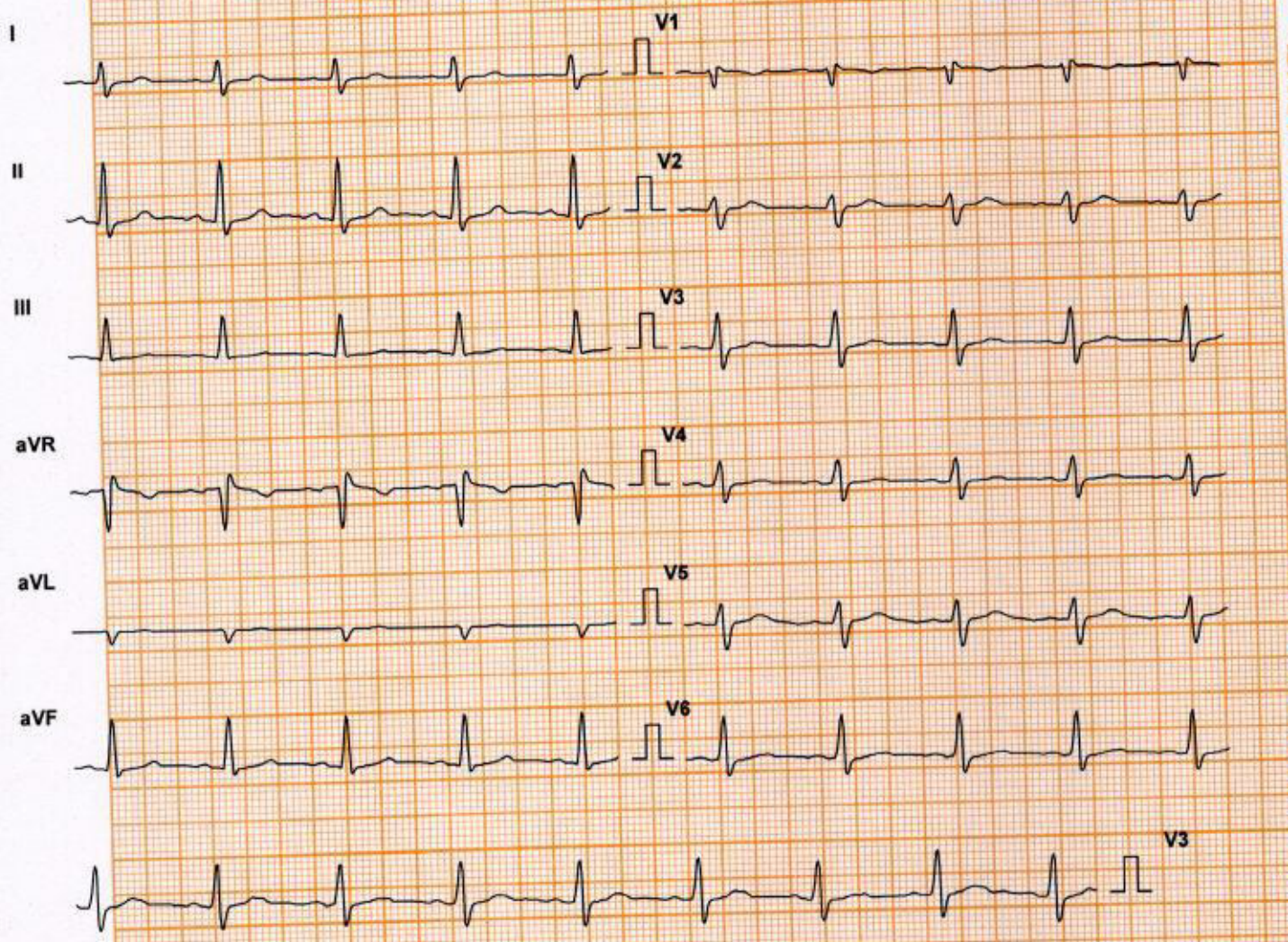
DDRC SRL

RIYAS SYED HUSSAIN (50 M)
Protocol: Bruce
Exec Time : 10 m 35 s

ID: 4182WA013102
Stage: Recovery(6)
Stage Time : 0 m 7 s

Date: 28-Jan-23
Speed: 0 mph
HR: 85 bpm

B.P: 140 / 80
Grade: 0 %
(THR: 153 bpm)



I	0.0	aVR	-0.2	V1	0.2	V4	0.2	ST Level (mm)
	1.1		-1.1		0.0		0.7	ST Slope (mV / s)
II	0.2	aVL	0.0	V2	0.4	V5	0.6	
	1.4		0.0		0.7		0.7	
III	0.0	aVF	0.0	V3	0.4	V6	0.2	
	0.4		0.7		1.1		1.1	

Chart Speed: 25 mm/sec
Schiller Spandan V 4.7

Filter: 35 Hz
Iso = R - 60 ms J = R + 60 ms

Mains Filt: ON
Post J = J + 60 ms

Amp: 5 mm
Linked Median

DDRC SRL DIAGNOSTICS (P) LTD. TRIVANDRUM, KOTTAYAM, COCHIN, CALICUT.