



Patient Ref. No. 77700002364181

CLIENT CODE : C000138364

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL LTD

GRAND MALL, OPPOSITE SBI ZONAL OFFICE, SM ROAD, AMBAWADI,
AHMEDABAD, 380015
GUJRAT, INDIA
Tel : 079-48912999, 079-48913999, 079-48914999
Email : customercare.ahmedabad@srl.in

PATIENT NAME : ABHISHEKKUMAR TIWARI

PATIENT ID : ABHIM240884321

ACCESSION NO : 0321VI002090 AGE : 38 Years SEX : Male

ABHA NO :

DRAWN : 24/09/2022 00:00:00

RECEIVED : 24/09/2022 09:34:50

REPORTED : 27/09/2022 18:12:15

REFERRING DOCTOR : SELF

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Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	15.5	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.39	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL COUNT	6.82	4.0 - 10.0	thou/ μ L
PLATELET COUNT	311	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT	48.2	40.0 - 50.0	%
MEAN CORPUSCULAR VOL	89.4	83.0 - 101.0	fL
MEAN CORPUSCULAR HGB.	28.8	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	32.2	31.5 - 34.5	g/dL
MENTZER INDEX	16.6		
RED CELL DISTRIBUTION WIDTH	15.1	High 11.6 - 14.0	%
MEAN PLATELET VOLUME	8.6	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	50	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.41	2.0 - 7.0	thou/ μ L
LYMPHOCYTES	41	High 20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.80	1.0 - 3.0	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.2		
EOSINOPHILS	2	1.0 - 6.0	%
ABSOLUTE EOSINOPHIL COUNT	0.14	0.02 - 0.50	thou/ μ L
MONOCYTES	6	2.0 - 10.0	%
ABSOLUTE MONOCYTE COUNT	0.41	0.2 - 1.0	thou/ μ L
BASOPHILS	1	0 - 1	%
ABSOLUTE BASOPHIL COUNT	0.07	0.02 - 0.10	thou/ μ L

DIFFERENTIAL COUNT PERFORMED ON:

EDTA SMEAR

MORPHOLOGY

RBC NORMOCYTIC NORMOCHROMIC

WBC NORMAL MORPHOLOGY

PLATELETS ADEQUATE

REMARKS NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITES ARE NOT DETECTED.



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ERYTHRO SEDIMENTATION RATE, BLOOD

SEDIMENTATION RATE (ESR)	07	0 - 14	mm at 1 hr
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GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA	86	74 - 99	mg/dL
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GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
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MEAN PLASMA GLUCOSE

105.4

< 116.0

mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA

117

70 - 140

mg/dL

CORONARY RISK PROFILE, SERUM

CHOLESTEROL

248

High Desirable: < 200
BorderlineHigh: 200 - 239
High: > or = 240

mg/dL

TRIGLYCERIDES

180

High Desirable: < 150
BorderlineHigh: 150 - 199
High: 200 - 499
Very High: > or = 500

mg/dL

HDL CHOLESTEROL

36

Low < 40 Low
> or = 60 High

mg/dL

CHOLESTEROL LDL

176

High Adult levels:
Optimal < 100
Near optimal/above optimal: 100-129
Borderline high : 130-159
High : 160-189
Very high : = 190

mg/dL

NON HDL CHOLESTEROL

212

High Desirable: Less than 130
Above Desirable: 130 - 159
Borderline High: 160 - 189
High: 190 - 219
Very high: > or = 220

mg/dL

CHOL/HDL RATIO

6.9

LDL/HDL RATIO

4.9

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

VERY LOW DENSITY LIPOPROTEIN

36

mg/dL

LIVER FUNCTION PROFILE, SERUM



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DIAGNOSTIC REPORT



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BILIRUBIN, TOTAL		0.70	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.22	High Upto 0.2	mg/dL
BILIRUBIN, INDIRECT		0.48	0.00 - 1.00	mg/dL
TOTAL PROTEIN		7.7	6.4 - 8.3	g/dL
ALBUMIN		5.0	3.5 - 5.2	g/dL
GLOBULIN		2.7	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO		1.9	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		19	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		23	0 - 41	U/L
ALKALINE PHOSPHATASE		110	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		33	8 - 61	U/L
LACTATE DEHYDROGENASE		151	135 - 225	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN		5	Low 6 - 20	mg/dL
CREATININE, SERUM				
CREATININE		0.81	0.70 - 1.30	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO		6.17	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		5.8	3.4 - 7.0	mg/dL
ALBUMIN, SERUM				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM		143.3	136- 145	mmol/L
POTASSIUM		4.46	3.50- 5.10	mmol/L
CHLORIDE		101.7	98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR		Yellow		
APPEARANCE		Clear		
SPECIFIC GRAVITY		<=1.005	1.003 - 1.035	
CHEMICAL EXAMINATION, URINE				
PH		5.5	4.7 - 7.5	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	



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KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		NOT DETECTED	NOT DETECTED	
BILIRUBIN		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
PUS CELL (WBC'S)		NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS		1-2	0-5	/HPF
ERYTHROCYTES (RBC'S)		NOT DETECTED	NOT DETECTED	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	
REMARKS		MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.		
THYROID PANEL, SERUM				
T3		89.9	80.00 - 200.00	ng/dL
T4		6.42	5.10 - 14.10	µg/dL
TSH 3RD GENERATION		2.560	0.270 - 4.200	µIU/mL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP		TYPE B		
RH TYPE		POSITIVE		
XRAY-CHEST				
IMPRESSION		NO ABNORMALITY DETECTED		
TMT OR ECHO				



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TMT OR ECHO

2D ECHO:-

- 1) NORMAL CHAMBERS AND VALVES.
- 2) GOOD LV SYSTOLIC FUNCTION. LVEF 60%. NO RWMA AT REST.
- 3) NO MR, AR, TR.
- 4) NORMAL LV COMPLIANCE.
- 5) NO PAH.
- 6) NO LV CLOT, VEGETATION OR PERICARDIAL EFFUSION.
- 7) IAS/IVS INTACT.

ECG

ECG

NORMAL SINUS RHYTHM

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

NOT SIGNIFICANT

RELEVANT PAST HISTORY

NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

RELEVANT FAMILY HISTORY

HYPERTENSION

OCCUPATIONAL HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.65

mts

WEIGHT IN KGS.

78.7

Kgs

BMI

29

BMI & Weight Status as follows: kg/sqmts

Below 18.5: Underweight

18.5 - 24.9: Normal

25.0 - 29.9: Overweight

30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE

NORMAL

PHYSICAL ATTITUDE

NORMAL

GENERAL APPEARANCE / NUTRITIONAL STATUS

OVERWEIGHT

BUILT / SKELETAL FRAMEWORK

AVERAGE

FACIAL APPEARANCE

NORMAL

SKIN

NORMAL





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UPPER LIMB	NORMAL
LOWER LIMB	NORMAL
NECK	NORMAL
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER
THYROID GLAND	NOT ENLARGED
TEMPERATURE	NORMAL
PULSE	68/MIN
RESPIRATORY RATE	NORMAL

CARDIOVASCULAR SYSTEM

BP	130/80 MM HG (SITTING)	mm/Hg
PERICARDIUM	NORMAL	
APEX BEAT	NORMAL	
HEART SOUNDS	S1, S2 HEARD NORMALLY	
MURMURS	ABSENT	

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST	NORMAL
MOVEMENTS OF CHEST	SYMMETRICAL
BREATH SOUNDS INTENSITY	NORMAL
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)
ADDED SOUNDS	ABSENT

PER ABDOMEN

APPEARANCE	NORMAL
LIVER	NOT PALPABLE
SPLEEN	NOT PALPABLE

CENTRAL NERVOUS SYSTEM

HIGHER FUNCTIONS	NORMAL
CRANIAL NERVES	NORMAL
CEREBELLAR FUNCTIONS	NORMAL
SENSORY SYSTEM	NORMAL
MOTOR SYSTEM	NORMAL
REFLEXES	NORMAL

MUSCULOSKELETAL SYSTEM





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SPINE

NORMAL

JOINTS

NORMAL

BASIC EYE EXAMINATION

DISTANT VISION RIGHT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

DISTANT VISION LEFT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

NEAR VISION RIGHT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

NEAR VISION LEFT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

COLOUR VISION

NORMAL

SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

S.CHOLESTEROL:- HIGH, TRIGLYCERIDES:- HIGH, HDL:- LOW, LDL:- HIGH

RELEVANT NON PATHOLOGY DIAGNOSTICS

USG ABDOMEN:- FATTY LIVER

REMARKS / RECOMMENDATIONS

S.CHOLESTEROL:- HIGH, TRIGLYCERIDES:- HIGH, HDL:- LOW, LDL:- HIGH

ADV:- LOW FAT DIET, REGULAR PHYSICAL EXERCISE

Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

CHECK UP DONE BY:- DR. NAMRATA AGRAWAL (M.B.B.S)

REPORT REVIEWED BY:- DR. PRIYANK KAPADIYA (M.B.B.S DNB MEDICINE)

RADIOLOGIST:- DR. KALPANA MODI (M.D.RADIOLOGY) // DR. SAHIL N SHAH (M.D.RADIOLOGY)



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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN****FATTY LIVER****Interpretation(s)****BLOOD COUNTS, EDTA WHOLE BLOOD-**

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

WBC DIFFERENTIAL COUNT - NLR-

The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 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.

ERYTHRO SEDIMENTATION RATE, BLOOD-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin
3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"

GLUCOSE, FASTING, PLASMA-

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: > or = 126 mg/dL

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycosylated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycosylated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycosylated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

References

1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R. Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus: A rational plan for management. Postgrad Med 1982, 71, 139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

LIVER FUNCTION PROFILE, SERUM-**LIVER FUNCTION PROFILE**

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when



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there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenström's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

SERUM BLOOD UREA NITROGEN-

Causes of Increased levels

Pre renal

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal

Renal Failure

Post Renal

- Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- Liver disease

- SIADH.

CREATININE, SERUM-

Higher than normal level may be due to:

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

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM-

Causes of Increased levels

Dietary

- High Protein Intake.
- Prolonged Fasting,
- Rapid weight loss.

Gout

Lesch nyhan syndrome.

Type 2 DM.

Metabolic syndrome.

Causes of decreased levels

- Low Zinc Intake
- OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High Fibre foods
- Vit C Intake



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Scan to View Report



CLIENT CODE : C000138364

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
 NEW DELHI 110030
 DELHI INDIA
 8800465156

SRL LTD
 GRAND MALL, OPPOSITE SBI ZONAL OFFICE, SM ROAD, AMBAWADI,
 AHMEDABAD, 380015
 GUJRAT, INDIA
 Tel : 079-48912999, 079-48913999, 079-48914999
 Email : customercare.ahmedabad@srl.in

PATIENT NAME : ABHISHEKKUMAR TIWARI

PATIENT ID : ABHIM240884321

ACCESSION NO : 0321VI002090 **AGE :** 38 Years **SEX :** Male **ABHA NO :**

DRAWN : 24/09/2022 00:00:00 **RECEIVED :** 24/09/2022 09:34:50 **REPORTED :** 27/09/2022 18:12:15

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

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

MICROSCOPIC EXAMINATION, URINE-
 Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
 Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
 Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
 Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
 Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
 Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
 Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
 Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
 Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

THYROID PANEL, SERUM-
 Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
 Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
 Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy	6.6 - 12.4	0.1 - 2.5	81 - 190
1st Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
2nd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260
3rd Trimester			

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

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

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
 Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
 1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
 2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
 3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
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.
MEDICAL



DIAGNOSTIC REPORT

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Test Report Status	Final	Results	Biological Reference Interval	Units
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HISTORY-*****

THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr. Sahil .N. Shah
 Consultant Radiologist

Dr. Priyank Kapadia
 Physician

Dr. Kalpana Modi
 Radiologist

Dr. Miral Gajera
 Consultant Pathologist

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
 - i. Specimen received is insufficient or inappropriate
 - ii. Specimen quality is unsatisfactory
 - iii. Incorrect specimen type
 - iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

SRL Limited

Fortis Hospital, Sector 62, Phase VIII,
 Mohali 160062

