

## ECHOCARDIOGRAPHY REPORT

<b>Patient ID</b>	: 10140000281235	<b>Report Date</b>	: 4-4-2023
<b>Patient Name:</b>	: Miss Nandini M K		
<b>Age / Gender</b>	: 32 Years / female	<b>Cath Number</b>	:
<b>Render No</b>	:		

### MEASUREMENT

**AO** : 24 ( 20 - 40 )mm      **LVID(d)** : 32 (36 - 52 )mm      **IVS** : 9 ( 6 - 11 )mm  
**LA** : 22 ( 19 - 40 )mm      **LVID s** : 28 ( 23 - 39)mm      **PWD** : 9 (6 - 11 )mm  
**EF** : 60% (>50%)      **ESV** : 15 ml      **EDV** : 40 ml

### VALVES

**Mitral Valve** : Normal  
**Aortic valve** : Normal  
**Tricuspid Valve** : Normal  
**Pulmonary Valve** : Normal

### CHAMBERS

**Left Atrium** : Normal  
**Right Atrium** : Normal  
**Left Ventricle** : Normal  
**Right Ventricle** : Normal

### SEPTAE

**IVS** : Intact  
**IAS** : Intact

### GREAT ARTERIES

**Aorta** : Normal  
**Pulmonary Artery** : Normal

**DOPPLER DATA**

**Mitral** : E/A 0.9/0.6 m/s  
**Aortic** : Normal  
**Tricuspid** : Trivial TR / Mild PAH, PASP 30mmHg  
**Pulmonary** : Normal  
**LVOT** : Normal  
**Vegetation/Thrombus** : Normal  
**Pericardium** : Normal

**WALL MOTION ABNORMALITIES**

NO RWMA

**FINAL DIAGNOSIS**

- NORMAL CHAMBER DIMENSIONS
- TRIVIAL TRICUSPID REGURGITATION / MILD PULMONARY ARTERIAL HYPERTENSION
- NO RWMA
- NORMAL LV FUNCTION (LVEF-60%)
- LEFT ARCH / NO COA

**DR KESHAVA MURTHY.V**  
(SENIOR INTERVENTIONAL  
CARDIOLOGIST)

**DR SRINIVAS P**  
(INTERVENTIONAL  
CARDIOLOGIST)

**DR ANAND LINGAN**  
(SENIOR PEDIATRIC / ADULT  
INTERVENTIONAL CARDIOLOGIST)



DONE BY: SUVARNA

Patient Name : Miss Nandini M K  
MRN : 281235

Page 2 of 2 Typed by : Mrs Sunitha

**Narayana Multispeciality Hospital**

Narayana Hrudayalaya Surgical Hospital Pvt. Ltd. CIN: LB5100KA2010PTC055453

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NARAYANA MULTISPECIALITY HOSPITAL  
DEVANUR  
MYSORE-19

Station  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: MRS.NANDINI M.K.  
Patient ID: 10140000281235  
Height: 152 cm  
Weight: 53 kg

DOB: 25.09.1990  
Age: 32 yrs  
Gender: Female  
Race: Indian

Study Date: 04.04.2023  
Test Type: Treadmill Stress Test  
Protocol: BRUCE

Referring Physician: DR.CHYTHANYA D.C.  
Attending Physician: DR.ANAND LINGAN  
Technician: Mr.BHARATH KUMAR

Medications:  
NIL

Medical History:  
NIL

Reason for Exercise Test:  
Screening for IHD

### Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed [mph]	Grade [%]	HR [bpm]	BP [mmHg]	Comment
PRETEST	SUPINE	00:23	0.00	0.00	68	100/60	
	STANDING	00:01	0.00	0.00	67		
	WARM-UP	01:24	0.90	0.00	71	100/60	
EXERCISE	STAGE 1	03:00	1.70	10.00	112	110/70	
	STAGE 2	03:00	2.50	12.00	136	120/70	
	STAGE 3	02:41	3.40	14.00	150	130/70	
RECOVERY		05:41	0.00	0.00	80	110/70	

The patient exercised according to the BRUCE for 8:40 min:s, achieving a work level of Max. METS: 10.10. The resting heart rate of 66 bpm rose to a maximal heart rate of 153 bpm. This value represents 81 % of the maximal, age-predicted heart rate. The resting blood pressure of 100/60 mmHg, rose to a maximum blood pressure of 130/70 mmHg. The exercise test was stopped due to Fatigue.

### Interpretation

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### Conclusions

GOOD EFFORT TOLERANCE  
NORMAL HR AND BP RESPONSE  
NO ANGINA OR ARRHYTHMIA  
SLOW UPSLOPING ST-DEPRESSION NOTED DURING EXERCISE, WHICH DID NOT PERSIST IN RECOVERY  
IMP:-- STRESS TEST NEGATIVE FOR INDUCIBLE ISCHAEMIA

Physician



Technician

**MRS. NANDINI M.K.**

Patient ID: 10140000281235

04.04.2023 Female 152 cm 53 kg

1:27:51pm 32 yrs Indian

Meds: NIL

Test Reason: Screening for IHD  
Medical History: NIL

Ref. MD: DR. CHYTHANYA D.C. Ordering MD:  
Technician: Mr. BHARATH KUMAR Test Type: Treadmill Stress Test

BRUCE: Exercise Time 08:40  
Max HR: 153 bpm 81 % of max predicted 188 bpm HR at rest: 66  
Max BP: 130/70 mmHg BP at rest: 100/60 Max RPP: 19890 mmHg\*<sup>3</sup>bpm  
Maximum Workload: 10.10 METS  
Max. ST: -2.05 mm, -0.47 mV/s in V<sub>6</sub>; EXERCISE STAGE 3 7:00  
Arrhythmia: VBIG:2, PVC:29, PSVC:4  
ST/HR index: 1.82  $\mu$ V/bpm  
ST/HR slope: 2.13  $\mu$ V/bpm (V<sub>5</sub>)  
HR reserve used: 68 %  
HR recovery: 39 bpm  
VE recovery: 0 VE/min  
ST/HR hysteresis: -0.012 mV (I)  
QRS duration: BASELINE: 84 ms, PEAK EX: 84 ms, REC: 90 ms  
Reasons for Termination: Fatigue  
Conclusion: GOOD EFFORT TOLERANCE  
NORMAL HR AND BP RESPONSE  
NO ANGINA OR ARRHYTHMIA  
SLOW UPSLOPING ST-DEPRESSION NOTED DURING EXERCISE, WHICH  
DID NOT PERSIST IN RECOVERY  
IMP: - STRESS TEST NEGATIVE FOR INDUCIBLE ISCHAEMIA  
Room:  
Location: \* 0 \*

Phase Name	Stage Name	Time in Stage	Speed [mph]	Grade [%]	Workload [METs]	HR [bpm]	BP [mmHg]	RPP [mmHg* <sup>3</sup> bpm]	VE [l/min]	ST Level [mm]	Comment
PRETEST	SUPINE	00:23	0.00	0.00	1.0	68	100/60	6800	0	0.00	
	STANDING	00:01	0.00	0.00	1.0	67		6700	0	0.00	
	WARM-UP	01:24	0.90	0.00	1.6	71	100/60	7100	0	0.30	
EXERCISE	STAGE 1	03:00	1.70	10.00	4.6	112	110/70	12320	3	-0.35	
	STAGE 2	03:00	2.50	12.00	7.0	136	120/70	16320	4	-1.50	
	STAGE 3	02:41	3.40	14.00	10.1	150	130/70	19500	1	-1.50	
RECOVERY		05:41	0.00	0.00	1.0	80	110/70	8800	0	-0.05	

GE CASE V7.0 (10)

Unconfirmed

Attending MD: DR. ANAND LINGAN

<b>Patient Name</b>	NANDINI M K	<b>Requested By</b>	Dr. Chythanya D C
<b>MRN</b>	10140000281235	<b>Procedure DateTime</b>	2023-04-04 09:18:58
<b>Age/Sex</b>	32y/ Female	<b>Hospital</b>	NH-Mysore

**X-RAY CHEST PA VIEW**

Clinical details : Health check up

The C.T.Ratio is within normal limits.

The lung fields are clear.

The costo and cardiophrenic angles are free.

The domes of diaphragm are normally placed.

The bony thorax shows no gross abnormality.

**IMPRESSION: No abnormality detected.**

To correlate clinically.



**Dr. Rakesh Sharma**  
Consultant Radiologist

This is a digitally signed valid document. Reported Date/Time: 2023-04-04 11:09:59



<b>Patient Name</b>	NANDINI M K	<b>Requested By</b>	Dr. Chythanya D C
<b>MRN</b>	10140000281235	<b>Procedure DateTime</b>	2023-04-04 11:47:01
<b>Age/Sex</b>	/ Female	<b>Hospital</b>	NH-Mysore

**ULTRASOUND SCAN OF ABDOMEN AND PELVIS (MHC)**

LIVER - Normal in size and echotexture. No obvious focal lesions.

BILIARY RADICLES - No dilatation.

CBD - Normal in size. No evidence of calculi.

GALL BLADDER - Partially distended.

PORTAL VEIN - Normal in caliber.

PANCREAS - Head and body of pancreas show normal echotexture.

SPLEEN - Normal.

KIDNEYS - Both kidneys are normal in size and echotexture. No evidence of calyceal dilatation or calculi seen.

BLADDER - Distended and appears normal.

UTERUS - appears normal.

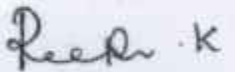
EMT - 4.3mm.

Both ovaries show normal echotexture.

No free fluid seen in the abdomen.

**IMPRESSION: No abnormality detected sonologically.**

To correlate clinically.



**Dr. Roopa K**  
Consultant Radiologist

This is a digitally signed valid document. Reported Date/Time: 2023-04-04 11:53:31

2023-04-04 09:43:52

ID: 1014000281235  
Name: MISS NANDINI M K  
Age: 32 Years  
Gender: Female

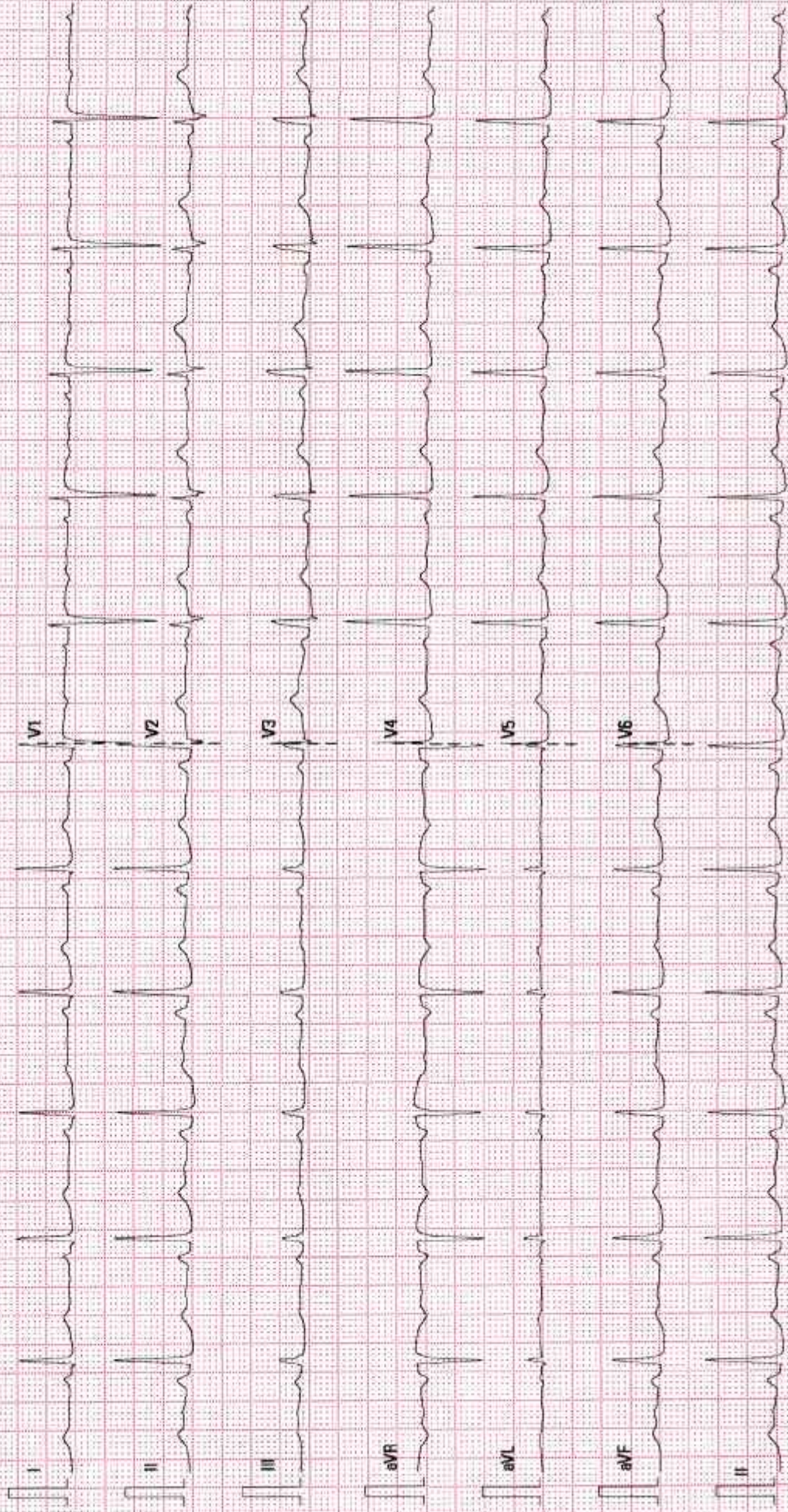


Vent. Rate  
PR Interval  
QRS Duration  
QT/QTc Interval  
P/QRS/T Axes  
aTc/Hodges

71 bpm  
152 ms  
82 ms  
418/437 ms  
59/49/52 deg

Sinus rhythm  
Lateral ST abnormality is nonspecific  
Borderline ECG

Unconfirmed Diagnosis



25 mm/s

10 mm/mV

50 Hz

8DR 35 Hz

NARAYANA SURGICAL HOSPITAL MYSURU

02 10:00 V28 4 1

SN FN 21032459

**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 12:14 PM

Barcode : 602304040067 Specimen : Serum Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

Test	BIOCHEMISTRY		Biological Reference Interval	
	Result	Unit		
<b>SERUM CREATININE</b>				
Serum Creatinine (Spectrophotometry)	0.7	mg/dL	0.6-1.2	
eGFR (Calculated By MDRD Formula)	97.0	mL/min/1.73m <sup>2</sup>	-	
<b>Blood Urea Nitrogen (BUN)</b> (Spectrophotometry)	8	mg/dL	7.0-20.0	
<b>Serum Sodium</b> (Spectrophotometry)	143	mmol/L	135.0-150.0	
<b>Serum Potassium</b> (Spectrophotometry)	4.6	mmol/L	3.5-5.0	
<b>Serum Calcium</b> (Spectrophotometry)	9.2	mg/dL	8.4-10.2	
<b>Serum Magnesium</b> (Spectrophotometry)	2.0	mg/dL	1.6-2.3	
<b>Serum Phosphorus</b> (Spectrophotometry)	3.7	mg/dL	3.7-6.5	
<b>LIPID PROFILE (CHOL,TRIG,HDL,LDL,VLDL)</b>				
Cholesterol Total (Spectrophotometry)	159	mg/dL	Normal High Borderline	<200 >240 200 - 239
Triglycerides (Spectrophotometry)	91	mg/dL	Very High Borderline High High	>500 150 - 199 200 - 499
HDL Cholesterol (HDLC) (Spectrophotometry)	50	mg/dL	40.0-60.0	
Non-HDL Cholesterol (Spectrophotometry)	109.0	-	-	
LDL Cholesterol (Calculated)	91	mg/dL	Desirable: <100 Optimal: 100-129 Borderline High: 130-159 High : 160-189 Very High: >190	
VLDL Cholesterol (Spectrophotometry)	18	mg/dL	0.0-40.0	

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Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)			
Cholesterol /HDL Ratio (Spectrophotometry )	3.2	-	0.0-5.0
<b>Vitamin B-12</b> (Enhanced Chemiluminescence Immunoassay (CLIA))	159	pg/mL	159.0-1000.0
<b>Vitamin D 25 Hydroxy (Vitamin D Total)</b> (Enhanced Chemiluminescence Immunoassay (CLIA))	63.0	ng/mL	30.0-100.0
<b>LIVER FUNCTION TEST(LFT)</b>			
Bilirubin Total (Spectrophotometry )	0.9	mg/dL	0.0-1.3
Conjugated Bilirubin (Direct) (Spectrophotometry )	0.3	mg/dL	0.0-0.3
Unconjugated Bilirubin (Indirect) (Spectrophotometry)	0.6	mg/dL	0.3-0.8
Total Protein (Spectrophotometry )	8.0	g/dL	6.4-8.2
Serum Albumin (Spectrophotometry)	4.5	g/dL	3.4-5.0
Serum Globulin (Spectrophotometry)	3.5	-	-
Albumin To Globulin (A/G)Ratio (Spectrophotometry)	1.29	-	1.0-2.1
SGOT (AST) (Spectrophotometry )	29	IU/L	15.0-37.0
SGPT (ALT) (Spectrophotometry )	30	IU/L	30.0-65.0
Alkaline Phosphatase (ALP) (Spectrophotometry )	82	IU/L	50.0-136.0
Gamma Glutamyl Transferase (GGT) (Spectrophotometry )	37	IU/L	15.0-85.0
<b>THYROID PROFILE (T3, T4, TSH)</b>			
Tri Iodo Thyronine (T3) (Enhanced Chemiluminescence Immunoassay (CLIA))	1.36	ng/dL	0.6-1.81
Thyroxine (T4) (Enhanced Chemiluminescence Immunoassay (CLIA))	11.8	ug/dl	3.2-12.6

Patient Name : Miss N<sup>o</sup>NDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

TSH (Thyroid Stimulating Hormone) (Enhanced Chemiluminescence Immunoassay (CLIA)) **1.138** mIU/L

> 18 Year(s) : 0.4 -4.5  
Pregnancy:  
1st Trimester: 0.129-3.120  
2nd Trimester: 0.274-2.652  
3rd Trimester: 0.312-2.947

--End of Report--



Dr. Shivaprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST



**Note**

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically



**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 10:43 AM Received On : 04/04/2023 11:04 AM Reported On : 04/04/2023 11:37 AM

Barcode : 602304040132 Specimen : Plasma Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

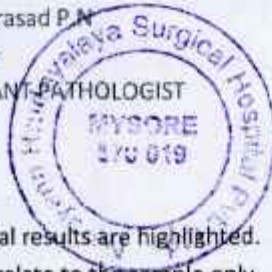
**BIOCHEMISTRY**

Test	Result	Unit	Biological Reference Interval
<b>Post Prandial Blood Sugar (PPBS)</b> (Spectrophotometry )	110	mg/dL	100.0-140.0

--End of Report--



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MBBS, MD  
CONSULTANT PATHOLOGIST



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**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 09:35 AM

Barcode : 622304040012 Specimen : Urine Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

**PATHOLOGY**

Test	Result	Unit	Biological Reference Interval
<b>URINE ROUTINE &amp; MICROSCOPY</b>			
<b>PHYSICAL EXAMINATION</b>			
Volume	20	ml	-
Colour	Pale Yellow	-	-
Appearance	Clear	-	-
<b>CHEMICAL EXAMINATION</b>			
pH(Reaction)	5.5	-	4.8-7.5
Sp. Gravity	1.030	-	1.005 - 1.030
Protein	Negative	-	-
Urine Glucose	Negative	-	-
Ketone Bodies	Negative	-	Negative
Bile Salts	Negative	-	Negative
Bile Pigment (Bilirubin)	Negative	-	Negative
Urobilinogen	Normal	-	-
Urine Leucocyte Esterase	Negative	-	Negative
Blood Urine	Negative	-	Negative
Nitrite	Negative	-	Negative
<b>MICROSCOPIC EXAMINATION</b>			



Patient Name: Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Pus Cells	1-2/hpf	-	0-2
RBC	Nil	-	-
Epithelial Cells	1-2/hpf	-	2-4
Crystals	Not Seen	-	-
Casts	Not Seen	-	-

--End of Report--

Dr. Shivaprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST



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**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 09:47 AM

Barcode : 602304040068 Specimen : Plasma Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

**BIOCHEMISTRY**

Test	Result	Unit	Biological Reference Interval
<b>Fasting Blood Sugar (FBS)</b> (Spectrophotometry)	91	mg/dL	70.0-100.0

--End of Report--



Dr. Shivaprasad P.N

MBBS, MD

CONSULTANT PATHOLOGIST

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 10:42 AM

Barcode : 602304040069 Specimen : Whole Blood Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

BIOCHEMISTRY

Test	Result	Unit	Biological Reference Interval
HBA1C			
HbA1c (HPLC METHOD)	5.1	%	Upto - Normal (Non Diabetic Level): < 5 Good Control: 6.01-7.00 Fair Control: 7.01-8.00 Poor Control: > 8.01
Estimated Average Glucose (HPLC METHOD)	99.67	-	-

Interpretation:

- HbA1C above 6.5% can be used to diagnose diabetes provided the patient has symptoms. If the patient does not have symptoms with HbA1C>6.5%, repeat measurement on further sample. If the repeat test result is <6.5%, consider as diabetes high risk and repeat measurement after 6 months.
- HbA1C measurement is not appropriate in diagnosing diabetes in children, suspicion of type 1 diabetes, symptoms of diabetes for less than 2 months, pregnancy, hemoglobinopathies, medications that may result sudden increase in glucose, anemia, renal failure, HIV infection, malignancies, severe chronic hepatic, and renal disease.
- Any sample with >15% should be suspected of having a haemoglobin variant.

--End of Report--

Dr. Shivaprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST

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Page 1 of 1



**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)  
 Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 09:53 AM  
 Barcode : 612304040031 Specimen : Whole Blood Consultant : Dr. Chythanya D C(GENERAL MEDICINE)  
 Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

**HAEMATOLOGY LAB**

Test	Result	Unit	Biological Reference Interval
<b>BLOOD GROUP &amp; RH TYPING</b>			
Blood Group (Slide Technique And Tube Technique)	"B"	-	-
RH Typing (Slide Technique And Tube Technique)	Positive	-	-
<b>COMPLETE BLOOD COUNT (CBC)</b>			
Haemoglobin (Hb%) (Coulter Principle)	14.51	g/dL	12.0-15.0
Red Blood Cell Count (Coulter Principle)	4.95	Million/ul	3.8-5.8
PCV (Packed Cell Volume) / Hematocrit (Calculated)	43.3	%	36.0-46.0
MCV (Mean Corpuscular Volume) (Derived From RBC Histogram)	87.5	fL	76.0-96.0
MCH (Mean Corpuscular Haemoglobin) (Calculated)	29.3	pg	27.0-32.0
MCHC (Mean Corpuscular Haemoglobin Concentration) (Calculated)	33.5	g/L	30.0-35.0
Red Cell Distribution Width (RDW) (Derived From RBC Histogram)	13.7	%	11.6-14.0
Platelet Count (Coulter Principle)	250	Thous/ $\mu$ L	150.0-400.0
Mean Platelet Volume (MPV)	7.91	fL	7.0-11.7
Total Leucocyte Count(WBC) (Coulter Principle)	<b>3.88 L</b>	Thous/cumm	4.0-11.0
<b>DIFFERENTIAL COUNT (DC)</b>			
Neutrophils (Optical/Impedance)	<b>33.28 L</b>	%	40.0-75.0





Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE, 32y (25/09/1990)

Lymphocytes (Optical/Impedance)	<b>59.07 H</b>	%	20.0-45.0
Monocytes (Optical/Impedance)	4.91	%	2.0-10.0
Eosinophils (Optical/Impedance)	2.50	%	1.0-6.0
Basophils	0.24	%	0.0-1.0
Absolute Neutrophil Count	1.29	-	-
Absolute Lymphocyte Count	2.29	-	-
Absolute Monocyte Count	0.19	-	-
Absolute Eosinophil Count	0.1	-	-
Absolute Basophil Count	0.01	-	-

As per the recommendation of International Council for Standardization in Hematology, the differential counts are additionally being reported as absolute numbers.

--End of Report--

*Shivprasad*

Dr. Shivprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST

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DEPARTMENT OF LABORATORY MEDICINE

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 08:55 AM Received On : 04/04/2023 09:16 AM Reported On : 04/04/2023 09:52 AM

Barcode : 612304040032 Specimen : Whole Blood - ESR Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

HAEMATOLOGY LAB

Test	Result	Unit	Biological Reference Interval
<b>Erythrocyte Sedimentation Rate (ESR)</b> (Westergren Method)	22 H	mm/1hr	0.0-19.0

--End of Report--



Dr. Shivaprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST

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**DEPARTMENT OF LABORATORY MEDICINE**

Final Report

Patient Name : Miss NANDINI M K MRN : 10140000281235 Gender/Age : FEMALE , 32y (25/09/1990)

Collected On : 04/04/2023 10:43 AM Received On : 04/04/2023 12:37 PM Reported On : 04/04/2023 01:16 PM

Barcode : 622304040027 Specimen : Urine Consultant : Dr. Chythanya D C(GENERAL MEDICINE)

Sample adequacy : Satisfactory Visit No : OP-001 Patient Mobile No : 8861482505

**PATHOLOGY**

Test	Result	Unit
<b>Urine For Sugar</b> (Semi-quantitative Strip Method- Glucose Oxidase Technique)	Negative	-

--End of Report--

Dr. Shivaprasad P.N  
MBBS, MD  
CONSULTANT PATHOLOGIST



**Note**

- Abnormal results are highlighted.
- Results relate to the sample only.
- Kindly correlate clinically.

