



Patient Ref. No. 7100000304823

CLIENT CODE : C000138381

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
SRL Wellness Centre, SCO. 13, Sector 16 Market, Faridabad
FARIDABAD, 121001
Haryana, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : NEHA MITTAL

PATIENT ID : NEHAF13098871

ACCESSION NO : 0071VI000826 AGE : 34 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 21/09/2022 09:15

REPORTED : 22/09/2022 11:03

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN	10.6	Low	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL COUNT	5.37	High	3.8 - 4.8	mil/ μ L
METHOD : IMPEDANCE				
WHITE BLOOD CELL COUNT	8.78		4.0 - 10.0	thou/ μ L
METHOD : IMPEDANCE				
PLATELET COUNT	261		150 - 410	thou/ μ L
METHOD : IMPEDANCE				

RBC AND PLATELET INDICES

HEMATOCRIT	34.0	Low	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOL	63.4	Low	83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MEAN CORPUSCULAR HGB.	19.8	Low	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	31.2	Low	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	11.8			
RED CELL DISTRIBUTION WIDTH	17.3	High	11.6 - 14.0	%
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MEAN PLATELET VOLUME	10.6		6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	69		40 - 80	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT	6.07		2.0 - 7.0	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
LYMPHOCYTES	22		20 - 40	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE LYMPHOCYTE COUNT	1.90		1 - 3	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.2			
METHOD : CALCULATED				
EOSINOPHILS	1		1 - 6	%



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METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT		0.09	0.02 - 0.50	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
MONOCYTES		8	2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE MONOCYTE COUNT		0.66	0.20 - 1.00	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
BASOPHILS		0	0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE BASOPHIL COUNT		0.03	0.02 - 0.10	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)		22	High 0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA		91	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)		5.4	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
MEAN PLASMA GLUCOSE		108.3	< 116	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA				
RESULT PENDING				
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL		136	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL
TRIGLYCERIDES		74	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: > / = 500	mg/dL





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HDL CHOLESTEROL		49	Low HDL Cholesterol <40	mg/dL
CHOLESTEROL LDL		79	High HDL Cholesterol >/= 60 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		87	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		3.0	Low Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO		1.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		14.7	< OR = 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.5	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.3	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.20	0.1 - 1.0	mg/dL
TOTAL PROTEIN		7.0	6.0 - 8.0	g/dL
ALBUMIN		4.4	3.97 - 4.94	g/dL
GLOBULIN		2.6	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.7	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		19	< OR = 35	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		17	< OR = 35	U/L
ALKALINE PHOSPHATASE		142	High 35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		15	0 - 40	U/L
LACTATE DEHYDROGENASE		174	125 - 220	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN		8.9	6 - 20	mg/dL
CREATININE, SERUM				
CREATININE		0.58	0.5 - 0.9	mg/dL
BUN/CREAT RATIO				





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BUN/CREAT RATIO		15.30	High 8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		3.6	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.0	6.0 - 8.0	g/dL
ALBUMIN, SERUM				
ALBUMIN		4.4	3.97 - 4.94	g/dL
GLOBULIN				
GLOBULIN		2.6	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM		141	136 - 145	mmol/L
POTASSIUM		4.9	3.5 - 5.1	mmol/L
CHLORIDE		108	High 98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR		PALE YELLOW		
APPEARANCE		CLEAR		
SPECIFIC GRAVITY		>=1.030	1.003 - 1.035	
Comments				
NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT. IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.				
CHEMICAL EXAMINATION, URINE				
PH		5.5	4.7 - 7.5	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		NOT DETECTED	NOT DETECTED	
BILIRUBIN		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
PUS CELL (WBC'S)		0-1	0-5	/HPF
EPITHELIAL CELLS		0-1	0-5	/HPF
ERYTHROCYTES (RBC'S)		NOT DETECTED	NOT DETECTED	/HPF
CASTS		NOT DETECTED		



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CRYSTALS

NOT DETECTED

BACTERIA

NOT DETECTED

NOT DETECTED

THYROID PANEL, SERUM

T3

138.0

80 - 200

ng/dL

T4

6.70

5.1 - 14.1

µg/dL

TSH 3RD GENERATION

2.640

0.27 - 4.2

µIU/mL

STOOL: OVA & PARASITE

RESULT PENDING

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

AB

RH TYPE

RH+

XRAY-CHEST

>>

BOTH THE LUNG FIELDS ARE CLEAR

>>

BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGLES ARE CLEAR

>>

BOTH THE HILA ARE NORMAL

>>

CARDIAC AND AORTIC SHADOWS APPEAR NORMAL

>>

BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL

>>

VISUALIZED BONY THORAX IS NORMAL

IMPRESSION

NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

REPORT ENCLOSED

ECG

ECG

PROBABLY NORMAL. PLEASE CORRELATE CLINICALLY.

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

NOT SIGNIFICANT

RELEVANT PAST HISTORY

NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY

MARRIED, 2 CHILDRENS. VEGETERIAN/EGG

MENSTRUAL HISTORY (FOR FEMALES)

LACTATING

LMP (FOR FEMALES)

03.09.2022

OBSTETRIC HISTORY (FOR FEMALES)

G2P2

LCB (FOR FEMALES)

07.04.2022

RELEVANT FAMILY HISTORY

FATHER- HTN

OCCUPATIONAL HISTORY

MBA

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI



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HEIGHT IN METERS		1.55		mts
WEIGHT IN KGS.		66.8		Kgs
BMI		28	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	HEALTHY
BUILT / SKELETAL FRAMEWORK	AVERAGE
FACIAL APPEARANCE	NORMAL
SKIN	NORMAL
UPPER LIMB	NORMAL
LOWER LIMB	NORMAL
NECK	NORMAL
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER
THYROID GLAND	NOT ENLARGED
CAROTID PULSATION	NORMAL
BREAST (FOR FEMALES)	NORMAL
TEMPERATURE	NORMAL
PULSE	106 MIN/REGULAR, ALL PERIPHERAL PULSES WELL FELT
RESPIRATORY RATE	NORMAL

CARDIOVASCULAR SYSTEM

BP	130/89 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)



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ADDED SOUNDS

ABSENT

PER ABDOMEN

APPEARANCE

NORMAL

VENOUS PROMINENCE

ABSENT

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

SPINE

NORMAL

JOINTS

NORMAL

BASIC EYE EXAMINATION

CONJUNCTIVA

NORMAL

EYELIDS

NORMAL

EYE MOVEMENTS

NORMAL

CORNEA

NORMAL

DISTANT VISION RIGHT EYE WITHOUT GLASSES

6/6

DISTANT VISION LEFT EYE WITHOUT GLASSES

6/6

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL

NORMAL

TYMPANIC MEMBRANE

NORMAL

NOSE

NO ABNORMALITY DETECTED

SINUSES

CLEAR

THROAT

NO ABNORMALITY DETECTED

TONSILS

NOT ENLARGED

SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

WITHIN NORMAL LIMITS



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RELEVANT NON PATHOLOGY DIAGNOSTICS NO ABNORMALITIES DETECTED

REMARKS / RECOMMENDATIONS NONE

FITNESS STATUS

FITNESS STATUS FIT (AS PER REQUESTED PANEL OF TESTS)

Interpretation(s)

BLOOD COUNTS, EDTA WHOLE BLOOD-

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

RBC AND PLATELET INDICES-

Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>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 - 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. AAC 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





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(indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

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

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels 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, 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. 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
- Antioxidant rich foods

TOTAL PROTEIN, SERUM-





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Haryana, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : NEHA MITTAL

PATIENT ID : NEHAF13098871

ACCESSION NO : 0071VI000826 AGE : 34 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 21/09/2022 09:15 REPORTED : 22/09/2022 11:03

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Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodialysis, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

ELECTROLYTES (NA/K/CL), SERUM-

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

MICROSCOPIC EXAMINATION, URINE-

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

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

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

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

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

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

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

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

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

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

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

THYROID PANEL, SERUM-

Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

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

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

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

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

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

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

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

Reference:

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

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.



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DIAGNOSTIC REPORT



Patient Ref. No. 7100000304823



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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 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.

FITNESS STATUS-

Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
- Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
- Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.



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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

REPORTS ENCLOSED

****End Of Report****Please visit www.srlworld.com for related Test Information for this accession

Dr. Arpita Roy, MD
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Clinical Biochemist

Dr. Geeta
Pathologist



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