



Name : Mrs. NONI JAIN  
Age/Gender: 32 Y/Female  
Patient ID : 012302110026  
BarcodeNo : 10075972  
Referred By : Self

Registration No: 51755  
Registered : 11/Feb/2023 09:07AM  
Analysed : 12/Feb/2023 02:27PM  
Reported : 12/Feb/2023 02:27PM  
Panel : Medi Wheel (ArcoFemi  
Healthcare Ltd)

## DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.

Domes of diaphragm are normally placed.

Transverse diameter of heart appears with normal limits.

**IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.**

\*\*\* End Of Report \*\*\*

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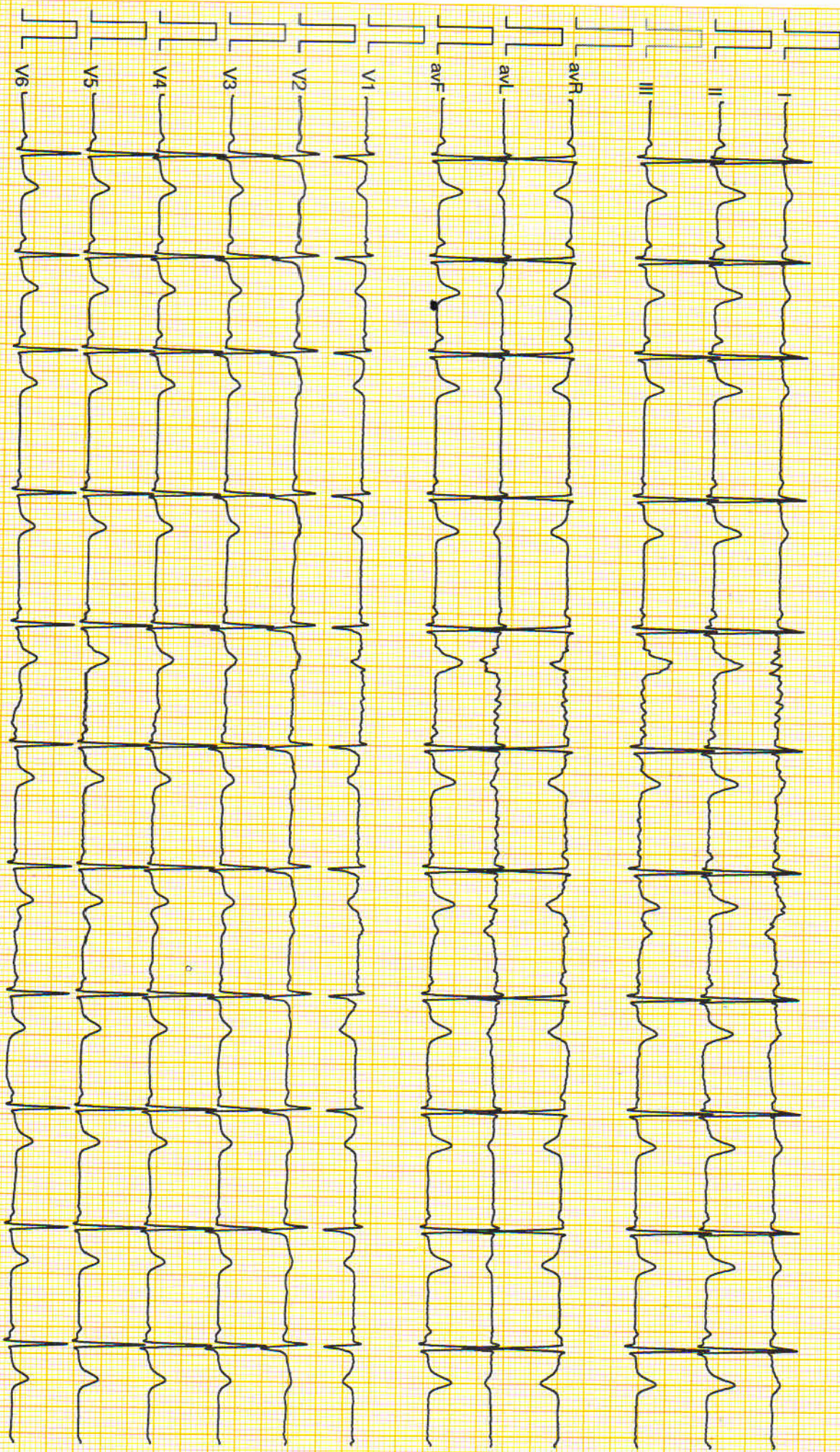


Dr. Neera Mehta  
M.B.B.S., D.M.R.D.  
RMCNO.005807/14853



78 / MRS NONI JAIN / 32 Yrs / F / 0 Gms / 0 Kg / HR 68

Date: 11-Feb-2023 10:14:36 AM BP: 101/71 mmHg ECG On Notch On HF: 0.05 Hz LF: 100 Hz



FNAC

Dr. NITIZ GOYAL  
M.D.S. MD  
RMC-023.HD



Stage	Time	Duration	Speed(mph)	Elevation	METs	Rate	%THR	BP	RPP	PVC	Comments
Supine	00:07	0:07	01.1	00.0	01.0	065	35%	---/---	000	00	
Standing	00:31	0:24	00.0	00.0	01.0	097	52%	---/---	000	00	
HV	00:35	0:04	00.0	00.0	01.0	097	52%	---/---	000	00	
Warm Up	00:47	0:12	00.0	00.0	01.0	071	38%	---/---	000	00	
ExStart	00:51	0:04	00.0	00.0	01.0	071	38%	101/71	147	00	
BRUCE Stage 1	03:51	3:00	01.7	10.0	04.7	146	78%	101/71	162	00	
PeakEx	06:34	2:43	02.5	12.0	06.9	161	86%	101/71	118	00	
Recovery	07:34	1:00	00.0	00.0	01.0	117	62%	115/64	116	00	
Recovery	08:34	2:00	00.0	00.0	01.0	101	54%	115/64	110	00	
Recovery	09:33	3:00	00.0	00.0	01.0	096	51%	115/64	110	00	

**REPORT :**

FINAL IMPRESSION :- TEST IS NEGATIVE FOR INDUCIBLE ISCHAEMIA.

Doctor : DR NITIZ GOYAL

Doctor : DR NITIZ GOYAL  
 M.B.B.S., M.D.  
 RMC - 023319



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Analysed : 11/Feb/2023 12:52PM  
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### USG: WHOLE ABDOMEN (Female)

- LIVER** : Is normal in size, shape and echogenicity.  
The IHBR and hepatic radicals are not dilated.  
No evidence of focal echopoor/echorich lesion seen.  
Portal vein diameter and Common bile duct normal in size
- GALL** : Is normal in size, shape and echotexture. Walls are smooth and  
**BLADDER** regular with normal thickness. There is no evidence of cholelithiasis.
- PANCREAS**: Is normal in size, shape and echotexture. Pancreatic duct is not dilated.  
**SPLEEN** : Is normal in size, shape and echogenicity. Splenic hilum is not dilated.
- KIDNEYS** : Bilateral Kidneys are normal in size, shape and echotexture,  
corticomedullary differentiation is fair and ratio appears normal.  
Pelvi calyceal system is normal. No evidence of hydronephrosis/ nephrolithiasis.
- URINARY** : Bladder walls are smooth, regular and normal thickness.  
**BLADDER** : No evidence of mass or stone in bladder lumen.
- UTERUS** : Uterus is anteverted with normal in size shape & echotexture.  
Uterine muscular shadows normal echopattern.  
Endometrium is normal and centrally placed.  
No evidence of mass lesion is seen.
- ADNEXA** : Both the ovaries are normal in size shape and echotexture.  
No mass lesion/ polycystic ovarian cyst is seen.
- SPECIFIC** : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.  
NO evidence of lymphadenopathy or mass lesion in retroperitoneum.  
Visualized bowel loop appear normal. Great vessels appear normal.
- IMPRESSION**: Ultra Sonography findings are suggestive of: **NORMAL STUDY.**

\*\*\* End Of Report \*\*\*

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M.B.B.S., D.M.R.D.  
RMCNO.005807/14853



PATIENT NAME : NONI JAIN

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN  
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG  
JAIPUR 302017  
9314660100

ACCESSION NO : 0251WB000818

PATIENT ID : NONIF110291251

CLIENT PATIENT ID: 012302110026

ABHA NO :

AGE/SEX : 32 Years Female

DRAWN : 11/02/2023 09:07:00

RECEIVED : 11/02/2023 10:21:20

REPORTED : 11/02/2023 17:39:37

Test Report Status **Final**

Results

Biological Reference Interval Units

## HAEMATOLOGY - CBC

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	12.6	12.0 - 15.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL (RBC) COUNT	4.23	3.8 - 4.8	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.30	4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	374	150 - 410	thou/ $\mu$ L
METHOD : ELECTRONIC IMPEDANCE			

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	38.5	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	91.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.6	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.3	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	21.5		
MEAN PLATELET VOLUME (MPV)	9.0	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
LYMPHOCYTES	37	20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
MONOCYTES	04	2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
EOSINOPHILS	04	1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			

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Consultant Pathologist

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JAIPUR, 302015  
Rajasthan, INDIA



Patient Ref. No. 775000002325245



MC-5333

PATIENT NAME : NONI JAIN

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000049066

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AAKRITI LABS PVT LTD. A-430, AGRASEN MARG  
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BASOPHILS		00	0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		4.02	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.70	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.29	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.29	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.5		

**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-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.  
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504  
This ratio element is a calculated parameter and out of NABL scope.

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Consultant Pathologist

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Patient Ref. No. 775000002325245

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REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000049066

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## HAEMATOLOGY

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	11	0 - 20	mm at 1 hr
-------	----	--------	------------

METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

## Interpretation(s)

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

## TEST INTERPRETATION

**Increase** in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy 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: Polycythemia 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.



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Consultant Pathologist

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Rajasthan, INDIA



Patient Ref. No. 775000002325245

PATIENT NAME : NONI JAIN

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000049066

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 JAIPUR 302017  
 9314660100

ACCESSION NO : 0251WB000818

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Test Report Status **Final**

Results

Biological Reference Interval Units

### IMMUNOHAEMATOLOGY

#### MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

#### ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

#### Interpretation(s)

ABO GROUP &amp; 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.



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 Consultant Pathologist

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**Patient Ref. No. 775000002325245**





MC-5333

<b>PATIENT NAME : NONI JAIN</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000049066</b>		<b>ACCESSION NO : 0251WB000818</b>	
SRL JAIPUR WELLNESS CORPORATE WALK IN		AGE/SEX : 32 Years Female	
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG		DRAWN : 11/02/2023 09:07:00	
JAIPUR 302017		RECEIVED : 11/02/2023 10:21:20	
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		PATIENT ID : NONIF110291251	
		CLIENT PATIENT ID: 012302110026	
		ABHA NO :	

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**BIOCHEMISTRY**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR) **111 High** 74 - 99 mg/dL  
 METHOD : GLUCOSE OXIDASE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C 5.7  
 Non-diabetic: < 5.7 %  
 Pre-diabetics: 5.7 - 6.4  
 Diabetics: > or = 6.5  
 Therapeutic goals: < 7.0  
 Action suggested : > 8.0  
 (ADA Guideline 2021)

METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG) **116.9 High** < 116.0 mg/dL  
 METHOD : CALCULATED PARAMETER

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR) 108 70 - 140 mg/dL  
 METHOD : GLUCOSE OXIDASE

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL 150  
 < 200 Desirable mg/dL  
 200 - 239 Borderline High  
 >/= 240 High

METHOD : CHOLESTEROL OXIDASE

TRIGLYCERIDES 48  
 < 150 Normal mg/dL  
 150 - 199 Borderline High  
 200 - 499 High  
 >/=500 Very High

METHOD : LIPASE/GPO-PAP NO CORRECTION

HDL CHOLESTEROL 60  
 < 40 Low mg/dL  
 >/=60 High

METHOD : DIRECT CLEARANCE METHOD

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CHOLESTEROL LDL	81	< 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
NON HDL CHOLESTEROL	90	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO	9.6 2.5 Low	<= 30.0 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	mg/dL
LDL/HDL RATIO	1.4	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

**Interpretation(s)****LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.40	0 - 1	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID			
BILIRUBIN, DIRECT	0.17	0.00 - 0.25	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID			
BILIRUBIN, INDIRECT	0.23	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.0	6.4 - 8.2	g/dL
METHOD : BIURET REACTION, END POINT			
ALBUMIN	4.0	3.8 - 4.4	g/dL

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MC-5333

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SRL JAIPUR WELLNESS CORPORATE WALK IN		<b>PATIENT ID : NONIF110291251</b>	<b>DRAWN : 11/02/2023 09:07:00</b>
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METHOD : BROMOCRESOL GREEN				
<b>GLOBULIN</b>	3.0	2.0 - 4.1		g/dL
METHOD : CALCULATED PARAMETER				
<b>ALBUMIN/GLOBULIN RATIO</b>	1.3	1.0 - 2.1		RATIO
METHOD : CALCULATED PARAMETER				
<b>ASPARTATE AMINOTRANSFERASE (AST/SGOT)</b>	13	0 - 31		U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
<b>ALANINE AMINOTRANSFERASE (ALT/SGPT)</b>	7	0 - 31		U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
<b>ALKALINE PHOSPHATASE</b>	71	39 - 117		U/L
METHOD : AMP OPTIMISED TO IFCC 37° C				
<b>GAMMA GLUTAMYL TRANSFERASE (GGT)</b>	12	7 - 32		U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
<b>LACTATE DEHYDROGENASE</b>	246	230 - 460		U/L
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
<b>BLOOD UREA NITROGEN</b>	8	5.0 - 18.0		mg/dL
METHOD : UREASE KINETIC				
<b>CREATININE, SERUM</b>				
<b>CREATININE</b>	0.73	0.6 - 1.2		mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
<b>BUN/CREAT RATIO</b>				
<b>BUN/CREAT RATIO</b>	10.96			
METHOD : CALCULATED PARAMETER				
<b>URIC ACID, SERUM</b>				
<b>URIC ACID</b>	3.6	2.4 - 5.7		mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
<b>TOTAL PROTEIN, SERUM</b>				
<b>TOTAL PROTEIN</b>	7.0	6.4 - 8.3		g/dL
METHOD : BIURET REACTION, END POINT				
<b>ALBUMIN, SERUM</b>				
<b>ALBUMIN</b>	4.0	3.8 - 4.4		g/dL
METHOD : BROMOCRESOL GREEN				
<b>GLOBULIN</b>				
<b>GLOBULIN</b>	3.0	2.0 - 4.1		g/dL

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**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM	138.5	137 - 145	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

POTASSIUM, SERUM	4.33	3.6 - 5.0	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

CHLORIDE, SERUM	102.5	98 - 107	mmol/L
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METHOD : ION-SELECTIVE ELECTRODE

**Interpretation(s)****Interpretation(s)****GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in**

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). 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 glycaemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.

3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.

2. eAG gives an evaluation of blood glucose levels for the last couple of months.

3. eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

**HbA1c Estimation can get affected due to :**

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 addition 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c

LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

**Dr. Akansha Jain**  
Consultant Pathologist

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Patient Ref. No. 775000002325245



<b>PATIENT NAME : NONI JAIN</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000049066</b>		<b>ACCESSION NO : 0251WB000818</b>	<b>AGE/SEX : 32 Years Female</b>
SRL JAIPUR WELLNESS CORPORATE WALK IN		<b>PATIENT ID : NONIF110291251</b>	<b>DRAWN : 11/02/2023 09:07:00</b>
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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 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 are 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.

**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

**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

**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.

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

**Dr. Akansha Jain**  
Consultant Pathologist



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**Patient Ref. No. 775000002325245**



MC-5333

<b>PATIENT NAME : NONI JAIN</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000049066</b>		<b>ACCESSION NO : 0251WB000818</b>	<b>AGE/SEX : 32 Years Female</b>
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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**PHYSICAL EXAMINATION, URINE**

COLOR PALE YELLOW  
METHOD : GROSS EXAMINATION

APPEARANCE CLEAR  
METHOD : GROSS EXAMINATION

**CHEMICAL EXAMINATION, URINE**

PH 6.0 4.7 - 7.5  
METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY <=1.005 1.003 - 1.035  
METHOD : IONIC CONCENTRATION METHOD

PROTEIN NOT DETECTED NOT DETECTED  
METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE

GLUCOSE NOT DETECTED NOT DETECTED  
METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS

KETONES NOT DETECTED NOT DETECTED  
METHOD : SODIUM NITROPRUSSIDE REACTION

BLOOD NOT DETECTED NOT DETECTED  
METHOD : PEROXIDASE ANTI PEROXIDASE

BILIRUBIN NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK

UROBILINOGEN NORMAL NORMAL  
METHOD : EHRlich REACTION REFLECTANCE

NITRITE NOT DETECTED NOT DETECTED  
METHOD : NITRATE TO NITRITE CONVERSION METHOD

LEUKOCYTE ESTERASE **DETECTED** NOT DETECTED

**MICROSCOPIC EXAMINATION, URINE**

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF  
METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 1-2 0-5 /HPF  
METHOD : DIPSTICK, MICROSCOPY

EPITHELIAL CELLS 3-5 0-5 /HPF  
METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED

**Dr. Akansha Jain**  
Consultant Pathologist



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PATIENT ID : NONIF110291251

CLIENT PATIENT ID: 012302110026

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AGE/SEX : 32 Years Female

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METHOD : MICROSCOPIC EXAMINATION

**CRYSTALS**

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

**BACTERIA**

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

**YEAST**

NOT DETECTED

NOT DETECTED

**Interpretation(s)**

**Dr. Akansha Jain**  
Consultant Pathologist



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## CYTOLOGY

**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****PAPANICOLAOU SMEAR**

TEST METHOD

SAMPLE NOT RECEIVED

**Dr. Akansha Jain**  
Consultant Pathologist

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### CLINICAL PATH - STOOL ANALYSIS

#### MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

#### PHYSICAL EXAMINATION,STOOL

COLOUR

SAMPLE NOT RECEIVED

METHOD : GROSS EXAMINATION

**Dr. Abhishek Sharma**  
Consultant Microbiologist

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## SPECIALISED CHEMISTRY - HORMONE

## MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

## THYROID PANEL, SERUM

T3	120.21	60.0 - 181.0	ng/dL
METHOD : CHEMILUMINESCENCE			
T4	9.00	4.5 - 10.9	µg/dL
METHOD : CHEMILUMINESCENCE			
TSH (ULTRASENSITIVE)	2.036	0,550 - 4.780	µIU/mL
METHOD : CHEMILUMINESCENCE			

## 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

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Consultant Pathologist

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MC-5333

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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. TIFTZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.  
**NOTE: It is advisable to detect Free T3, Free T4 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.

**\*\*End Of Report\*\***Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession**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

**Dr. Akansha Jain**  
Consultant Pathologist

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