

PATIENT NAME : . AMPERAYANI VENKATA NAGASRI P

REF. DOCTOR :

CODE/NAME & ADDRESS : C000138369

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

ACCESSION NO : **0042WB004188**

PATIENT ID : AMPEF21087442

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 48 Years Female

DRAWN : 25/02/2023 08:43:52

RECEIVED : 25/02/2023 08:34:23

REPORTED : 27/02/2023 14:38:13

Test Report Status	Final	Results	Biological Reference Interval	Units
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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 6/36

DISTANT VISION LEFT EYE WITHOUT GLASSES 6/36

NEAR VISION RIGHT EYE WITHOUT GLASSES N/24

NEAR VISION LEFT EYE WITHOUT GLASSES N/24

COLOUR VISION NORMAL

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL NORMAL

TYMPANIC MEMBRANE NORMAL

NOSE NO ABNORMALITY DETECTED

SINUSES NORMAL

THROAT NO ABNORMALITY DETECTED

TONSILS NOT ENLARGED

BASIC DENTAL EXAMINATION

TEETH NORMAL

GUMS HEALTHY

SUMMARY

RELEVANT HISTORY NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS NOT SIGNIFICANT



Dr. Ravi Teja J
Consultant Pathologist

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Patient Ref. No. 77500002438890

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RELEVANT LAB INVESTIGATIONS

RELEVANT NON PATHOLOGY DIAGNOSTICS

REMARKS / RECOMMENDATIONS

HBA1C:5.9,TSH:6.930

NO ABNORMALITIES DETECTED

NEEDS SIGNIFICANTS WEIGHT REDUCTION, PHYSICAL EXERCISES
ARE SUGGEST. AVOID OILY AND JUNK FOODS. HAVE DIETICIAN
OPINION FOR WEIGHT REDUCTION.
ADVICE TO FOLLOW UP WITH PHYSICIAN FOR HBA1C AND TSH LEVELS.
ADVICE TO FOLLOWUP WITH OPTHAMOLOGIST FOR VISUAL
CORRECTION.

FITNESS STATUS

FITNESS STATUS

FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)



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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE - I FATTY LIVER.

Interpretation(s)

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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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

BLOOD COUNTS,EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	12.3	12.0 - 15.0	g/dL
<small>METHOD : CYANMETHEMOGLOBIN METHOD</small>			
RED BLOOD CELL (RBC) COUNT	4.44	3.8 - 4.8	mil/ μ L
<small>METHOD : ELECTRICAL IMPEDANCE</small>			
WHITE BLOOD CELL (WBC) COUNT	7.10	4.0 - 10.0	thou/ μ L
<small>METHOD : ELECTRICAL IMPEDANCE</small>			
PLATELET COUNT	297	150 - 410	thou/ μ L
<small>METHOD : ELECTRICAL IMPEDANCE</small>			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	38.2	36 - 46	%
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR VOLUME (MCV)	86.0	83 - 101	fL
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.7	27.0 - 32.0	pg
<small>METHOD : CALCULATED PARAMETER</small>			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.3	31.5 - 34.5	g/dL
<small>METHOD : CALCULATED PARAMETER</small>			
RED CELL DISTRIBUTION WIDTH (RDW)	14.6 High	11.6 - 14.0	%
<small>METHOD : CALCULATED PARAMETER</small>			
MENTZER INDEX	19.4		
MEAN PLATELET VOLUME (MPV)	7.4	6.8 - 10.9	fL
<small>METHOD : CALCULATED PARAMETER</small>			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	58	40 - 80	%
<small>METHOD : ACV TECHNOLOGY</small>			
LYMPHOCYTES	36	20 - 40	%
<small>METHOD : ACV TECHNOLOGY</small>			
MONOCYTES	4	2 - 10	%
<small>METHOD : ACV TECHNOLOGY</small>			
EOSINOPHILS	2	1 - 6	%
<small>METHOD : ACV TECHNOLOGY</small>			



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BASOPHILS		0	0 - 2	%
METHOD : ACV TECHNOLOGY				
ABSOLUTE NEUTROPHIL COUNT		4.12	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.56	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.28	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.14	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6		
METHOD : CALCULATED				
MORPHOLOGY				
RBC		NORMOCYTIC NORMOCHROMIC.		
METHOD : MICROSCOPIC EXAMINATION				
WBC		WITHIN NORMAL LIMITS.		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE ON SMEAR.		
METHOD : MICROSCOPIC EXAMINATION				

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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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R	22 High	0 - 20	mm at 1 hr
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METHOD : WESTERGREN METHOD

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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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 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 & 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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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.9 High	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)	%
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METHOD : ION- EXCHANGE HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	122.6 High	< 116.0	mg/dL
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METHOD : ION- EXCHANGE HPLC

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	88	74 - 99	mg/dL
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METHOD : SPECTROPHOTOMETRY HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	84	70 - 139	mg/dL
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METHOD : SPECTROPHOTOMETRY HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	177	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
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METHOD : SPECTROPHOTOMETRY,CHOLESTEROL OXIDASE ESTERASE PEROXIDASE

TRIGLYCERIDES	29	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
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METHOD : SPECTROPHOTOMETRY, LIPASE

HDL CHOLESTEROL	71 High	< 40 Low >/=60 High	mg/dL
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METHOD : SPECTROPHOTOMETRY,POLYANIONIC DETERGENT/CHOD



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CHOLESTEROL LDL		100	< 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
NON HDL CHOLESTEROL		106	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO		5.8 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	0.32	0.2 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF			
BILIRUBIN, DIRECT	0.11	0.0 - 0.2	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF			
BILIRUBIN, INDIRECT	0.21	0.1 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY,CALCULATED			
TOTAL PROTEIN	7.5	6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRY, MODIFIED BIURET			
ALBUMIN	3.7	3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY, BCP - DYE BINDING			



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GLOBULIN		3.8	2.0 - 4.1	g/dL
METHOD : SPECTROPHOTOMETRY,CALCULATED				
ALBUMIN/GLOBULIN RATIO		1.0	1.0 - 2.1	RATIO
METHOD : SPECTROPHOTOMETRY,CALCULATED				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		17	15 - 37	U/L
METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		28	< 34.0	U/L
METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE				
ALKALINE PHOSPHATASE		96	30 - 120	U/L
METHOD : SPECTROPHOTOMETRY, P-NPP (AMP BUFFER)				
GAMMA GLUTAMYL TRANSFERASE (GGT)		23	5 - 55	U/L
METHOD : SPECTROPHOTOMETRY, G-GLUTAMYL-CARBOXY-NITRONILIDE				
LACTATE DEHYDROGENASE		203 High	100 - 190	U/L
METHOD : SPECTROPHOTOMETRY, MODIFIED ENZYMATIC LACTATE - PYRUVATE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		14	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE UV				
CREATININE, SERUM				
CREATININE		0.88	0.60 - 1.10	mg/dL
METHOD : SPECTROPHOTOMETRY, ALKALINE PICRATE KINETIC JAFFE'S				
BUN/CREAT RATIO				
BUN/CREAT RATIO		15.91 High	5.00 - 15.00	
METHOD : SPECTROPHOTOMETRY,CALCULATED				
URIC ACID, SERUM				
URIC ACID		3.7	2.6 - 6.0	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.5	6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRY, MODIFIED BIURET				
ALBUMIN, SERUM				
ALBUMIN		3.7	3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY, BCP - DYE BINDING				
GLOBULIN				
GLOBULIN		3.8	2.0 - 4.1	g/dL
METHOD : SPECTROPHOTOMETRY,CALCULATED				



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Patient Ref. No. 77500002438890

PATIENT NAME : . AMPERAYANI VENKATA NAGASRI P

REF. DOCTOR :

CODE/NAME & ADDRESS : C000138369

ACCESSION NO : 0042WB004188

AGE/SEX : 48 Years Female

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHI

PATIENT ID : AMPEF21087442

DRAWN : 25/02/2023 08:43:52

NEW DELHI 110030
8800465156

CLIENT PATIENT ID:

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

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 145 136 - 145 mmol/L

METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT

POTASSIUM, SERUM 4.50 3.50 - 5.10 mmol/L

METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT

CHLORIDE, SERUM 106 98 - 107 mmol/L

METHOD : INTEGRATED MULTISENSOR TECHNOLOGY-INDIRECT

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants {SSRI}, antipsychotics.	Decreased in: Low potassium intake,prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome,osmotic diuresis (e.g., hyperglycemia),alkalosis, familial periodic paralysis,trauma (transient). Drugs: Adrenergic agents, diuretics.	Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalininsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.
Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.	Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration,renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics,NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	Increased in: Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (loss of HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)

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

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well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
 1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
 2. eAG gives an evaluation of blood glucose levels for the last couple of months.
 3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
- 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.
- Interference of hemoglobinopathies in HbA1c estimation is seen in

- Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
- Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- 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 FASTING,FLUORIDE PLASMA-TEST DESCRIPTION

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

Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.

Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hyopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.

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

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-

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** results 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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.

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,Waldenstroms 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 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

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Consultant Pathologist



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ACCESSION NO : 0042WB004188

PATIENT ID : AMPEF21087442

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AGE/SEX : 48 Years Female

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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, Muscuophy

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-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,Waldenstroms 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.



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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

METHOD : MANUAL

APPEARANCE CLEAR

METHOD : MANUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5

METHOD : REFLECTANCE SPECTROPHOTOMETRY

SPECIFIC GRAVITY 1.005 1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY

PROTEIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

KETONES NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

BLOOD NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

BILIRUBIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

UROBILINOGEN NORMAL NORMAL

METHOD : REFLECTANCE SPECTROPHOTOMETRY

NITRITE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 3-5 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

EPITHELIAL CELLS 1-2 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED



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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

Comments

NOTE : URINE MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINE SEDIMENT.

Interpretation(s)



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Consultant Pathologist



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CYTOLOGY

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

TEST METHOD

CONVENTIONAL GYNEC CYTOLOGY

SPECIMEN TYPE

TWO UNSTAINED CERVICAL SMEARS RECEIVED

REPORTING SYSTEM

2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY

SPECIMEN ADEQUACY

SMEAR IS SATISFACTORY FOR EVALUATION WITH ABSENCE OF ENDOCERVICAL CELLS.

MICROSCOPY

SMEAR STUDIED REVEAL SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS, PARABASAL CELLS. NO EVIDENCE OF MALIGNANCY/FUNGAL ELEMENTS NOTED.

INTERPRETATION / RESULT

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

Comments

NOTE:1. PLEASE NOTE PAPANICOLAOU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS,HENCE SHOULD BE INTERPRETED WITH CAUTION.
2. NO CYTOLOGIC EVIDENCE OF HPV INFECTION IN THE SMEAR STUDIED.



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Consultant Pathologist

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Results

Biological Reference Interval Units

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE**MICROSCOPIC EXAMINATION,STOOL**

REMARK

SAMPLE NOT RECEIVED

Interpretation(s)


Dr M. Prasanthi
Consultant Microbiologist

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

THYROID PANEL, SERUM

T3 86.49 Non-Pregnant Women ng/dL
80.0 - 200.0
Pregnant Women
1st Trimester:105.0 - 230.0
2nd Trimester:129.0 - 262.0
3rd Trimester:135.0 - 262.0

METHOD : ECLIA

T4 9.99 Non-Pregnant Women µg/dL
5.10 - 14.10
Pregnant Women
1st Trimester: 7.33 - 14.80
2nd Trimester: 7.93 - 16.10
3rd Trimester: 6.95 - 15.70

METHOD : ECLIA

TSH (ULTRASENSITIVE) **6.930 High** Non Pregnant Women µIU/mL
0.27 - 4.20
Pregnant Women
1st Trimester: 0.33 - 4.59
2nd Trimester: 0.35 - 4.10
3rd Trimester: 0.21 - 3.15

METHOD : ECLIA

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
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Dr. Ravi Teja J
Consultant Pathologist



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Patient Ref. No. 775000002438890

PATIENT NAME : . AMPERAYANI VENKATA NAGASRI P

REF. DOCTOR :

CODE/NAME & ADDRESS : C000138369

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DELHI
NEW DELHI 110030
8800465156

ACCESSION NO : 0042WB004188

PATIENT ID : AMPEF21087442

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 48 Years Female

DRAWN : 25/02/2023 08:43:52

RECEIVED : 25/02/2023 08:34:23

REPORTED : 27/02/2023 14:38:13

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

1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

RRP: 1. Tietz 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****

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Test Report Status **Final**

Results

Biological Reference Interval Units

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



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Consultant Pathologist

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