



UHD	5720514	Date	11/03/2023	
Name	Mr. Dhiraj Joshi	Sex	Male	Age 39
OPD	Ophthal 14	Health Check-up		

Drug allergy: → Not known.
 Sys illness: → No.

Clr. No.

Ng. NTW (since 1.5yr).

Unit → R 6/6.
 L 6/6

MVA → N6P
 NCP

Ref → R Plus 6/6.
 L Plus 6/6
 Add → +0.75 → N6
 N6

Lio.P. → R 7. 12.2.
 L 12.0

All good

C. v. d.
 20-20 rule
 ↓
 20 mi / 30 mi ✓
 ↓
 20 pc / 30 pc ✓
 (rad)

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
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Emergency: 022 - 39199100 | Ambulance: 1255
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GST IN: 27AABCH5894DIZG | PAN NO: AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

UHID	5720514	Date	11/03/2023		
Name	Mr.Dhiraj Joshi	Sex	Male	Age	39
OPD	Dental 12	Health Check-up			

O/E

Drug allergy: N/A
Sys illness:

Stain ++

Calculus ++

Treatment plan

Scaling for oral prophylaxis

Dr. Trupti.



PATIENT NAME : MR.DHRIAJ RAJENDRA PRASAD JOSHI		REF. DOCTOR : SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS	ACCESSION NO : 0022WC002095	AGE/SEX : 39 Years Male
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.5720514	DRAWN : 11/03/2023 10:52:00
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:5720514	RECEIVED : 11/03/2023 10:53:03
MUMBAI 440001	ABHA NO :	REPORTED : 11/03/2023 16:01:39

CLINICAL INFORMATION :
 UID:5720514 REQNO-1384197
 CORP-OPD
 BILLNO-150123OPCR014382
 BILLNO-150123OPCR014382

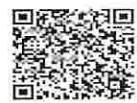
Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	15.1	13.0 - 17.0		g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	5.15	4.5 - 5.5		mil/ μ L
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	7.43	4.0 - 10.0		thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	185	150 - 410		thou/ μ L
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	45.0	40 - 50		%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	87.4	83 - 101		fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.3	27.0 - 32.0		pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.6	31.5 - 34.5		g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	14.0	11.6 - 14.0		%
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	17.0			
MEAN PLATELET VOLUME (MPV)	12.3 High	6.8 - 10.9		fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	61	40 - 80		%
METHOD : FLOWCYTOMETRY				
LYMPHOCYTES	28	20 - 40		%
METHOD : FLOWCYTOMETRY				

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Dr.Akta Dubey
 Counsultant Pathologist



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 CIN - U74599PB1995PLC045956
 Email : -

Patient Ref. No. 22000000833628



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REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
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FORTIS HOSPITAL # VASHI,
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MONOCYTES		7	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		4	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		4.53	2.0 - 7.0	thou/μL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.08	1.0 - 3.0	thou/μL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.52	0.2 - 1.0	thou/μL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.30	0.02 - 0.50	thou/μL
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/μL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.1		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)

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.

Dr. Akta Dubey
Consultant Pathologist



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MC-2275

Fortis

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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 54 (2020) 106504
 This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	04	0 - 14	mm at 1 hr
METHOD : WESTERGREEN 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, Vasculitis, 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 0-40 mm/hr(52 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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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE A
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

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSTIK AND GROFF	1.35 High	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSTIK AND GROFF	0.22 High	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	1.13 High	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.8	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	4.6	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.2	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.4	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH PSP	22	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH PSP	42	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	68	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANTILIDE	31	15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	166	100 - 190	U/L
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	81	74 - 99	mg/dL

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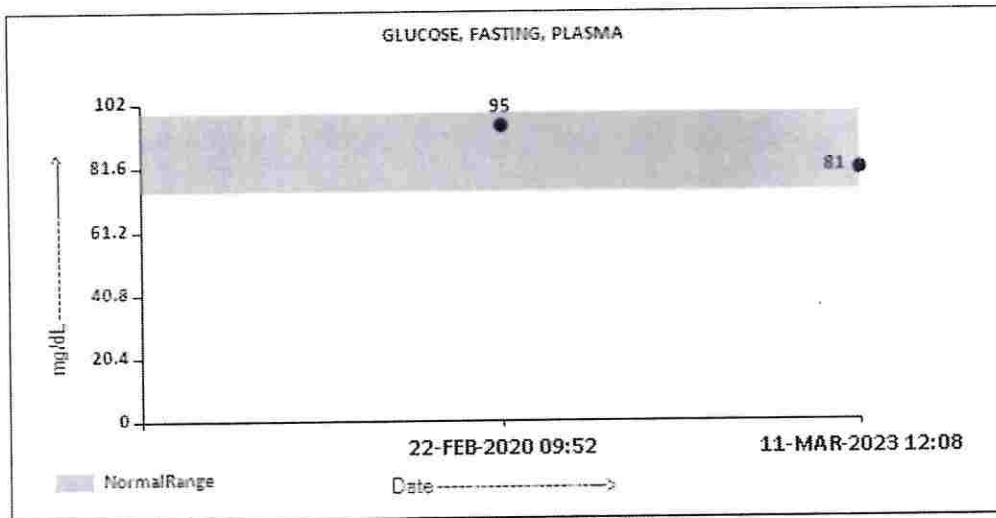
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.9	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)	%
ESTIMATED AVERAGE GLUCOSE(EAG)	93.9	< 116.0	mg/dL

METHOD : HB VARIANT (HPLC)
 METHOD : CALCULATED PARAMETER

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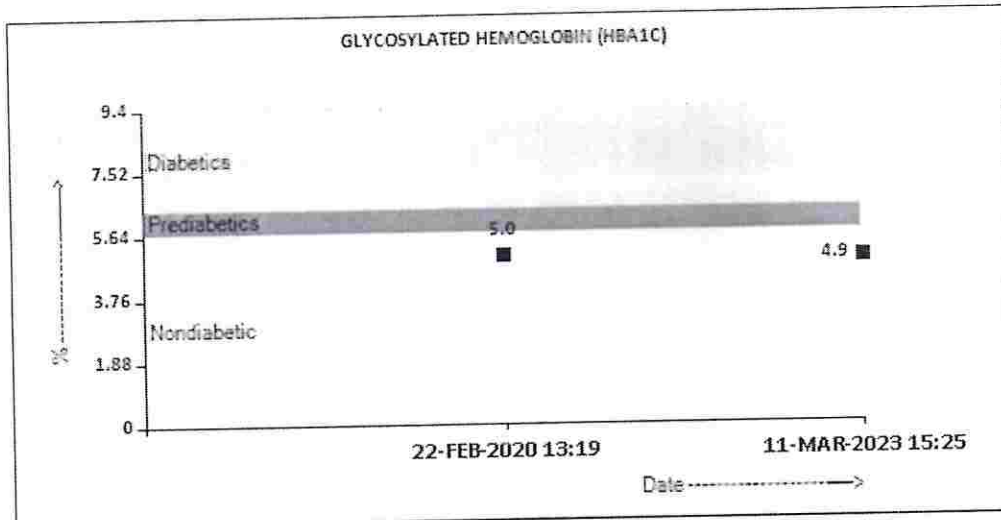
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 8 6 - 20 mg/dL
METHOD : UREASE - UV

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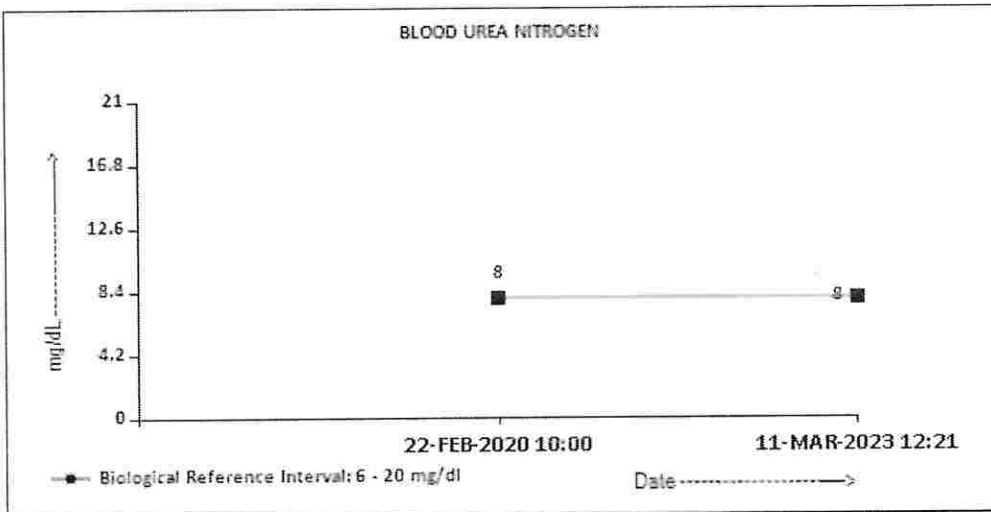
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CREATININE EGFR- EPI

CREATININE	0.75 Low	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	39		years
GLOMERULAR FILTRATION RATE (MALE)	117.72	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			

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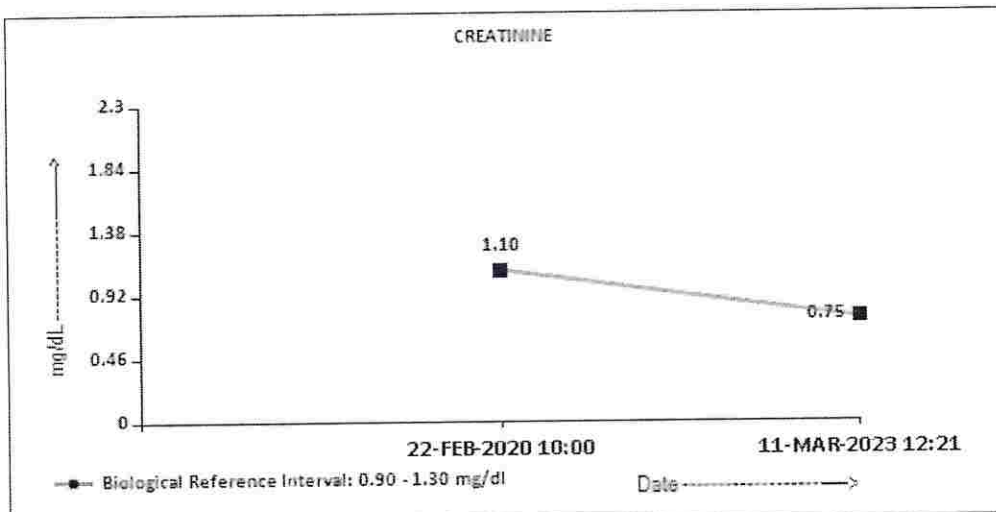
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BUN/CREAT RATIO

BUN/CREAT RATIO 10.67 5.00 - 15.00
 METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 6.3 3.5 - 7.2 mg/dL
 METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.8 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.6 3.4 - 5.0 g/dL
 METHOD : BCP DYE BINDING

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 REPORTED : 11/03/2023 16:01:39

CLINICAL INFORMATION :

UID:5720514 REQNO-1384197
 CORP-OPD
 BILLNO-150123OPCR014382
 BILLNO-150123OPCR014382

Test Report Status	Final	Results	Biological Reference Interval	Units
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GLOBALIN

GLOBALIN	3.2	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER.			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	138	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.12	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	100	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Interpretation(s)

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 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, 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

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Patient Ref. No. 22000000833628



MC-2275

Fortis

PATIENT NAME : MR.DHRIAJ RAJENDRA PRASAD JOSHI

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WC002095
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 ABHA NO :

AGE/SEX : 39 Years Male
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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
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, sulfonyleureas, 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.
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
- 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 EGFR- EPI-GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
 A GFR of 60 or higher is in the normal range.
 A GFR below 60 may mean kidney disease.
 A GFR of 15 or lower may mean kidney failure.
 Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
 The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.
 The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
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

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CODE/NAME & ADDRESS : C000045507 - FORTIS	ACCESSION NO : 0022WC002095	AGE/SEX : 39 Years Male
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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.

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL	185	< 200 Desirable 200 - 239 Borderline High ≥ 240 High		mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	188 High	< 150 Normal 150 - 199 Borderline High 200 - 499 High ≥ 500 Very High		mg/dL
METHOD : ENZYMATIC ASSAY				
HDL CHOLESTEROL	45	< 40 Low ≥ 60 High		mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	122	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High ≥ 190 Very High		mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT				
NON HDL CHOLESTEROL	140 High	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	37.6 High	<= 30.0		mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	4.1	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk		
METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO	2.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk		
METHOD : CALCULATED PARAMETER				

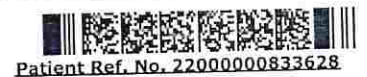
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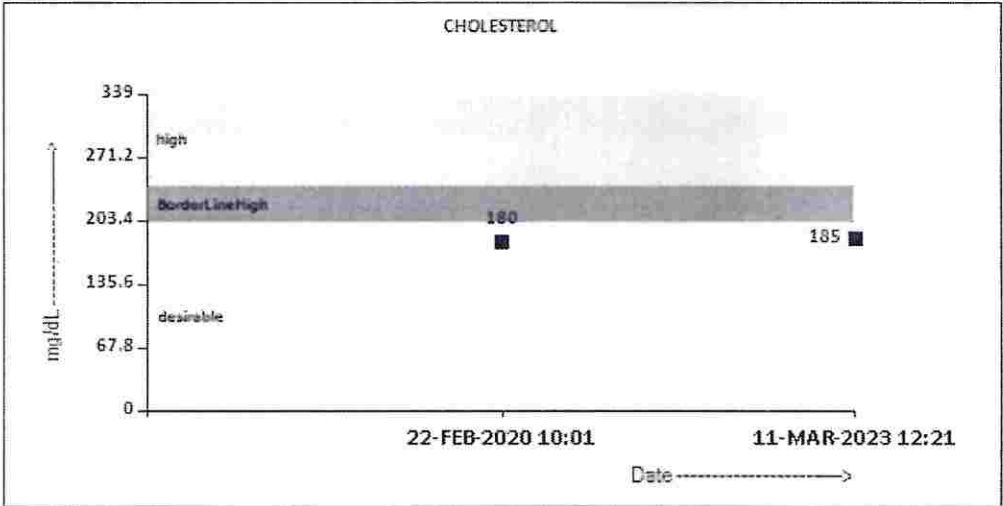
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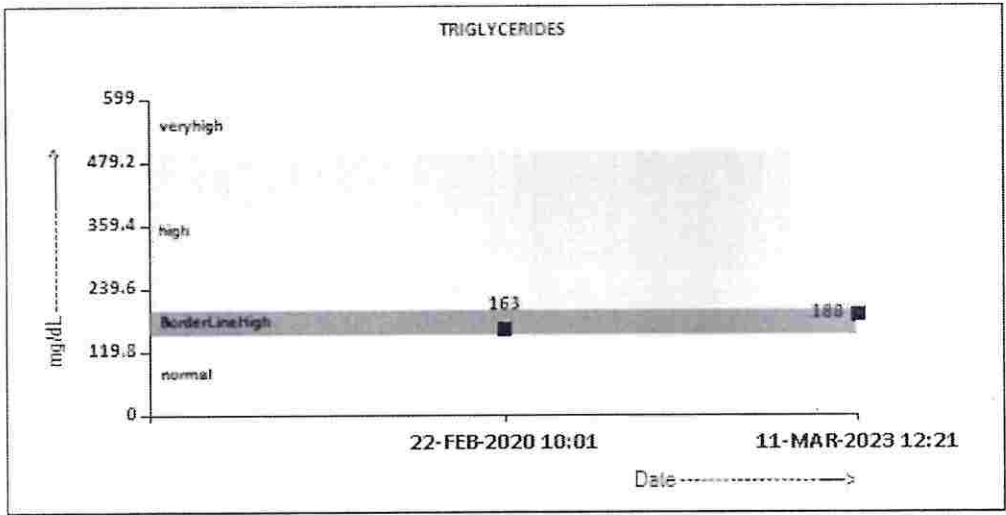
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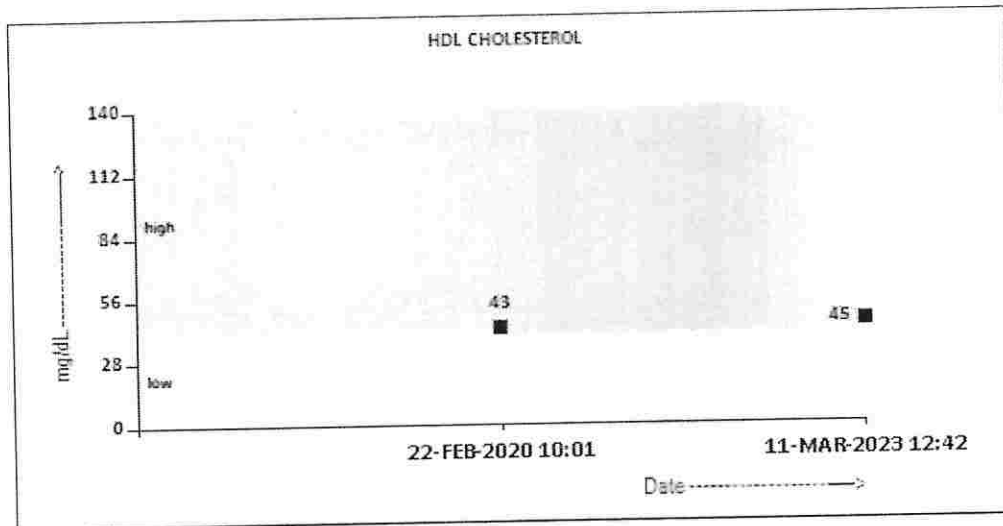
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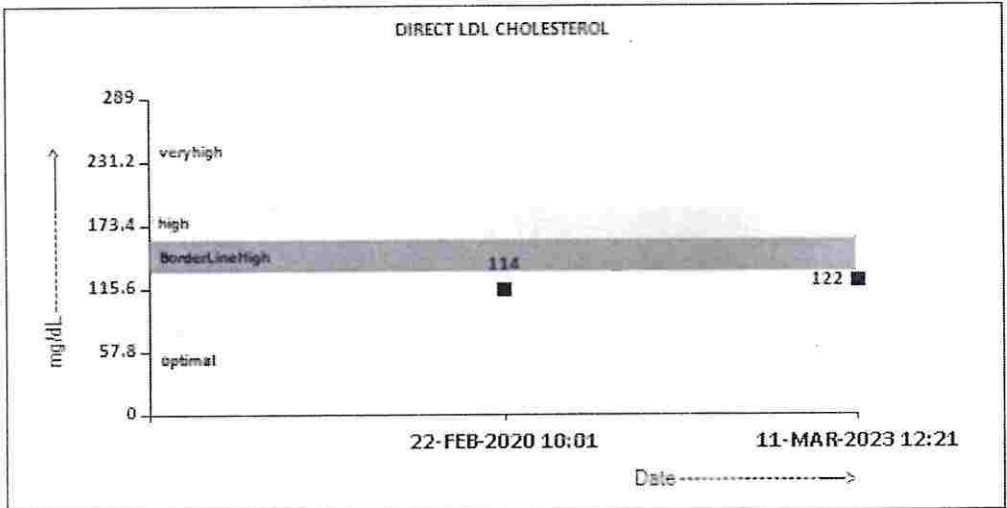


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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

METHOD : PHYSICAL

APPEARANCE SLIGHTLY HAZY

METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5

METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY 1.020 1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD

KETONES NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD DETECTED (+) NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN

BILIRUBIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT

UROBILINOGEN NORMAL NORMAL

METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)

NITRITE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS 5 - 7 NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

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Rekha N

Dr. Rekha Nair, MD
 Microbiologist



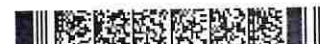
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PUS CELL (WBC'S)		3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

End Of Report

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

Dr. Akta Dubey
Consultant Pathologist

Dr. Rekha Nair, MD
Microbiologist



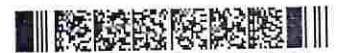
View Details



View Report

PERFORMED AT :

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222, 022-49723322,
CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000833628



PATIENT NAME : MR.DHRIAJ RAJENDRA PRASAD JOSHI		REF. DOCTOR : SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WC002095 PATIENT ID : FH.5720514 CLIENT PATIENT ID: UID:5720514 ABHA NO :	AGE/SEX : 39 Years Male DRAWN : 11/03/2023 10:52:00 RECEIVED : 11/03/2023 10:53:03 REPORTED : 11/03/2023 17:41:29

CLINICAL INFORMATION :
UID:5720514 REQNO-1384197
CORP-OPD
BILLNO-150123OPCR014382
BILLNO-150123OPCR014382

Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM				
T3	55.42 Low		80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
T4	3.14 Low		5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
TSH (ULTRASENSITIVE)	1.270		0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				

Comments

NOTE: RECHECKED FOR SERUM TOTAL T3 AND SERUM TOTAL T4
PLEASE CORRELATE VALUES OF THYROID FUNCTION TEST WITH THE
CLINICAL & TREATMENT HISTORY OF THE PATIENT.

Interpretation(s)

Dr. Swapnil Sirmukaddam
Consultant Pathologist



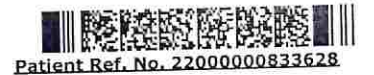
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SRL Ltd
BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4, KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956



Patient Ref. No. 22000000833628

PATIENT NAME : MR.DHRIAJ RAJENDRA PRASAD JOSHI		REF. DOCTOR : SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS	ACCESSION NO : 0022WC002095	AGE/SEX : 39 Years Male
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.5720514	DRAWN : 11/03/2023 10:52:00
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:5720514	RECEIVED : 11/03/2023 10:53:03
MUMBAI 440001	ABHA NO :	REPORTED : 11/03/2023 17:41:29

CLINICAL INFORMATION :

UID:5720514 REQNO-1384197
CORP-OPD
BILLNO-150123OPCR014382
BILLNO-150123OPCR014382

Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM				
PROSTATE SPECIFIC ANTIGEN	0.267	< 1.4		ng/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY				

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
 - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
 - It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

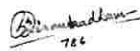
Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

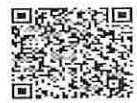
References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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



Dr. Swapnil Sirmukaddam
Consultant Pathologist



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NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
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CIN - U74899PB1995PLC045956



Patient Ref. No. 2200000833628



MC-2275

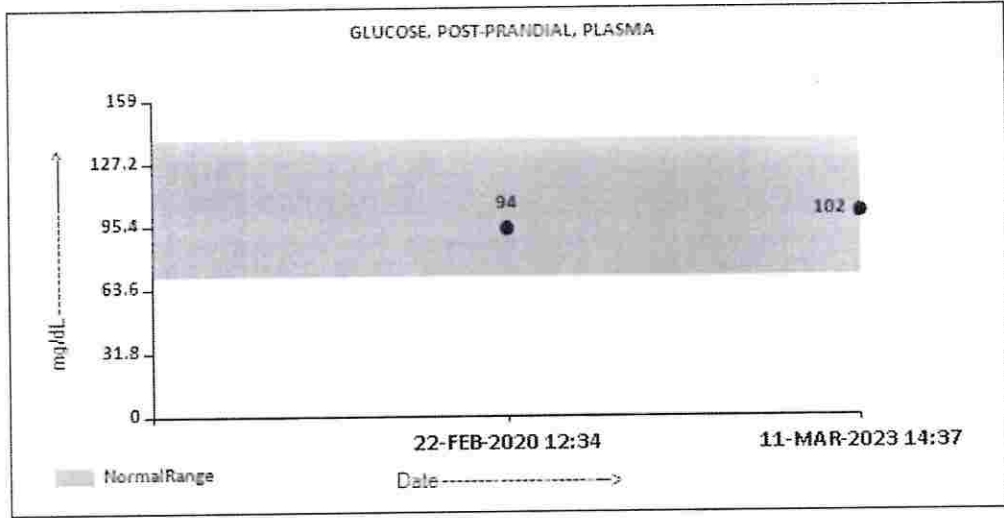
PATIENT NAME : MR.DHRIAJ RAJENDRA PRASAD JOSHI		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507 - FORTIS	ACCESSION NO : 0022WC002166	AGE/SEX : 39 Years Male	
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.5720514	DRAWN : 11/03/2023 13:26:00	
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:5720514	RECEIVED : 11/03/2023 13:26:41	
MUMBAI 440001	ABHA NO :	REPORTED : 11/03/2023 14:48:42	

CLINICAL INFORMATION :
 UID:5720514 REQNO-1384197
 CORP-OPD
 BILLNO-150123OPCR014382
 BILLNO-150123OPCR014382

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	102	70 - 139		mg/dL
METHOD : HEXOKINASE				



Interpretation(s)
 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

****End Of Report****

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

Dubey

Dr.Akta Dubey
 Consultant Pathologist



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PERFORMED AT :
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 NAVI MUMBAI, 400703
 MAHARASHTRA, INDIA
 Tel : 022-39199222,022-49723322,
 CIN - U74899PB1995PLC045956
 Email : -

Patient Ref. No. 2200000833699

5720514
39 Years

DERIAJ JOSHI
Male

3/11/2023 12:30:17 PM

HE

Rate 67 : Sinus rhythm.....normal P axis, V-rate 50- 99
 PR 153 : Abnormal R-wave progression, early transition.....QRS area>0 in V2
 QRS 90 : Left ventricular hypertrophy.....multiple voltage criteria
 QT 379 : Minimal ST elevation, inferior leads.....ST >0.06mV, II III aVF
 QTc 400

sinus

sinus

[Signature]

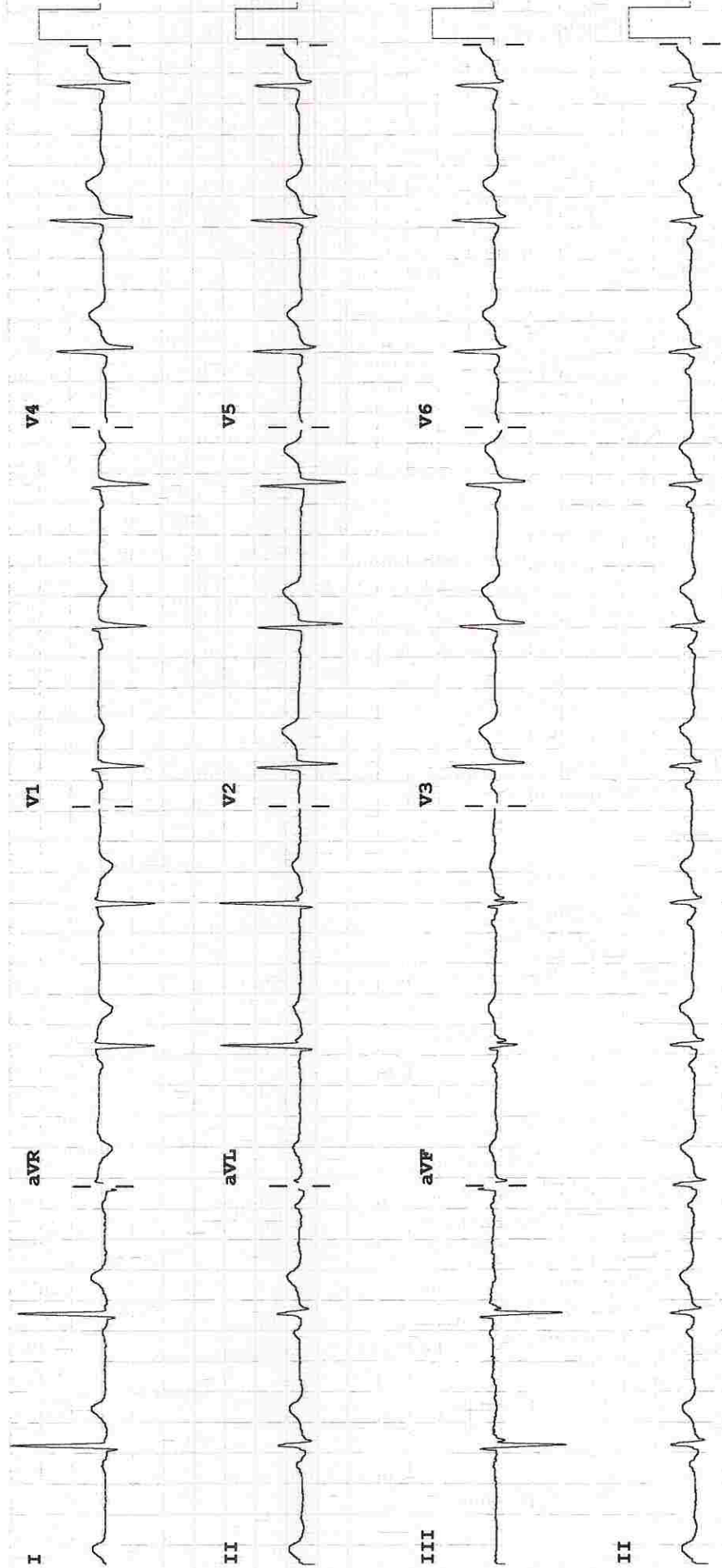
--AXIS--

P 55
 QRS -8
 T 30

12 Lead; Standard Placement

- ABNORMAL ECG -

Unconfirmed Diagnosis



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?



Date: 11/Mar/2023

DEPARTMENT OF NIC

Name: Mr. Dhriaj Rajendra Prasad Joshi

Age | Sex: 39 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5720514 | 14604/23/1501

Order No | Order Date: 1501/PN/OP/2303/30259 | 11-Mar-2023

Admitted On | Reporting Date : 11-Mar-2023 15:34:57

Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	32	mm
AO Root	29	mm
AO CUSP SEP	18	mm
LVID (s)	31	mm
LVID (d)	40	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	17	mm
RA	29	mm
LVEF	60	%

**DEPARTMENT OF NIC**

Date: 11/Mar/2023

Name: Mr. Dhriaj Rajendra Prasad Joshi

UHID | Episode No : 5720514 | 14604/23/1501

Age | Sex: 39 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/30259 | 11-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Mar-2023 15:34:57

Bed Name :

Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.

A WAVE VELOCITY:0.8 m/sec

E/A RATIO:1.4

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

- Normal 2 Dimensional and colour doppler echocardiography study.


DR. PRASHANT PAWAR
DNB(MED), DNB (CARDIOLOGY)



DEPARTMENT OF RADIOLOGY

Date: 13/Mar/2023

Name: Mr. Dhriaj Rajendra Prasad Joshi

UHID | Episode No : 5720514 | 14604/23/1501

Age | Sex: 39 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/30259 | 11-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 13-Mar-2023 14:59:21

Bed Name :

Order Doctor Name : Dr.SELF.

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appear normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

Aditya

DR. ADITYA NALAWADE

M.D. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 11/Mar/2023

Name: Mr. Dhriaj Rajendra Prasad Joshi

UHID | Episode No : 5720514 | 14604/23/1501

Age | Sex: 39 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/30259 | 11-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Mar-2023 15:19:06

Bed Name :

Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection. **CBD** appears normal in calibre.

SPLEEN is normal in size and echogenicity..

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 11.1 x 4.5 cm.
Left kidney measures 12.0 x 5.4 cm.

PANCREAS: Head and body of pancreas is visualized and appears normal. Rest of the pancreas is obscured.

AORTA AND RETROPERITONEAL structures are obscured due to bowel gas.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical mass/calculi.

PROSTATE is normal in size & echogenicity. It measures ~ 21.7 cc in volume.

No evidence of pelvic mass. No evidence of ascites.

IMPRESSION:

- **Grade I fatty infiltration of liver.**

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)