



ഭാരത സർക്കാർ
Unique Identification Authority of India
Government of India

കാർഡ് നമ്പർ / Enrollment No. 2003/37019/02861

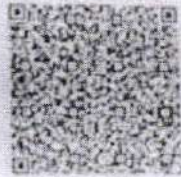
To
Mathew George
കാർഡ് നമ്പർ
C/O Bilalo Abraham
Kiduthattil Rote 53 A
Karimakkadu
Vazhakkala Village
Thrikkakara North
Thrikkakara, Emakulam
Kerala - 682021
9447088990

30/09/2012



KL027187304DF

2718730



നിങ്ങളുടെ ആധാർ നമ്പർ / Your Aadhaar No. :

6822 7525 1617

ആധാർ - സാധാരണക്കാരന്റെ അവകാശം

Mathew George



ഭാരത സർക്കാർ
GOVERNMENT OF INDIA



കാർഡ് നമ്പർ
Mathew George

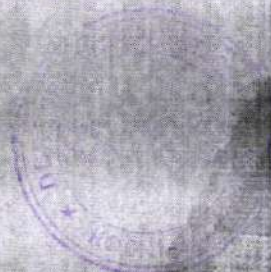
ജനന വർഷം / Year of Birth: 1970

ലിംഗം : Male

6822 7525 1617



ആധാർ - സാധാരണക്കാരന്റെ അവകാശം





Patient Ref. No. 66600003704722

 CLIENT CODE : CA00010147 - MEDIWHEEL
 CLIENT'S NAME AND ADDRESS: MEDIWHEEL HEALTHCARE LIMITED

 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
 F701A, LADO SARAI, NEW DELHI,
 SOUTH DELHI, DELHI,
 SOUTH DELHI 110030
 DELHI INDIA
 8800465156

 DDRC SRL DIAGNOSTICS
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 PANAMPALLY NAGAR, 682036
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

PATIENT NAME : MR. MATHEW GEORGE

PATIENT ID : MATHM1103704126

ACCESSION NO : 4126WC003812 AGE : 53 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 11/03/2023 11:17

REPORTED : 11/03/2023 17:06

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	9	Adult(<60 yrs) : 6 to 20	mg/dL
METHOD : UREASE - UV			

BUN/CREAT RATIO

BUN/CREAT RATIO	5.73		
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CREATININE, SERUM

CREATININE	1.57	18 - 60 yrs : 0.9 - 1.3	mg/dL
METHOD : JAFFE KINETIC METHOD			

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	84	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
METHOD : HEXOKINASE			

GLUCOSE FASTING, FLUORIDE PLASMA

GLUCOSE, FASTING, PLASMA	88	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
METHOD : HEXOKINASE			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.3	Normal : 4.0 - 5.6%. % Non-diabetic level : < 5.7%. Diabetic : >6.5%	
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 Glycemic control goal
 More stringent goal : < 6.5 %.
 General goal : < 7%.
 Less stringent goal : < 8%.

 Glycemic targets in CKD :-
 If eGFR > 60 : < 7%.
 If eGFR < 60 : 7 - 8.5%.

MEAN PLASMA GLUCOSE	105.4	< 116.0	mg/dL
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LIPID PROFILE, SERUM

CHOLESTEROL	182	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
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METHOD : CHOD-POD			
TRIGLYCERIDES	246	High Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	33	Low General range : 40-60	mg/dL
METHOD : DIRECT ENZYME CLEARANCE			
DIRECT LDL CHOLESTEROL	109	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : > or = 190	mg/dL
NON HDL CHOLESTEROL	149	High 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	49.2	High Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	5.5	High 3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	3.3	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

Comments

Factors that can influence triglyceride level in blood include diet (non-12 hrs. fasting status), Alcohol, Drug intake, Pregnancy, Smoking, Obesity, Stress and inflammation. So, if clinically not correlating contact lab within 24 hours.



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Interpretation(s)

1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.

2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL.

4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.

5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)



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Extreme Risk Group Category A	<50 (Optional goal <OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL METHOD : DIAZO METHOD	0.80	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.37	High General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.43	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.3	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.5	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.8	2.0 - 4.0 Neonates - Pre Mature : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.6	1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	17	Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : IFCC WITHOUT PDP	17	Adults : < 45	U/L
ALKALINE PHOSPHATASE METHOD : IFCC	107	Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	28	Adult (Male) : < 60	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	7.3	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM			
URIC ACID	5.9	Adults : 3.4-7	mg/dL



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Test Report Status	Preliminary	Results	Units
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METHOD : SPECTROPHOTOMETRY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O

METHOD : GEL CARD METHOD

RH TYPE POSITIVE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN 15.6 13.0 - 17.0 g/dL

METHOD : NON CYANMETHHEMOGLOBIN

RED BLOOD CELL COUNT 5.20 4.5 - 5.5 mil/ μ L

METHOD : IMPEDANCE

WHITE BLOOD CELL COUNT 6.67 4.0 - 10.0 thou/ μ L

METHOD : IMPEDANCE

PLATELET COUNT 195 150 - 410 thou/ μ L

METHOD : IMPEDANCE

RBC AND PLATELET INDICES

HEMATOCRIT 46.1 40 - 50 %

METHOD : CALCULATED

MEAN CORPUSCULAR VOL 88.6 83 - 101 fL

METHOD : DERIVED FROM IMPEDANCE MEASURE

MEAN CORPUSCULAR HGB. 30.0 27.0 - 32.0 pg

METHOD : CALCULATED

MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION 33.9 31.5 - 34.5 g/dL

METHOD : CALCULATED

RED CELL DISTRIBUTION WIDTH 15.2 12.0 - 18.0 %

MENTZER INDEX 17.0

MEAN PLATELET VOLUME 9.8 6.8 - 10.9 fL

METHOD : DERIVED FROM IMPEDANCE MEASURE

WBC DIFFERENTIAL COUNT

SEGMENTED NEUTROPHILS 62 40 - 80 %

METHOD : DHSS FLOWCYTOMETRY

LYMPHOCYTES 26 20 - 40 %

METHOD : DHSS FLOWCYTOMETRY

MONOCYTES 6 2 - 10 %

METHOD : DHSS FLOWCYTOMETRY

EOSINOPHILS 6 1 - 6 %

METHOD : DHSS FLOWCYTOMETRY



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CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
BASOPHILS		0	0 - 2 %
METHOD : IMPEDANCE			
ABSOLUTE NEUTROPHIL COUNT		4.14	2.0 - 7.0 thou/ μ L
METHOD : CALCULATED			
ABSOLUTE LYMPHOCYTE COUNT		1.73	1 - 3 thou/ μ L
METHOD : CALCULATED			
ABSOLUTE MONOCYTE COUNT		0.40	0.20 - 1.00 thou/ μ L
METHOD : CALCULATED			
ABSOLUTE EOSINOPHIL COUNT		0.40	0.02 - 0.50 thou/ μ L
METHOD : CALCULATED			
ABSOLUTE BASOPHIL COUNT		0.00	0.00 - 0.10 thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.4	
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD			
SEDIMENTATION RATE (ESR)		16	High 0 - 14 mm at 1 hr
METHOD : WESTERGREN METHOD			
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL		NOT DETECTED	NOT DETECTED
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN		2.400	Age Specific :- <49yrs : <2.5 50-59yrs : <3.5 60-69yrs : <4.5 >70yrs : <6.5 ng/mL
METHOD : ECLIA			
THYROID PANEL, SERUM			
T3		85.05	80 - 200 ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4		6.87	5.1 - 14.1 μ g/dl
METHOD : ELECTROCHEMILUMINESCENCE			
TSH 3RD GENERATION		1.410	50-80 yrs : 0.35 - 4.5 μ IU/mL
METHOD : ELECTROCHEMILUMINESCENCE			



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Results

Units

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
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. 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, FreeT4 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.

PHYSICAL EXAMINATION, URINE

COLOR

PALE YELLOW

APPEARANCE

CLEAR

CHEMICAL EXAMINATION, URINE

PH

5.0

4.8 - 7.4



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SPECIFIC GRAVITY		1.025	1.015 - 1.030
PROTEIN		NOT DETECTED	NOT DETECTED
GLUCOSE		NOT DETECTED	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BLOOD		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
NITRITE		NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS		NOT DETECTED	/HPF
WBC		1-2	/HPF
EPITHELIAL CELLS		0-1	/HPF
CASTS		NOT DETECTED	
CRYSTALS		NOT DETECTED	
BACTERIA		NOT DETECTED	NOT DETECTED
YEAST		NOT DETECTED	NOT DETECTED



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REPORTED : 13/03/2023 12:12

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT PATIENT ID :

Test Report Status	Results	Units
Preliminary		

Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

SUGAR URINE - FASTING

SUGAR URINE - FASTING

NOT DETECTED

NOT DETECTED

PHYSICAL EXAMINATION, STOOL

RESULT PENDING

CHEMICAL EXAMINATION, STOOL

RESULT PENDING

MICROSCOPIC EXAMINATION, STOOL

RESULT PENDING



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CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" Overleaf)



Patient Ref. No. 66600003704722

 CLIENT CODE : CA00010147 - MEDIWHEEL
 CLIENT'S NAME AND ADDRESS : THICARE LIMITED

 MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

PATIENT NAME : MR. MATHEW GEORGE

PATIENT ID : MATHM1103704126

ACCESSION NO : 4126WC003812 AGE : 53 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 11/03/2023 11:17

REPORTED : 11/03/2023 17:06

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of anti-diarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

- Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT)**: This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL**: In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
- Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery



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Patient Ref. No. 66600003704722

CLIENT CODE : CA00010147 - MEDIWHEEL
 CLIENT'S NAME AND ADDRESS : MEDIWHEEL HEALTHCARE LIMITED

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PATIENT NAME : MR. MATHEW GEORGE

PATIENT ID : MATHM1103704126

ACCESSION NO : 4126WC003812 AGE : 53 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 11/03/2023 11:17

REPORTED : 11/03/2023 17:06

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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diarrhoea, vomiting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

Interpretation(s)

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 (preedampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

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

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 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

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.



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Patient Ref. No. 66600003704722

CLIENT CODE : CA00010147 - MEDIWHEEL
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 Email : customercare.ddrc@srl.in
PATIENT NAME : MR. MATHEW GEORGE**PATIENT ID :** MATHM1103704126**ACCESSION NO :** 4126WC003812 **AGE :** 53 Years **SEX :** Male**ABHA NO :****DRAWN :** **RECEIVED :** 11/03/2023 11:17**REPORTED :** 11/03/2023 17:06**REFERRING DOCTOR :** DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED**CLIENT PATIENT ID :**

Test Report Status	Preliminary	Results	Units
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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.

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

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.

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.

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,(Sickle Cells,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. AACCC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is Practical Haematology by Dacie and Lewis, 10th edition.

SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST

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



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Patient Ref. No. 66600003704722

CLIENT CODE : CA00010147 - MEDIWHEEL
 CLIENT'S NAME AND ADDRESS: MEDIWHEEL HEALTHCARE LIMITED

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PATIENT NAME : MR. MATHEW GEORGE

PATIENT ID : MATHM1103704126

ACCESSION NO : 4126WC003812 AGE : 53 Years SEX : Male

ABHA NO :

DRAWN : RECEIVED : 11/03/2023 11:17

REPORTED : 11/03/2023 17:06

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT PATIENT ID :

Test Report Status **Preliminary**

Results

Units

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



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Patient Ref. No. 66600003704722

CLIENT CODE : CA00010147 - MEDIWHEEL
 CLIENT'S NAME AND ADDRESS: MEDIWHEEL HEALTHCARE LIMITED

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PATIENT NAME : MR. MATHEW GEORGE

PATIENT ID : MATHM1103704126

ACCESSION NO : 4126WC003812 AGE : 53 Years SEX : Male

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RECEIVED : 11/03/2023 11:17

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CLIENT PATIENT ID :

Test Report Status	Results	Units
Preliminary		

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT**ECG WITH REPORT****REPORT**

TEST COMPLETED

USG ABDOMEN AND PELVIS**REPORT**

TEST COMPLETED

CHEST X-RAY WITH REPORT**REPORT**

TEST COMPLETED

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

DR.HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
 Immunology

DR.VIJAY K N, MBBS MD(PATH)
 (Reg No - KMC:91816)
 HEAD-HAEMATOLOGY &
 CLINICAL PATHOLOGY

DR.SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY &
 CYTOLOGY



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Date..11.03.2022

OPHTHALMOLOGY REPORT

This is to certify that I have examined

Mr / Ms : Matthew George.....Aged 53.....and his / her

visual standards is as follows :

Visual Acuity:

For far vision

R: 6/6.....

L: 6/6.....

For near vision

R: N10.....

*2 PUPIL NB
L NB*

L: N10.....

Color Vision : Normal.....

.....



Nannu Elizabeth

Nannu Elizabeth

(Optometrist)

This is to certify that I have examined

MR / MS MATHEW GEORGEaged 53 and

his / her oral findings are as follows

D - Decay

M - Missing ✓

F - Filling ✓

M		7											7	7	M
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
M		7											7	M	

Oral hygiene status : Good / Fair / Poor ✓

Calculus / Stains : ✓

Any other findings : _____

Date : 10/3/23


Dr. K C Jose



NAME: MR MATHEW GEORGE	STUDY DATE 11/03/2023
AGE / SEX :53 YRS / M	REPORTING DATE :11/03/2023
REFERRED BY : MEDIWHEEL	ACC NO : 4126WC003812

X - RAY - CHEST PA VIEW

- Both the lung fields are clear.
- B/L hila and mediastinal shadows are normal.
- Cardiac silhouette appears normal.
- Cardio - thoracic ratio is normal.
- Bilateral CP angles and domes of diaphragm appear normal.

IMPRESSION: NORMAL STUDY**Kindly correlate clinically****Dr. NAVNEET KAUR, MBBS,MD
Consultant Radiologist.**

ID: 3812
MATHEW GEORGE
Male 53Years

11-03-2023 01:04:42 PM
HR : 58 bpm
P : 90 ms
PR : 140 ms
QRS : 88 ms
QT/QTc : 403/398 ms
P:QRST : 12/15/22 °
RV5/SV1 : 1.355/0.619 mV

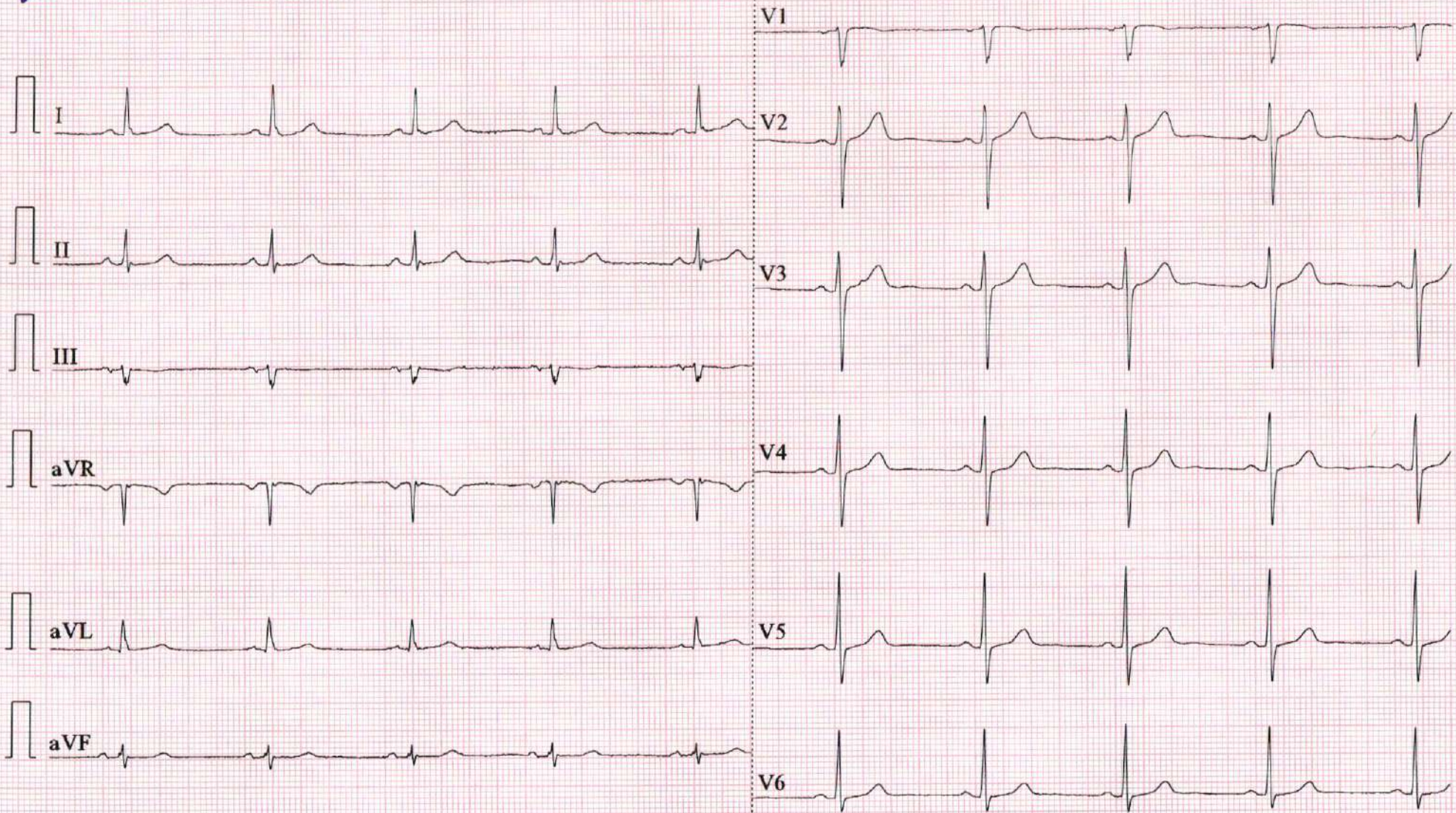
Diagnosis Information:

Within normal limits
Dr. George Thomas MD,FCSI,FIAE
Cardiologist



Mathew George

Technician : ALEENA
Ref-Phys. : MEDIWHEEL
Report Confirmed by:



NAME	MR MATHEW GEORGE	AGE	53 YRS
SEX	MALE	DATE	March 11, 2023
REFERRAL	MEDIWHEEL ARCOFEMI	ACC NO	4126WC003812

USG ABDOMEN AND PELVIS

LIVER	Measures ~ 13.1 cm. Mildly bright echotexture. Smooth margins and no obvious focal lesion within. No IHBR dilatation. Portal vein normal in caliber.
GB	Partially contracted with echogenic wall foci showing comet tail artifacts.
SPLEEN	Measures ~ 8 cm, normal to visualized extent. Splenic vein normal.
PANCREAS	Normal to visualized extent. PD is not dilated.
KIDNEYS	RK: 10.5 x 4.2 cm, appears normal in size and echotexture LK: 9.4 x 5.2 cm, appears normal in size and echotexture. No focal lesion / calculus within. Maintained corticomedullary differentiation and normal parenchymal thickness. No hydroureteronephrosis.
BLADDER	Normal wall caliber, no internal echoes/calculus within.
PROSTATE	Normal in volume and echopattern.
NODES/FLUID	Nil to visualized extent.
BOWEL	Visualized bowel loops appear normal.
IMPRESSION	<ul style="list-style-type: none"> ✦ <i>Grade I fatty liver.</i> ✦ <i>GB cholesterosis.</i>

Kindly correlate clinically.

Navneet
Dr. NAVNEET KAUR MBBS . MD
 Consultant Radiologist

Thank you for referral. Your feedback will be appreciated.

NOTE: This report is only a professional opinion based on the real time image finding and not a diagnosis by itself. It has to be correlated and interpreted with clinical and other investigation findings. Review scan is advised, if this ultrasound opinion and other clinical findings / reports don't correlate.



