

Anmol Kumar
31 yrs/ male

24/02/2024

No fresh complaints
No comorbidities

SH - Lap cholecystectomy
in 2020.

FM - Mother - } healthy
 Father - }

HT - 183 cm

WT - 89 kg

BMI - 26.6 kg/m²

(overweight)

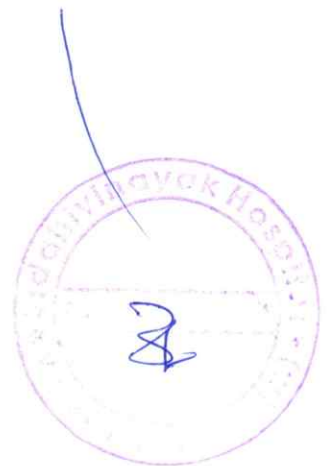
BP - 130/80 mmHg

P - 77/min

SpO₂ - 98%

PT is fit and can resume
his normal duties.

Consult with physician for blood changes



HELPLINE

022 - 2588 3531

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606

www.siddhivinayakhospitals.org





| | |
|------------------------------------|-------------------|
| Name - Mr. Amol Kumar | Age - 31 Y/M |
| Ref by Dr.- Siddhivinayak Hospital | Date - 24/02/2024 |

USG ABDOMEN & PELVIS

FINDINGS: -

The **liver** dimension is normal in size. It appears normal in morphology with **raised echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally. Wall thickness is normal.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size (9.2 cm) and morphology.

Both **kidneys** demonstrate normal morphology.

Both kidneys show normal cortical echogenicity.

The right kidney measures 9.7 x 5.2 cm.

The left kidney measures 9.8 x 4.7 cm.

Urinary bladder: -normally distended. Wall thickness - normal.

Prostate is normal in size and morphology Size:23.0 gms.

No **free fluid** is seen.

IMPRESSION:-

- Fatty liver (Grade I)

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST





| | |
|------------------------------------|-------------------|
| Name - Mr. Amol Kumar | Age - 31 Y/M |
| Ref by Dr.- Siddhivinayak hospital | Date - 24/02/2024 |

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





ECHOCARDIOGRAM

| | |
|---------------------|------------------------|
| NAME | MR. AMOL KUMAR |
| AGE/SEX | 31 YRS/M |
| REFERRED BY | SIDDHIVINAYAK HOSPITAL |
| DATE OF EXAMINATION | 24 /02/2024 |

2D/M-MODE ECHOCARDIOGRAPHY

| | |
|--|--|
| VALVES: MITRAL VALVE: <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent AORTIC VALVE: Normal <ul style="list-style-type: none"> • No. of cusps: 3 PULMONARY VALVE: Normal TRICUSPID VALVE: Normal | CHAMBERS: LEFT ATRIUM: Normal <ul style="list-style-type: none"> • Left atrial appendage: Normal LEFT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal RIGHT ATRIUM: Normal RIGHT VENTRICLE: Normal <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal |
| GREAT VESSELS: <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal | SEPTAE: <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact |
| CORONARIES: Proximal coronaries normal CORONARY SINUS: Normal PULMONARY VEINS: Normal | VENACAVAE: <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration PERICARDIUM: Normal |

MEASUREMENTS:

| AORTA | | LEFT VENTRICLE STUDY | | RIGHT VENTRICLE STUDY | |
|-----------------------|----------------|----------------------|----------------|-----------------------|----------------|
| PARAMETER | OBSERVED VALUE | PARAMETER | OBSERVED VALUE | PARAMETER | OBSERVED VALUE |
| Aortic annulus | 21 mm | Left atrium | 36 mm | Right atrium | mm |
| Aortic sinus | mm | LVIDD | 46.7 mm | RVd (Base) | mm |
| Sino-tubular junction | mm | LVIDS | 29.0 mm | RVEF | % |
| Ascending aorta | mm | IVSd | 8.4 mm | TAPSE | mm |
| Arch of aorta | mm | LYPWd | 8.4 mm | MPA | mm |
| Desc. thoracic aorta | mm | LVEF | 68 % | RVOT | mm |
| Abdominal aorta | mm | LVOT | mm | IVC | 15.0 mm |

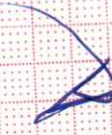


ID: 959

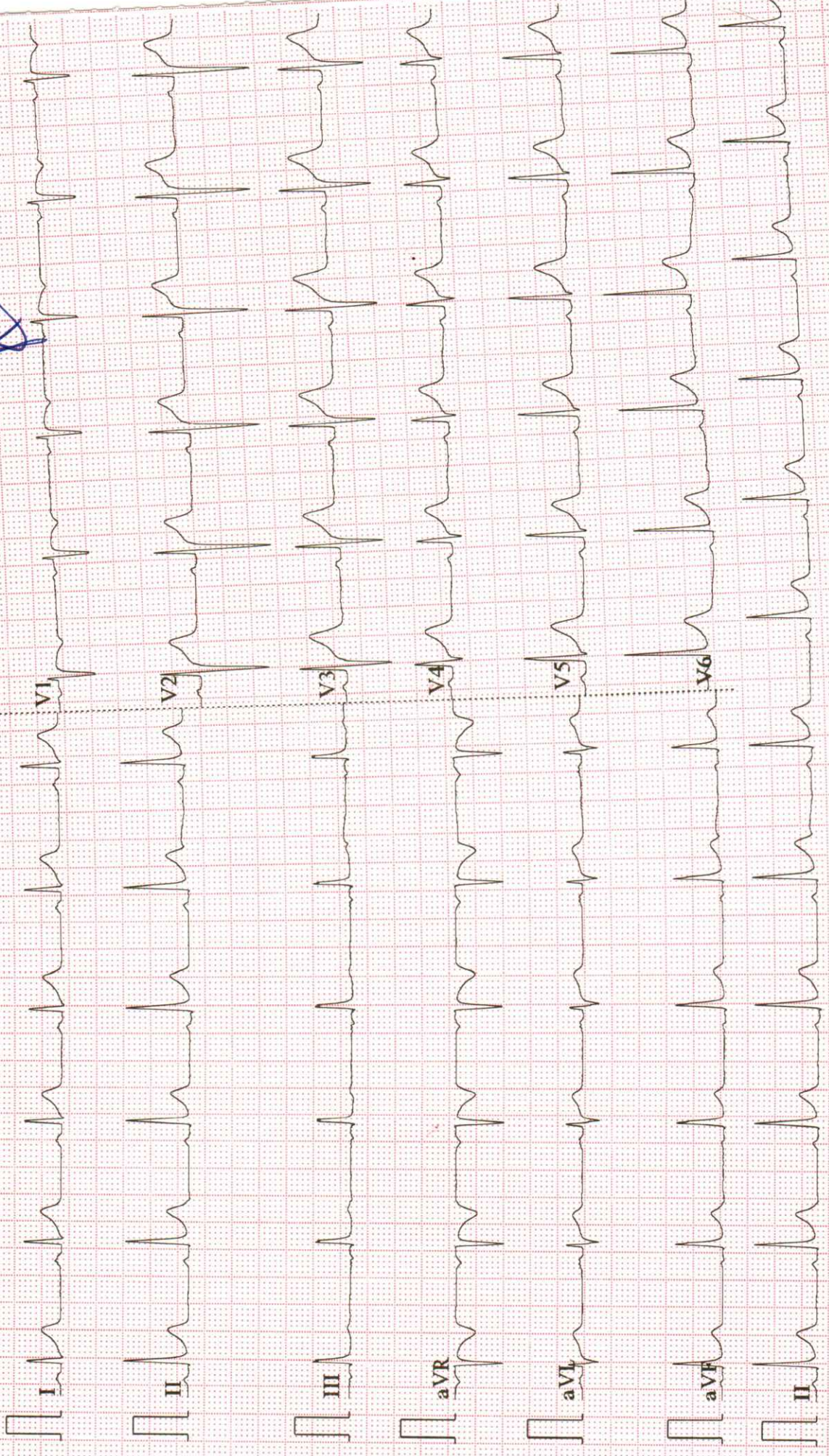
24-02-2024 09:25:20 AM

Arno Kumar
 Female
 Years 81
 Req. No. : BP-130180
 PR - 77h
 SpO2 - 98%

Diagnosis Information:
 Sinus Rhythm
 Slight ST Elevation (V2, V3)

WNL


Report Confirmed by:



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

AMOL KUMAR

AGE

31

DATE -

24.02.2024

Spects : Without Glasses

| | RT Eye | Lt Eye |
|------------------|--------|--------|
| NEAR | N/6 | N/6 |
| DISTANT | 6/6 | 6/6 |
| Color Blind Test | NORMAL | |

SIDDHIVINAYAK HOSPITALS



Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|--|--------------|-------|--|
| TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE) | 225.0 | mg/dL | Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl. |
| S.HDL CHOLESTEROL (DIRECT MEASURE - PEG) | 36.5 | mg/dL | Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease: >=80 mg/dl. |
| S. TRIGLYCERIDE (ENZYMATIC, END POINT) | 112.5 | mg/dL | Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl. |
| VLDL CHOLESTEROL (CALCULATED VALUE) | 23 | mg/dL | UPTO 40 |
| S.LDL CHOLESTEROL (CALCULATED VALUE) | 166 | mg/dL | Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl. |
| LDL CHOL/HDL RATIO (CALCULATED VALUE) | 4.55 | | UPTO 3.5 |
| CHOL/HDL CHOL RATIO (CALCULATED VALUE) | 6.16 | | <5.0 |

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



COMPLETE BLOOD COUNT

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|----------------------------------|-------------------------|----------------------|-----------------|
| HEMOGLOBIN | 13.1 | gm/dl | 13 - 18 |
| HEMATOCRIT (PCV) | 42 | % | 42 - 52 |
| RBC COUNT | 5.04 | x10 ⁶ /uL | 4.70 - 6.50 |
| MCV | 83 | fl | 80 - 96 |
| MCH | 26.0 | pg | 27 - 33 |
| MCHC | 31 | g/dl | 33 - 36 |
| RDW-CV | 15.1 | % | 11.5 - 14.5 |
| TOTAL LEUCOCYTE COUNT | 7280 | /cumm | 4000 - 11000 |
| <u>DIFFERENTIAL COUNT</u> | | | |
| NEUTROPHILS | 59 | % | 40 - 80 |
| LYMPHOCYTES | 33 | % | 20 - 40 |
| EOSINOPHILS | 03 | % | 0 - 6 |
| MONOCYTES | 05 | % | 2 - 10 |
| BASOPHILS | 00 | % | 0 - 1 |
| PLATELET COUNT | 165000 | /cumm | 150000 - 450000 |
| MPV | 16.6 | fl | 6.5 - 11.5 |
| PDW | 15.9 | % | 9.0 - 17.0 |
| PCT | 0.280 | % | 0.200 - 0.500 |
| RBC MORPHOLOGY | Normocytic Normochromic | | |
| WBC MORPHOLOGY | Normal | | |
| PLATELETS ON SMEAR | Adequate | | |

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|--|-------------|-------|-----------------|
| <u>URINE ROUTINE EXAMINATION</u> | | | |
| <u>PHYSICAL EXAMINATION</u> | | | |
| VOLUME | 25ml | | |
| COLOUR | Pale Yellow | | Pale Yellow |
| APPEARANCE | Clear | | Clear |
| <u>CHEMICAL EXAMINATION</u> | | | |
| REACTION (methyl red and Bromothymol blue indicator) | Acidic | | Acidic |
| SP. GRAVITY (Bromothymol blue indicator) | 1.005 | | 1.005 - 1.022 |
| PROTEIN (Protein error of PH indicator) | Absent | | Absent |
| BLOOD (Peroxidase Method) | Absent | | Absent |
| SUGAR (GOD/POD) | Absent | | Absent |
| KETONES (Acetoacetic acid) | Absent | | Absent |
| BILE SALT & PIGMENT (Diazonium Salt) | Absent | | Absent |
| UROBILINOGEN (Red azodye) | Normal | | Normal |
| LEUKOCYTES (pyrrole amino acid ester diazonium salt) | Absent | | Absent |
| NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol) | Absent | | Negative |
| <u>MICROSCOPIC EXAMINATION</u> | | | |
| RED BLOOD CELLS | Absent | / HPF | Absent |
| PUS CELLS | 1-2 | / HPF | 0 - 5 |
| EPITHELIAL | 0-2 | / HPF | 0 - 5 |
| CASTS | Absent | | |

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|--------------------|---------|------|-----------------|
| CRYSTALS | Absent | | |
| BACTERIA | Absent | | Absent |
| YEAST CELLS | Absent | | Absent |
| ANY OTHER FINDINGS | Absent | | |

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



| | | | |
|----------------|-------------------------------------|----------------------|---------------------|
| Name | : Mr. AMOL KUMAR (A) | Collected On | : 24/2/2024 9:18 am |
| Lab ID. | : 184727 | Received On | : 24/2/2024 9:28 am |
| Age/Sex | : 31 Years / Male | Reported On | : 24/2/2024 5:26 pm |
| Ref By | : SIDDHIVINAYAK HOSPITAL CGHS /ESIS | Report Status | : FINAL |



IMMUNO ASSAY

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|--|----------------|----------------------------------|-----------------|
| <u>TFT (THYROID FUNCTION TEST)</u> | | | |
| SPACE | | Space | - |
| SPECIMEN | Serum | | |
| T3 | 126.5 | ng/dl | 84.63 - 201.8 |
| T4 | 8.42 | µg/dl | 5.13 - 14.06 |
| TSH | 2.56 | µIU/ml | 0.270 - 4.20 |
| T3 (Triiodo Thyronine hormone) | T4 (Thyroxine) | TSH(Thyroid stimulating hormone) | |
| AGE | RANGE | AGE | RANGES |
| 1-30 days | 100-740 | 1-14 Days | 11.8-22.6 |
| 1-11 months | 105-245 | 1-2 weeks | 9.9-16.6 |
| 1-5 yrs | 105-269 | 1-4 months | 7.2-14.4 |
| 6-10 yrs | 94-241 | 4 -12 months | 7.8-16.5 |
| 11-15 yrs | 82-213 | 1-5 yrs | 7.3-15.0 |
| 0.1-2.5 | | | |
| 15-20 yrs | 80-210 | 5-10 yrs | 6.4-13.3 |
| 0.20-3.0 | | | |
| | | 11-15 yrs | 5.6-11.7 |
| 0.30-3.0 | | | |

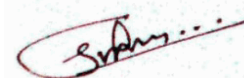
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
 Priyanka_Deshmukh



DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



HAEMATOLOGY

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|---|--------------------------|------|-----------------|
| <u>BLOOD GROUP</u> | | | |
| SPECIMEN | WHOLE BLOOD EDTA & SERUM | | |
| * ABO GROUP | 'AB' | | |
| RH FACTOR | POSITIVE | | |
| Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping) | | | |
| Result relates to sample tested, Kindly correlate with clinical findings. | | | |
| ----- END OF REPORT ----- | | | |

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***RENAL FUNCTION TEST**

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|---|---------|-------|-----------------|
| BLOOD UREA (Urease UV GLDH Kinetic) | 23.5 | mg/dL | 19 - 45 |
| BLOOD UREA NITROGEN (Calculated) | 10.98 | mg/dL | 5 - 20 |
| S. CREATININE (Enzymatic) | 0.89 | mg/dL | 0.6 - 1.4 |
| S. URIC ACID (Uricase) | 7.2 | mg/dL | 3.5 - 7.2 |
| S. SODIUM (ISE Direct Method) | 140.0 | mEq/L | 137 - 145 |
| S. POTASSIUM (ISE Direct Method) | 4.10 | mEq/L | 3.5 - 5.1 |
| S. CHLORIDE (ISE Direct Method) | 100.0 | mEq/L | 98 - 110 |
| S. PHOSPHORUS (Ammonium Molybdate) | 3.76 | mg/dL | 2.5 - 4.5 |
| S. CALCIUM (Arsenazo III) | 10.1 | mg/dL | 8.6 - 10.2 |
| PROTEIN (Biuret) | 6.96 | g/dl | 6.4 - 8.3 |
| S. ALBUMIN (BGC) | 4.05 | g/dl | 3.2 - 4.6 |
| S.GLOBULIN (Calculated) | 2.91 | g/dl | 1.9 - 3.5 |
| A/G RATIO calculated | 1.39 | | 0 - 2 |

NOTE BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200) ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 4 7 2 7 *

Peripheral smear examination

| TEST NAME | RESULTS |
|-------------------|--|
| SPECIMEN RECEIVED | WHOLE BLOOD EDTA |
| RBC | Normocytic, Normochromic |
| WBC | Total leukocytes count is normal on smear. |
| | NEUTROPHILS :59% |
| | LYMPHOCYTES :33% |
| | EOSINOPHILS :03% |
| | MONOCYTES :05% |
| | BASOPHILS :00% |
| PLATELET | Adequate on smear |
| HEMOPARASITE | No parasites seen. |

Result relates to sample tested, Kindly correlate with clinical findings.
----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



LIVER FUNCTION TEST

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|--|---------|-------|-----------------|
| TOTAL BILLIRUBIN (Method-Diazo) | 0.36 | mg/dL | 0.1 - 1.2 |
| DIRECT BILLIRUBIN (Method-Diazo) | 0.18 | mg/dL | 0.0 - 0.4 |
| INDIRECT BILLIRUBIN Calculated | 0.18 | mg/dL | 0 - 0.8 |
| SGOT(AST) (UV without PSP) | 21.5 | U/L | 0 - 37 |
| SGPT(ALT) UV Kinetic Without PLP (P-L-P) | 28.9 | U/L | UP to 40 |
| ALKALINE PHOSPHATASE (Method-ALP-AMP) | 62.0 | U/L | 53 - 128 |
| S. PROTIEN (Method-Biuret) | 6.96 | g/dl | 6.4 - 8.3 |
| S. ALBUMIN (Method-BCG) | 4.05 | g/dl | 3.5 - 5.2 |
| S. GLOBULIN Calculated | 2.91 | g/dl | 1.90 - 3.50 |
| A/G RATIO Calculated | 1.39 | | 0 - 2 |

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 4 7 2 7 *

HAEMATOLOGY

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|------------|---------|---------|-----------------|
| ESR | | | |
| ESR | 12 | mm/1hr. | 0 - 20 |

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



BIOCHEMISTRY

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|-----------|---------|------|-----------------|
|-----------|---------|------|-----------------|

BLOOD GLUCOSE FASTING & PP

| | | | |
|-----------------------|-------|-------|----------|
| BLOOD GLUCOSE FASTING | 95.7 | mg/dL | 70 - 110 |
| BLOOD GLUCOSE PP | 110.6 | mg/dL | 70 - 140 |

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

| | | | |
|----------|------|-----|----------|
| GAMMA GT | 32.0 | U/L | 13 - 109 |
|----------|------|-----|----------|

GLYCOCELATED HEMOGLOBIN (HBA1C)

| | | | |
|-----------------------------------|-------|-------|---|
| HBA1C (GLYCOSALATED HAEMOGLOBIN) | 5.9 | % | Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level |
| AVERAGE BLOOD GLUCOSE (A. B. G.) | 122.6 | mg/dL | NON - DIABETIC : ≤ 5.6 PRE - DIABETIC : 5.7 - 6.4 DIABETIC : > 6.5 |

METHOD Particle Enhanced Immunoturbidimetry

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mr. AMOL KUMAR (A) Collected On : 24/2/2024 9:18 am
Lab ID. : 184727 Received On : 24/2/2024 9:28 am
Age/Sex : 31 Years / Male Reported On : 24/2/2024 5:26 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 4 7 2 7 *

BIOCHEMISTRY

| TEST NAME | RESULTS | UNIT | REFERENCE RANGE |
|-----------|---------|------|-----------------|
|-----------|---------|------|-----------------|

HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

