DIAGNOSTIC REPORT

Patient Ref. No. 775000001916785

SRL Diagnostics

**CLIENT CODE :** C000138362

**CLIENT'S NAME AND ADDRESS :**
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Ground floor 365/6, Aaj Ka Aanand building, Shivaji Nagar
PUNE, 411005
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : 020 30251212
CIN - U74899PB1995PLC045956
Email : customercare.pune@srl.in

**PATIENT NAME : SHITESH KUMAR** PATIENT ID : **SHITM01038030**

ACCESSION NO : **0030VK005236** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 24/11/2022 09:07:50 REPORTED : 25/11/2022 16:05:06

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|---|---|---|---|---|
| **MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE** | | | | |
| **BLOOD COUNTS,EDTA WHOLE BLOOD** | | | | |
| HEMOGLOBIN (HB) | 14.9 | | 13.0 - 17.0 | g/dL |
| RED BLOOD CELL (RBC) COUNT | 5.09 | | 4.5 - 5.5 | mil/µL |
| WHITE BLOOD CELL (WBC) COUNT | 7.30 | | 4.0 - 10.0 | thou/µL |
| PLATELET COUNT | 150 | | 150 - 410 | thou/µL |
| **RBC AND PLATELET INDICES** | | | | |
| HEMATOCRIT (PCV) | 45.8 | | 40 - 50 | % |
| MEAN CORPUSCULAR VOLUME (MCV) | 90.0 | | 83 - 101 | fL |
| MEAN CORPUSCULAR HEMOGLOBIN (MCH) | 29.3 | | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) | 32.6 | | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH (RDW) | 12.6 | | 11.6 - 14.0 | % |
| MENTZER INDEX | 17.7 | | | |
| MEAN PLATELET VOLUME (MPV) | **13.4** | **High** | 6.8 - 10.9 | fL |
| **WBC DIFFERENTIAL COUNT** | | | | |
| NEUTROPHILS | 63 | | 40 - 80 | % |
| LYMPHOCYTES | 26 | | 20 - 40 | % |
| MONOCYTES | 4 | | 2 - 10 | % |
| EOSINOPHILS | **7** | **High** | 1 - 6 | % |
| BASOPHILS | 0 | | 0 - 2 | % |
| ABSOLUTE NEUTROPHIL COUNT | 4.60 | | 2.0 - 7.0 | thou/µL |
| ABSOLUTE LYMPHOCYTE COUNT | 1.90 | | 1.0 - 3.0 | thou/µL |
| ABSOLUTE MONOCYTE COUNT | 0.29 | | 0.2 - 1.0 | thou/µL |
| ABSOLUTE EOSINOPHIL COUNT | **0.51** | **High** | 0.02 - 0.50 | thou/µL |
| ABSOLUTE BASOPHIL COUNT | **0.00** | **Low** | 0.02 - 0.10 | thou/µL |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 2.5 | | | |
| **MORPHOLOGY** | | | | |
| REMARKS | RBCS: PREDOMINANTLY NORMOCYTIC NORMOCHROMIC.<br><br>WBCS: MILD EOSINOPHILIA.<br><br>PLATELETS: ADEQUATE ON PERIPHERAL SMEAR, MACROPLATELETS (+) NOTED. | | | |

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| **ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD** | | | | |
| E.S.R | 10 | | 0 - 14 | mm at 1 hr |
| METHOD : WESTERGREN METHOD | | | | |
| **GLUCOSE FASTING,FLUORIDE PLASMA** | | | | |
| FBS (FASTING BLOOD SUGAR) | **274** | **High** | 74 - 99 | mg/dL |
| METHOD : HEXOKINASE | | | | |
| **GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD** | | | | |
| HBA1C | **10.6** | **High** | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>ADA Target: 7.0<br>Action suggested: > 8.0 | % |
| METHOD : HPLC | | | | |
| ESTIMATED AVERAGE GLUCOSE(EAG) | **257.5** | **High** | < 116.0 | mg/dL |
| **GLUCOSE, POST-PRANDIAL, PLASMA** | | | | |
| PPBS(POST PRANDIAL BLOOD SUGAR) | **363** | **High** | Normal: < 140,<br>Impaired Glucose Tolerance:140-199<br>Diabetic > or = 200 | mg/dL |
| METHOD : HEXOKINASE | | | | |
| **LIPID PROFILE, SERUM** | | | | |
| CHOLESTEROL, TOTAL | 124 | | Desirable: <200<br>BorderlineHigh : 200-239<br>High : > or = 240 | mg/dL |
| TRIGLYCERIDES | **235** | **High** | Desirable: < 150<br>Borderline High: 150 - 199<br>High: 200 - 499<br>Very High : > or = 500 | mg/dL |
| METHOD : ENZYMATIC WITH GLYCEROL BLANK | | | | |
| HDL CHOLESTEROL | **29** | **Low** | < 40 Low<br>> or = 60 High | mg/dL |
| METHOD : DIRECT MEASURE - PEG | | | | |
| CHOLESTEROL LDL | 48 | | Adult levels:<br>Optimal < 100<br>Near optimal/above optimal: 100-129<br>Borderline high : 130-159<br>High : 160-189<br>Very high : = 190 | mg/dL |

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| NON HDL CHOLESTEROL | 95 | | Desirable: Less than 130<br>Above Desirable: 130 - 159<br>Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | mg/dL |
| CHOL/HDL RATIO | 4.3 | | | |
| LDL/HDL RATIO | 1.7 | | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |
| VERY LOW DENSITY LIPOPROTEIN | 47.0 | | | mg/dL |
| **LIVER FUNCTION PROFILE, SERUM** | | | | |
| BILIRUBIN, TOTAL | 0.75 | | 0.0 - 1.2 | mg/dL |
| METHOD : DIAZONIUM ION, BLANKED (ROCHE) | | | | |
| BILIRUBIN, DIRECT | **0.28** | **High** | 0.0 - 0.2 | mg/dL |
| METHOD : DIAZOTIZATION | | | | |
| BILIRUBIN, INDIRECT | 0.47 | | 0.00 - 1.00 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | | |
| TOTAL PROTEIN | 7.0 | | 6.4 - 8.3 | g/dL |
| METHOD : BIURET, REAGENT BLANK, END POINT | | | | |
| ALBUMIN | 5.1 | | 3.50 - 5.20 | g/dL |
| METHOD : BROMOCRESOL GREEN (BCG) | | | | |
| GLOBULIN | **1.9** | **Low** | 2.0 - 4.1 | g/dL |
| METHOD : CALCULATED PARAMETER | | | | |
| ALBUMIN/GLOBULIN RATIO | **2.7** | **High** | 1.0 - 2.0 | RATIO |
| METHOD : CALCULATED PARAMETER | | | | |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT) | 18 | | UPTO 40 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 28 | | UP TO 45 | U/L |
| ALKALINE PHOSPHATASE | **136** | **High** | 40 - 129 | U/L |
| METHOD : PNPP - AMP BUFFER | | | | |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 20 | | 8 - 61 | U/L |
| METHOD : GAMMA GLUTAMYL-3-CARBOXY-4-NITROANALIDE (IFCC) | | | | |
| LACTATE DEHYDROGENASE | 172 | | 135 - 225 | U/L |
| METHOD : LACTATE -PYRUVATE | | | | |
| **BLOOD UREA NITROGEN (BUN), SERUM** | | | | |
| BLOOD UREA NITROGEN | 6 | | 6 - 20 | mg/dL |
| METHOD : UREASE COLORIMETRIC | | | | |
| **CREATININE, SERUM** | | | | |

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| CREATININE | 0.76 | | 0.70 - 1.20 | mg/dL |
| METHOD : JAFFE'S ALKALINE PICRATE -IFCC IDMS STANDARDIZED | | | | |
| **BUN/CREAT RATIO** | | | | |
| BUN/CREAT RATIO | 7.89 | | 5.0 - 15.0 | |
| **URIC ACID, SERUM** | | | | |
| URIC ACID | 6.6 | | 3.5 - 7.2 | mg/dL |
| METHOD : URICASE, COLORIMETRIC | | | | |
| **TOTAL PROTEIN, SERUM** | | | | |
| TOTAL PROTEIN | 7.0 | | 6.4 - 8.3 | g/dL |
| METHOD : BIURET, REAGENT BLANK, END POINT | | | | |
| **ALBUMIN, SERUM** | | | | |
| ALBUMIN | 5.1 | | 3.5 - 5.2 | g/dL |
| METHOD : BROMOCRESOL GREEN (BCG) | | | | |
| **GLOBULIN** | | | | |
| GLOBULIN | **1.9** | **Low** | 2.0 - 4.1 | g/dL |
| METHOD : CALCULATED PARAMETER | | | | |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | | |
| SODIUM, SERUM | **135** | **Low** | 137 - 145 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| POTASSIUM, SERUM | **5.20** | **High** | 3.6 - 5.0 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| CHLORIDE, SERUM | 98 | | 98 - 107 | mmol/L |
| METHOD : ISE INDIRECT | | | | |
| **Interpretation(s)** | | | | |
| **PHYSICAL EXAMINATION, URINE** | | | | |
| COLOR | PALE YELLOW | | | |
| APPEARANCE | CLEAR | | | |
| METHOD : DIPSTICK, MICROSCOPY | | | | |
| **CHEMICAL EXAMINATION, URINE** | | | | |
| PH | 6.0 | | 4.7 - 7.5 | |
| METHOD : DIPSTICK | | | | |
| SPECIFIC GRAVITY | 1.015 | | 1.003 - 1.035 | |
| METHOD : DIPSTICK | | | | |

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| PROTEIN | NOT DETECTED | NOT DETECTED | |
| METHOD : DIPSTICK | | | |
| GLUCOSE | **DETECTED (++)** | NOT DETECTED | |
| METHOD : DIPSTICK | | | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| METHOD : DIPSTICK | | | |
| BLOOD | NOT DETECTED | NOT DETECTED | |
| METHOD : DIPSTICK | | | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| METHOD : DIPSTICK (DIAZOTISED DICHLOROANILINE) | | | |
| UROBILINOGEN | NORMAL | NORMAL | |
| METHOD : DIPSTICK | | | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| METHOD : DIPSTICK | | | |
| **MICROSCOPIC EXAMINATION, URINE** | | | |
| RED BLOOD CELLS | NOT DETECTED | NOT DETECTED | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| PUS CELL (WBC'S) | 1-2 | 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 | | | |
| REMARKS | URINE ANALYSIS : MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT. | | |

**Interpretation(s)**

**THYROID PANEL, SERUM**

| | | | |
|---|---|---|---|
| T3 | 97.88 | 58 - 159 | ng/dL |
| METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA) | | | |
| T4 | 9.29 | 4.87 - 11.71 | µg/dL |

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| METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA) | | | |
| TSH (ULTRASENSITIVE) | 2.870 | 0.350 - 4.940 | µIU/mL |

METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA)

**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.
owidctlparowidctlparBelow 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.Guidlines of the American Thyroid association duriing 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.

**STOOL: OVA & PARASITE**

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| COLOUR<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | BROWN | | |
| CONSISTENCY<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | SEMI FORMED | | |
| ODOUR<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | FAECAL | | |
| MUCUS<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| VISIBLE BLOOD<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | ABSENT | ABSENT | |
| POLYMORPHONUCLEAR LEUKOCYTES<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | 0 - 1 | 0 - 5 | /HPF |
| RED BLOOD CELLS<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | /HPF |
| MACROPHAGES<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| CHARCOT-LEYDEN CRYSTALS<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| TROPHOZOITES<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| CYSTS<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| OVA<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | | |
| LARVAE<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | NOT DETECTED | |
| ADULT PARASITE<br>METHOD : CONCENTRATION + BIOCHEMICAL + MICROSCOPY | NOT DETECTED | | |
| OCCULT BLOOD<br>METHOD : MODIFIED GUAIAC METHOD | NOT DETECTED | NOT DETECTED | |

**Interpretation(s)**

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

| | | | |
|---|---|---|---|
| ABO GROUP<br>METHOD : TUBE AGGLUTINATION | TYPE B | | |

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| RH TYPE | POSITIVE | | |
| METHOD : TUBE AGGLUTINATION | | | |
| **XRAY-CHEST** | | | |
| IMPRESSION | NO ABNORMALITY DETECTED | | |
| **TMT OR ECHO** | | | |
| TMT OR ECHO | TMT TEST DONE AND IT IS - NEGATIVE | | |
| **ECG** | | | |
| ECG | TALL T WAVES REST NORMAL. | | |
| **MEDICAL HISTORY** | | | |
| RELEVANT PRESENT HISTORY | DIABETIC AND HYPERTENSION. | | |
| RELEVANT PAST HISTORY | ANGIOPLASTY IN 2008 | | |
| RELEVANT PERSONAL HISTORY | NOT SIGNIFICANT | | |
| RELEVANT FAMILY HISTORY | HIGH BLOOD PRESSURE AND DIABETES. | | |
| OCCUPATIONAL HISTORY | NOT SIGNIFICANT | | |
| HISTORY OF MEDICATIONS | TAB. TELMA 40, TAB. ECOSPRIN 75, TAB. METPURE. | | |
| **ANTHROPOMETRIC DATA & BMI** | | | |
| HEIGHT IN METERS | 1.64 | | mts |
| WEIGHT IN KGS. | 66 | | Kgs |
| BMI | 25 | BMI & Weight Status as follows:<br>Below 18.5: Underweight<br>18.5 - 24.9: Normal<br>25.0 - 29.9: Overweight<br>30.0 and Above: Obese | kg/sqmts |
| **GENERAL EXAMINATION** | | | |
| MENTAL / EMOTIONAL STATE | NORMAL | | |
| PHYSICAL ATTITUDE | NORMAL | | |
| GENERAL APPEARANCE / NUTRITIONAL STATUS | HEALTHY | | |
| BUILT / SKELETAL FRAMEWORK | AVERAGE | | |
| FACIAL APPEARANCE | NORMAL | | |
| SKIN | NORMAL | | |
| UPPER LIMB | NORMAL | | |
| LOWER LIMB | NORMAL | | |
| NECK | NORMAL | | |
| NECK LYMPHATICS / SALIVARY GLANDS | NOT ENLARGED OR TENDER | | |

DIAGNOSTIC REPORT

Patient Ref. No. 775000001916785

SRL Diagnostics

**CLIENT CODE :** C000138362

**CLIENT'S NAME AND ADDRESS :**
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Ground floor 365/6, Aaj Ka Aanand building, Shivaji Nagar
PUNE, 411005
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : 020 30251212
CIN - U74899PB1995PLC045956
Email : customercare.pune@srl.in

**PATIENT NAME : SHITESH KUMAR** PATIENT ID : **SHITM01038030**

ACCESSION NO : **0030VK005236** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 24/11/2022 09:07:50 REPORTED : 25/11/2022 16:05:06

**REFERRING DOCTOR :** SELF CLIENT PATIENT ID :

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| THYROID GLAND | NOT ENLARGED | | |
| CAROTID PULSATION | NORMAL | | |
| TEMPERATURE | NORMAL | | |
| PULSE | 60/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT | | |
| RESPIRATORY RATE | NORMAL | | |
| **CARDIOVASCULAR SYSTEM** | | | |
| BP | 110/90 MM HG (SITTING) | | mm/Hg |
| PERICARDIUM | NORMAL | | |
| APEX BEAT | NORMAL | | |
| HEART SOUNDS | NORMAL | | |
| MURMURS | ABSENT | | |
| **RESPIRATORY SYSTEM** | | | |
| SIZE AND SHAPE OF CHEST | NORMAL | | |
| MOVEMENTS OF CHEST | SYMMETRICAL | | |
| BREATH SOUNDS INTENSITY | NORMAL | | |
| BREATH SOUNDS QUALITY | VESICULAR (NORMAL) | | |
| ADDED SOUNDS | ABSENT | | |
| **PER ABDOMEN** | | | |
| APPEARANCE | NORMAL | | |
| VENOUS PROMINENCE | ABSENT | | |
| LIVER | NOT PALPABLE | | |
| SPLEEN | NOT PALPABLE | | |
| HERNIA | ABSENT | | |
| **CENTRAL NERVOUS SYSTEM** | | | |
| HIGHER FUNCTIONS | NORMAL | | |
| CRANIAL NERVES | NORMAL | | |
| CEREBELLAR FUNCTIONS | NORMAL | | |
| SENSORY SYSTEM | NORMAL | | |
| MOTOR SYSTEM | NORMAL | | |
| REFLEXES | NORMAL | | |
| **MUSCULOSKELETAL SYSTEM** | | | |

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|---|---|---|---|
| SPINE | NORMAL | | |
| JOINTS | NORMAL | | |
| **BASIC EYE EXAMINATION** | | | |
| CONJUNCTIVA | PALLOR | | |
| EYELIDS | NORMAL | | |
| EYE MOVEMENTS | NORMAL | | |
| CORNEA | NORMAL | | |
| DISTANT VISION RIGHT EYE WITHOUT GLASSES | NO VISION. | | |
| DISTANT VISION LEFT EYE WITHOUT GLASSES | DISTANT VISION - 6/9 | | |
| NEAR VISION RIGHT EYE WITHOUT GLASSES | NO VISION. | | |
| NEAR VISION LEFT EYE WITHOUT GLASSES | NEAR VISION - N 6 (NORMAL) | | |
| COLOUR VISION | NORMAL | | |
| **BASIC ENT EXAMINATION** | | | |
| EXTERNAL EAR CANAL | NORMAL | | |
| TYMPANIC MEMBRANE | NORMAL | | |
| NOSE | NO ABNORMALITY DETECTED | | |
| SINUSES | NORMAL | | |
| THROAT | NO ABNORMALITY DETECTED | | |
| TONSILS | NOT ENLARGED | | |
| **SUMMARY** | | | |
| RELEVANT HISTORY | NOT SIGNIFICANT | | |
| RELEVANT GP EXAMINATION FINDINGS | NOT SIGNIFICANT | | |
| RELEVANT LAB INVESTIGATIONS | EOSINOPHILIC COUNT RAISED (7 %)<br>FASTING BLOOD SUGAR LEVEL RAISED - 274 mg/dL<br>POST PRANDIAL BLOOD SUGAR LEVEL RAISED - 363 mg/dL<br>HBA1C - GLYCOSYLATED HEMOGLOBIN RAISED - 10.6 %<br>MEAN PLASMA GLUCOSE RAISED - 257.5 mg/dL<br>GLUCOSE DETECTED (2+) IN URINE<br>TRIGLYCERIDE RAISED (235 mg/dL)<br>HDL CHOLESTEROL LOW (29 mg/dL)<br>DIRECT BILLIRUBIN RAISED - 0.28 mg/dL | | |
| RELEVANT NON PATHOLOGY DIAGNOSTICS | NO ABNORMALITIES DETECTED | | |

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REMARKS / RECOMMENDATIONS

ADV. ? ALLERGY, ADV. STOOL ROUTINE, DEWORMING,
REDUCE INTAKE OF SWEETS, SUGAR AND STARCH IN DIET.
DIABETIC DIET, REGULLAR EXRCISE.
DO FASTING AND POST PRANDIAL BLOOD SUGAR LEVEL AFTER 1 MONTH
REDUCE PROCESSED FOOD IN DIET, TAKE STATINS DO CARDIOLOGIST CONSULTATION.
INCREASE UNSATURATED FATS IN DIET
REPEAT BILIRUBIN AFTER 15 DAYS.
FOLLOW UP WITH FAMILY PHYSICIAN / SRL DR. / DIABETOLOGIST.

ADV. FOLLOW UP WITH EYE SPECIALIST.

**FITNESS STATUS**

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

**Comments**

**********
OUR DOCTORS ON PANEL FOR NON-PATHOLOGICAL REPORTS:

1. DR. JIGNESH PARIKH: DNB (CARDIOLOGY), N.B.E (CONSULTANT CARDIOLOGIST)
2. DR.SANJAY JOSHI, D M R D, DNB - RADIOLOGIST
3. DR. SUCHARITA PARANJPE, MBBS, FCPS (OPHTHALMOLOGY)
4. DR. (MRS.) MANJUSHA PRABHUNE - GYNAECOLOGIST.
5. DR. (MRS.) NIMKAR - GYNAECOLOGIST.

This report bears the signature of the in-charge of the facility.
Panel doctors are responsible for the results/reports of their individual specialty.
**********

DIAGNOSTIC REPORT

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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

LIVER - Shows early changes of fatty liver.

LEFT KIDNEY - 2 or 3 midcalyceal echoreflective foci of 3 to 5 mm are seen in dicalycix and 3 mm lower calyceal echoreflective foci is seen could be calculi.

Clinical correlation.

**Interpretation(s)**
BLOOD COUNTS,EDTA WHOLE BLOOD-
The cell morphology is well preservec 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 recommendec for an accurate differential count anc 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, Vasculities, 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: Polycythermia 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.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
**Increased in**
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
**Decreased in**

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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:**
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
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 Glyosuria, 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-controllec type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

**HbA1c Estimation can get affected due to :**
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 recommendec 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 addiction 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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommendec for detecting a hemoglobinopathy
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
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 unconjugatec (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 founc 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 syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.

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CREATININE, SERUM-Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
URIC ACID, SERUM-
**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
**Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.
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.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

**********
FITNESS STATUS-
Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depenc on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipic levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

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

**DIAGNOSTIC REPORT**

Patient Ref. No. 775000001916785

SRL Diagnostics

**CLIENT CODE :** C000138362

**CLIENT'S NAME AND ADDRESS :**
ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
Ground floor 365/6, Aaj Ka Aanand building, Shivaji Nagar
PUNE, 411005
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : 020 30251212
CIN - U74899PB1995PLC045956
Email : customercare.pune@srl.in

**PATIENT NAME : SHITESH KUMAR** PATIENT ID : **SHITM01038030**

ACCESSION NO : **0030VK005236** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 24/11/2022 09:07:50 REPORTED : 25/11/2022 16:05:06

**REFERRING DOCTOR :** SELF CLIENT PATIENT ID :

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

**Dr.Swati Pravin Mulani**
**Lab Head**

**Dr.Snehal Vilas Dhayagude**
**Consultant Microbiologist**

## CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

**SRL Limited**
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062