

## BMI CHART

Date: 18/2/23

Name: Mrs. Tejashee Gosavi Age: 30 yrs Sex: M/F

BP: 110/70 Height (cms): 153 cm Weight(kgs): 54 kg BMI: 23

*mm of Hg*

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7	
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese					Extremely Obese				
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40	
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39	
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38	
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37	
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35	
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34	
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33	
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32	
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31	
5'10" - 177.8	14	15	15	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30	30	
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30	
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29	
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	
6'3" - 190.5	12	13	13	14	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26	26	
6'4" - 193.0	12	12	13	14	14	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26	26	

**Doctors Notes:**

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Signature

Hiranandani Healthcare Pvt. Ltd.  
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703  
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CIN : U85100MH2005PTC154823  
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani  
HOSPITAL  
(A Fortis Network Hospital)

<b>UHID</b>	<b>5651013</b>	<b>Date</b>	<b>18/02/2023</b>		
<b>Name</b>	<b>Mrs. Tejashri Ravindra Gosavi</b>	<b>Sex</b>	<b>Female</b>	<b>Age</b>	<b>30</b>
<b>OPD</b>	<b>PAP</b>				

Drug allergy:  
Sys illness:



UHID	5651013	Date	18/02/2023		
Name	Mrs. Tejashri Ravindra Gosavi	Sex	Female	Age	30
OPD	Ophthal 14				

chr. wateris, Pulm...

Drug allergy: → Not know  
 Sys illness: →

Na. No.

U... → R 6/6.  
 → G 6/6.

P... → R Phew 6/6.  
 → G Phew 6/6.

NV → R No.  
 → G No.

Lo t. → R 14.2.  
 → G 11.5

All well

Agulube (1) (1) (1).  
 ↓  
 G... =

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UHID	5651013	Date	18/02/2023		
Name	Mrs. Tejashri Ravindra Gosavi	Sex	Female	Age	30
OPD	Dental 12				

Drug allergy:  
Sys illness:

No significant findings

Adv Routine Oral prophylaxis.

Dr Diksha Kekar.



PATIENT NAME : TEJASHRI RAVINDRA GOSAVI

REF. DOCTOR : SELF

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

ACCESSION NO : 0022WB003424  
 PATIENT ID : FH.5651013  
 CLIENT PATIENT ID: UID:5651013  
 ABHA NO :

AGE/SEX : 30 Years Female  
 DRAWN : 18/02/2023 08:31:00  
 RECEIVED : 18/02/2023 08:31:42  
 REPORTED : 18/02/2023 12:34:28

## CLINICAL INFORMATION :

UID:5651013 REQNO-1373656  
 CORP-OPD  
 BILLNO-150123OPCR009974  
 BILLNO-150123OPCR009974

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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## HAEMATOLOGY - CBC

## CBC-5, EDTA WHOLE BLOOD

## BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	12.1	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.81 High	3.8 - 4.8	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	6.87	4.0 - 10.0	thou/ $\mu$ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	340	150 - 410	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE			

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	37.0	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	77.0 Low	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	25.1 Low	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.6	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	14.3 High	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	16.0		
MEAN PLATELET VOLUME (MPV)	7.7	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	47	40 - 80	%
METHOD : FLOWCYTOMETRY			
LYMPHOCYTES	40	20 - 40	%
METHOD : FLOWCYTOMETRY			



Dr. Akta Dubey  
 Counsultant Pathologist



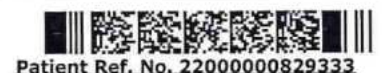
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MONOCYTES		6	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		7 High	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		3.23	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.75	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.41	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.48	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.1		
METHOD : CALCULATED PARAMETER				
<b>MORPHOLOGY</b>				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD MICROCYTOSIS		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

**Interpretation(s)**

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.



**Dr. Akta Dubey**  
 Counsultant Pathologist



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WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.  
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504  
 This ratio element is a calculated parameter and out of NABL scope.



Dr. Akta Dubey  
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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

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

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-TEST DESCRIPTION :-  
 Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm/hr(95 if anemic). ESR returns to normal 4th week post partum.  
 Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia  
 False Decreased : Poikilocytosis,(SickleCells.spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

*Dubey*  
 Dr. Akta Dubey  
 Consultant Pathologist



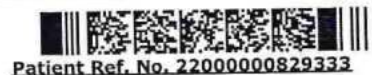
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**IMMUNOHAEMATOLOGY**

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

**ABO GROUP**  
 METHOD : TUBE AGGLUTINATION

**RH TYPE**  
 METHOD : TUBE AGGLUTINATION

TYPE A  
 POSITIVE

**Interpretation(s)**

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

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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MC-2275

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## BIOCHEMISTRY

## LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.33	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.10	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.23	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.0	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.5	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.5	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.0	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH PSP	14 Low	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH PSP	19	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	55	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	20	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	140	100 - 190	U/L
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	92	74 - 99	mg/dL

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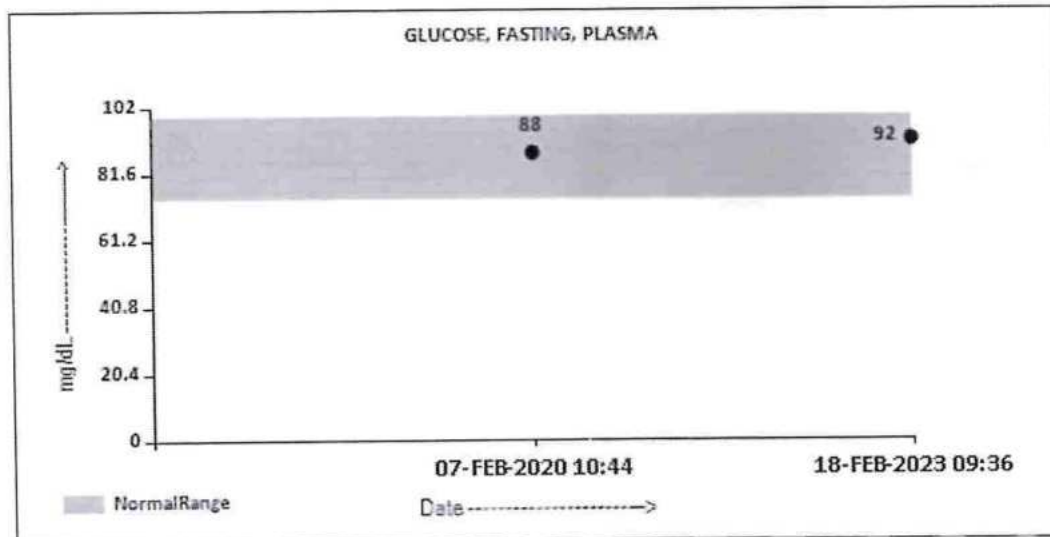
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	105.4	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			



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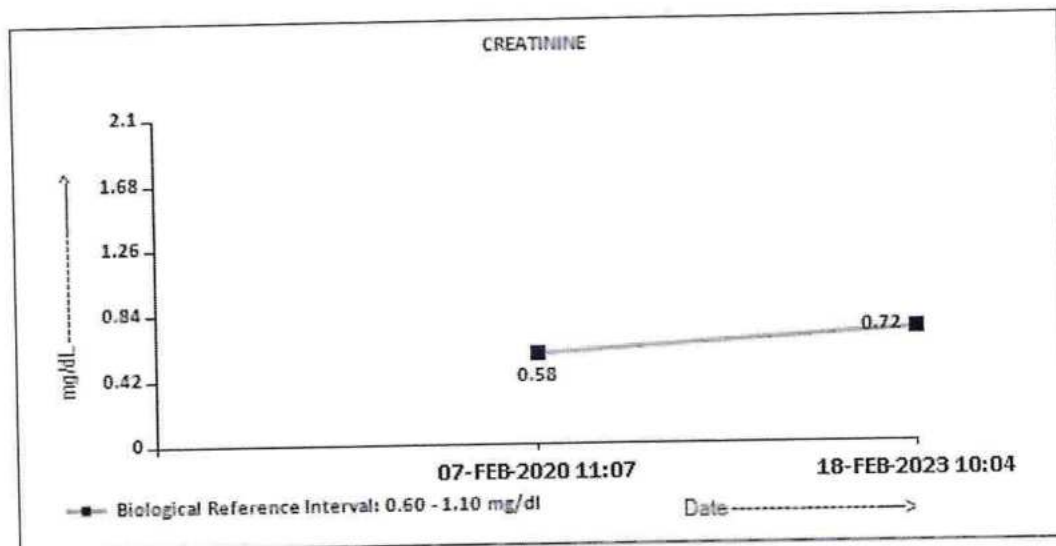
ACCESSION NO : 0022WB003424  
 PATIENT ID : FH.5651013  
 CLIENT PATIENT ID: UID:5651013  
 ABHA NO :

AGE/SEX : 30 Years Female  
 DRAWN : 18/02/2023 08:31:00  
 RECEIVED : 18/02/2023 08:31:42  
 REPORTED : 18/02/2023 12:34:28

CLINICAL INFORMATION :

UID:5651013 REQNO-1373656  
 CORP-OPD  
 BILLNO-150123OPCR009974  
 BILLNO-150123OPCR009974

Test Report Status	Results	Biological Reference Interval	Units
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BUN/CREAT RATIO

BUN/CREAT RATIO 13.89 5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 3.1 2.6 - 6.0 mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM


TOTAL PROTEIN 7.0 6.4 - 8.2 g/dL

METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 3.5 3.4 - 5.0 g/dL

METHOD : BCP DYE BINDING



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 Consultant Pathologist



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



Patient Ref. No. 22000000829333

PATIENT NAME : TEJASHRI RAVINDRA GOSAVI

REF. DOCTOR : SELF

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

GLOBULIN	3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	141	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.39	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	105	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels are seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic

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Consultant Pathologist



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Patient Ref. No. 2200000829333



<b>PATIENT NAME : TEJASHRI RAVINDRA GOSAVI</b>		<b>REF. DOCTOR : SELF</b>	
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syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

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

**Increased in**

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

**Decreased in**

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol; 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

**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, STADH.

**CREATININE EGFR- EPI-GFR-** Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test.

Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

**URIC ACID, SERUM-** Causes of Increased levels:- Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome

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Page 12 Of 19

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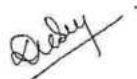
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**Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis  
TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease  
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.  
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.



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Counsultant Pathologist



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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	168	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	37	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	58	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	104	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	110	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	7.4	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	2.9 Low	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	1.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			



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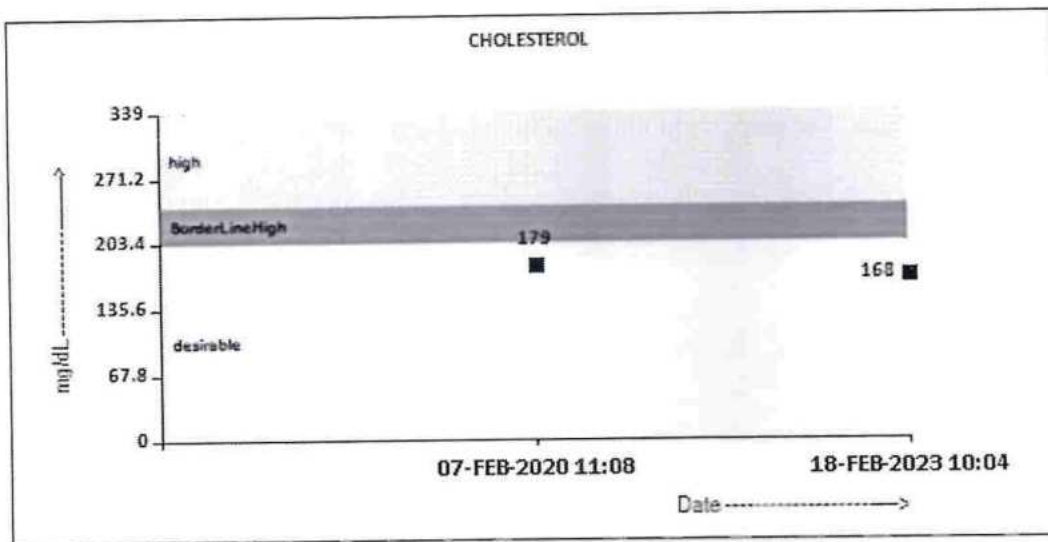
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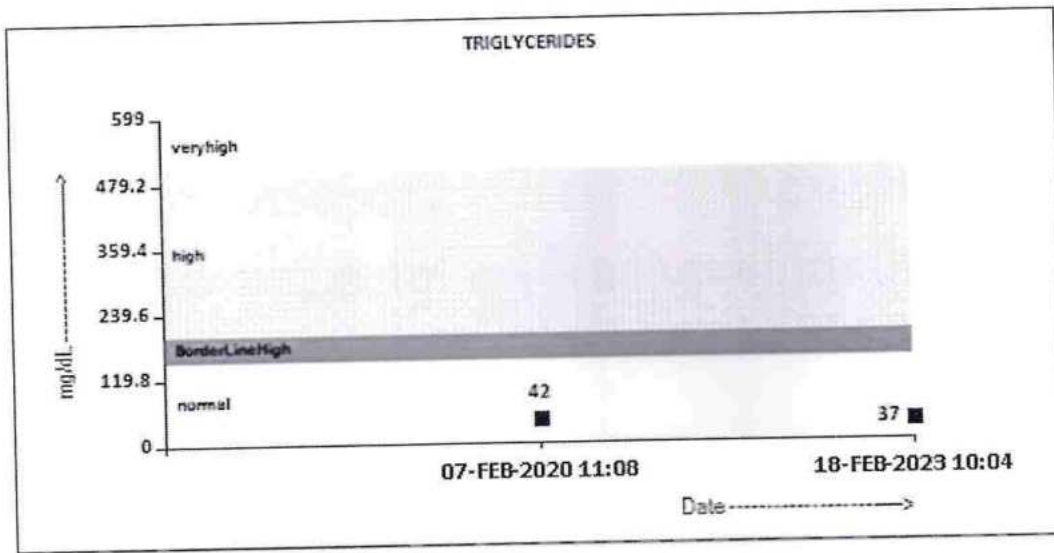
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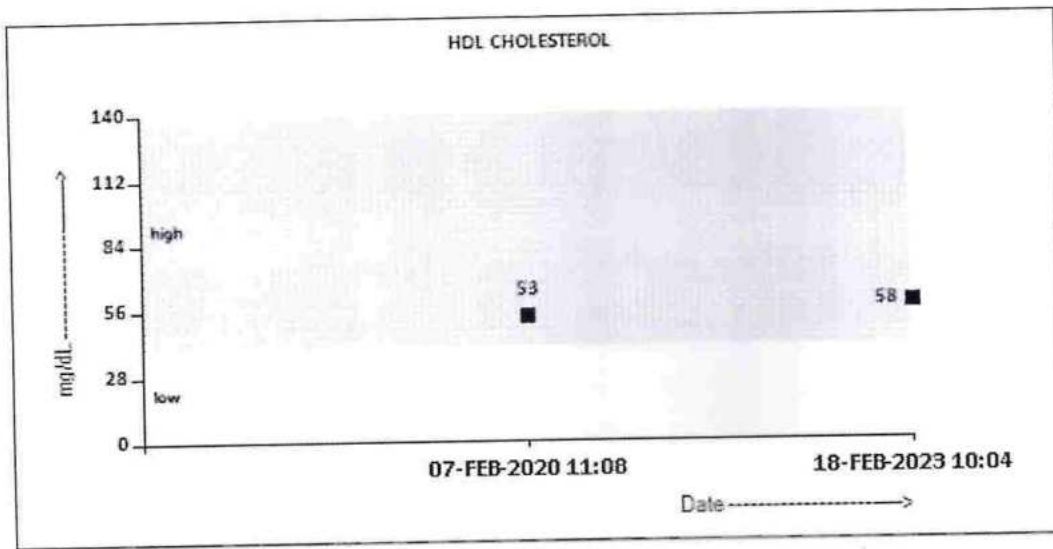
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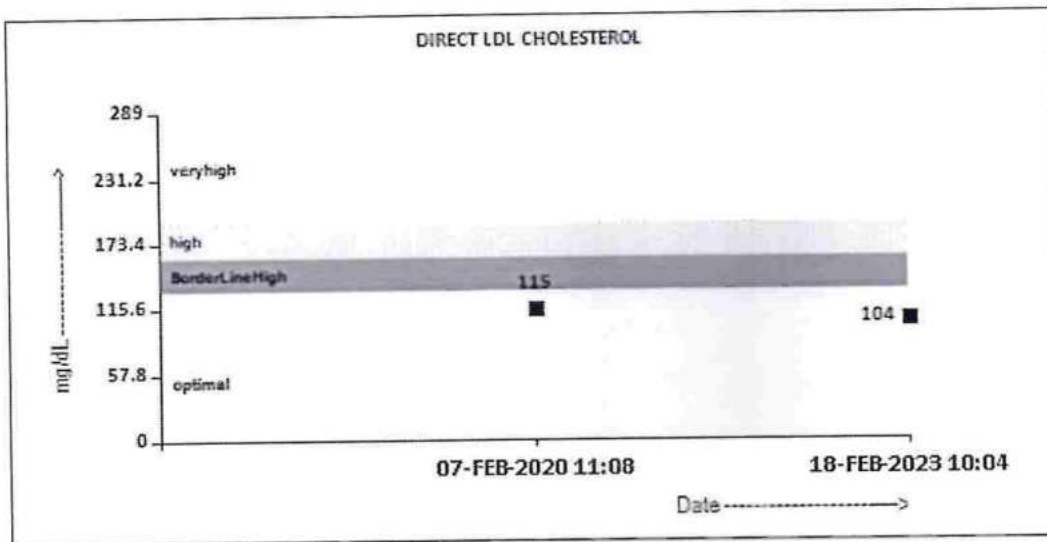
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CLINICAL PATH - URINALYSIS

<b>KIDNEY PANEL - 1</b>	RESULT PENDING
PHYSICAL EXAMINATION, URINE	RESULT PENDING
CHEMICAL EXAMINATION, URINE	RESULT PENDING
MICROSCOPIC EXAMINATION, URINE	RESULT PENDING

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PATIENT NAME : TEJASHRI RAVINDRA GOSAVI

REF. DOCTOR : SELF

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

ACCESSION NO : 0022WB003424  
PATIENT ID : FH.5651013  
CLIENT PATIENT ID: UID:5651013  
ABHA NO :

AGE/SEX : 30 Years Female  
DRAWN : 18/02/2023 08:31:00  
RECEIVED : 18/02/2023 08:31:42  
REPORTED : 18/02/2023 14:15:33

CLINICAL INFORMATION :

UID:5651013 REQNO-1373656  
CORP-OPD  
BILLNO-150123OPCR009974  
BILLNO-150123OPCR009974

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

THYROID PANEL, SERUM

T3	105.90	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
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METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

T4	7.19	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
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METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

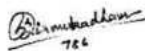
TSH (ULTRASENSITIVE)	1.060	0.270 - 4.200	µIU/mL
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METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

Interpretation(s)

\*\*End Of Report\*\*

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession



Dr. Swapnil Sirmukaddam  
Consultant Pathologist



View Details



View Report

PERFORMED AT :

SRL Ltd  
BHoomi Tower, 1st Floor, Hall No.1, Plot No.28 Sector 4, Kharghar  
Navi Mumbai, 410210  
Maharashtra, India  
Tel : 9111591115,  
CIN - U74999PB1995PLC045956



Patient Ref. No. 2200000829333



PATIENT NAME : MRS.TEJASHRI RAVINDRA GOSAVI

REF. DOCTOR :

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

ACCESSION NO : 0022WB003473  
 PATIENT ID : FH.5651013  
 CLIENT PATIENT ID: UID:5651013  
 ABHA NO :

AGE/SEX : 30 Years Female  
 DRAWN : 18/02/2023 10:50:00  
 RECEIVED : 18/02/2023 10:51:32  
 REPORTED : 18/02/2023 12:29:49

CLINICAL INFORMATION :

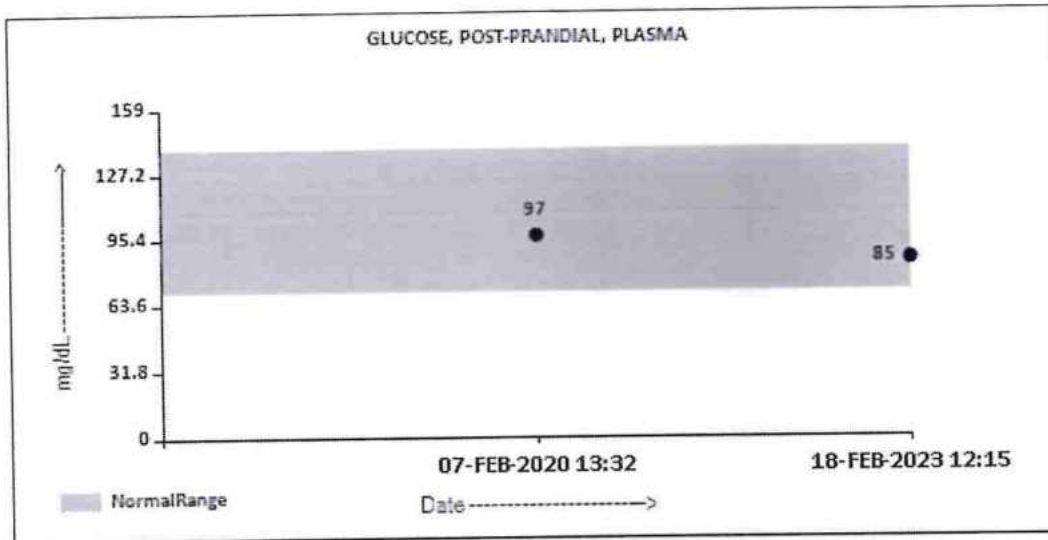
UID:5651013 REQNO-1373656  
 CORP-OPD  
 BILLNO-150123OPCR009974  
 BILLNO-150123OPCR009974

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 85 70 - 139 mg/dL  
 METHOD : HEXOKINASE



Comments

NOTE: - POST PRANDIAL PLASMA GLUCOSE VALUES. TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

*Dubey*

Dr.Akta Dubey  
 Counsultant Pathologist



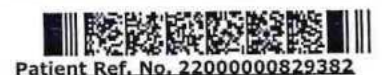
View Details



View Repo

PERFORMED AT :

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



Patient Ref. No. 2200000829382



5651013  
30 Years

TEJASHRI GOSAVI  
female

2/18/2023 9:18:35 AM  
FORTIS HIRANANDANIHOSPITAL, VASHI

HC

Rate 81 . Sinus rhythm.....normal P axis, V-rate 50- 99  
Borderline T abnormalities, diffuse leads.....T flat/neg

*Sinus rhythm*

*[Signature]*

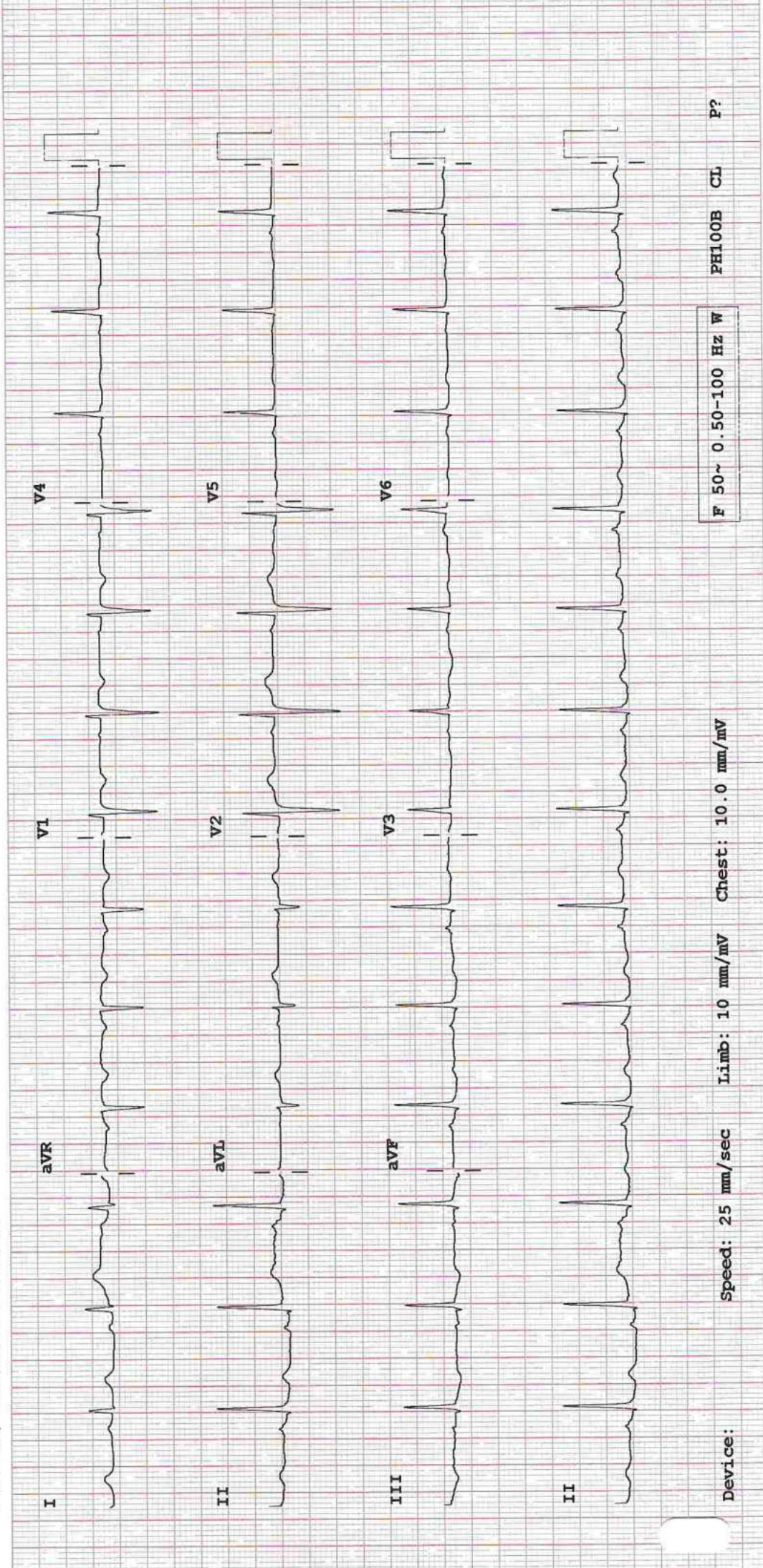
PR 156  
QRS 82  
QT 354  
QTc 411

--AXIS--  
P 39  
QRS 69  
T -5

-- BORDERLINE ECG --

Unconfirmed Diagnosis

12 Lead; Standard Placement



F 50~ 0.50-100 Hz W

Speed: 25 mm/sec    Limb: 10 mm/mV    Chest: 10.0 mm/mV

PH100B CL P?

Device:





(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 20/Feb/2023

Name: Mrs. Tejashri Ravindra Gosavi  
Age | Sex: 30 YEAR(S) | Female  
Order Station : FO-OPD  
Bed Name :

UHID | Episode No : 5651013 | 10173/23/1501  
Order No | Order Date: 1501/PN/OP/2302/20995 | 18-Feb-2023  
Admitted On | Reporting Date : 20-Feb-2023 11:59:57  
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

**FINDINGS:**

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

**M-MODE MEASUREMENTS:**

LA	31	mm
AO Root	21	mm
AO CUSP SEP	17	mm
LVID (s)	24	mm
LVID (d)	39	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	19	mm
RA	27	mm
LVEF	60	%



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 20/Feb/2023

Name: Mrs. Tejashri Ravindra Gosavi

UHID | Episode No : 5651013 | 10173/23/1501

Age | Sex: 30 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2302/20995 | 18-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 20-Feb-2023 11:59:57

Bed Name :

Order Doctor Name : Dr.SELF.

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.9 m/sec.


A WAVE VELOCITY:0.6 m/sec

E/A RATIO:1.3

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	08			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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





DEPARTMENT OF RADIOLOGY

Date: 18/Feb/2023

Name: Mrs. Tejashri Ravindra Gosavi

UHID | Episode No : 5651013 | 10173/23/1501

Age | Sex: 30 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2302/20995 | 18-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 18-Feb-2023 16:14:09

Bed Name :

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appear normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

*Aditya*

**DR. ADITYA NALAWADE**

**M.D. (Radiologist)**



DEPARTMENT OF RADIOLOGY

Date: 18/Feb/2023

Name: Mrs. Tejashri Ravindra Gosavi

UHID | Episode No : 5651013 | 10173/23/1501

Age | Sex: 30 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2302/20995 | 18-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 18-Feb-2023 09:21:50

Bed Name :

Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

**LIVER** is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

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

**CBD** appears normal in caliber.

**SPLEEN** is normal in size and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 9.6 x 4.0 cm.

Left kidney measures 9.5 x 4.3 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

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

**UTERUS** is normal in size, measuring 5.6 x 2.6 x 3.7 cm. Endometrium measures 2.5 mm in thickness.

Both ovaries are normal.


Right ovary measures 2.1 x 1.3 cm.

Left ovary measures 2.1 x 1.5 cm.

No evidence of ascites.

**IMPRESSION:**

- No significant abnormality is detected.

  
**DR. ADITYA NALAWADE**  
M.D. (Radiologist)