PATIENT NAME : RAVINDER YADAV **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138379
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI
NEW DELHI 110030
8800465156

ACCESSION NO : **0065WC001857**
PATIENT ID : RAVIM08088965
CLIENT PATIENT ID:
ABHA NO :

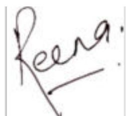
AGE/SEX : 33 Years Male
DRAWN :
RECEIVED : 17/03/2023 08:58:56
REPORTED : 18/03/2023 15:29:46

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

HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

Test	Results	Biological Reference Interval	Units
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : PHOTOMETRIC MEASUREMENT	15.3	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : COULTER PRINCIPLE	4.93	4.5 - 5.5	mil/μL
WHITE BLOOD CELL (WBC) COUNT METHOD : COULTER PRINCIPLE	5.90	4.0 - 10.0	thou/μL
PLATELET COUNT METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY	304	150 - 410	thou/μL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	45.1	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM	91.5	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	31.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	34.0	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM	13.7	11.6 - 14.0	%
MENTZER INDEX	18.6		
MEAN PLATELET VOLUME (MPV) METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM	8.2	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : VCSN TECHNOLOGY/ MICROSCOPY	55	40 - 80	%
LYMPHOCYTES METHOD : VCSN TECHNOLOGY/ MICROSCOPY	33	20 - 40	%
MONOCYTES METHOD : VCSN TECHNOLOGY/ MICROSCOPY	6	2.0 - 10.0	%
EOSINOPHILS METHOD : VCSN TECHNOLOGY/ MICROSCOPY	5	1.0 - 6.0	%



Dr. Reena Mittal, MD
Senior Consultant
Hematopathologist

Dr. Sushant Chikane
Consultant Pathologist

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CIN - U74899PB1995PLC045956

Patient Ref. No. 775000002630800

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SRL Diagnostics

PATIENT NAME : RAVINDER YADAV **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138379 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0065WC001857** PATIENT ID : RAVIM08088965 CLIENT PATIENT ID: ABHA NO :	AGE/SEX :33 Years Male DRAWN : RECEIVED :17/03/2023 08:58:56 REPORTED :18/03/2023 15:29:46

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BASOPHILS METHOD : VCSN TECHNOLOGY/ MICROSCOPY	1	0 - 1	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	3.24	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.00	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.35	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.30	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	0.06	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED	1.7		

Interpretation(s)

BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

	Results	Biological Reference Interval	Units
E.S.R	8	0 - 14	mm at 1 hr

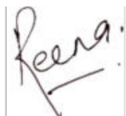
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)

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, 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.



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

IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

Test	Result
ABO GROUP METHOD : HAEMAGGLUTINATION (AUTOMATED)	B
RH TYPE METHOD : HAEMAGGLUTINATION (AUTOMATED)	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.

Dr. Sushant Chikane
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Test Report Status **Final**	Results	Biological Reference Interval	Units

BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

Test	Results	Biological Reference Interval	Units
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	83	Normal <100 Impaired fasting glucose:100 to 125 Diabetes mellitus: > = 126 (on more than 1 occassion) (ADA guidelines 2021)	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.3	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : ION- EXCHANGE HPLC			
ESTIMATED AVERAGE GLUCOSE(EAG)	105.4	< 116	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	91	Normal <140 Impaired glucose tolerance:140 to 199 Diabetes mellitus : > = 200 (on more than 1 occassion) ADA guideline 2021	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	190	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - CHOLETSEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	**284 High**	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC ENDPOINT WITH GLYCEROL BLANK			

S.S.Wadal

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Test Report Status **Final**	**Results**	**Biological Reference Interval**	**Units**
HDL CHOLESTEROL	**28 Low**	At Risk: < 40 Desirable: > or = 60	mg/dL
METHOD : SPECTROPHOTOMETRY, HOMOGENEOUS DIRECT ENZYMATIC COLORIMETRIC			
CHOLESTEROL LDL	**105 High**	Optimal : < 100 Near optimal/above optimal : 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
METHOD : CALCULATED PARAMETER			
NON HDL CHOLESTEROL	**162 High**	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	**57.0 High**	< or = 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**6.8 High**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	**4.2 High**	Desirable/Low Risk : 0.5 - 3.0 Borderline/Moderate Risk : 3.1 - 6.0 High Risk : > 6.0	
METHOD : CALCULATED PARAMETER			

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.60	Upto 1.2	mg/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -DIAZO METHOD			
BILIRUBIN, DIRECT	0.20	< or = 0.3	mg/dL
METHOD : SPECTROPHOTOMETRY, JENDRASSIK & GROFF - DIAZOTIZATION			
BILIRUBIN, INDIRECT	0.40	0.0 - 0.9	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.0	6.0 - 8.0	g/dL

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CODE/NAME & ADDRESS : C000138379	ACCESSION NO : **0065WC001857**	AGE/SEX : 33 Years Male
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8800465156		

Test Report Status **Final**	Results	Biological Reference Interval	Units
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK			
ALBUMIN	4.3	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN	2.7	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.6	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	16	Upto 40	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	25	Upto 41	U/L
METHOD : SPECTROPHOTOMETRY, WITHOUT PYRIDOXAL PHOSPHATE ACTIVATION(P5P) - IFCC			
ALKALINE PHOSPHATASE	**140 High**	40 - 129	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	21	< 60	U/L
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC - G-GLUTAMYL-CARBOXY-NITROANILIDE - IFCC			
LACTATE DEHYDROGENASE	148	< 232	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	6	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY, UREASE -COLORIMETRIC			
CREATININE, SERUM			
CREATININE	**0.78 Low**	0.90 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, JAFFE'S ALKALINE PICRATE KINETIC - RATE BLANKED - IFCC-IDMS STANDARIZED			
BUN/CREAT RATIO			
BUN/CREAT RATIO	**7.69 Low**	8 - 15	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	5.4	3.4 - 7.0	mg/dL
METHOD : SPECTROPHOTOMETRY, ENZYMATIC COLORIMETRIC- URICASE			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.0	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, COLORIMETRIC -BIURET, REAGENT BLANK, SERUM BLANK			
ALBUMIN, SERUM			
ALBUMIN	4.3	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			

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GLOBULIN			
GLOBULIN	2.7	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	136	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.20	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	101	98 - 106	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Sodium	Potassium	Chloride
Decreased in: CCF,cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy,adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide,carbamazepine,anti depressants (SSRI), antipsychotics.	**Decreased in:** Low potassium intake,prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome,osmotic diuresis (e.g., hyperglycemia),alkalosis, familial periodic paralysis,trauma (transient).Drugs: Adrenergic agents, diuretics.	**Decreased in:** Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenalinsufficiency, hyperaldosteronism,metabolic alkalosis. Drugs: chronic laxative,corticosteroids, diuretics.
Increased in: Dehydration (excessivesweating, severe vomiting or diarrhea),diabetes mellitus, diabetesinsipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice,oral contraceptives.	**Increased in:** Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration,renal failure, Addison' s disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium- sparing diuretics,NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	**Increased in:** Renal failure, nephrotic syndrome, RTA,dehydration, overtreatment with saline,hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO3-), respiratory alkalosis,hyperadrenocorticism. Drugs: acetazolamide,androgens, hydrochlorothiazide,salicylates.
Interferences: Severe lipemia or hyperproteinemi, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	**Interferences:** Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	**Interferences:** Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**

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Patient Ref. No. 775000002630800

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 :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 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-controlled 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 :
1. 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.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. 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.
4. 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 recommended 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 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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.
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,Waldenstroms 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 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

Dr. Sneha Wadalkar,M.D
(Reg.no.MMC2012/06/1868)
Junior Biochemist

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Patient Ref. No. 775000002630800

PATIENT NAME : RAVINDER YADAV **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138379
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI
NEW DELHI 110030
8800465156

ACCESSION NO : **0065WC001857**
PATIENT ID : RAVIM08088965
CLIENT PATIENT ID:
ABHA NO :

AGE/SEX : 33 Years Male
DRAWN :
RECEIVED : 17/03/2023 08:58:56
REPORTED : 18/03/2023 15:29:46

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

(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.
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, Muscuophy
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-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,Waldenstroms 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.

Dr. Sneha Wadalkar,M.D
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE			
COLOR	YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.5	5.00 - 7.50	
SPECIFIC GRAVITY	1.015	1.010 - 1.030	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NOT DETECTED		
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	2-3	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

METHOD : URINE ROUTINE & MICROSCOPY EXAMINATION BY INTEGRATED AUTOMATED SYSTEM

Interpretation(s)

Dr. Sneha Wadalkar,M.D
(Reg.no.MMC2012/06/1868)
Junior Biochemist

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CIN - U74899PB1995PLC045956

Patient Ref. No. 775000002630800

PATIENT NAME : RAVINDER YADAV **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138379	ACCESSION NO : **0065WC001857**	AGE/SEX : 33 Years Male
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)	PATIENT ID : RAVIM08088965	DRAWN :
F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI	CLIENT PATIENT ID:	RECEIVED : 17/03/2023 08:58:56
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8800465156		

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

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

MICROSCOPIC EXAMINATION,STOOL

REMARK	TEST CANCELLED AS SPECIMEN NOT RECEIVED		

Interpretation(s)

Dr. Ekta Patil
Microbiologist

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Patient Ref. No. 775000002630800

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PATIENT NAME : **RAVINDER YADAV**		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000138379 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0065WC001857** PATIENT ID : RAVIM08088965 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 33 Years Male DRAWN : RECEIVED : 17/03/2023 08:58:56 REPORTED : 18/03/2023 15:29:46

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

SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

THYROID PANEL, SERUM

Test	Results	Biological Reference Interval	Units
T3 METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY	123.0	80.0 - 200.0	ng/dL
T4 METHOD : COMPETITIVE ELECTROCHEMILUMINESCENCE IMMUNOASSAY	10.20	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : SANDWICH ELECTROCHEMILUMINESCENCE IMMUNOASSAY	1.370	0.270 - 4.200	µIU/mL

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

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Patient Ref. No. 775000002630800

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

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.

S.S.Wadal

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PATIENT NAME : RAVINDER YADAV		**REF. DOCTOR :** SELF
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Test Report Status **Final**	Results	Biological Reference Interval	Units

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

XRAY-CHEST

IMPRESSION	NO ABNORMALITY DETECTED		

Comments

.

TMT OR ECHO

TMT OR ECHO	2D ECHO DONE NORMAL		

ECG

ECG	WITHIN NORMAL LIMITS		

MEDICAL HISTORY

RELEVANT PRESENT HISTORY	CVS 2ND DOSE DONE		
RELEVANT PAST HISTORY	JAUNDICE - (2014) FRACTURE RIGHT ARM PTB - 2017 ATT FOR 6 MONTH		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	HIGH BLOOD PRESSURE HEART DISEASE DIABETES		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.73		mts
WEIGHT IN KGS.	78		Kgs
BMI	26	BMI & Weight Status as follows: Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 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		

Dr.Rajesh Nayak
Consultant Radiologist

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Patient Ref. No. 775000002630800

PATIENT NAME : RAVINDER YADAV **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138379 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0065WC001857** PATIENT ID : RAVIM08088965 CLIENT PATIENT ID: ABHA NO :	AGE/SEX : 33 Years Male DRAWN : RECEIVED : 17/03/2023 08:58:56 REPORTED : 18/03/2023 15:29:46

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SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	82/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	118/78MM HG (SUPINE)		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		

Dr.Rajesh Nayak
Consultant Radiologist

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Test Report Status **Final**	Results	Biological Reference Interval	Units
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
CORNEA	NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT(6/6)		
DISTANT VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT(6/6)		
NEAR VISION RIGHT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT		
NEAR VISION LEFT EYE WITHOUT GLASSES	WITHIN NORMAL LIMIT		
COLOUR VISION	OUT OF 17 NUMBERED PLATES 17		
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	CVS 2ND DOSE DONE		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	RAISED ALKALINE PHOSPHATASE (140) LOW CREATININE (0.78) RAISED TRIGLYCERIDES (284) LOW HDL CHOLESTEROL (28) RAISED NON HDL CHOLESTEROL (162) RAISED LDL CHOLESTEROL (105)		

Dr.Rajesh Nayak
Consultant Radiologist

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SRL Diagnostics

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Test Report Status **Final**	**Results**	**Biological Reference Interval**	**Units**
RELEVANT NON PATHOLOGY DIAGNOSTICS	SONO - MILD FATTY LIVER TINY RIGHT RENAL CALCULUS MINIMALLY COMPLEX LEFT RENAL CYST , BOSNIAK TYPE II ECG - RAISED QT		
REMARKS / RECOMMENDATIONS	REGULAR PHYSICAL EXERCISES LOW CALORIC DIET REDUCE FATTY AND PROCESSED FOOD IN DIET FOLLOW UP WITH PHYSICIAN FOR RAISED TRIGLYCERIDES		

Dr.Rajesh Nayak
Consultant Radiologist

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

MILD FATTY LIVER.TINY RIGHT RENAL CALCULUS.MINIMALLY COMPLEX LEFT RENAL CYST, BOSNIAK TYPE II.

Interpretation(s)

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.

****

****End Of Report****

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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.

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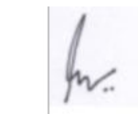

Dr.Rajesh Nayak
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