Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: ___/___/___

Name: Mrs. Nishtha. P. Age: ____ yrs Sex: M / F

BP: 120/80 mm Height (cms): 158 cm Weight(kgs): 60 kg BMI: _____

WEIGHT lbs	100	105	100	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	20	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	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	**2359554**	**Date**	**11/03/2023**		
Name	**Mrs.Nishtha Pandey**	**Sex**	**Female**	**Age**	**41**
OPD	**Pap Smear**	**Health Check Up**			

Drug allergy:
Sys illness:

F/B Dr. Shefali

41/F Nulliparous came for Pap Smear
No Comorbidities

LMP → 5/3/23
H/o Recurrent UTI

Adv

- Pap Smear to be done on Day 10 of menses
- Plenty of Oral hydration
- Counselled abt Vaginal hygiene.
- F/u for Pap Smear
- Kiegel's exercise

Dr

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UHID	**2359554**	**Date**	**11/03/2023**		
Name	**Mrs.Nishtha Pandey**	**Sex**	**Female**	**Age**	**41**
OPD	**Dental 12**	**Health Check Up**			

Drug allergy: N/A.
Sys illness:

O/E

- Root canal done Need to ~~done~~ place crown.

Treatment

Adv.

- crown. ~~17~~

Dr. Gupti

LABORATORY REPORT

MC-2275

PATIENT NAME : MRS.NISHTHA PANDEY		**REF. DOCTOR :** SELF
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002062** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 09:51:00 RECEIVED :11/03/2023 09:51:48 REPORTED :11/03/2023 15:02:55

CLINICAL INFORMATION :

UID:2359554 OLD UHID -FHL34.229445 REQNO-1384016
CORP-OPD
BILLNO-150123OPCR014325
BILLNO-150123OPCR014325

Test Report Status **Final**	Results	Biological Reference Interval	Units
HAEMATOLOGY - CBC			
CBC-5, EDTA WHOLE BLOOD			
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	**11.5 Low**	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	3.85	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	6.19	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	211	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	**33.4 Low**	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	86.8	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	30.0	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	34.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.6	11.6 - 14.0	%
MENTZER INDEX	22.6		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	9.9	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : FLOWCYTOMETRY	59	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	33	20 - 40	%

Dr.Akta Dubey
Counsultant Pathologist

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Patient Ref. No. 22000000833595

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MONOCYTES METHOD : FLOWCYTOMETRY	6	2 - 10	%
EOSINOPHILS METHOD : FLOWCYTOMETRY	2	1 - 6	%
BASOPHILS METHOD : FLOWCYTOMETRY	0	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	3.65	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.04	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.37	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.12	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0 Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	1.8		
MORPHOLOGY			
RBC METHOD : MICROSCOPIC EXAMINATION	MILD HYPOCHROMASIA, NORMOCYTIC NORMOCHROMIC		
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY		
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE		

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.

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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.

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HAEMATOLOGY			
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
E.S.R	15	0 - 20	mm at 1 hr
METHOD : WESTERGREN 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, 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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LABORATORY REPORT

MC-2275 Fortis SRL Diagnostics

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE A		
RH TYPE METHOD : TUBE AGGLUTINATION	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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FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : **0022WC002062**
PATIENT ID : FH.2359554
CLIENT PATIENT ID: UID:2359554
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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.37	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	0.27	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.0	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.6	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.4	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P	**14 Low**	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	17	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	50	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	19	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	119	100 - 190	U/L
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	87	74 - 99	mg/dL

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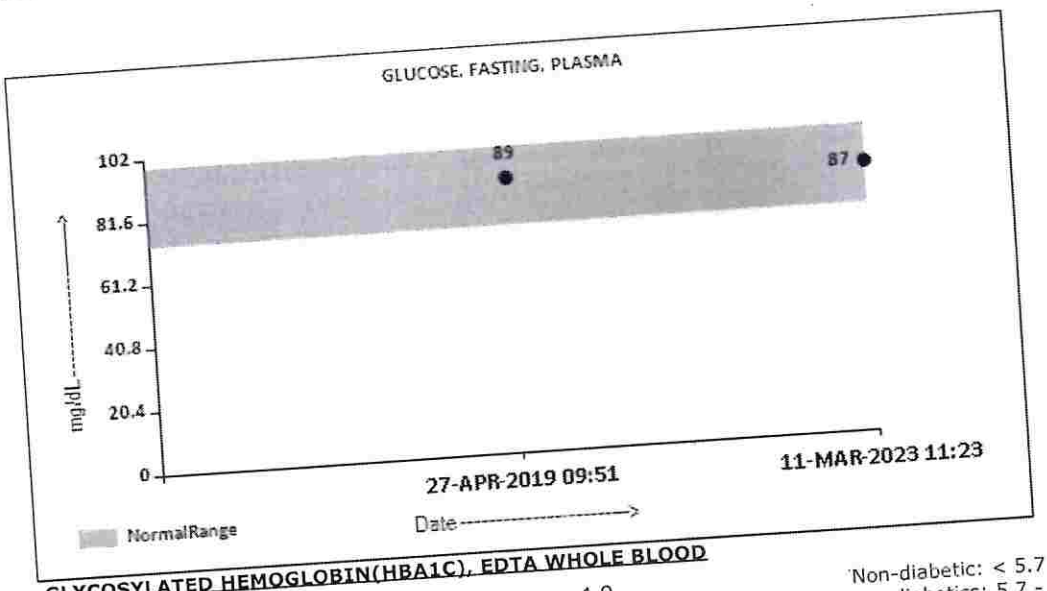

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.9	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) METHOD : CALCULATED PARAMETER	93.9	< 116.0	mg/dL

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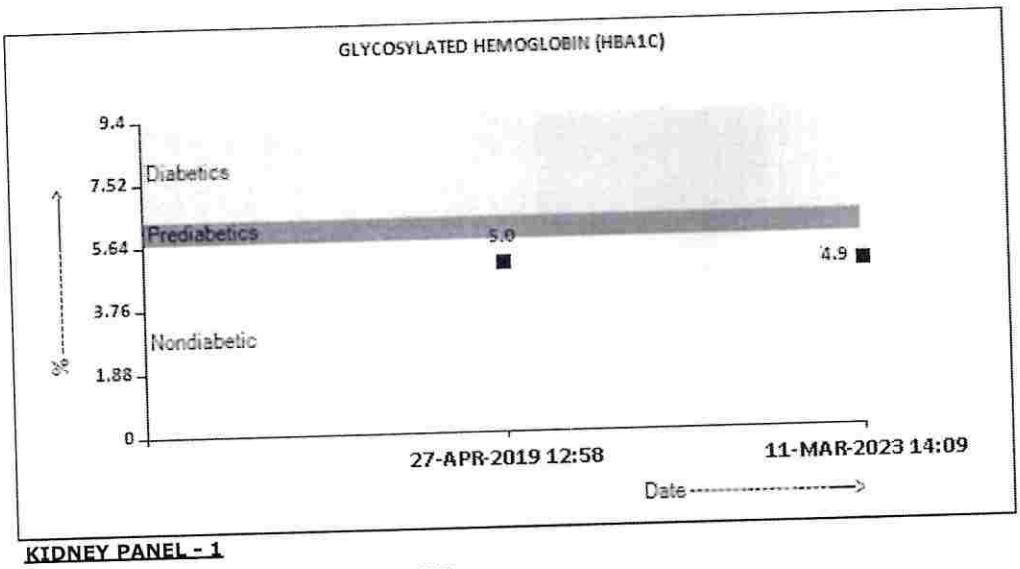

KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	6	6 - 20	mg/dL

METHOD : UREASE - UV

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MC-2275

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CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002062** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 09:51:00 RECEIVED :11/03/2023 09:51:48 REPORTED :11/03/2023 15:02:55

CLINICAL INFORMATION :

UID:2359554 OLD UHID -FHL34.229445 REQNO-1384016
CORP-OPD
BILLNO-150123OPCR014325
BILLNO-150123OPCR014325

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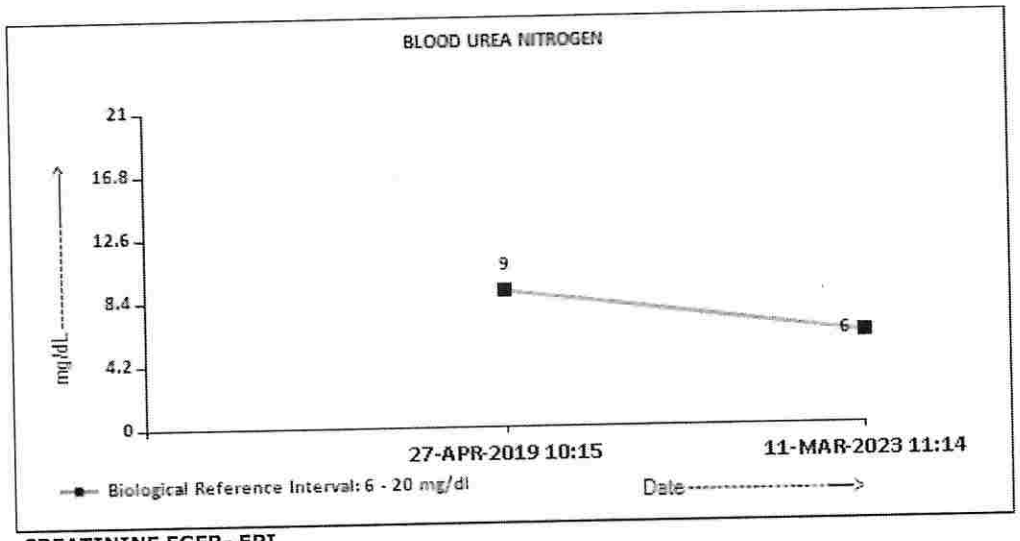

CREATININE EGFR- EPI

CREATININE	**0.50 Low**	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	41		years
GLOMERULAR FILTRATION RATE (FEMALE)	120.77	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER			

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Patient Ref. No. 22000000833595

PATIENT NAME : MRS.NISHTHA PANDEY | **REF. DOCTOR :** SELF

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

ACCESSION NO : **0022WC002062**
PATIENT ID : FH.2359554
CLIENT PATIENT ID: UID:2359554
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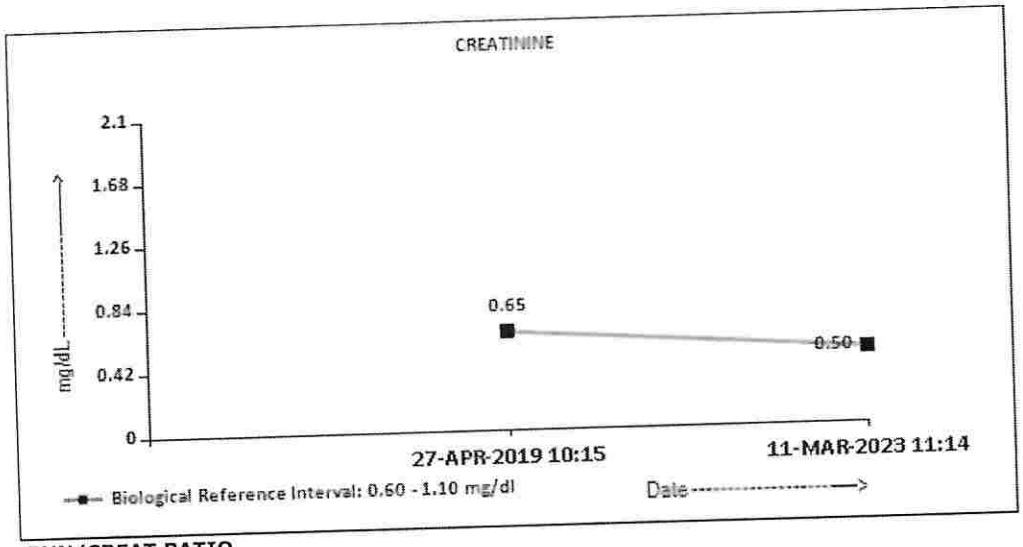

BUN/CREAT RATIO

BUN/CREAT RATIO	12.00	5.00 - 15.00	

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID	**1.2 Low**	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	3.6	3.4 - 5.0	g/dL

METHOD : BCP DYE BINDING

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GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	3.4	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	137	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	3.61	3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	102	98 - 107	mmol/L

Interpretation(s)

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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, 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

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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 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 :

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, hyperbiliirubinemia, 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 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, SIADH.

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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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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LABORATORY REPORT

MC-2275 Fortis SRL Diagnostics

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	145	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	43	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	57	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	85	< 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	88	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	8.6	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**2.5 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	1.5	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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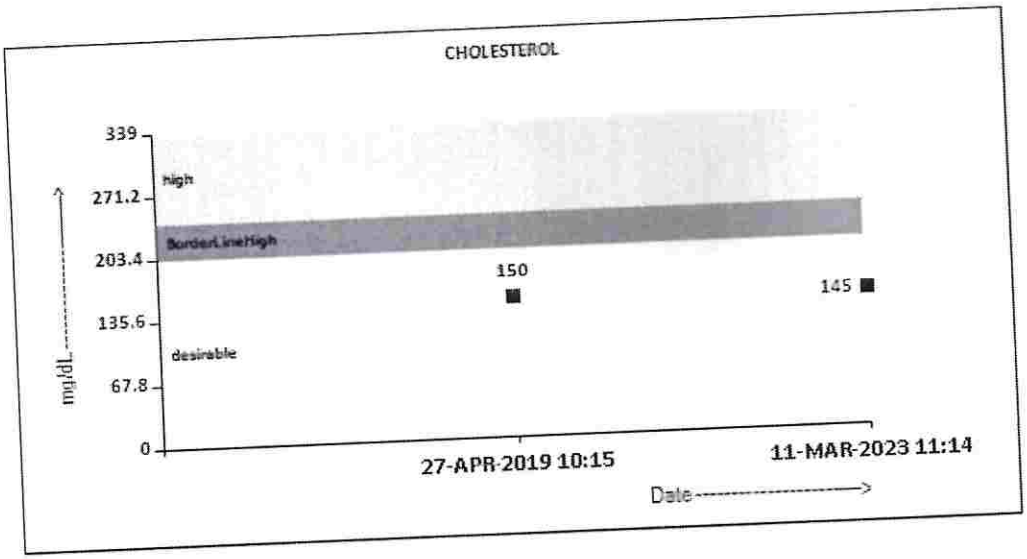

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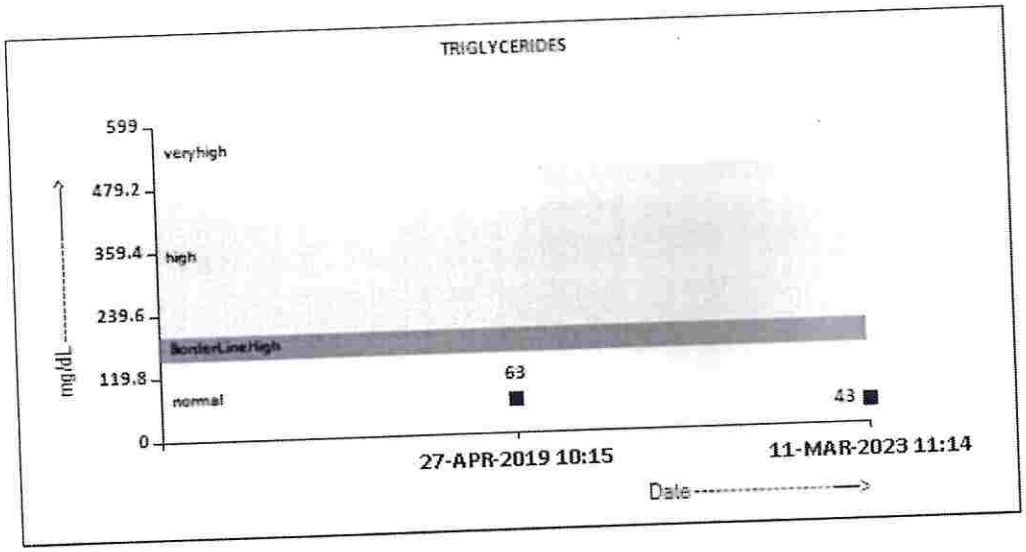

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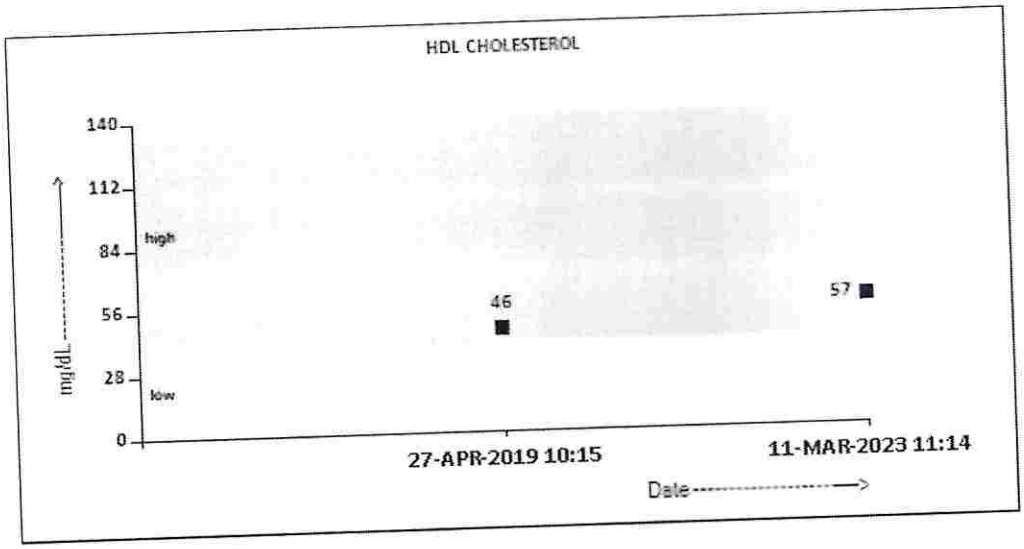

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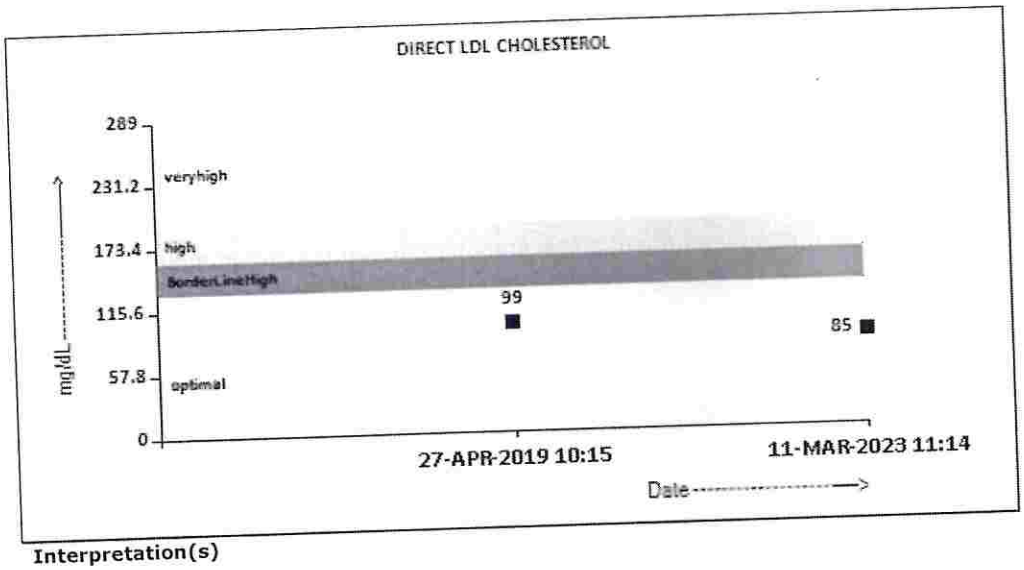

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LABORATORY REPORT

MC-2275

PATIENT NAME : MRS.NISHTHA PANDEY	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002062** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 09:51:00 RECEIVED :11/03/2023 09:51:48 REPORTED :11/03/2023 15:02:55

CLINICAL INFORMATION :

UID:2359554 OLD UHID -FHL34.229445 REQNO-1384016
CORP-OPD
BILLNO-150123OPCR014325
BILLNO-150123OPCR014325

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

CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**		

CHEMICAL EXAMINATION, URINE

PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	1.025	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	**DETECTED (++)**	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	**DETECTED (FEW)**	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	**10 - 15**	NOT DETECTED	/HPF

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

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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. 22000000833595

LABORATORY REPORT

MC-2275

PATIENT NAME : MRS.NISHTHA PANDEY	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002062** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 09:51:00 RECEIVED :11/03/2023 09:51:48 REPORTED :11/03/2023 15:02:55

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CORP-OPD
BILLNO-150123OPCR014325
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Test Report Status **Final**	Results	Biological Reference Interval	Units
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	**5-7**	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	**8-10**	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	**DETECTED**	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

****End Of Report****
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Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

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Patient Ref. No. 22000000833595

LABORATORY REPORT

MC-2984

PATIENT NAME : MRS.NISHTHA PANDEY	**REF. DOCTOR :** SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002062** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 09:51:00 RECEIVED :11/03/2023 09:51:48 REPORTED :11/03/2023 16:15:28

CLINICAL INFORMATION :

UID:2359554 OLD UHID -FHL34.229445 REQNO-1384016
CORP-OPD
BILLNO-150123OPCR014325
BILLNO-150123OPCR014325

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	106.70	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
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	6.03	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
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	0.999	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

****End Of Report****
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Dr. Swapnil Sirmukaddam
Consultant Pathologist

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NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

Patient Ref. No. 22000000833595

LABORATORY REPORT

MC-2275 Fortis SRL Diagnostics

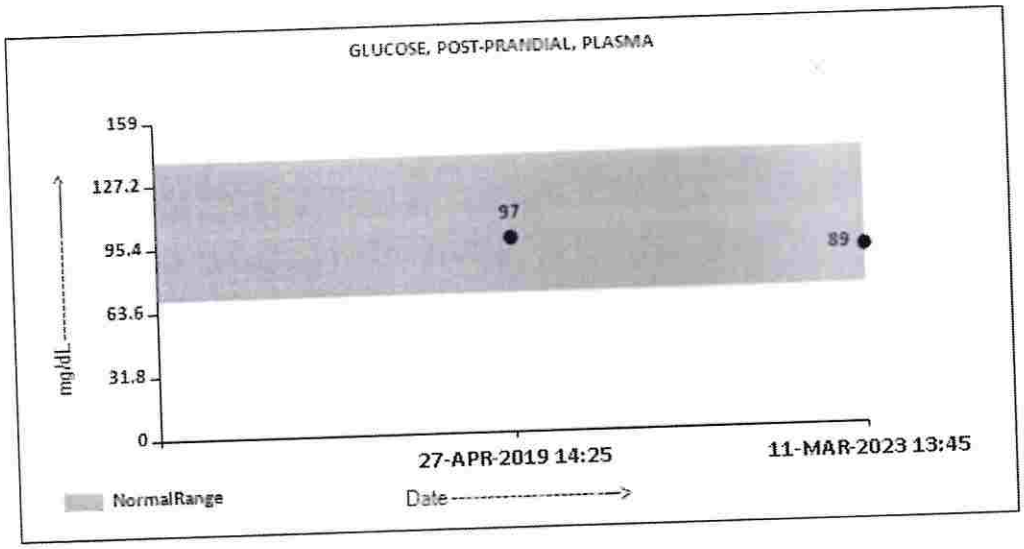
PATIENT NAME : MRS.NISHTHA PANDEY	**REF. DOCTOR :**	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : **0022WC002160** PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX :41 Years Female DRAWN :11/03/2023 12:54:00 RECEIVED :11/03/2023 12:54:47 REPORTED :11/03/2023 14:47:42

CLINICAL INFORMATION :

UID:2359554 REQNO-1384016
CORP-OPD
BILLNO-150123OPCR014325
BILLNO-150123OPCR014325

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	89	70 - 139	mg/dL

METHOD : HEXOKINASE



Comments

NOTE: - RECHECKED FOR POST PRANDIAL PLASMA GLUCOSE VALUE. 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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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Dr.Akta Dubey
Counsultant Pathologist

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CIN - U74899PB1995PLC045956
Email : -

Patient Ref. No. 22000000833693

2359554
41 Years

NISTHA PANDEY
Female

3/11/2023 11:32:24 AM

HC

Rate	71	. Sinus rhythm.....normal P axis, V-rate 50- 99
		. RSR' in V1 or V2, right VCD or RVH.....QRS area positive & R' V1/V2
PR	135	. Borderline T abnormalities, anterior leads.....T flat or neg, V2-V4
QRSD	93	
QT	408	
QTc	444	

--AXIS--

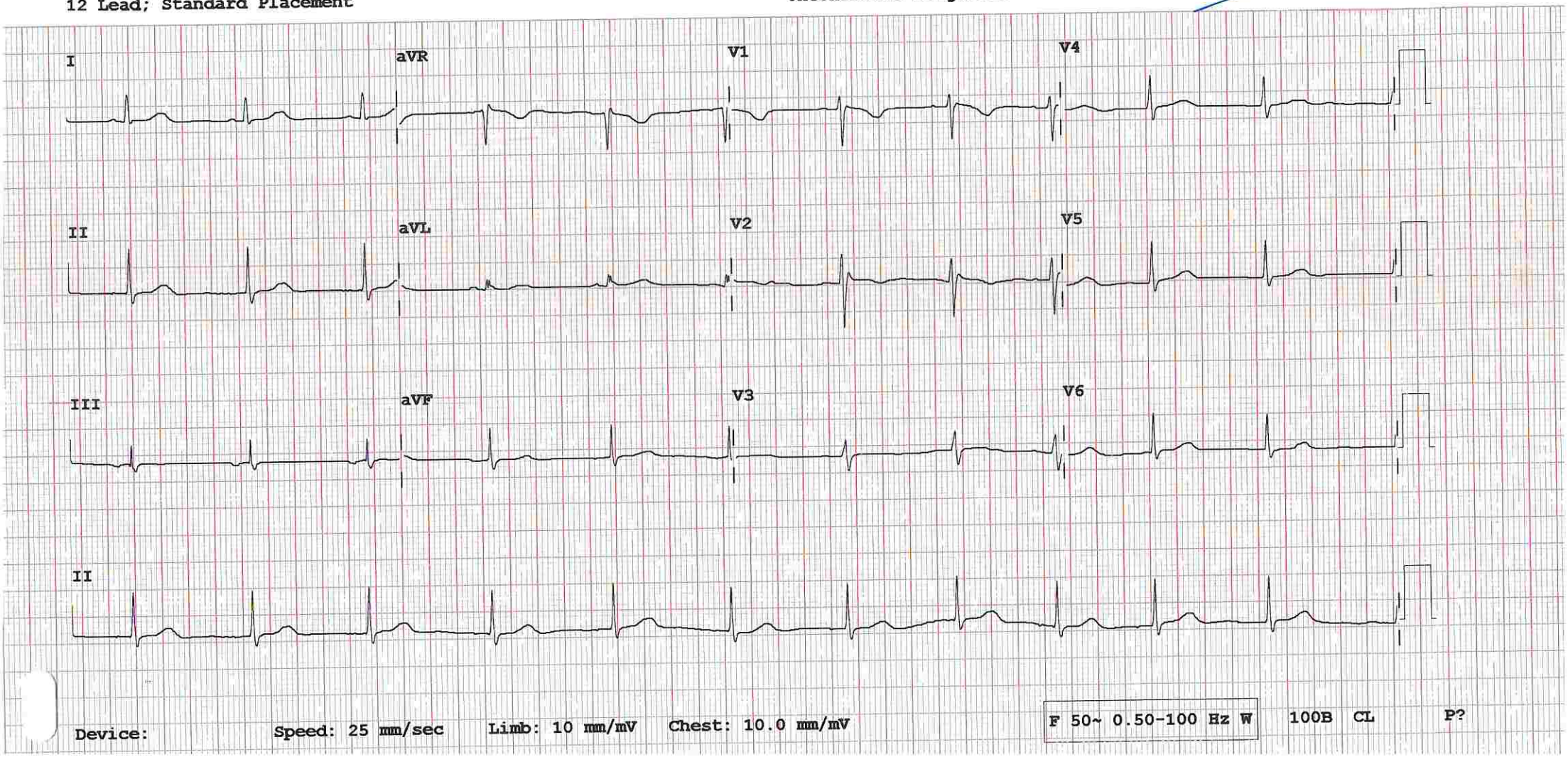
P	-38
QRS	18
T	28

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

sinus rhythm
RBBB



Device:

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

F 50~ 0.50-100 Hz W 100B CL P?

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www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 11/Mar/2023

DEPARTMENT OF NIC

Name: Mrs. Nishtha Pandey
Age | Sex: 41 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 2359554 | 14559/23/1501
Order No | Order Date: 1501/PN/OP/2303/30138 | 11-Mar-2023
Admitted On | Reporting Date : 11-Mar-2023 17:35:52
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	35	mm
AO Root	29	mm
AO CUSP SEP	22	mm
LVID (s)	28	mm
LVID (d)	36	mm
IVS (d)	07	mm
LVPW (d)	08	mm
RVID (d)	20	mm
RA	27	mm
LVEF	60	%

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Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 1.3 m/sec.
A WAVE VELOCITY:0.8 m/sec
E/A RATIO:1.4

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	06			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)

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PAN NO : AABCH5894D

Hiranandani HOSPITA
(A Fortis Network Hospit

DEPARTMENT OF RADIOLOGY

Date: 11/Mar/2023

Name: Mrs. Nishtha Pandey	**UHID | Episode No : 2359554 | 14559/23/1501**
Age | Sex: 41 YEAR(S) | Female	**Order No | Order Date: 1501/PN/OP/2303/30138 | 11-Mar-2023**
Order Station : FO-OPD	**Admitted On | Reporting Date : 11-Mar-2023 12:47:07**
Bed Name :	**Order Doctor Name : Dr.SELF .**

US-WHOLE ABDOMEN

LIVER is normal in size and echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein is normal.

GALL BLADDER is contracted. **CBD** appears normal in caliber.

SPLEEN is normal in size and echogenicity. No evidence of perisplenic collection.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 9.2 x 4.2 cm.
Left kidney measures 10.9 x 4.3 cm.

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

AORTA AND RETROPERITONEAL structures are normal. No evidence of retroperitoneal lymphadenopathy.

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

UTERUS is normal in size and shows sub-septate morphology, measuring 7.7 x 2.8 x 5.1 cm.
Endometrium 1 measures 6 mm in thickness.
Endometrium 2 measures 6.2 mm in thickness.

Right ovary is normal in size and measures 2.9 x 2.8 cm. Haemorrhagic follicle is seen within.
Left ovary is normal in size and measures 3.4 x 1.9 cm.

No evidence of ascites.

Impression:

- **No significant abnormality is detected.**
  Kindly evaluate patient NBM for better evaluation of gall bladder.

DR. ADITYA NALAWADE
M.D. (Radiologist)