



BMI CHART

Date: ___ / ___ / ___

Name: _____ Age: _____ yrs Sex: M / F

BP: 120/70 Height (cms): 150 ^{cm} ~~kg~~ Weight(kgs): 58.5 ^{kg} ~~kg~~ BMI: _____

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		
kg	45.5	47.7	50.0	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	<div style="display: flex; justify-content: space-between; width: 100%;"> Underweight Healthy Overweight Obese Extremely Obese </div>																									
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	36		
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	35		
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	34		
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	33		
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:

Signature



UHID	2359554	Date	10/02/2024		
Name	Mrs. Nishtha Pandey	Sex	Female	Age	42
OPD	Pap Smear	Health Check-up			

Drug allergy:
 Sys illness:

ump 8/02/2024

8/5.0/2d ← Flow Med
 25-28d

> Ds - 10

Obs - Nulligravida.

Part - ? Anterior S. / No Sx / NA - Allergies drugs
 - ? Deberges.

Flu - Both - neg.

Adv

- Pap smear not taken today
- for pap smear next week.

!



UHID	2359554	Date	10/02/2024		
Name	Mrs. Nishtha Pandey	Sex	Female	Age	42
OPD	Dental 12	Health Check-up			

O/E - Stains + +
calculus + +

Drug allergy:
Sys illness:

- Missing \bar{c} $\frac{3}{1}$

Treatment

1) Scaling Grade I

2) CBCT (xray)

To pay,

CBCT = Rs 4500/-

Dr. Trupti

PATIENT NAME : MRS. NISHTHA PANDEY

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022XB001987

PATIENT ID : FH.2359554

CLIENT PATIENT ID: UID:2359554

ABHA NO :

AGE/SEX : 42 Years Female

DRAWN : 10/02/2024 08:28:00

RECEIVED : 10/02/2024 08:29:58

REPORTED : 10/02/2024 13:36:21

CLINICAL INFORMATION :

UID:2359554 REQNO-1660147

CORP-OPD

BILLNO-150124OPCR007841

BILLNO-150124OPCR007841

Test Report Status	Results	Biological Reference Interval	Units
Preliminary			

HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD


HEMOGLOBIN (HB) METHOD : SLS METHOD	12.1	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.08	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	6.41	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	219	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	37.0	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	90.7	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	29.7	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	32.7	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	12.0	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	22.2		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	9.9	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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Patient Ref. No. 22000000901584

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NEUTROPHILS		67	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		26	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		5	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		2	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		4.29	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.67	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.32	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.13	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.6		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE



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Patient Ref. No. 2200000901584

PATIENT NAME : MRS. NISHTHA PANDEY

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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.

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), EDTA BLOOD

E.S.R	18	0 - 20	mm at 1 hr
METHOD : WESTERGRN METHOD			

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)	%
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METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	93.9	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

METHOD : CALCULATED PARAMETER


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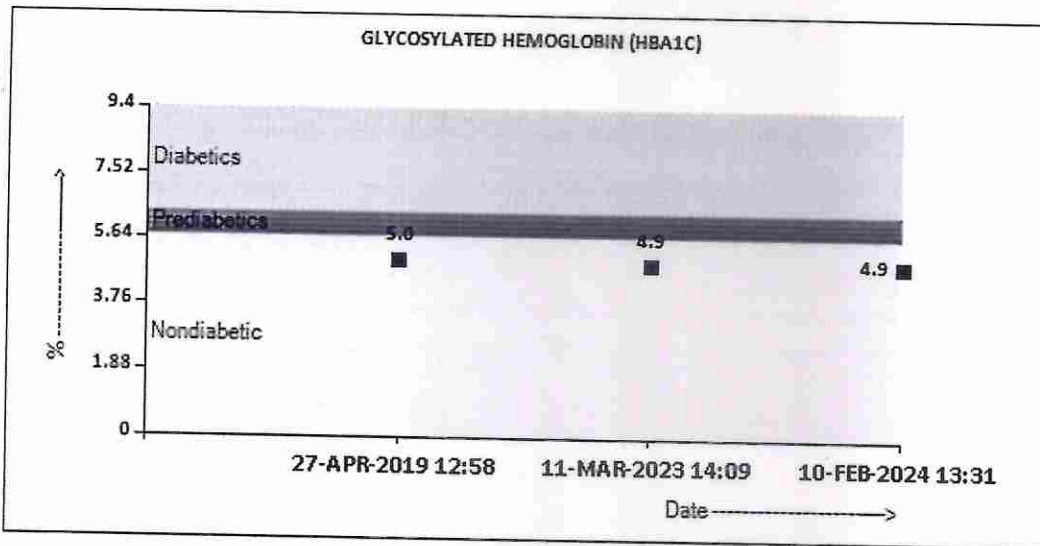
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Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA 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, (Sickle Cells, 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

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REF. DOCTOR : SELF

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the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.
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 :

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 addition 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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

ABO GROUP	TYPE A
METHOD : TUBE AGGLUTINATION	
RH TYPE	POSITIVE
METHOD : TUBE AGGLUTINATION	

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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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.67	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.17	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.50	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.6	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	15	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	15	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	52	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	24	5 - 55	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	139	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	89	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
METHOD : HEXOKINASE			



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CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 2200000901584

PATIENT NAME : MRS. NISHTHA PANDEY

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022XB001987

PATIENT ID : FH.2359554

CLIENT PATIENT ID: UID:2359554

ABHA NO :

AGE/SEX : 42 Years Female

DRAWN : 10/02/2024 08:28:00

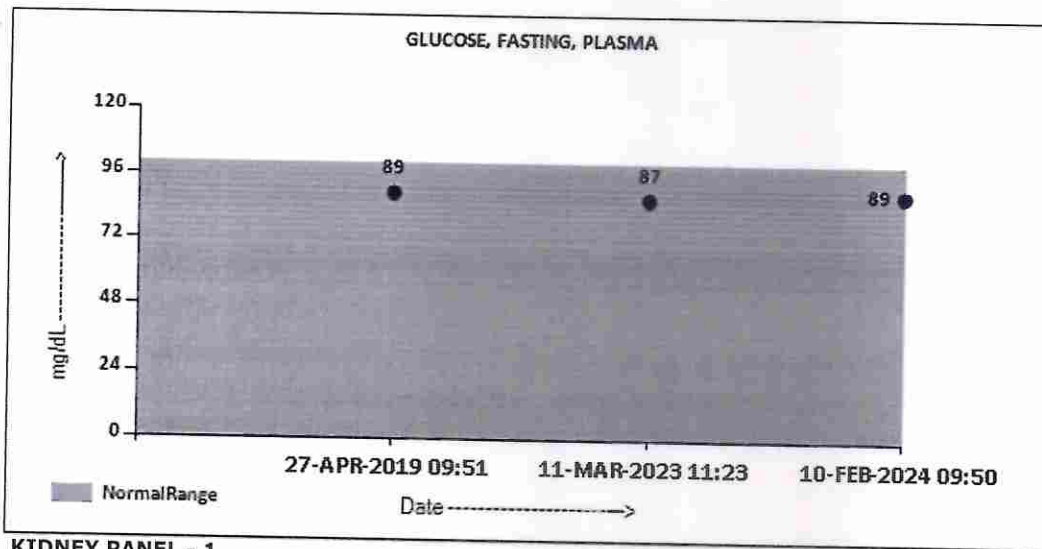
RECEIVED : 10/02/2024 08:29:58

REPORTED : 10/02/2024 13:36:21

CLINICAL INFORMATION :

UID:2359554 REQNO-1660147
 CORP-OPD
 BILLNO-150124OPCR007841
 BILLNO-150124OPCR007841

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 8 6 - 20 mg/dL
 METHOD : UREASE - UV

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 Consultant Pathologist



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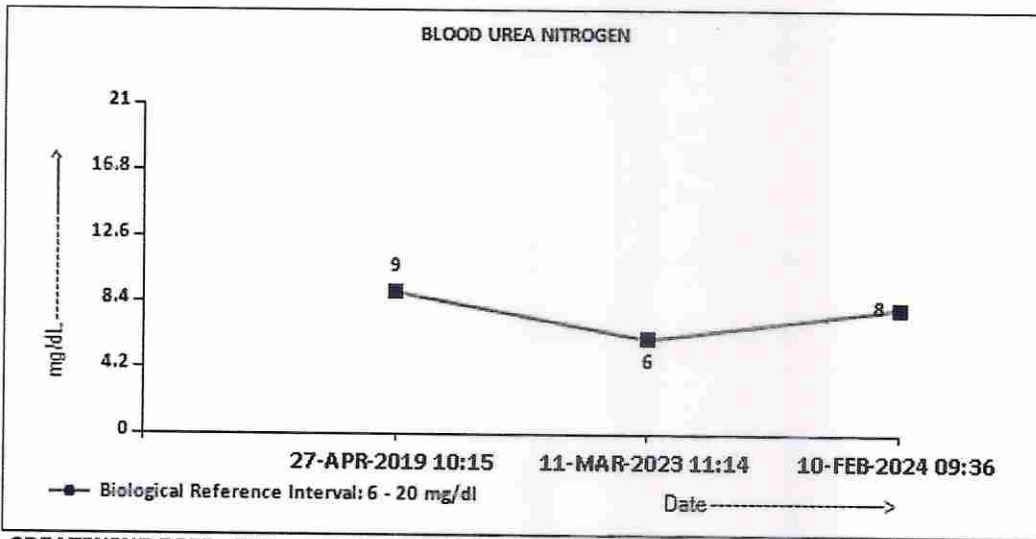
PATIENT NAME : MRS. NISHTHA PANDEY **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000045507 FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022XB001987 PATIENT ID : FH.2359554 CLIENT PATIENT ID: UID:2359554 ABHA NO :	AGE/SEX : 42 Years Female DRAWN : 10/02/2024 08:28:00 RECEIVED : 10/02/2024 08:29:58 REPORTED : 10/02/2024 13:36:21
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CREATININE EGFR- EPI

CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	0.75	0.60 - 1.10	mg/dL
AGE	42		years
GLOMERULAR FILTRATION RATE (FEMALE) METHOD : CALCULATED PARAMETER	108.84	Refer Interpretation Below	mL/min/1.73m2

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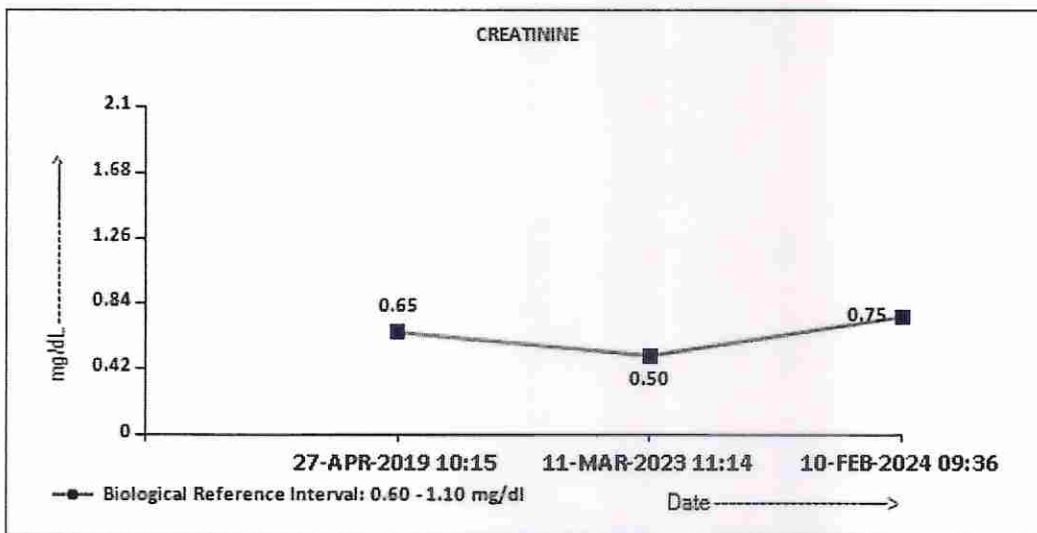
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BUN/CREAT RATIO

BUN/CREAT RATIO 10.67 5.00 - 15.00
 METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 1.5 Low 2.6 - 6.0 mg/dL
 METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.4 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

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ALBUMIN		3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN		3.6	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		136	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		3.98	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM		102	98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-

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

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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, Waldenström'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 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, sulfonyleureas, 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.

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-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons. Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m²). This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).

Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.uw.edu/guideline/egfr>

Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation, Kidney Med 2022, 4:100471. 35756325

Harrison's Principle of Internal Medicine, 21st ed, pg 62 and 334

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, Waldenström'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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Patient Ref. No. 2200000901584

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CODE/NAME & ADDRESS : C000045507

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FORTIS HOSPITAL # VASHI,

MUMBAI 440001

ACCESSION NO : 0022XB001987

PATIENT ID : FH.2359554

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AGE/SEX : 42 Years Female

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	148	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
--------------------	-----	---	-------

METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES	50	< 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	81	< 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	91	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	10.0	<= 30.0	mg/dL
------------------------------	------	---------	-------

METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO	2.6 Low	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
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METHOD : CALCULATED PARAMETER



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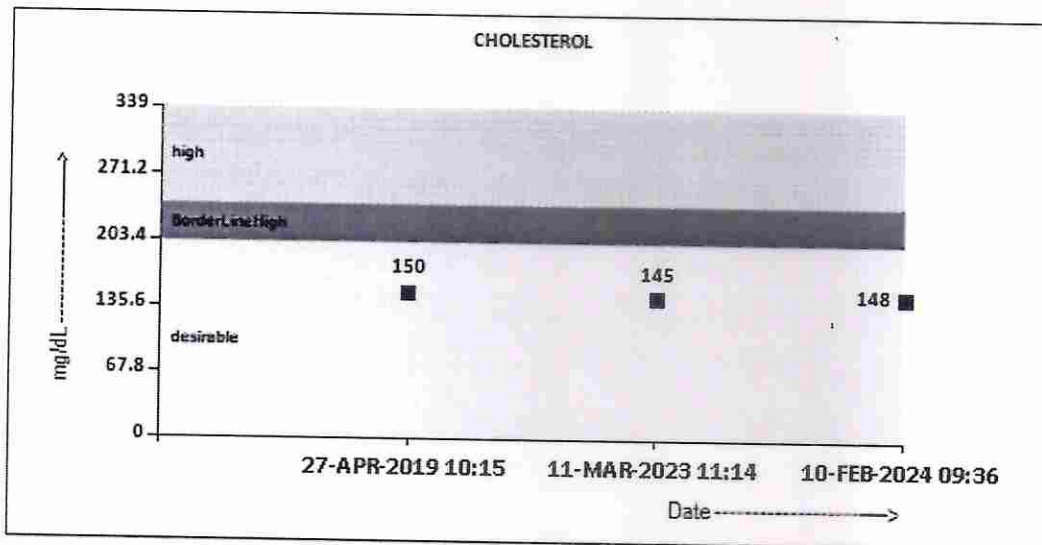
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LDL/HDL RATIO 1.4 0.5 - 3.0 Desirable/Low Risk
3.1 - 6.0 Borderline/Moderate Risk
>6.0 High Risk

METHOD : CALCULATED PARAMETER



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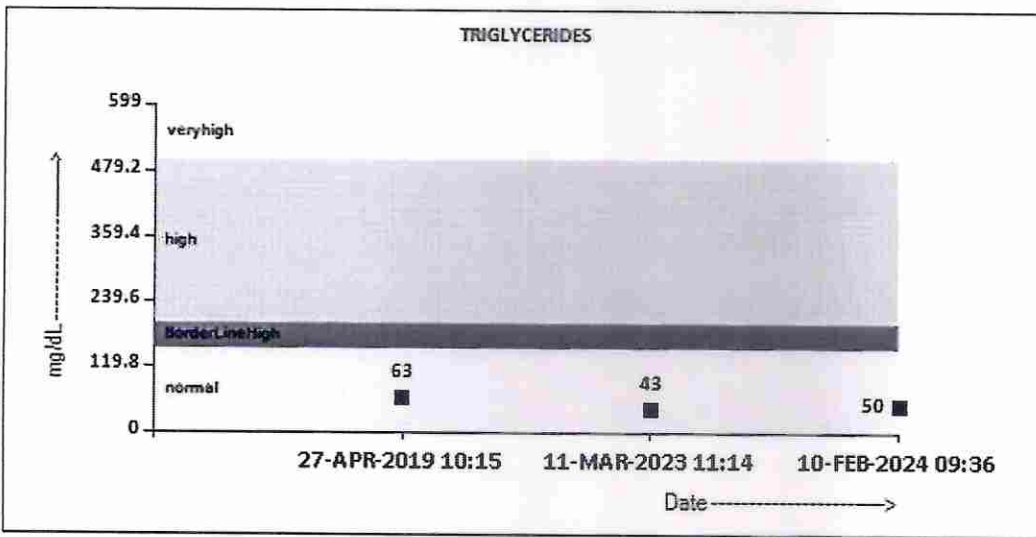
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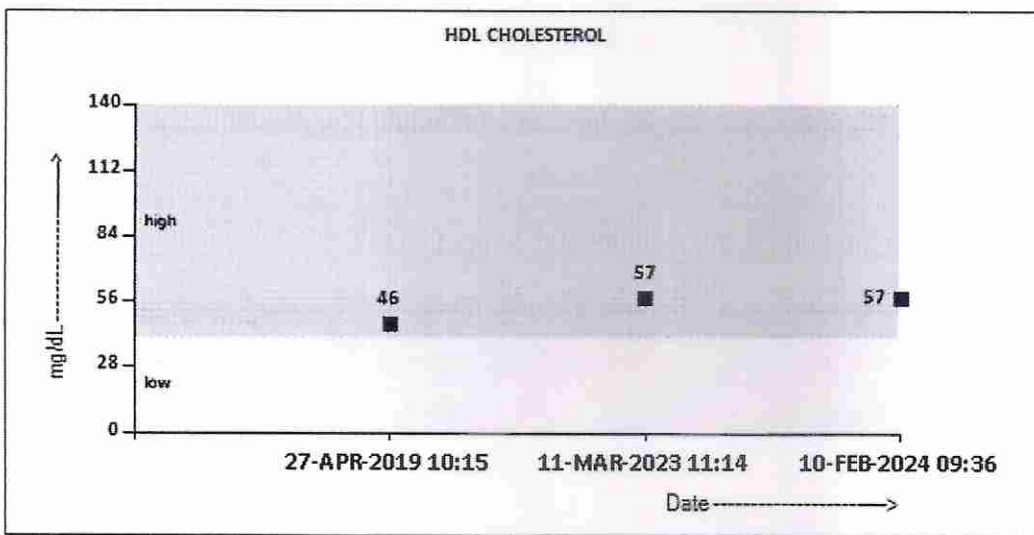
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Patient Ref. No. 22000000901584



DEPARTMENT OF NIC

Date: 12/Feb/2024

Name: Mrs. Nishtha Pandey
 Age | Sex: 42 YEAR(S) | Female
 Order Station : FO-OPD
 Bed Name :

UHID | Episode No : 2359554 | 8123/24/1501
 Order No | Order Date: 1501/PN/OP/2402/16714 | 10-Feb-2024
 Admitted On | Reporting Date : 12-Feb-2024 18:18:14
 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 e/o raised LVEDP.
- No l mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 25 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	27	mm
AO Root	19	mm
AO CUSP SEP	14	mm
LVID (s)	21	mm
LVID (d)	37	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	27	mm
RA	26	mm
LVEF	60	%

12/2/2024



DEPARTMENT OF NIC

Date: 12/Feb/2024

Name: Mrs. Nishtha Pandey

UHID | Episode No : 2359554 | 8123/24/1501

Age | Sex: 42 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2402/16714 | 10-Feb-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 12-Feb-2024 18:18:14

Bed Name :

Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 1.1 0.9 m/sec.

A WAVE VELOCITY: 0.7m/sec

E/A RATIO: 1.5

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

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

DR. AMIT SINGH,
MD(MED),DM(CARD)

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 10/Feb/2024

Name: Mrs. Nishtha Pandey

Age | Sex: 42 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 2359554 | 8123/24/1501

Order No | Order Date: 1501/PN/OP/2402/16714 | 10-Feb-2024

Admitted On | Reporting Date : 10-Feb-2024 14:35:50

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 appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH

DMRD., DNB. (Radiologist)



(For Billing/Reports & Discharge Summary only)

Patient Name	: Nishtha Pandey	Patient ID	: 2359554
Sex / Age	: F / 42Y 2M 25D	Accession No.	: PHC.7447053
Modality	: US	Scan DateTime	: 10-02-2024 10:14:34
IPID No	: 8123/24/1501	ReportDatetime	: 10-02-2024 10:25:08

USG - 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 contracted.

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 10.4 x 4.6 cm.

Left kidney measures 10.9 x 4.9 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 7.9 x 5.9 x 3.5 cm.

Endometrium measures 3.7 mm in thickness.

Both ovaries are bulky.

Right ovary measures 4.0 x 3.2 x 2.3 cm, volume ~ 16 cc.

Left ovary measures 3.7 x 3.5 x 2.4 cm, volume ~ 16 cc.

No evidence of ascites.

Impression:

- **Bilateral bulky ovaries. Recommended clinic-hormonal correlation.**

DR. KUNAL NIGAM
M.D. (Radiologist)

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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Admitted On | Reporting Date : 10-Feb-2024 10:34:19

Order Doctor Name : Dr.SELF.

USG - BOTH BREAST

Previous reports and films are not available for comparison.

Findings:

Multiple cysts are seen in right breast, largest measuring 12 x 8 mm at 11 o'clock position.

Few cysts are also seen in the left breast, largest of size 5.6 x 6.2 mm at 2 o'clock position.

Rest of the breast parenchyma appears normal.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

Impression:

Multiple cysts in both breasts as described.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)