

PATIENT NAME : PRIYANKA

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138362
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULISOUTH WEST
 DELHI
 NEW DELHI 110030
 8800465156

ACCESSION NO : 0030WD001436
 PATIENT ID : PRIYF19098830
 CLIENT PATIENT ID:
 ABHA NO :

AGE/SEX : 34 Years Female
 DRAWN :
 RECEIVED : 08/04/2023 08:46:32
 REPORTED : 10/04/2023 15:17:24

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**XRAY-CHEST**

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO TMT TEST DONE AND IT IS - NEGATIVE

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY NOT SIGNIFICANT
 RELEVANT PAST HISTORY NOT SIGNIFICANT
 RELEVANT PERSONAL HISTORY NOT SIGNIFICANT
 MENSTRUAL HISTORY (FOR FEMALES) REGULAR.
 LMP (FOR FEMALES) LMP - 26-03-2023
 RELEVANT FAMILY HISTORY HIGH BLOOD PRESSURE AND DIABETES.
 OCCUPATIONAL HISTORY NOT SIGNIFICANT
 HISTORY OF MEDICATIONS THYRONORM 75 MG ONCE A DAY.

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS	1.61	mts
WEIGHT IN KGS.	78	Kgs
BMI	30	kg/sqmts

BMI & Weight Status as follows:
 Below 18.5: Underweight
 18.5 - 24.9: Normal
 25.0 - 29.9: Overweight
 30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE NORMAL
 PHYSICAL ATTITUDE NORMAL
 GENERAL APPEARANCE / NUTRITIONAL STATUS OVERWEIGHT
 BUILT / SKELETAL FRAMEWORK AVERAGE
 FACIAL APPEARANCE NORMAL
 SKIN NORMAL
 UPPER LIMB NORMAL
 LOWER LIMB NORMAL



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 Lab Head

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 CIN - U74899PB1995PLC045956
 Email : customercare.pune@srl.in



Patient Ref. No. 775000002843846

PATIENT NAME : PRIYANKA**REF. DOCTOR : SELF**

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NECK	NORMAL			
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER			
THYROID GLAND	HYPOTHYROIDISM.			
CAROTID PULSATION	NORMAL			
TEMPERATURE	NORMAL			
PULSE	73/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT			
RESPIRATORY RATE	NORMAL			
CARDIOVASCULAR SYSTEM				
BP	130/80 MM HG (SITTING)		mm/Hg	
PERICARDIUM	NORMAL			
APEX BEAT	NORMAL			
HEART SOUNDS	NORMAL			
MURMURS	ABSENT			
RESPIRATORY SYSTEM				
SIZE AND SHAPE OF CHEST	NORMAL			
MOVEMENTS OF CHEST	SYMMETRICAL			
BREATH SOUNDS INTENSITY	NORMAL			
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)			
ADDED SOUNDS	ABSENT			
PER ABDOMEN				
APPEARANCE	NORMAL			
VENOUS PROMINENCE	ABSENT			
LIVER	NOT PALPABLE			
SPLEEN	NOT PALPABLE			
HERNIA	ABSENT			
CENTRAL NERVOUS SYSTEM				
HIGHER FUNCTIONS	NORMAL			
CRANIAL NERVES	NORMAL			
CEREBELLAR FUNCTIONS	NORMAL			
SENSORY SYSTEM	NORMAL			
MOTOR SYSTEM	NORMAL			



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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	DISTANT VISION - 6/36
DISTANT VISION LEFT EYE WITHOUT GLASSES	DISTANT VISION - 6/36
NEAR VISION RIGHT EYE WITHOUT GLASSES	NEAR VISION - N 6 (NORMAL)
NEAR VISION LEFT EYE WITHOUT GLASSES	NEAR VISION - N 6 (NORMAL)
COLOUR VISION	NORMAL
BASIC ENT EXAMINATION	
EXTERNAL EAR CANAL	NORMAL
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	NORMAL
THROAT	NO ABNORMALITY DETECTED
TONSILS	NOT ENLARGED
SUMMARY	
RELEVANT HISTORY	NOT SIGNIFICANT
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT
RELEVANT LAB INVESTIGATIONS	LOW HAEMOGLOBIN - 11.2 g/dL ESR RAISED - 30 mm/hrs HBA1C - GLYCOSYLATED HEMOGLOBIN RAISED - 6.2 % MEAN PLASMA GLUCOSE RAISED - 131.2 mg/dL DIRECT LDL CHOLESTEROL RAISED (128 mg/dL) NON HDL CHOLESTEROL RAISED (153 mg/dL) ALT / SGPT RAISED - 57 U/L AST / SGOT RAISED - 39 U/L LACTATE DEHYDROGENASE RAISED - 252 U/L URIC ACID RAISED - 7.4 mg/dL



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RELEVANT NON PATHOLOGY DIAGNOSTICS

LIVER - Grade I / II changes of fatty liver are noted.

GALL BLADDER - Evidence of 14 mm calculi is seen in the neck region.

OVARIES - Right ovary is normal.
Left ovary not seen.

REMARKS / RECOMMENDATIONS

ADV. TAKE SUPPLEMENTS OF IRON, B12 AND FOLIC ACID ? INFECTION - REPEAT ESR AFTER 15 DAYS.
REPEAT GLYCOSYLATED HEMOGLOBIN AFTER 1 MONTH
REDUCE SATURATED FATS IN DIET.
REDUCE FRIED AND OILY FOOD IN DIET.
REPEAT LACTATE DEHYDROGENASE AFTER 15 DAYS.
REDUCED ORGAN MEAT, PULSES ETC.
TAKE TAB. ZYLORIC TO REDUCED URIC ACID,
REPEAT URIC ACID AFTER 15 DAYS.
FOLLOW UP WITH FAMILY PHYSICIAN / SRL DR.

ADV. FOLLOW UP WITH EYE SPECIALIST.

FITNESS STATUS

FITNESS STATUS

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

Comments

OUR DOCTORS ON PANEL FOR NON-PATHOLOGICAL REPORTS:

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

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



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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

LIVER - Grade I / II changes of fatty liver are noted.

GALL BLADDER - Evidence of 14 mm calculi is seen in the neck region.

OVARIES - Right ovary is normal.
Left ovary not seen.

Clinical correlation.

Sub optimal window due to obesity.

Interpretation(s)

MEDICAL HISTORY:*****
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

FITNESS STATUS-Conclusion on an individual's fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for. These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) - SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
- Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
- Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.



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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	11.2 Low	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	4.51	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.50	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	312	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED	35.5 Low	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED	79.0 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	24.9 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED	31.7	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED	14.8 High	11.6 - 14.0	%
MENTZER INDEX	17.5		
MEAN PLATELET VOLUME (MPV) METHOD : CELL COUNTER (CALCULATED)	11.6 High	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	52	40 - 80	%
LYMPHOCYTES METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	37	20 - 40	%
MONOCYTES	5	2 - 10	%
EOSINOPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	6	1 - 6	%
BASOPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	0	0 - 2	%

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ABSOLUTE NEUTROPHIL COUNT		2.86	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		2.04	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.28	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.33	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.4		
METHOD : CALCULATED				

MORPHOLOGY**REMARKS**

RBCS: NORMOCYTIC NORMOCHROMIC, FEW MICROCYTES.

WBCS: WBCS ARE NORMAL IN NUMBER & MORPHOLOGY.

PLATELETS: ADEQUATE ON PERIPHERAL SMEAR.

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 CHECKUP BELOW 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R. **30 High** 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, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Issue injury, Pregnancy, Estrogen medication, Aging.

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

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

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS


False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

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

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

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

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40 FEMALE

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	95	74 - 99	mg/dL
METHOD : HEXOKINASE			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	6.2 High	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 : HPLC			

ESTIMATED AVERAGE GLUCOSE(EAG)	131.2 High	< 116.0	mg/dL
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GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	104	Normal: < 140, Impaired Glucose Tolerance: 140-199 Diabetic > or = 200	mg/dL
METHOD : HEXOKINASE			

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	194	Desirable: < 200 Borderline High : 200-239 High : > or = 240	mg/dL
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TRIGLYCERIDES	125	Desirable: < 150 Borderline High: 150 - 199 High: 200 - 499 Very High : > or = 500	mg/dL
METHOD : ENZYMATIC WITH GLYCEROL BLANK			

HDL CHOLESTEROL	41	< 40 Low > or = 60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			


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Lab Head



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CIN - U74899PB1995PLC045956
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Patient Ref. No. 775000002843846

PATIENT NAME : PRIYANKA

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138362
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULISOUTH WEST
 DELHI
 NEW DELHI 110030
 8800465156

ACCESSION NO : **0030WD001436**
 PATIENT ID : PRIYF19098830
 CLIENT PATIENT ID:
 ABHA NO :

AGE/SEX : 34 Years Female
 DRAWN :
 RECEIVED : 08/04/2023 08:46:32
 REPORTED : 10/04/2023 15:17:24

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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CHOLESTEROL LDL	128 High	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	153 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	25.0	< or = 30	mg/dL
CHOL/HDL RATIO	4.7 High	3.3 - 4.4	
LDL/HDL RATIO	3.1		

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.23	0.0 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.12	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.11	0.00 - 1.00	mg/dL
TOTAL PROTEIN METHOD : BIURET, REAGENT BLANK, END POINT	7.1	6.4 - 8.3	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN (BCG)	4.7	3.50 - 5.20	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.4	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	2.0	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	39 High	UPTO 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	57 High	UPTO 34	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	52	35 - 104	U/L

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GAMMA GLUTAMYL TRANSFERASE (GGT) 22 5 - 36 U/L
METHOD : GAMMA GLUTAMYL-3-CARBOXY-4-NITROANALIDE (IFCC)

LACTATE DEHYDROGENASE 252 High 135 - 214 U/L
METHOD : LACTATE -PYRUVATE

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 9 6 - 20 mg/dL
METHOD : UREASE COLORIMETRIC

CREATININE, SERUM

CREATININE 0.51 0.50 - 0.90 mg/dL
METHOD : JAFFE'S ALKALINE PICRATE -IFCC IDMS STANDARDIZED

BUN/CREAT RATIO

BUN/CREAT RATIO 17.65 High 5.0 - 15.0

URIC ACID, SERUM

URIC ACID 7.4 High 2.6 - 6.0 mg/dL
METHOD : URICASE, COLORIMETRIC

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.1 6.4 - 8.3 g/dL
METHOD : BIURET, REAGENT BLANK, END POINT

ALBUMIN, SERUM

ALBUMIN 4.7 3.5 - 5.2 g/dL
METHOD : BROMOCRESOL GREEN (BCG)

GLOBULIN

GLOBULIN 2.4 2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 139 137 - 145 mmol/L
METHOD : ISE INDIRECT

POTASSIUM, SERUM 4.60 3.6 - 5.0 mmol/L
METHOD : ISE INDIRECT

CHLORIDE, SERUM 106 98 - 107 mmol/L
METHOD : ISE INDIRECT

Interpretation(s)

Sodium	Potassium	Chloride
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Test Report Status Preliminary **Results** **Biological Reference Interval** **Units**

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, antidepressants (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, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, 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 HCO ₃ ⁻), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemia, 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

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

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

Decreased in: Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), **Drugs:** insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

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

GLYCOSYLATED HEMOGLOBIN (HBA1C), ED IA 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

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HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- 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.
- 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

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c 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 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 (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. Swati Pravin Mulani
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Patient Ref. No. 77500002843846

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CODE/NAME & ADDRESS : C000138362 ACROFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : 0030WD001436 PATIENT ID : PRIYF19098830 CLIENT PATIENT ID : ABHA NO :	AGE/SEX : 34 Years Female DRAWN : RECEIVED : 08/04/2023 08:46:32 REPORTED : 10/04/2023 15:17:24

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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR
METHOD : DIPSTICK, MICROSCOPY	

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : DIPSTICK		
SPECIFIC GRAVITY	<= 1.005	1.003 - 1.035
METHOD : DIPSTICK		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK (DIAZOTISED DICHLOROANILINE)		
UROBILINOGEN	NORMAL	NORMAL
METHOD : DIPSTICK		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : DIPSTICK		

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		



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METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

REMARKS

URINE ANALYSIS : MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

Interpretation(s)



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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 35 FEMALE	RESULT PENDING
PAPANICOLAOU SMEAR	RESULT PENDING
LETTER	RESULT PENDING



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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3	100.38	58 - 159	ng/dL
T4	8.55	4.87 - 11.71	µg/dL
TSH (ULTRASENSITIVE)	4.758	0.350 - 4.940	µIU/mL

End Of Report

Please visit www.srlworld.com for related Test Information for this accession


CONDITIONS OF LABORATORY TESTING & REPORTING

- It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
- All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
- 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.
- A requested test might not be performed if:
 - Specimen received is insufficient or inappropriate
 - Specimen quality is unsatisfactory
 - Incorrect specimen type
 - Discrepancy between identification on specimen container label and test requisition form
- SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
- 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.
- 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.
- Test results cannot be used for Medico legal purposes.
- In case of queries please call customer care (91115 91115) within 48 hours of the report.

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