



UHID 8178772
 Name Mr. Ravish Anand
 OPD ~~Dental 12~~
 Ophthalmology

Date 24/12/2022
 Sex Male Age 32
 Health Check Up

Drug allergy: \rightarrow Not known
 Sys illness: \rightarrow No

Clr. No.

H/ser. No.

U.I.H.K. \rightarrow 6/60
 \rightarrow 6/60 (Bh)

Ref. \rightarrow -2.50 on 6/6
 \rightarrow -2.75 on 6/6

I.O.P. \rightarrow 13.8 (Same as P.U.P.)
 \rightarrow 14.9

of 6: 7.5 J.W.R.C.

Dandy exam J.W.R.C.

\rightarrow

La.
 Cyclopol (Bh)
 Biotens gel.
 (CB) 1-1-1-1
 - use blue block +
 ARC glasses.

PATIENT NAME : MR.RAVISH ANAND

PATIENT ID : **FH.8178772**

CLIENT PATIENT ID : UID:8178772

ACCESSION NO : **0022VL005409**

AGE : 32 Years

SEX : Male

ABHA NO :

DRAWN : 24/12/2022 10:43:00

RECEIVED : 24/12/2022 10:47:05

REPORTED : 24/12/2022 15:26:59

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

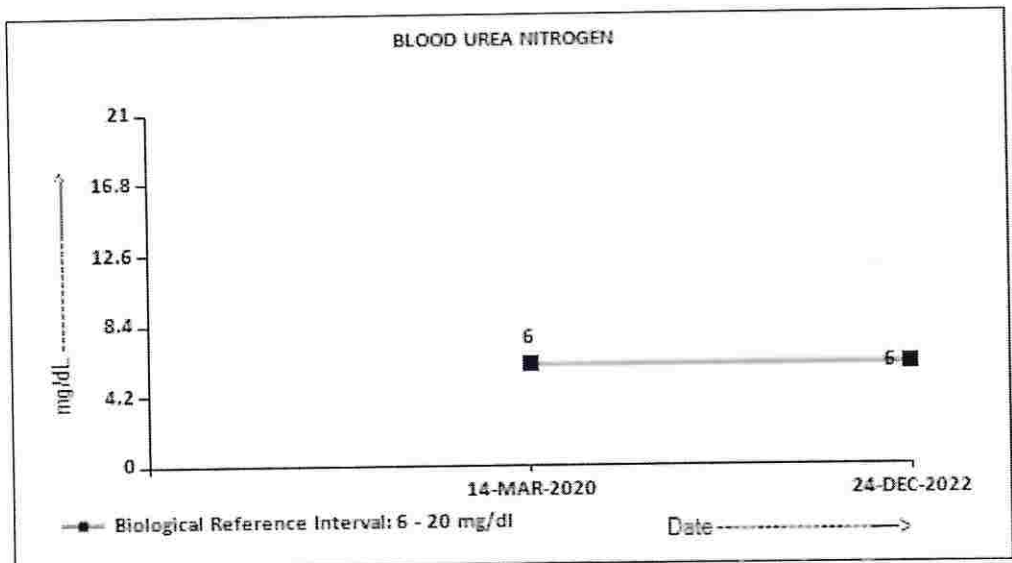
UID:8178772 REQNO-1349344
CORP-OPD
BILLNO-150122OPCR066101
BILLNO-150122OPCR066101

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

BLOOD UREA NITROGEN (BUN), SERUM

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



CREATININE EGFR- EPI

CREATININE 0.61 Low 0.90 - 1.30 mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE 32 years

GLOMERULAR FILTRATION RATE (MALE) 130.88 Refer Interpretation Below mL/min/1.73m
METHOD : CALCULATED PARAMETER



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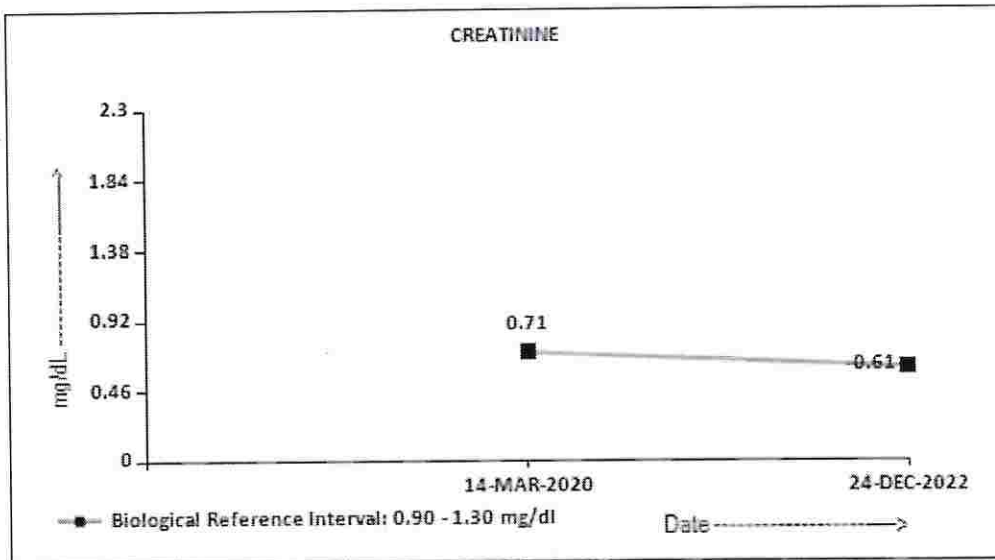
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BUN/CREAT RATIO

BUN/CREAT RATIO 9.84 5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 5.7 3.5 - 7.2 mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.6 6.4 - 8.2 g/dL

METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.1 3.4 - 5.0 g/dL

METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN 3.5 2.0 - 4.1 g/dL

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 139 136 - 145 mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM 3.96 3.50 - 5.10 mmol/L

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METHOD : ISE INDIRECT

CHLORIDE, SERUM

103

98 - 107

mmol/L

METHOD : ISE INDIRECT

Interpretation(s)

Interpretation(s)

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

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, 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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HAEMATOLOGY - CBC**CBC-5, EDTA WHOLE BLOOD****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	14.3	13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	4.59	4.5 - 5.5	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	5.61	4.0 - 10.0	thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	290	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	42.2	40 - 50	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	92.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	31.1	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.9	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	15.7	High 11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	20.0		
MEAN PLATELET VOLUME (MPV)	9.7	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	51	40 - 80	%
METHOD : FLOW CYTOMETRY			
LYMPHOCYTES	41	High 20 - 40	%
METHOD : FLOW CYTOMETRY			
MONOCYTES	7	2 - 10	%
METHOD : FLOW CYTOMETRY			
EOSINOPHILS	1	1 - 6	%
METHOD : FLOW CYTOMETRY			

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BASOPHILS		00	0 - 2	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		2.86	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.30	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.39	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.06	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)		1.2		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC			PREDOMINANTLY NORMOCYTIC NORMOCHROMIC	
METHOD : MICROSCOPIC EXAMINATION				
WBC			NORMAL MORPHOLOGY	
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS			ADEQUATE	
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
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) 10650
This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R 12 0 - 14 mm at 1 hr
METHOD : WESTERGREN METHOD



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Test Report Status Final**Results****Biological Reference Interval****Interpretation(s)**

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

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

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

TEST INTERPRETATION

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

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

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

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

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

REFERENCE :

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

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.

BIOCHEMISTRY**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL

0.75

0.2 - 1.0

mg/dL

METHOD : JENDRASSIK AND GROFF

BILIRUBIN, DIRECT

0.15

0.0 - 0.2

mg/dL

METHOD : JENDRASSIK AND GROFF

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BILIRUBIN, INDIRECT		0.60	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN		7.6	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN		4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN		3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO		1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		36	15 - 37	U/L
METHOD : UV WITH P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		74	High < 45.0	U/L
METHOD : UV WITH P5P				
ALKALINE PHOSPHATASE		103	30 - 120	U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)		39	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE				
LACTATE DEHYDROGENASE		150	100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING, FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		95	74 - 99	mg/dL
METHOD : HEXOKINASE				



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Patient Ref. No. 2200000081

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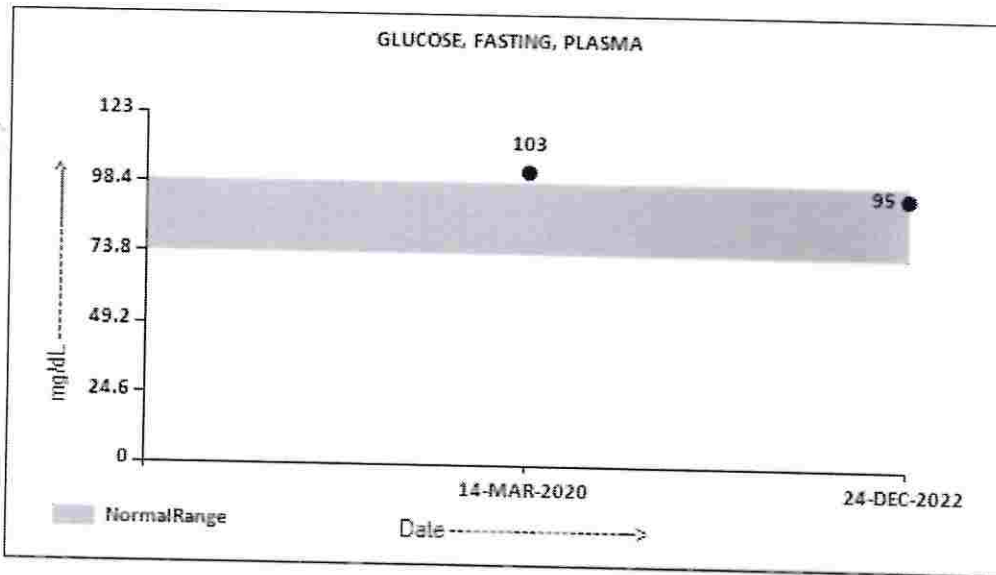
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.4	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)	108.3	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			



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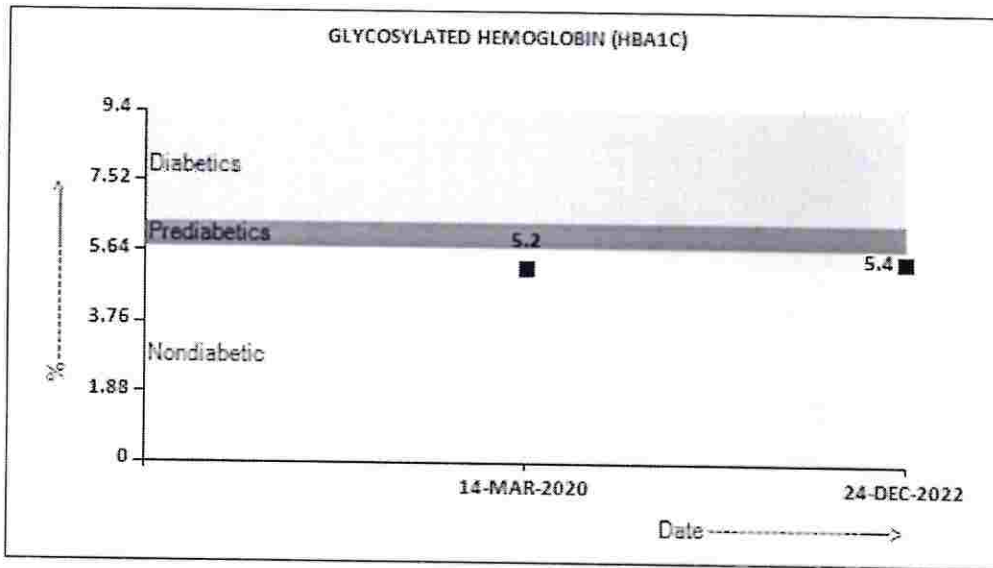
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Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE

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

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

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels 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 syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

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

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ACCESSION NO : **0022VL005409**

AGE : 32 Years SEX : Male

ABHA NO :

DRAWN : 24/12/2022 10:43:00

RECEIVED : 24/12/2022 10:47:05

REPORTED : 24/12/2022 15:26:59

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:8178772 REQNO-1349344
CORP-OPD
BILLNO-150122OPCR066101
BILLNO-150122OPCR066101

Test Report Status	Final	Results	Biological Reference Interval
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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.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- 1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
- 2.Diagnosing diabetes.
- 3.Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

- 1.eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

- I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
- III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods,falsely increasing results.
- IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
 - a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - c.HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

BIOCHEMISTRY- LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	184	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	125	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	49	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	128	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL



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PATIENT NAME : MR.RAVISH ANAND

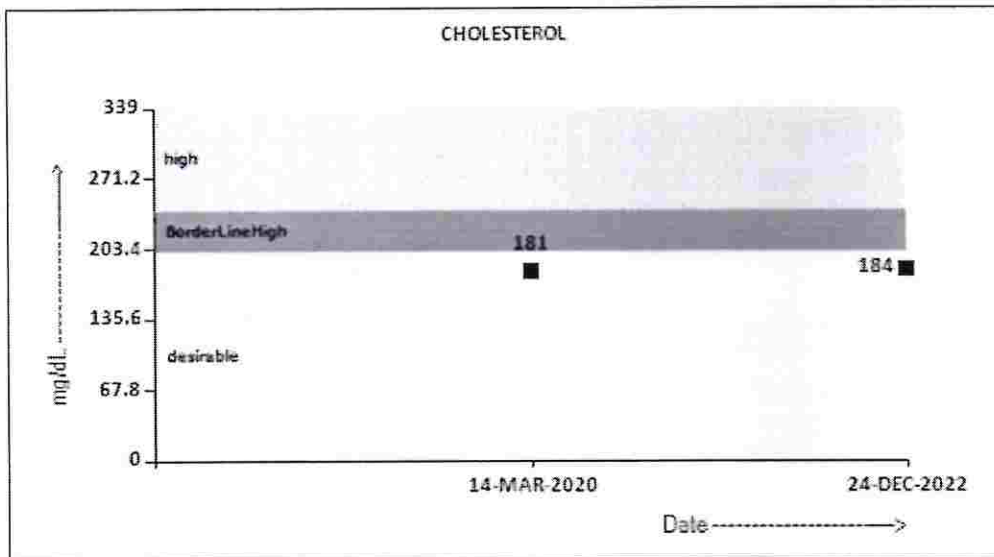
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Test Report Status	Final	Results	Biological Reference Interval
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METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	135	High	Desirable: Less than 130 mg/dL Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.8		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	2.6		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	25.0		</= 30.0 mg/dL
METHOD : CALCULATED PARAMETER			



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PATIENT ID : FH.8178772

CLIENT PATIENT ID : UID:8178772

ACCESSION NO : 0022VL005409

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SEX : Male

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REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

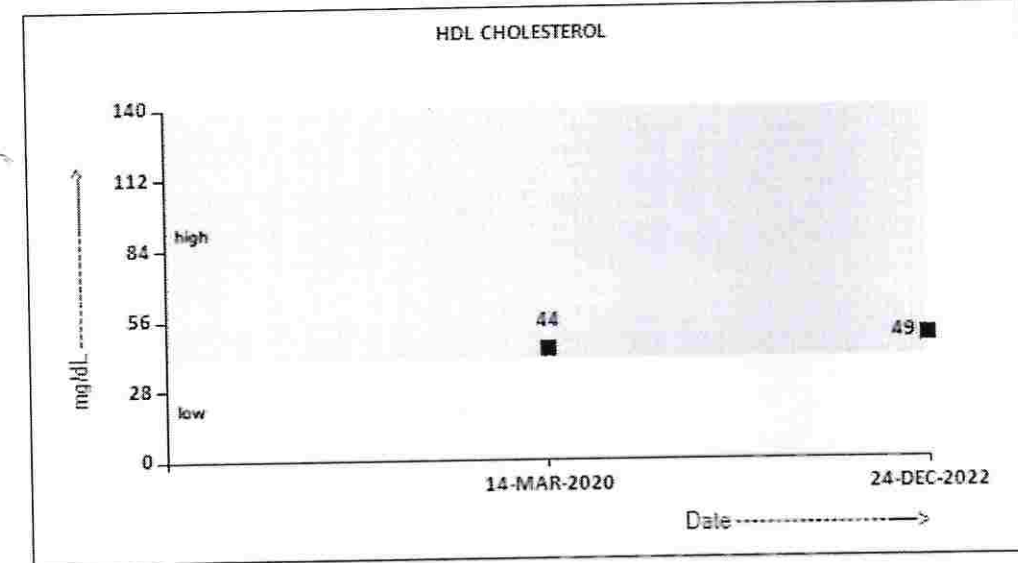
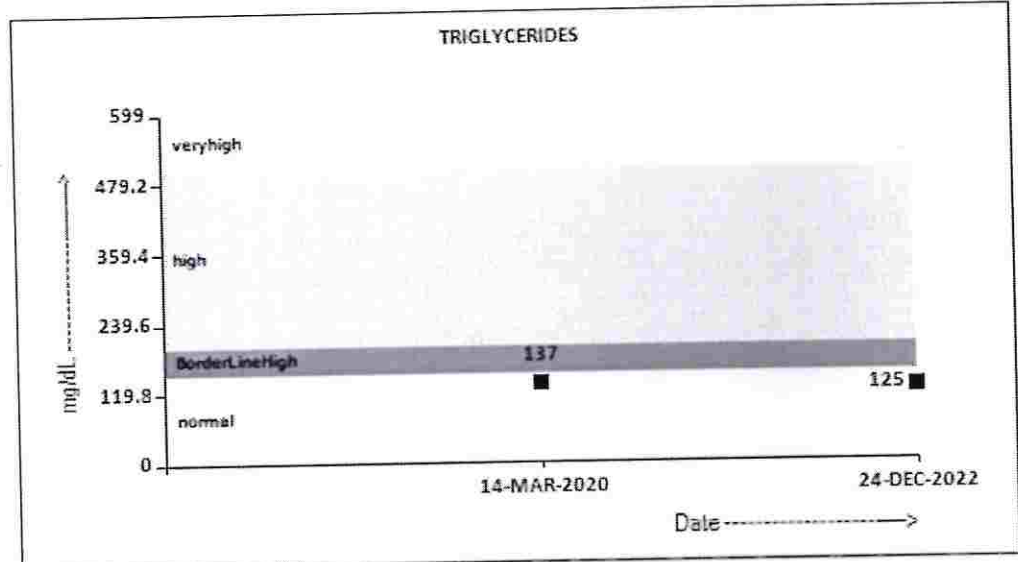
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CORP-OPD

BILLNO-150122OPCR066101

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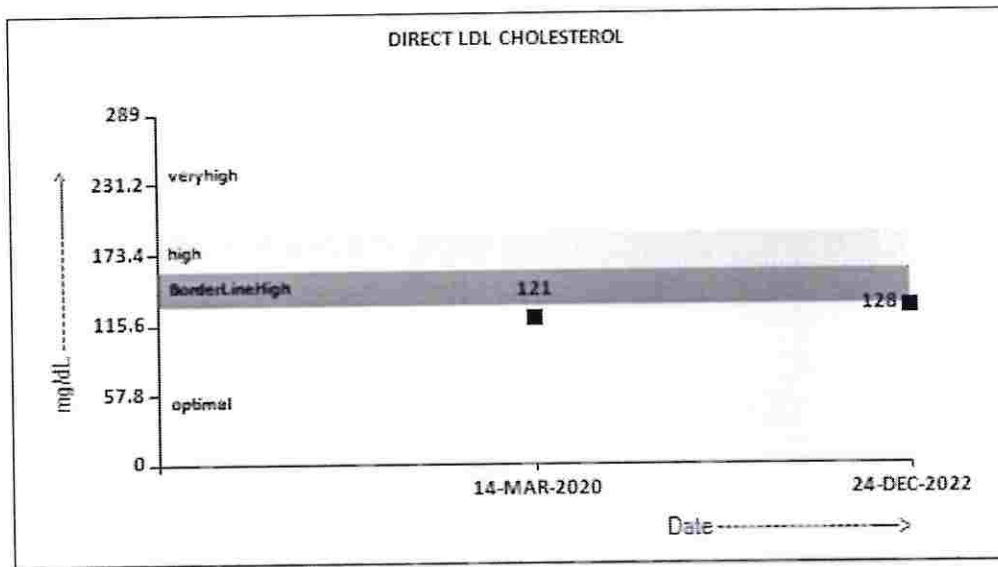
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Interpretation(s)

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease. This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

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PATIENT NAME : MR.RAVISH ANAND

PATIENT ID : **FH.8178772** CLIENT PATIENT ID : UID:8178772
 ACCESSION NO : **0022VL005409** AGE : 32 Years SEX : Male ABHA NO :
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NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
 METHOD : PHYSICAL
 APPEARANCE CLEAR
 METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.020	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
BLOOD	DETECTED (TRACE)	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	0 - 1	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	2-3	0-5	/HPF

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Patient Ref. No. 22000000817676

PATIENT NAME : MR.RAVISH ANAND

PATIENT ID : **FH.8178772**

CLIENT PATIENT ID : UID:8178772

ACCESSION NO : **0022VL005409**

AGE : 32 Years

SEX : Male

ABHA NO :

DRAWN : 24/12/2022 10:43:00

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CORP-OPD

BILLNO-150122OPCR066101

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METHOD : MICROSCOPIC EXAMINATION

CASTS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

REMARKS

URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.

Interpretation(s)

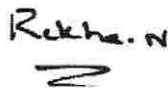
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Dr.Akta Dubey

Consultant Pathologist



Dr. Rekha Nair, MD

Microbiologist

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PATIENT NAME : MR.RAVISH ANAND

PATIENT ID : **FH.8178772**

CLIENT PATIENT ID : UID:8178772

ACCESSION NO : **0022VL005503**

AGE : 32 Years

SEX : Male

ABHA NO :

DRAWN : 24/12/2022 13:20:00

RECEIVED : 24/12/2022 13:20:24

REPORTED : 24/12/2022 14:48:38

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:8178772 REQNO-1349344

CORP-OPD

BILLNO-150122OPCR066101

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Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

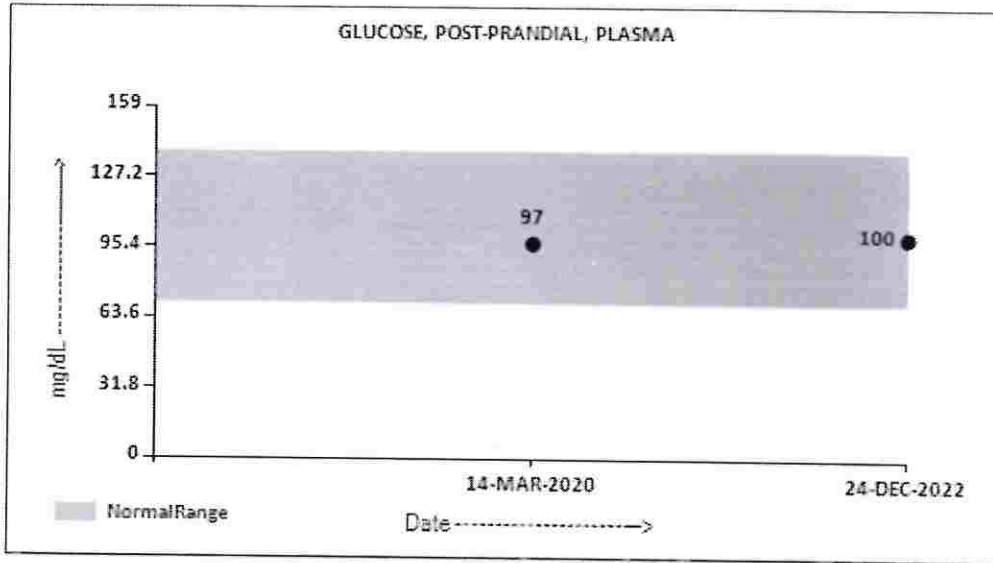
PPBS(POST PRANDIAL BLOOD SUGAR)

100

70 - 139

mg/dL

METHOD : HEXOKINASE



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**

Consultant Pathologist



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CLIENT PATIENT ID : UID:8178772

PATIENT ID : FH.8178772

AGE : 32 Years SEX : Male

ABHA NO :

REPORTED : 24/12/2022 17:11:51

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

THYROID PANEL, SERUM

T3	156.7	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	10.30	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.230	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)



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Test Report Status	Results	Biological Reference Interval	Units
Final			

SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN

0.305

< 1.4

ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

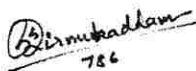
PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
 - It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)
 References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

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Dr. Swapnil Sirmukaddam
 Consultant Pathologist

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Patient Ref. No. 2200000817

HC

Rate 75 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . ST elev, probable normal early repol pattern.....ST elevation, age<55
 . Baseline wander in lead(s) V1

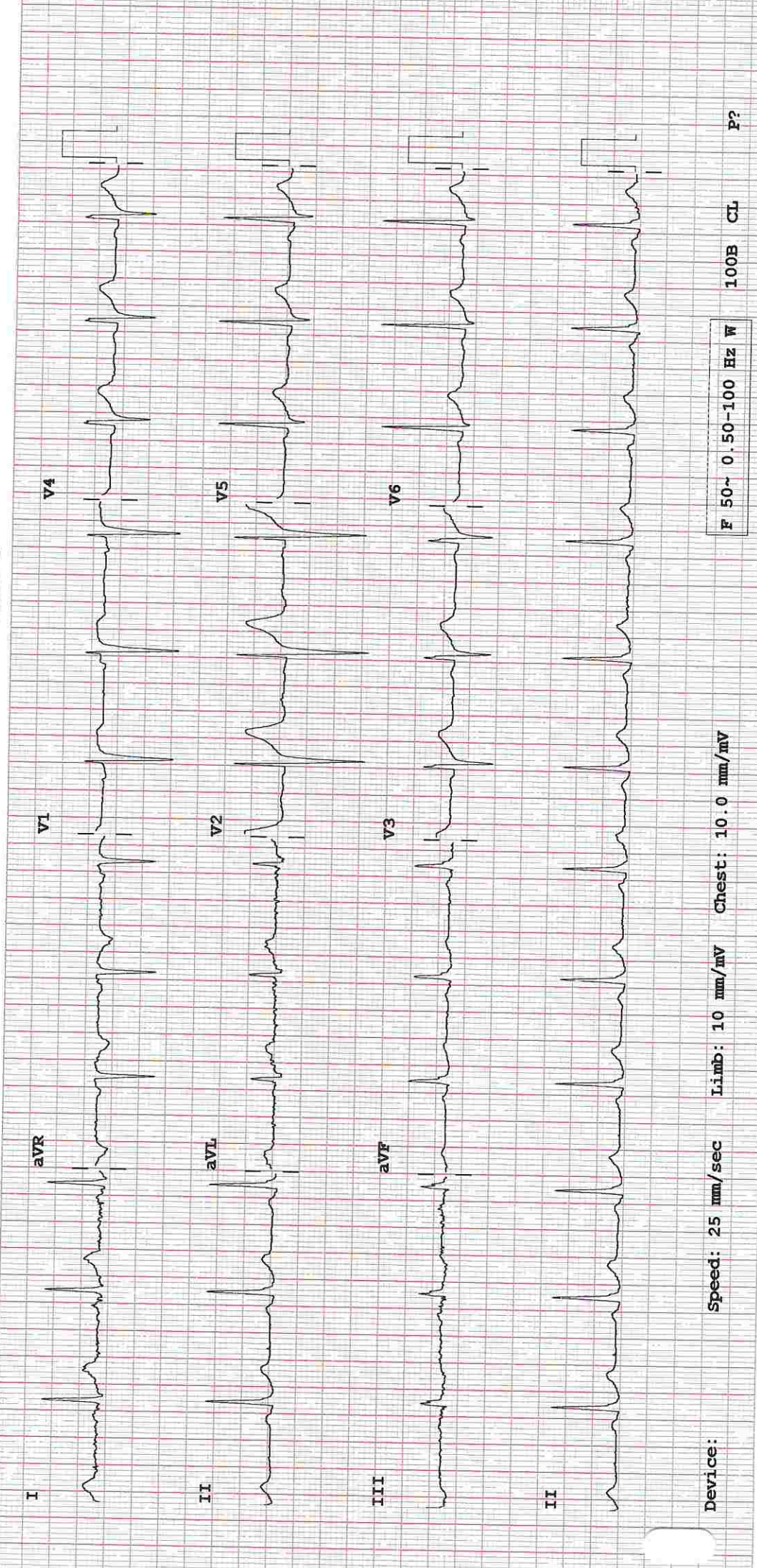
Sinus rhythm
HC

--AXIS--
 P 55
 QRS 45
 T 17

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



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

F 50~ 0.50-100 Hz W

100B CL

P?



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mr. Ravish Anand
Age | Sex: 32 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 8178772 | 65399/22/1501
Order No | Order Date: 1501/PN/OP/2212/139085 | 24-Dec-2022
Admitted On | Reporting Date : 24-Dec-2022 16:40:35
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	29	mm
AO Root	25	mm
AO CUSP SEP	22	mm
LVID (s)	29	mm
LVID (d)	41	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	23	mm
RA	28	mm
LVEF	60	%



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mr. Ravish Anand

UHID | Episode No : 8178772 | 65399/22/1501

Age | Sex: 32 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2212/139085 | 24-Dec-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 24-Dec-2022 16:40:35

Bed Name :

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.

A WAVE VELOCITY:0.6 m/sec

E/A RATIO:1.1

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			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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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mr. Ravish Anand

Age | Sex: 32 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 8178772 | 65399/22/1501

Order No | Order Date: 1501/PN/OP/2212/139085 | 24-Dec-2022

Admitted On | Reporting Date : 24-Dec-2022 22:03:53

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.

Y. Shah

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



DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mr. Ravish Anand
Age | Sex: 32 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 8178772 | 65399/22/1501
Order No | Order Date: 1501/PN/OP/2212/139085 | 24-Dec-2022
Admitted On | Reporting Date : 24-Dec-2022 14:35:02
Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

LIVER is normal in size (12.8 cm) and shows raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

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

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis. Right kidney measures 9.9 x 4.9 cm. Left kidney measures 10.3 x 5.1 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 mass/calculi.

PROSTATE is normal in size & echogenicity. It measures ~ 19 cc in volume. No evidence of ascites.

IMPRESSION:

- Fatty infiltration of liver.


DR. CHETAN KHADKE
M.D. (Radiologist)