

CLIENT CODE : C000138394
CLIENT'S NAME AND ADDRESS :
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
 NEW DELHI 110030
 DELHI INDIA
 8800465156

SRL Ltd
 S.K. Tower, Hari Niwas, LBS Marg
 THANE, 400602
 MAHARASHTRA, INDIA
 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
 Email : customercare.thane@srl.in

PATIENT NAME : MANOJ SHIRSH SALVI

PATIENT ID : MANOM08108143

ACCESSION NO : **0181WC000610** AGE : 41 Years SEX : Male

DRAWN : RECEIVED : 11/03/2023 10:53 REPORTED : 23/03/2023 12:38

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
Final			

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	11.0	Low 13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	4.75	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
WHITE BLOOD CELL (WBC) COUNT	7.42	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	317	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	36.7	Low 40.0 - 50.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	77.3	Low 83.0 - 101.0	fL
METHOD : CALCULATED FROM RBC & HCT			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	23.2	Low 27.0 - 32.0	pg
METHOD : CALCULATED FROM THE RBC & HGB			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	30.0	Low 31.5 - 34.5	g/dL
METHOD : CALCULATED FROM THE HGB & HCT			
RED CELL DISTRIBUTION WIDTH (RDW)	13.9	11.6 - 14.0	%
METHOD : CALCULATED FROM RBC SIZE DISTRIBUTION CURVE			
MENTZER INDEX	16.3		
MEAN PLATELET VOLUME (MPV)	10.8	6.8 - 10.9	fL
METHOD : CALCULATED FROM PLATELET COUNT & PLATELET HEMATOCRIT			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	70	40 - 80	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	21	20 - 40	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	6	2 - 10	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
EOSINOPHILS	3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
ABSOLUTE NEUTROPHIL COUNT	5.16	2.0 - 7.0	thou/ μ L
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			



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METHOD : UV ABSORBANCE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	54	High	< OR = 50	U/L
METHOD : UV ABSORBANCE				
ALKALINE PHOSPHATASE	106		40 - 129	U/L
METHOD : COLORIMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	29		0 - 60	U/L
METHOD : ENZYMATIC, COLORIMETRIC				
LACTATE DEHYDROGENASE	149		125 - 220	U/L
METHOD : UV ABSORBANCE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	12		6 - 20	mg/dL
METHOD : ENZYMATIC ASSAY				
CREATININE, SERUM				
CREATININE	0.72		0.7 - 1.2	mg/dL
METHOD : COLORIMETRIC				
BUN/CREAT RATIO				
BUN/CREAT RATIO	16.67	High	8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID	7.2	High	3.4 - 7.0	mg/dL
METHOD : ENZYMATIC COLORIMETRIC ASSAY				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.1		6.0 - 8.0	g/dL
METHOD : COLORIMETRIC				
ALBUMIN, SERUM				
ALBUMIN	4.3		3.97 - 4.94	g/dL
METHOD : COLORIMETRIC				
GLOBULIN				
GLOBULIN	2.8		2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	141		136 - 145	mmol/L
POTASSIUM, SERUM	4.49		3.5 - 5.1	mmol/L
CHLORIDE, SERUM	106		98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION, URINE				



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PH		5.0	5.00 - 7.50	
SPECIFIC GRAVITY		1.030	1.010 - 1.030	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	
BLOOD		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)		0-1	0-5	/HPF
EPITHELIAL CELLS		1-2	0-5	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM				
T3		114.0	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE				
T4		6.26	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE				
TSH (ULTRASENSITIVE)		1.530	0.27 - 4.2	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE				
PHYSICAL EXAMINATION, STOOL				
COLOUR		BROWN		
METHOD : VISUAL				
CONSISTENCY		SEMI FORMED		
METHOD : VISUAL				
MUCUS		NOT DETECTED	NOT DETECTED	
METHOD : VISUAL				
VISIBLE BLOOD		ABSENT	ABSENT	
METHOD : VISUAL				
CHEMICAL EXAMINATION, STOOL				
OCCULT BLOOD		NOT DETECTED	NOT DETECTED	



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METHOD : HEMOSPOT

MICROSCOPIC EXAMINATION, STOOL

PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
FAT	ABSENT		
VEGETABLE CELLS	PRESENT		
CONCENTRATION METHOD	NO OVA CYST SEEN AFTER PERFORMING CONCENTRATION TECHNIQUE FOR STOOL SAMPLE		

Comments

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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE A

METHOD : GEL COLUMN AGGLUTINATION METHOD.

RH TYPE POSITIVE

METHOD : GEL COLUMN AGGLUTINATION METHOD.

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO 2D ECHO : NORMAL

ECG

ECG WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY K/C/O DIABETIC 6 MONTH
 RELEVANT PAST HISTORY NOT SIGNIFICANT
 RELEVANT PERSONAL HISTORY MARRIED / MIXED DIET / NO ALLERGIES / NO SMOKING / ALCOHOL
 RELEVANT FAMILY HISTORY HIGH BLOOD PRESSURE, DIABETES- MOTHER



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OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.78		mts
WEIGHT IN KGS.	97		Kgs
BMI	31	BMI & Weight Status as follows: kg/sqmts 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	OBESE
BUILT / SKELETAL FRAMEWORK	AVERAGE
FACIAL APPEARANCE	NORMAL
SKIN	NORMAL
UPPER LIMB	NORMAL
LOWER LIMB	NORMAL
NECK	NORMAL
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER
THYROID GLAND	NOT ENLARGED
CAROTID PULSATION	NORMAL
TEMPERATURE	NORMAL
PULSE	80/MIN.REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT
RESPIRATORY RATE	NORMAL

CARDIOVASCULAR SYSTEM

BP	130/80 MM HG (SUPINE)	mm/Hg
PERICARDIUM	NORMAL	
APEX BEAT	NORMAL	
HEART SOUNDS	NORMAL	
MURMURS	ABSENT	

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST	NORMAL
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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		
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		REDUCED VISUAL ACUITY 6/24		
DISTANT VISION LEFT EYE WITHOUT GLASSES		REDUCED VISUAL ACUITY 6/24		
DISTANT VISION RIGHT EYE WITH GLASSES		WITH GLASSES NORMAL		
DISTANT VISION LEFT EYE WITH GLASSES		WITH GLASSES NORMAL		
NEAR VISION RIGHT EYE WITHOUT GLASSES		REDUCED VISUAL ACUITY N/12		
NEAR VISION LEFT EYE WITHOUT GLASSES		REDUCED VISUAL ACUITY N/36		
COLOUR VISION		NORMAL		

SUMMARY

RELEVANT HISTORY NOT SIGNIFICANT



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RELEVANT GP EXAMINATION FINDINGS REMARKS / RECOMMENDATIONS	NOT SIGNIFICANT FOLLOW UP WITH PHYSICIAN FOR BLOOD SUGAR CONTROL AND DYSLIPIDEMIA. STRICK LOW FAT, LOW CALORIE, LOW CARBOHYDRATE, HIGH FIBRE DIET. REGULAR EXERCISE. REGULAR WALK FOR 30-40 MIN DAILY. REPEAT LIPID PROFILE, BLOOD SUGAR, URIC ACID AFTER 3 MONTHS OF DIET AND EXERCISE. OPHTHALMOLOGY CONSULT FOR REDUCED VISUAL ACUITY. DRINK 2-3 LITRE WATER DAILY. UROLOGU CONSULT FOR KIDNEY STONE.
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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.)
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD-TEST DESCRIPTION :-
 Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

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

TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
 Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
 In pregnancy BRI in first trimester is 0-48 mm/hr (62 if anemic) and in second trimester (0-70 mm /hr (95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: 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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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

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.

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,



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CLIENT CODE : C000138394
CLIENT'S NAME AND ADDRESS :
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
 NEW DELHI 110030
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 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956
 Email : customercare.thane@srl.in

PATIENT NAME : MANOJ SHIRSH SALVI **PATIENT ID : MANOM08108143**

ACCESSION NO : **0181WC000610** AGE : 41 Years SEX : Male

DRAWN : RECEIVED : 11/03/2023 10:53 REPORTED : 23/03/2023 12:38

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status	Results	Units
Final		

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

GRADE I FATTY LIVER.
 BILATERAL RENAL NON BOSTRUCTING CALCULS.

****End Of Report****

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

CONDITIONS OF LABORATORY TESTING & REPORTING

- | | |
|---|---|
| <ol style="list-style-type: none"> 1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form. 2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services. 3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event. 4. A requested test might not be performed if: <ol style="list-style-type: none"> i. Specimen received is insufficient or inappropriate ii. Specimen quality is unsatisfactory iii. Incorrect specimen type iv. Discrepancy between identification on specimen container label and test requisition form | <ol style="list-style-type: none"> 5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity. 6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis. 7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification. 8. Test results cannot be used for Medico legal purposes. 9. In case of queries please call customer care (91115 91115) within 48 hours of the report. |
|---|---|

SRL Limited
 Fortis Hospital, Sector 62, Phase VIII,
 Mohali 160062



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