Hiranandani
HOSPITAL
(A Fortis Network Hospital)

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

BMI CHART

Date: 12 / 11 / 22

Name: Mrs. Shehnaz Ansari Age: ____ yrs Sex: M / F

BP: 110/80 mmHg Height (cms): 153.5 Weight(kgs): 52.6 BMI: 22

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy						Overweight				Obese				Extremely Obese				
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

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

Hiranandani HOSPITAL
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UHID	**12115865**	**Date**	**12 /11/2022**		
Name	**Mrs.Shehnaz Ansari**	**Sex**	**Male**	**Sex**	**45** 41
OPD	**PAP**	**Health Check-up**			

Drug allergy:
Sys illness:

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UHID	**12115865**	**Date**	**12 /11/2022**		
Name	**Mrs.Shehnaz Ansari**	**Sex**	**Male**	**Sex**	~~45~~ 41
OPD	**Opthal 14**	**Health Check-up**			

Ch. No.

MR. No

Drug allergy: -> Not known
Sys illness: ->

United V → RE 6/9P.
→ LE 6/12P.

Ref → RE → Plano/ − 1.00 × 100° 6/6.
→ LE → Plano/ − 1.25 × 80° 6/6
Add → + 1.25 → N6
→ N6

IOP: → RE → 15.5
→ LE → 15.6

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UHID	**12115865**	**Date**	**12 /11/2022**		
Name	**Mrs.Shehnaz Ansari**	**Sex**	**Male**	**Sex**	**~~45~~ 41**
OPD	**Dental 12**	**Health Check-up**			

Drug allergy:
Sys illness:

LABORATORY REPORT

Cert. No. MC-2984

Fortis

SRL Diagnostics

PATIENT NAME : MRS. MRS.SHEHNAZ KHURSHID ANSARI

PATIENT ID : **FH.12115865** CLIENT PATIENT ID : UID:12115865

ACCESSION NO : **0022VK002635** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 12/11/2022 09:31:00 RECEIVED : 12/11/2022 09:31:46 REPORTED : 12/11/2022 14:41:24

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	87.6	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	6.39	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.880	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

Sirmukaddam 786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

SRL Ltd
BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4, KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000080806

PATIENT NAME : MRS. MRS.SHEHNAZ KHURSHID ANSARI

PATIENT ID : **FH.12115865** CLIENT PATIENT ID : UID:12115865

ACCESSION NO : **0022VK002635** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 12/11/2022 09:31:00 RECEIVED : 12/11/2022 09:31:46 REPORTED : 12/11/2022 12:50:52

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results		Biological Reference Interval	Units
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	**4**	**Low**	6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE	**0.53**	**Low**	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE	45			years
GLOMERULAR FILTRATION RATE (FEMALE)	116.16		Refer Interpretation Below	mL/min/1.73m
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO	7.55		5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	3.3		2.6 - 6.0	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	8.0		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	3.9		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM	138		136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM	3.94		3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM	103		98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

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CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
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Test Report Status **Final**	Results	Biological Reference Interval	Units

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, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.
ALBUMIN, SERUM-
Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results		Biological Reference Interval	Units
HAEMATOLOGY				
CBC-5, EDTA WHOLE BLOOD				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	37.0		36 - 46	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	**77.6**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**26.1**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.6		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	**14.6**	**High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	16.3			
MEAN PLATELET VOLUME (MPV)	9.7		6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	56		40 - 80	%
METHOD : FLOW CYTOMETRY				
LYMPHOCYTES	30		20 - 40	%
METHOD : FLOW CYTOMETRY				
MONOCYTES	8		2 - 10	%
METHOD : FLOW CYTOMETRY				
EOSINOPHILS	6		1 - 6	%
METHOD : FLOW CYTOMETRY				
BASOPHILS	0		0 - 2	%
METHOD : FLOW CYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT	3.30		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT	1.77		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT	0.47		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.35		0.02 - 0.50	thou/µL

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Test Report Status **Final**	Results		Biological Reference Interval	Units
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.8			
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD ANISOCYTOSIS			
METHOD : MICROSCOPIC EXAMINATION				
WBC	NORMAL MORPHOLOGY			
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS	ADEQUATE			
METHOD : MICROSCOPIC EXAMINATION				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R	**22**	**High**	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	12.4		12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.77		3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	5.90		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	357		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				

Interpretation(s)
RBC AND PLATELET INDICES-
Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

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Scan to View Report

Patient Ref. No. 2200000080806

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CORP-OPD
BILLNO-150122OPCR056874
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Test Report Status **Final**	Results	Biological Reference Interval

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

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

TEST INTERPRETATION

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

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

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

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIO CHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.52	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.07	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.45	0.1 - 1.0	mg/dL

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CORP-OPD
BILLNO-150122OPCR056874
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Test Report Status **Final**	Results	Biological Reference Interval	
TOTAL PROTEIN METHOD : BIURET	8.0	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	4.1	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.9	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P	23	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	21	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	58	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	26	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	172	100 - 190	U/L

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE	189	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES METHOD : ENZYMATIC ASSAY	102	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL CHOLESTEROL METHOD : DIRECT MEASURE - PEG	46	< 40 Low >/=60 High	mg/dL
LDL CHOLESTEROL, DIRECT METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT	117	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	**143** **High**	Desirable: Less than 130 Above Desirable: 130 - 159	mg/dL

PATIENT NAME : MRS. MRS.SHEHNAZ KHURSHID ANSARI

PATIENT ID : **FH.12115865** CLIENT PATIENT ID : UID:12115865

ACCESSION NO : **0022VK002635** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 12/11/2022 09:31:00 RECEIVED : 12/11/2022 09:31:46 REPORTED : 12/11/2022 12:50:52

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results	Biological Reference Interval	
		Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.1	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	2.5	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	20.4	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	89	74 - 99	mg/dL
METHOD : HEXOKINASE			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

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 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

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CLINICAL INFORMATION :

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

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-norma 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 tc 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
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. Hig triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or havir 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 primar 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.

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.
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in t 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:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.

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PATIENT ID : **FH.12115865** CLIENT PATIENT ID : UID:12115865

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DRAWN : 12/11/2022 09:31:00 RECEIVED : 12/11/2022 09:31:46 REPORTED : 12/11/2022 12:50:52

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
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Test Report Status **Final**	Results	Biological Reference Interval

3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

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

CLINICAL PATH

URINALYSIS

PHYSICAL EXAMINATION, URINE

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

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	<=1.005	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 (++)**	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

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ACCESSION NO : **0022VK002635** AGE : 45 Years SEX : Female ABHA NO :

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UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results	Biological Reference Interval	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	**DETECTED (++)**	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	**5 - 7**	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	**30-40**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	**40-50**	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	**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)			

****End Of Report****

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

Rekha. N

Dr. Rekha Nair, MD
Microbiologist

Dr.Akta Dubey

Dr.Akta Dubey
Counsultant Pathologist

LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MRS. MRS.SHEHNAZ KHURSHID ANSARI

PATIENT ID : **FH.12115865** CLIENT PATIENT ID : UID:12115865

ACCESSION NO : **0022VK002719** AGE : 45 Years SEX : Female ABHA NO :

DRAWN : 12/11/2022 12:47:00 RECEIVED : 12/11/2022 12:49:15 REPORTED : 12/11/2022 14:20:43

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

CLINICAL INFORMATION :

UID:12115865 REQNO-1319208
CORP-OPD
BILLNO-150122OPCR056874
BILLNO-150122OPCR056874

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIO CHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	97	70 - 139	mg/dL

Interpretation(s)
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

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Dr.Akta Dubey
Counsultant Pathologist

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CIN - U74899PB1995PLC045956
Email : -

Scan to View Details

Scan to View Report

Patient Ref. No. 2200000080815

12115865 shehnaz ansari 11/12/2022 11:22:08 AM
45 Years Female

HE

Rate	108	. Sinus tachycardia.....rate> 99
		. RSR' in V1 or V2, probably normal variant.....small R' only
PR	147	. Baseline wander in lead(s) V3
QRSD	88	
QT	324	
QTc	435	

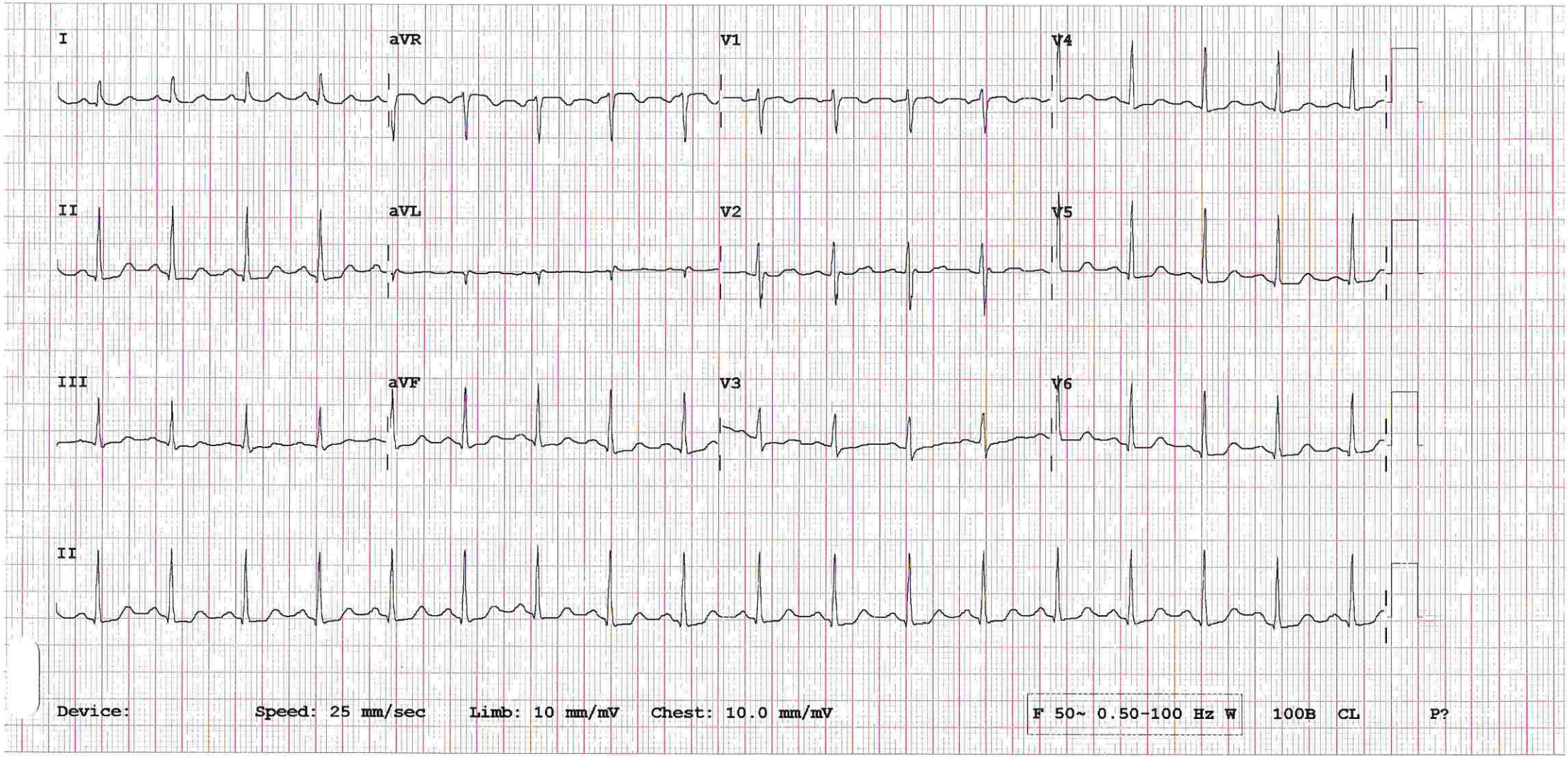
Sinus tachycardia

--AXIS--
P 53
QRS 59
T 48

- OTHERWISE 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?

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CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 12/Nov/2022

Name: Mrs. Shehnaz Khurshid Ansari
Age | Sex: 45 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12115865 | 56319/22/1501
Order No | Order Date: 1501/PN/OP/2211/119667 | 12-Nov-2022
Admitted On | Reporting Date : 12-Nov-2022 13:47:52
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

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

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Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 12/Nov/2022

DEPARTMENT OF RADIOLOGY

Name: Mrs. Shehnaz Khurshid Ansari
Age | Sex: 45 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12115865 | 56319/22/1501
Order No | Order Date: 1501/PN/OP/2211/119667 | 12-Nov-2022
Admitted On | Reporting Date : 12-Nov-2022 16:12:53
Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size (13.7 cm) and echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

GALL BLADDER is partially distended.

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 9.0 x 4.4 cm.
Left kidney measures 9.1 x 4.5 cm.

PANCREAS: Head of pancreas appear unremarkable. Rest of the pancreas is obscured.

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

UTERUS is normal in size, measuring 9.4 x 4.3 x 5.1 cm. Two intramural lesions of sizes 6.6 x 6.6 mm & 6.6 x 6.8 mm are noted at anterior wall of uterus – possibility of fibroids likely.
Endometrium measures 4.4 mm in thickness.

Both ovaries are normal.
Right ovary measures 2.1 x 1.4 cm.
Left ovary measures 2.3 x 1.0 cm.

No evidence of ascites.

IMPRESSION:

- **Two intramural lesions along the anterior wall of uterus – possibility of fibroids likely.**

Suggest clinical correlation.

DR. YOGESH PATHADE
(MD Radio-diagnosis)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 12/Nov/2022

Name: Mrs. Shehnaz Khurshid Ansari
Age | Sex: 45 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12115865 | 56319/22/1501
Order No | Order Date: 1501/PN/OP/2211/119667 | 12-Nov-2022
Admitted On | Reporting Date : 12-Nov-2022 14:07:04
Order Doctor Name : Dr.SELF .

MAMMOGRAM - BOTH BREAST

Findings:

Bilateral film screen mammography was performed in cranio-caudal and medio-lateral oblique views.

Both breasts show scattered areas of fibroglandular density.

No evidence of any dominant mass, clusters of microcalcifications, nipple retraction, skin thickening or abnormal vascularity is seen in either breast.

No evidence of axillary lymphadenopathy.

IMPRESSION:

- **No significant abnormality detected. (BI-RADS category I).**
- **No obvious mass lesion in the breasts.**

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