ranandani Healthcare Pvt. Ltd.
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GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

		Date	24/12/2022		
UHID	12197422	Sex	Female	Age	30
Name	Mrs.Pradnya Sawant	Health Check-up			
OPD	Papsmear				

30yrs | P2L0.

Drug allergy:
Sys illness:

Lmp: 10.12.22
Pmc: 3/30d, RMP

P/S: cx vg (N) pap

Breast exmn (N).

Adv
- F/u c reports
- Pap smear 3yrly.
- Self breast exmn mthly

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Hiranandani HOSPITAL
fortis

UHID	12197422	**Date**	24/12/2022
Name	Mrs.Pradnya Sawant	**Sex**	Female **Age** 30
OPD	Opthal 14	**Health Check Up**	

Drug allergy:→ Not known
Sys illness: → . NO

C/o. No.

H/o. D.M (since 1yr).

WT 64.1 kg
HT 147 cm
BP - 110/60 mmHg
plus - 86 b/m

Unaided V → Rt 6/6
→ Lt 6/6

Ref → Rt → Plano 6/6
→ Lt → Plano 6/6

NV → Rt N6
→ Lt N6

I.O.P. → Rt → 18.4
→ Lt → 18.6

[signature]

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9112

Hiranandani HOSPITAL

UHID	**12197422**	**Date**	**24/12/2022**
Name	**Mrs.Pradnya Sawant**	**Sex**	**Female Age 30**
OPD	**Dental 12**	**Health Check Up**	

Drug allergy:
Sys illness:

Caries 6 / 8 8

Re RCT procedure going on 6

Stains +

Calculus +

Treatment

Adv filling 8

Adv extraction 8

Adv oral prophylaxis

Dr Diksha Keka

Cert. No. MC-2275

Pap pending

LABORATORY REPORT

Fortis | SRL Diagnostics

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:42 REPORTED : 24/12/2022 15:11:16

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results		Biological Reference Interval	Units
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN METHOD : UREASE - UV	**5**	**Low**	6 - 20	mg/dL
CREATININE EGFR- EPI				
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	**0.46**	**Low**	0.60 - 1.10	mg/dL
AGE	30			years
GLOMERULAR FILTRATION RATE (FEMALE) METHOD : CALCULATED PARAMETER	131.94		Refer Interpretation Below	mL/min/1.73m2
BUN/CREAT RATIO				
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	10.87		5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID METHOD : URICASE UV	3.8		2.6 - 6.0	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN METHOD : BIURET	7.5		6.4 - 8.2	g/dL
ALBUMIN, SERUM				
ALBUMIN METHOD : BCP DYE BINDING	3.7		3.4 - 5.0	g/dL
GLOBULIN				
GLOBULIN METHOD : CALCULATED PARAMETER	3.8		2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM METHOD : ISE INDIRECT	**134**	**Low**	136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.05		3.50 - 5.10	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	99		98 - 107	mmol/L

Interpretation(s)

PHYSICAL EXAMINATION, URINE

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Patient Ref. No. 22000000817626

LABORATORY REPORT

PATIENT NAME :MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results	Biological Reference Interval	Units
COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	**SLIGHTLY HAZY**		
CHEMICAL EXAMINATION, URINE			
PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	6.0	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	<=1.005	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	NOT DETECTED	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	3-5	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	**5-7**	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		

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Patient Ref. No. 22000000817626

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:42 REPORTED : 24/12/2022 15:11:16

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results	Biological Reference Interval
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.	

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, 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.

LABORATORY REPORT

PATIENT NAME :MRS.PRADNYA SAWANT

Fortis | SRL Diagnostics

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results		Biological Reference Interval	
HAEMATOLOGY - CBC				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	12.1		12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	4.53		3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	**10.29**	**High**	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	407		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	36.0		36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	**79.6**	**Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	**26.7**	**Low**	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	33.5		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**15.1**	**High**	11.6 - 14.0	%
MENTZER INDEX	17.6			
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.2		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
NEUTROPHILS METHOD : FLOW CYTOMETRY	65		40 - 80	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY	27		20 - 40	%
MONOCYTES METHOD : FLOW CYTOMETRY	5		2 - 10	%
EOSINOPHILS METHOD : FLOW CYTOMETRY	3		1 - 6	%

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Patient Ref. No. 22000000817626

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results		Biological Reference Interval	
BASOPHILS METHOD : FLOW CYTOMETRY	0		0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	6.69		2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.78		1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.51		0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.31		0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0**	**Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	2.4			
MORPHOLOGY				
RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC			
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY			
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE			

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.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R METHOD : WESTERGREN METHOD	15		0 - 20	mm at 1 hr

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CLINICAL INFORMATION :

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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, 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.

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.44	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.13	0.0 - 0.2	mg/dL

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CLINICAL INFORMATION :

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BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results		Biological Reference Interval	
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.31		0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.5		6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.7		3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.8		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.0		1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P	**11**	**Low**	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	20		< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	97		30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	22		5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	150		100 - 190	U/L
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	**129**	**High**	74 - 99	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C METHOD : HB VARIANT (HPLC)	**9.6**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG) METHOD : CALCULATED PARAMETER	**228.8**	**High**	< 116.0	mg/dL

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

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

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 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 sothat 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 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.
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

Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:42 REPORTED : 24/12/2022 15:11:16

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

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

BIOCHEMISTRY- LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	156	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	109	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	47	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	110	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	109	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.3	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	2.3	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	21.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			

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

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Patient Ref. No. 22000000817626

Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:42 REPORTED : 24/12/2022 15:11:16

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

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

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.

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.

****End Of Report****

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Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005457** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 12:04:00 RECEIVED : 24/12/2022 12:04:12 REPORTED : 24/12/2022 13:27:34

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**222**	**High** 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
Counsultant Pathologist

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Patient Ref. No. 22000000817724

Cert. No. MC-2984

LABORATORY REPORT

PATIENT NAME : MRS.PRADNYA SAWANT

PATIENT ID : **FH.12197422** CLIENT PATIENT ID : UID:12197422

ACCESSION NO : **0022VL005359** AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 24/12/2022 09:12:00 RECEIVED : 24/12/2022 09:13:42 REPORTED : 24/12/2022 14:22:09

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

CLINICAL INFORMATION :

UID:12197422 REQNO-1349113
CORP-OPD
BILLNO-150122OPCR066024
BILLNO-150122OPCR066024

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	113.6	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	9.84	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.970	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

****End Of Report****

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Sirmukaddam 786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

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NAVI MUMBAI, 410210
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Patient Ref. No. 22000000817626

Male

Rate 75 . Sinus rhythm.....normal P axis, V-rate 50- 99
. Baseline wander in lead(s) V6

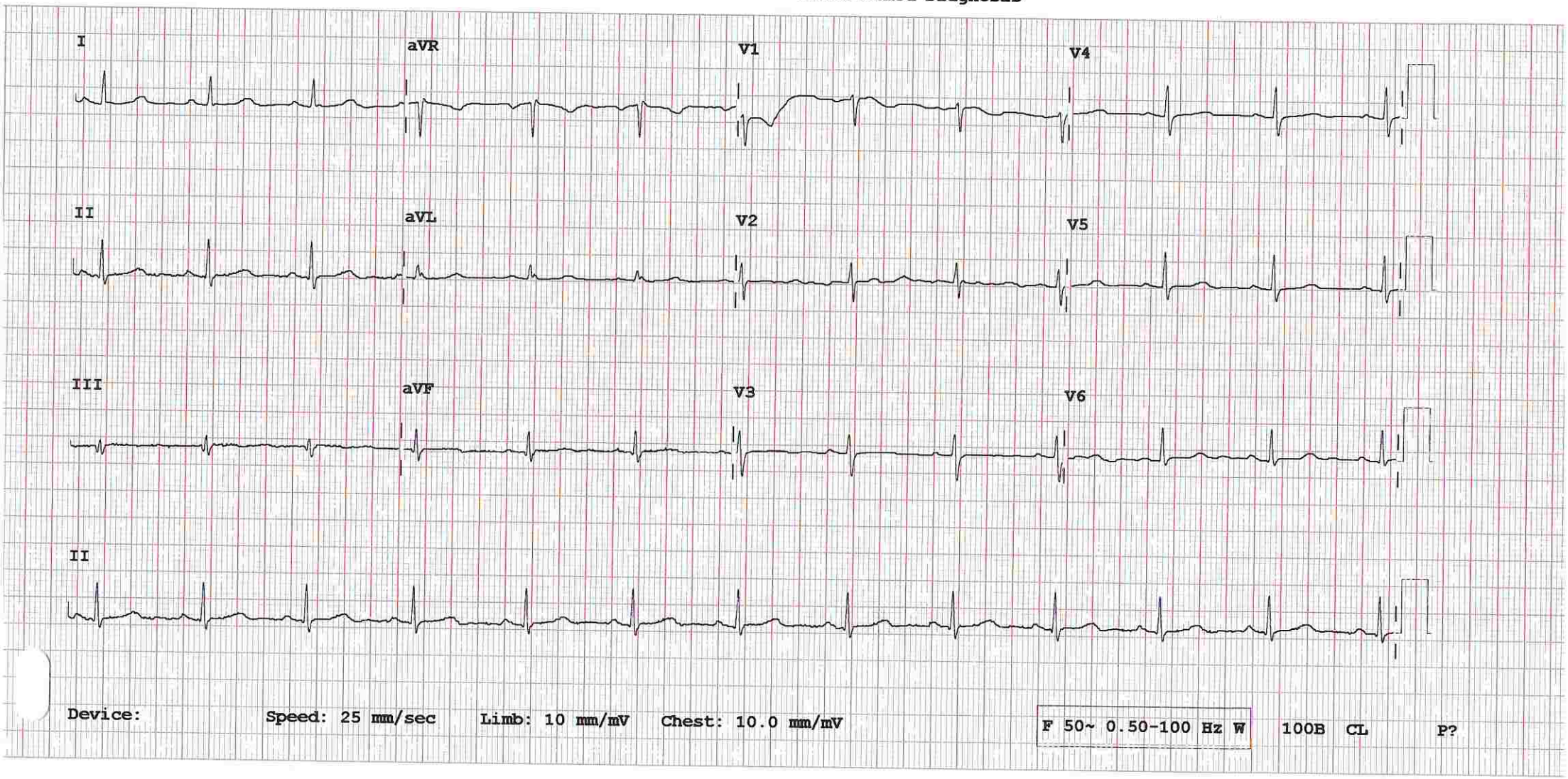
PR 153
QRSD 100
QT 419
QTc 468

--AXIS--
P 19
QRS 10
T 26

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mrs. Pradnya Sawant
Age | Sex: 30 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12197422 | 65333/22/1501
Order No | Order Date: 1501/PN/OP/2212/138924 | 24-Dec-2022
Admitted On | Reporting Date : 24-Dec-2022 11:50:54
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	32	mm
AO Root	22	mm
AO CUSP SEP	21	mm
LVID (s)	22	mm
LVID (d)	33	mm
IVS (d)	08	mm
LVPW (d)	08	mm
RVID (d)	20	mm
RA	30	mm
LVEF	60	%

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Date: 24/Dec/2022

Name: Mrs. Pradnya Sawant
Age | Sex: 30 YEAR(S) | Female
Order Station : FO-OPD
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Admitted On | Reporting Date : 24-Dec-2022 11:50:54
Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 1.1 m/sec.
A WAVE VELOCITY:0.6 m/sec
E/A RATIO:1.7

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	8			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	1.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mrs. Pradnya Sawant
Age | Sex: 30 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12197422 | 65333/22/1501
Order No | Order Date: 1501/PN/OP/2212/138924 | 24-Dec-2022
Admitted On | Reporting Date : 24-Dec-2022 18:49:09
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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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 26/Dec/2022

Name: Mrs. Pradnya Sawant
Age | Sex: 30 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12197422 | 65333/22/1501
Order No | Order Date: 1501/PN/OP/2212/138924 | 24-Dec-2022
Admitted On | Reporting Date : 26-Dec-2022 14:44:32
Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

Suboptimal study due gaseous abdominal distension and patient body habitus.

LIVER is normal in size (13.3 cm) and shows increased echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is partially distended.

SPLEEN is normal in size (10.0 cm) and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.
Right kidney measures 10.3 x 4.8 cm.
Left kidney measures 10.3 x 5.8 cm.

PANCREAS is obscured due to bowel gas.

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

UTERUS is normal in size, measuring 7.0 x 3.9 x 2.6 cm.
Endometrium measures mm in thickness.

Both ovaries are normal.
Right ovary measures 2.4 x 1.7 cm.
Left ovary measures 3.2 x 1.6 cm.

No evidence of ascites.

IMPRESSION:

- **Fatty infiltration of liver. Suggest: clinical correlation / further evaluation if clinically indicated.**

DR. YOGESH PATHADE
(MD Radio-diagnosis)