



CLIENT CODE : C000138384

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
30-B, CHOWRINGEE MANSION, JAWAHARLAL NEHRU ROAD,
KOLKATA, 700016
WEST BENGAL, INDIA
Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : NAGMA

PATIENT ID : NAGMF19018882

ACCESSION NO : 0082VK000371 AGE : 34 Years SEX : Female

ABHA NO :

DRAWN : 12/11/2022 08:40

RECEIVED : 12/11/2022 08:53

REPORTED : 14/11/2022 17:38

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

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Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	11.8	Low	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.07		3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	11.43	High	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	214		150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDANCE & MICROSCOPY				

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	35.5	Low	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOLUME (MCV)	87.3		83 - 101	fL
METHOD : ELECTRICAL IMPEDANCE				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.1		27.0 - 32.0	pg
METHOD : CALCULATED				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.4		31.5 - 34.5	g/dL
METHOD : CALCULATED				
RED CELL DISTRIBUTION WIDTH (RDW)	14.4	High	11.6 - 14.0	%
METHOD : ELECTRICAL IMPEDANCE				
MENTZER INDEX	21.5			
MEAN PLATELET VOLUME (MPV)	10.9		6.8 - 10.9	fL
METHOD : CALCULATED				

WBC DIFFERENTIAL COUNT

NEUTROPHILS	78		40 - 80	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
LYMPHOCYTES	16	Low	20 - 40	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
MONOCYTES	4		2 - 10	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
EOSINOPHILS	2		1 - 6	%
BASOPHILS	0		0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE NEUTROPHIL COUNT	8.92	High	2.0 - 7.0	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				





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ABSOLUTE LYMPHOCYTE COUNT		1.83	1 - 3	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.46	0.20 - 1.00	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.23	0.02 - 0.50	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00	Low 0.02 - 0.10	thou/ μ L
METHOD : FLOWCYTOMETRY & CALCULATED				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD				
E.S.R		19	0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		107	High 74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.5	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HPLC				
ESTIMATED AVERAGE GLUCOSE(EAG)		111.2	< 116.0	mg/dL



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SRL LIMITED - KOLKATA REF. LAB
Bio-Rad Variant II Turbo CDM 5.4 S/N : 13466

PATIENT REP
V2TURBO_A1c

Patient Data

Sample ID: 8212312300
Patient ID: 0082VK000371
Name: NAGMA
Physician:
Sex:
DOB:

Analysis Data

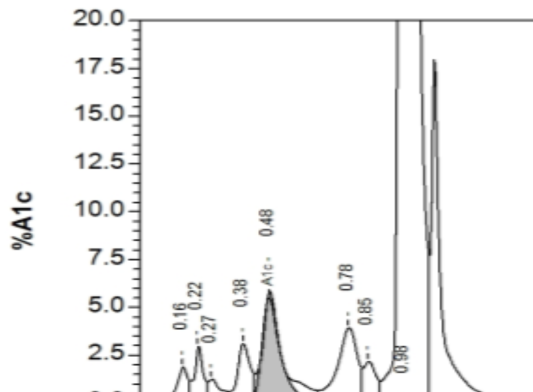
Analysis Performed: 12/11/2022 15:02:18
Injection Number: 2908
Run Number: 210
Rack ID:
Tube Number: 10
Report Generated: 12/11/2022 15:32:01
Operator ID:

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	0.9	0.158	30332
A1b	---	1.2	0.215	36901
F	---	0.7	0.266	21994
LA1c	---	1.8	0.384	58348
A1c	5.5	---	0.480	145068
P3	---	3.5	0.776	111251
P4	---	1.2	0.849	37479
Ao	---	86.2	0.981	2756595

Total Area: 3,197,968

HbA1c (NGSP) = 5.5 %



GLUCOSE, POST-PRANDIAL, PLASMA



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PPBS(POST PRANDIAL BLOOD SUGAR)		116	140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
LIPID PROFILE, SERUM				
CHOLESTEROL, TOTAL		196	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY				
TRIGLYCERIDES		161	High < 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE				
HDL CHOLESTEROL		48	Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY				
CHOLESTEROL LDL		116		mg/dL
NON HDL CHOLESTEROL		148		mg/dL
CHOL/HDL RATIO		4.1		
LDL/HDL RATIO		2.4		
VERY LOW DENSITY LIPOPROTEIN		32.2		mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.50	0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT				
BILIRUBIN, DIRECT		0.20	0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION				
BILIRUBIN, INDIRECT		0.33	0.1 - 1.0	mg/dL
METHOD : CALCULATED				
TOTAL PROTEIN		7.6	6.0 - 8.30	g/dL
METHOD : BIURET				
ALBUMIN		4.0	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN		3.6	High 2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.1	1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		17	5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		13	0 - 55	U/L





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METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALKALINE PHOSPHATASE		73	40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE				
GAMMA GLUTAMYL TRANSFERASE (GGT)		10	8 - 33	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD				
LACTATE DEHYDROGENASE		140	125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		9	7.0 - 18.7	mg/dL
METHOD : UREASE METHOD				
CREATININE, SERUM				
CREATININE		0.70	0.50 - 1.00	mg/dL
METHOD : KINETIC ALKALINE PICRATE				
BUN/CREAT RATIO				
BUN/CREAT RATIO		13.85	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		4.2	2.6 - 6.0	mg/dL
METHOD : URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.6	6.0 - 8.3	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN		4.0	3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN				
GLOBULIN		3.6	High 2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		135	Low 136 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				
POTASSIUM, SERUM		3.50	3.5 - 5.1	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				
CHLORIDE, SERUM		100	98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT				
PHYSICAL EXAMINATION, URINE				
COLOR		PALE YELLOW		
APPEARANCE		CLEAR		





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CHEMICAL EXAMINATION, URINE

PH	7.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.005	1.003 - 1.035	
METHOD : DIPSTICK			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : DIPSTICK			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
LEUKOCYTE ESTERASE	NEGATIVE	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	1-2	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	

Comments

URINALYSIS: MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

THYROID PANEL, SERUM

T3	66.0	35 - 193	ng/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
T4	9.00	4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	4.166	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			





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Interpretation(s)

Triiodothyronine T3, **Thyroxine T4**, and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4. TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PAPANICOLAOU SMEAR

SPECIMEN TYPE

TWO UNSTAINED CERVICAL SMEARS RECEIVED

REPORTING SYSTEM

2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY

SPECIMEN ADEQUACY

SMEARS ARE SATISFACTORY FOR EVALUATION.





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MICROSCOPY

SMEARS STUDIED ARE SATISFACTORY FOR EVALUATION AND SHOW MAINLY SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS AND PARABASAL CELLS. FEW METAPLASTIC CELLS ARE SEEN. MONILIA AND T. VAGINALIS ARE ABSENT. DYSPLASTIC AND MALIGNANT CELLS ARE ABSENT.

METHOD : MANUAL

INTERPRETATION / RESULT

NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

Comments

- 1) PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS. HENCE SHOULD BE INTERPRETED WITH CAUTION.
- 2) NO CYTOLOGIC EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

STOOL: OVA & PARASITE

COLOUR	BROWN		
METHOD : VISUAL			
CONSISTENCY	SEMI FORMED		
METHOD : MANUAL			
ODOUR	FAECAL		
METHOD : MANUAL			
MUCUS	PRESENT	NOT DETECTED	
METHOD : MANUAL			
VISIBLE BLOOD	ABSENT	ABSENT	
METHOD : VISUAL			
POLYMORPHONUCLEAR LEUKOCYTES	2-3	0 - 5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
MACROPHAGES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CHARCOT-LEYDEN CRYSTALS	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			





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CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
LARVAE		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
ADULT PARASITE		NOT DETECTED		
METHOD : VISUAL				
OCCULT BLOOD		NOT DETECTED	NOT DETECTED	
METHOD : MANUAL				
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP		TYPE AB		
METHOD : TUBE AGGLUTINATION				
RH TYPE		POSITIVE		
METHOD : TUBE AGGLUTINATION				
XRAY-CHEST				
IMPRESSION		NO ABNORMALITY DETECTED		
TMT OR ECHO				
TMT OR ECHO		ECHO DONE INSTEAD OF TMT ECHO : NORMAL STUDY		
ECG				
ECG		WITHIN NORMAL LIMITS		
MEDICAL HISTORY				
RELEVANT PRESENT HISTORY		HYPOTHYROID (5 YRS) : IS ON MEDICATION BACKACHE		
RELEVANT PAST HISTORY		NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY		NOT SIGNIFICANT		
MENSTRUAL HISTORY (FOR FEMALES)		REGULAR		
LMP (FOR FEMALES)		27/10/22		
RELEVANT FAMILY HISTORY		FATHER : DIABETIC, HYPERTENSIVE		
OCCUPATIONAL HISTORY		NOT SIGNIFICANT		
HISTORY OF MEDICATIONS		NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI				
HEIGHT IN METERS		1.60		mts
WEIGHT IN KGS.		73		Kgs
BMI		29		
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		



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CLIENT CODE : C000138384

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
30-B, CHOWRINGEE MANSION, JAWAHARLAL NEHRU ROAD,
KOLKATA, 700016
WEST BENGAL, INDIA
Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : NAGMA

PATIENT ID : NAGMF19018882

ACCESSION NO : 0082VK000371 AGE : 34 Years SEX : Female

ABHA NO :

DRAWN : 12/11/2022 08:40

RECEIVED : 12/11/2022 08:53

REPORTED : 14/11/2022 17:38

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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PHYSICAL ATTITUDE		NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS		OVERWEIGHT		
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		93/MINS		
RESPIRATORY RATE		NORMAL		
CARDIOVASCULAR SYSTEM				
BP		106/63		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		S1, S2 HEARD NORMALLY		
MURMURS		ABSENT		
RESPIRATORY SYSTEM				
SIZE AND SHAPE OF CHEST		NORMAL		
MOVEMENTS OF CHEST		SYMMETRICAL		
BREATH SOUNDS INTENSITY		NORMAL		
BREATH SOUNDS QUALITY		VESICULAR (NORMAL)		
ADDED SOUNDS		ABSENT		
PER ABDOMEN				
APPEARANCE		NORMAL		
VENOUS PROMINENCE		ABSENT		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		
CENTRAL NERVOUS SYSTEM				
HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		



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Test Report Status	Final	Results	Biological Reference Interval	Units
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		
DISTANT VISION RIGHT EYE WITHOUT GLASSES		6/6		
DISTANT VISION LEFT EYE WITHOUT GLASSES		6/6		
NEAR VISION RIGHT EYE WITHOUT GLASSES		N6		
NEAR VISION LEFT EYE WITHOUT GLASSES		N6		
COLOUR VISION		NORMAL		
BASIC ENT EXAMINATION				
EXTERNAL EAR CANAL		NORMAL		
TYMPANIC MEMBRANE		NORMAL		
NOSE		NO ABNORMALITY DETECTED		
SINUSES		NORMAL		
THROAT		NO ABNORMALITY DETECTED		
TONSILS		NOT ENLARGED		
BASIC DENTAL EXAMINATION				
TEETH		NORMAL		
GUMS		HEALTHY		

SUMMARY

REMARKS / RECOMMENDATIONS

Mrs. NAGMA CAME FOR ANNUAL HEALTH CHECK UP. SHE IS OVERWEIGHT (73 kgs). ADVISED :

1. DIET MODIFICATION AS DISCUSSED.
2. REDUCE BODY WEIGHT (ESTIMATED BODY WEIGHT SHOULD BE : 60 KGS).
3. REGULAR PHYSICAL EXERCISE AND WALKING.
4. DRINK PLENTY OF WATER.
5. CONSULT COMPANY MEDICAL OFFICER/FAMILY PHYSICIAN



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Tel : 033-22267333,46019048, Fax : 033-22271324
CIN - U74899PB1995PLC045956

PATIENT NAME : NAGMA

PATIENT ID : NAGMF1901882

ACCESSION NO : 0082VK000371 AGE : 34 Years SEX : Female ABHA NO :

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REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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Comments

MEDICAL EXAMINATION DONE BY:

DR. B. N. JANA, MBBS, DCH
CONSULTANT
WELLNESS CLINIC
PARK STREET, KOLKATA

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

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

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

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

False Decreased : Poikilocytosis, (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 the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

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:

Hypoglycemia is defined as a glucose of < 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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.



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CIN - U74899PB1995PLC045956

PATIENT NAME : NAGMA

PATIENT ID : NAGMF19018882

ACCESSION NO : 0082VK000371 AGE : 34 Years SEX : Female ABHA NO :

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CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
 - Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
 - Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
 - Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
- GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

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

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

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenström's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. 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

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

- CREATININE, SERUM-Higher than normal level may be due to:
- Blockage in the urinary tract
 - Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
 - Loss of body fluid (dehydration)
 - Muscle problems, such as breakdown of muscle fibers
 - Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

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



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 CIN - U74899PB1995PLC045956

PATIENT NAME : NAGMA **PATIENT ID : NAGMF1901882**

ACCESSION NO : 0082VK000371 **AGE : 34 Years** **SEX : Female** **ABHA NO :**

DRAWN : 12/11/2022 08:40 **RECEIVED : 12/11/2022 08:53** **REPORTED : 14/11/2022 17:38**

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Test Report Status	Results	Biological Reference Interval	Units
Final			

TOTAL PROTEIN, SERUM-
 Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenström's disease
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

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.

MEDICAL

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



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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

NO ABNORMALITIES DETECTED

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

Dr. B. N. Jana, MBBS, DCH
Consultant

CONDITIONS OF LABORATORY TESTING & REPORTING

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:
 - 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
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,
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