



BMI CHART

Date: 25/2/23

Name: Pooja Mone Age: 30 yrs Sex: M/F
 BP: 120/70 Height (cms): 160 cm Weight(kgs): 72.9 Kg BMI: —
mmHg

WEIGHT lbs	100	105	110	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	50.0	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	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	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
(A Fortis Network Hospital)

UHID	12316628	Date	25/02/2023		
Name	Mrs.Pooja Rupesh More	Sex	Female	Age	30
OPD	Pap Smear	Health Check Up			

Drug allergy:
Sys illness:

S/B Dr. Tina

7th day menses.
P.Li - 3 1/2 yrs | →. | F100

Flu
Flu after 4-5
days

↓



UHID	12316628	Date	25/02/2023		
Name	Mrs.Pooja Rupesh More	Sex	Female	Age	30
OPD	Opthal 14	Health Check Up			

Drug allergy: -> Not known
 Sys illness: -> NO

Chs. LG (Blind) (Scotom)

U/S. NO

U-milk -> R G/G.
 -> L G/G.

Ref -> R Phaco: G/G.
 -> L Phaco G/G
 NV -> R No
 -> L No.

I.O.A. -> R -> 14.2.
 -> L -> 15.2.

all well

C.V.S.
20-20 rule
 20m / 30m
 ↓
 20sec / 30sec
 (red)

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UHID	12316628	Date	25/02/2023		
Name	Mrs.Pooja Rupesh More	Sex	Female	Age	30
OPD	Dental 12	Health Check Up			

Drug allergy:
Sys illness:

O/E : - Stain++
Calculus++

- Decayed $\frac{8}{|}8$

Adv : - Extraction $\frac{8}{|}8$
- Oral prophylaxis

Dr. Bhagyashew

LABORATORY REPORT



Patient Ref. No. 22000000830867



CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

Cert. No. MC-2984

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

PATIENT NAME : MRS.POOJA RUPESH MORE

PATIENT ID : **FH.12316628**

ACCESSION NO : **0022WB004958** AGE : 30 Years SEX : Female

ABHA NO :

DRAWN : 25/02/2023 10:44:00

RECEIVED : 25/02/2023 10:45:05

REPORTED : 25/02/2023 18:29:21

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : UID:12316628

CLINICAL INFORMATION :

UID:12316628 REQNO-1377382
CORP-OPD
BILLNO-150123OPCR011527
BILLNO-150123OPCR011527

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	128.90	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	10.46	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)	2.780	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

Dr. Swapnil Sirmukaddam
Consultant Pathologist



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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 10 6 - 20 mg/dL
METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE 0.62 0.60 - 1.10 mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE 30 years

GLOMERULAR FILTRATION RATE (FEMALE) 122.78 Refer Interpretation Below mL/min/1.73m
METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO 16.13 High 5.00 - 15.00
METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 3.8 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 139 136 - 145 mmol/L
METHOD : ISE INDIRECT

POTASSIUM, SERUM 4.34 3.50 - 5.10 mmol/L
METHOD : ISE INDIRECT



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CHLORIDE, SERUM		103	98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
METHOD : PHYSICAL	

APPEARANCE	SLIGHTLY HAZY
METHOD : VISUAL	

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.025	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	NOT 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
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	DETECTED (++)	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		

MICROSCOPIC EXAMINATION, URINE



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BILLNO-150123OPCR011527

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RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		20-30	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		10-15	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)

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



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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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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	13.3	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	4.26	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	6.10	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	308	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	38.6	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	90.6	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	31.3	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	34.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	14.0	11.6 - 14.0	%
MENTZER INDEX	21.3		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	9.4	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOWCYTOMETRY	62	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	30	20 - 40	%



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MONOCYTES		5	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		3	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		3.78	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.83	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.31	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.18	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.1		
METHOD : CALCULATED PARAMETER				

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



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 MAHARASHTRA INDIA

Cert. No. MC-2275
 SRL Ltd
 HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 1C
 NAVI MUMBAI, 400703
 MAHARASHTRA, INDIA
 Tel : 022-39199222,022-49723322,
 CIN - U74899PB1995PLC045956
 Email : -

PATIENT NAME : MRS.POOJA RUPESH MORE PATIENT ID : FH.12316628

ACCESSION NO : 0022WB004958 AGE : 30 Years SEX : Female ABHA NO :

DRAWN : 25/02/2023 10:44:00 RECEIVED : 25/02/2023 10:45:05 REPORTED : 25/02/2023 14:37:08

REFERRING DOCTOR : SELF CLIENT PATIENT ID : UID:12316628

CLINICAL INFORMATION :

UID:12316628 REQNO-1377382
 CORP-OPD
 BILLNO-150123OPCR011527
 BILLNO-150123OPCR011527

Test Report Status	Final	Results	Biological Reference Interval	Units
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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	28	High	0 - 20	mm at 1 hr
-------	----	------	--------	------------

METHOD : WESTERGREIN METHOD

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: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

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

REFERENCE :

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

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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



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Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

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

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.40	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.12	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.28	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	8.0	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.9	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	14	Low 15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	21	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	95	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	27	5 - 55	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			



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 CORP-OPD
 BILLNO-150123OPCR011527
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Test Report Status	Final	Results	Biological Reference Interval	Units
LACTATE DEHYDROGENASE		131	100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		93	74 - 99	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C		5.1	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)		99.7	< 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 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 are 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



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Email : -

MUMBAI 440001
MAHARASHTRA INDIA

PATIENT NAME : MRS.POOJA RUPESH MORE

PATIENT ID : FH.12316628

ACCESSION NO : 0022WB004958 AGE : 30 Years SEX : Female

ABHA NO :

DRAWN : 25/02/2023 10:44:00

RECEIVED : 25/02/2023 10:45:05

REPORTED : 25/02/2023 14:37:08

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : UID:12316628

CLINICAL INFORMATION :

UID:12316628 REQNO-1377382
CORP-OPD
BILLNO-150123OPCR011527
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enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc
GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

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

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

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

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

HbA1c Estimation can get affected due to :

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

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	184	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
--------------------	-----	---	-------

METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES	119	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High	mg/dL
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METHOD : ENZYMATIC ASSAY



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Test Report Status	Final	Results	Biological Reference Interval	Units
HDL CHOLESTEROL		41	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT		128	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT				
NON HDL CHOLESTEROL		143	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN		23.8	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO		4.5	High 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		3.1	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				

Interpretation(s)

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Patient Ref. No. 22000000830867



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PATIENT ID : **FH.12316628**

ACCESSION NO : **0022WB004958** AGE : 30 Years SEX : Female

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Dr. Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist



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LABORATORY REPORT



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Cert. No. MC-2275

PATIENT NAME : MRS.POOJA RUPESH MORE

PATIENT ID : FH.12316628

ACCESSION NO : 0022WB005010 AGE : 30 Years SEX : Female

ABHA NO :

DRAWN : 25/02/2023 13:28:00

RECEIVED : 25/02/2023 13:29:22

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REFERRING DOCTOR :

CLIENT PATIENT ID : UID:12316628

CLINICAL INFORMATION :

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BILLNO-150123OPCR011527
BILLNO-150123OPCR011527

Table with 4 columns: Test Report Status (Final), Results, Biological Reference Interval, Units

BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

Table with 4 columns: Test Name (PPBS), Result (133), Reference Interval (70 - 139), Units (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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c

End Of Report

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Handwritten signature of Dr. Akta Dubey

Dr. Akta Dubey
Consultant Pathologist



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12316628
30 Years

POOJA MORE
female

2/25/2023 12:18:03 PM

HC

Rate 66 . Sinus rhythm.....normal P axis, V-rate 50- 99
PR 129 . Supraventricular bigeminy.....bigeminy string>4 w/ SV complexes

QRS 83
QT 391
QTc 410

--AXIS--

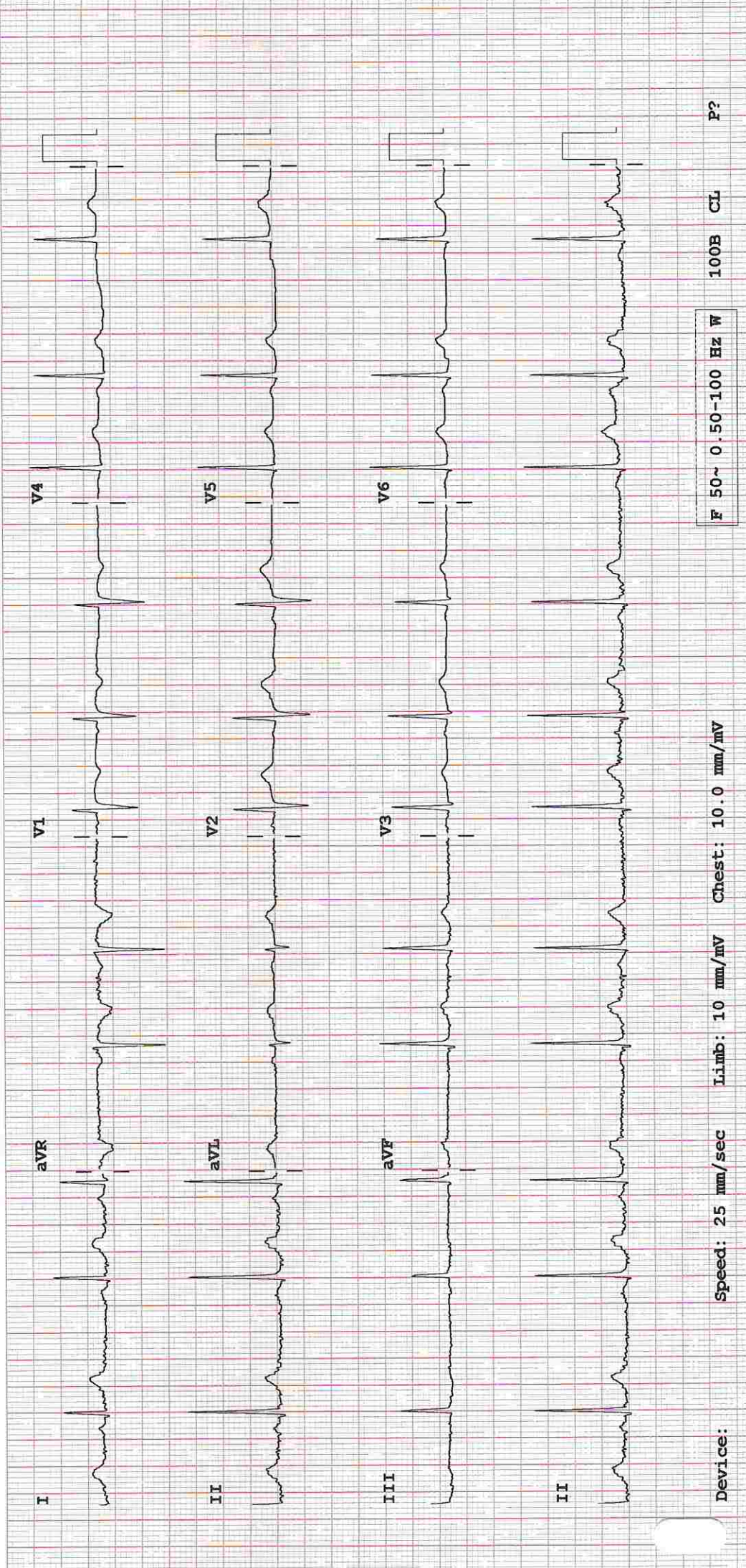
P 18
QRS 63
T 28

12 Lead; Standard Placement

-- ABNORMAL ECG --

Unconfirmed Diagnosis

Sinus rhythm
Supraventricular
bigeminy
supraventricular
bigeminy
ADP - 2 DEPT



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

F 50~ 0.50-100 Hz W

100B CL P?



(For Billing/Reports & Discharge Summary only)

Date: 27/Feb/2023

DEPARTMENT OF NIC

Name: Mrs. Pooja Rupesh More

Age | Sex: 30 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12316628 | 11699/23/1501

Order No | Order Date: 1501/PN/OP/2302/24290 | 25-Feb-2023

Admitted On | Reporting Date : 27-Feb-2023 17:39:07

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	35	mm
AO Root	29	mm
AO CUSP SEP	23	mm
LVID (s)	20	mm
LVID (d)	24	mm
IVS (d)	10	mm
LVPW (d)	11	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%



(For Billing/Reports & Discharge Summary only)

Date: 27/Feb/2023

DEPARTMENT OF NIC

Name: Mrs. Pooja Rupesh More
Age | Sex: 30 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12316628 | 11699/23/1501
Order No | Order Date: 1501/PN/OP/2302/24290 | 25-Feb-2023
Admitted On | Reporting Date : 27-Feb-2023 17:39:07
Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.
A WAVE VELOCITY:0.2 m/sec
E/A RATIO:1.2

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.


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

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



DEPARTMENT OF RADIOLOGY

Date: 25/Feb/2023

Name: Mrs. Pooja Rupesh More

UHID | Episode No : 12316628 | 11699/23/1501

Age | Sex: 30 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2302/24290 | 25-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 25-Feb-2023 13:06:23

Bed Name :

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 are unremarkable.

DR. CHETAN KHADKE

M.D. (Radiologist)



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Bed Name :

Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

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

CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal.

No evidence of calculi/hydronephrosis.

Right kidney measures 11.1 x 4.8 cm.

Left kidney measures 11.4 x 4.9 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

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

UTERUS is normal in size, measuring 7.5 x 3.5 x 3.7 cm.

Endometrium measures 6.1 mm in thickness.

Both ovaries are normal.

Right ovary measures 2.9 x 2.7 x 1.8 cm, volume 7.8 cc.

Left ovary measures 3.1 x 2.2 x 2.4 cm, volume 9.2 cc.

No evidence of ascites.

IMPRESSION:

- No significant abnormality is detected.


DR. CHETAN KHADKE
M.D. (RADIOLOGIST)