Patient Ref. No. 777000002277336

Cert. No.

CLIENT CODE : C000138378

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
BUILDING NO 744/52,CHINTAL PLAZA,33RD CROSS,10TH MAIN, 4TH BLOCK,
JAYANAGAR,
BANGALORE, 560011
KARNATAKA, INDIA
Tel : 08041211945

PATIENT NAME : S SUJATHA /EC152874 PATIENT ID : **SSUJF050263278**

ACCESSION NO : **0278VH001368** AGE : 59 Years SEX : Female ABHA NO :

DRAWN : 08/08/2022 09:57 RECEIVED : 08/08/2022 09:29 REPORTED : 09/08/2022 10:01

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

*** BLOOD COUNTS,EDTA WHOLE BLOOD**			
HEMOGLOBIN	12.9	12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	4.29	3.8 - 4.8	mil/µL
METHOD : IMPEDANCE			
WHITE BLOOD CELL COUNT	5.30	4.0 - 10.0	thou/µL
PLATELET COUNT	220	150 - 410	thou/µL
METHOD : IMPEDANCE			
*** RBC AND PLATELET INDICES**			
HEMATOCRIT	38.0	36 - 46	%
MEAN CORPUSCULAR VOL	89.0	83 - 101	fL
METHOD : CALCULATED			
MEAN CORPUSCULAR HGB.	30.1	27.0 - 32.0	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.0	31.5 - 34.5	g/dL
METHOD : CALCULATED			
MENTZER INDEX	20.8		
RED CELL DISTRIBUTION WIDTH	12.4	11.6 - 14.0	%
METHOD : CALCULATED			
MEAN PLATELET VOLUME	8.1	6.8 - 10.9	fL
METHOD : CALCULATED			
*** WBC DIFFERENTIAL COUNT - NLR**			
SEGMENTED NEUTROPHILS	63	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.34	2.0 - 7.0	thou/µL
METHOD : IMPEDANCE + ABSORBANCE			
LYMPHOCYTES	29	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	1.54	1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.2		
EOSINOPHILS	1	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.05	0.02 - 0.50	thou/µL
MONOCYTES	6	2 - 10	%
METHOD : IMPEDANCE + ABSORBANCE			
BASOPHILS	1	0 - 2	%
METHOD : IMPEDANCE + ABSORBANCE			
*** ERYTHRO SEDIMENTATION RATE, BLOOD**			

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SEDIMENTATION RATE (ESR)	17		0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.6		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HPLC				
MEAN PLASMA GLUCOSE	114.0		< 116.0	mg/dL
METHOD : CALCULATED				
*** GLUCOSE, FASTING, PLASMA**				
GLUCOSE, FASTING, PLASMA	89		74 - 106	mg/dL
METHOD : HEXOKINASE				
*** GLUCOSE, POST-PRANDIAL, PLASMA**				
GLUCOSE, POST-PRANDIAL, PLASMA	100		70 - 140	mg/dL
METHOD : HEXOKINASE				
*** CORONARY RISK PROFILE (LIPID PROFILE), SERUM.**				
CHOLESTEROL	**216**	**High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOD-POD				
TRIGLYCERIDES	54		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : GPO - POD METHOD				
HDL CHOLESTEROL	**68**	**High**	< 40 Low >/=60 High	mg/dL
DIRECT LDL CHOLESTEROL	**152**	**High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : HOMOGENOUS DIRECT ENZYMATIC COLORIMETRIC				
CHOL/HDL RATIO	**3.2**	**Low**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED				
VERY LOW DENSITY LIPOPROTEIN	10.8		Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED				

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Interpretation(s)

Serum lipid profile is measured for cardiovascular risk prediction, the test includes five basic parameters: total cholesterol, triglycerides, HDL cholesterol, LDL cholesterol and Non HDL cholesterol.

1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.

2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body.
- Both quantity and composition of the diet impact on plasma triglyceride concentrations
- Elevations in TG levels are the result of overproduction and impaired clearance.
- High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3)HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL

4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis.
The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.

5)Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies.
Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A.CAD with > 1 feature of high risk group
	B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >/= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors

Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5 Low HDL	

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Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)
Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months

References:
Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.31	UPTO 1.2	mg/dL
METHOD : DIAZO METHOD			
BILIRUBIN, DIRECT	0.14	0.00 - 0.30	mg/dL
METHOD : DIAZO METHOD			
BILIRUBIN, INDIRECT	0.17	0.00 - 0.60	mg/dL
METHOD : CALCULATED			
TOTAL PROTEIN	7.3	6.6 - 8.7	g/dL
METHOD : BIURET			
ALBUMIN	4.4	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN	2.9	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED			
ALBUMIN/GLOBULIN RATIO	1.5	1.0 - 2.0	RATIO
METHOD : CALCULATED			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	21	0 - 32	U/L
METHOD : IFCC WITHOUT PYRIDOXAL PHOSPHATE			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	13	0 - 31	U/L

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METHOD : IFCC WITHOUT PYRIDOXAL PHOSPHATE			
ALKALINE PHOSPHATASE	101	35 - 105	U/L
METHOD : IFCC AMP BUFFER			
GAMMA GLUTAMYL TRANSFERASE (GGT)	14	5 - 36	U/L
METHOD : IFCC			
LACTATE DEHYDROGENASE	207	135 - 214	U/L
METHOD : IFCC			
SERUM BLOOD UREA NITROGEN			
BLOOD UREA NITROGEN	11	6 - 20	mg/dL
METHOD : UREASE -GLDH			
CREATININE, SERUM			
CREATININE	0.79	0.50 - 0.90	mg/dL
METHOD : JAFFE, ALKALINE PICRATE, KINETIC WITH BLANK RATE CORRECTION			
*** BUN/CREAT RATIO**			
BUN/CREAT RATIO	13.92	5.00 - 15.00	
METHOD : CALCULATED			
*** URIC ACID, SERUM**			
URIC ACID	3.3	2.4 - 5.7	mg/dL
METHOD : ENZYMATIC, COLORIMETRIC			
*** TOTAL PROTEIN, SERUM**			
TOTAL PROTEIN	7.3	6.6 - 8.7	g/dL
METHOD : BIURET			
*** ALBUMIN, SERUM**			
ALBUMIN	4.4	3.97 - 4.94	g/dL
*** GLOBULIN**			
GLOBULIN	2.9	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	144	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM	5.00	3.5 - 5.1	mmol/L
CHLORIDE	106	98 - 107	mmol/L
METHOD : ISE INDIRECT			
*** PHYSICAL EXAMINATION, URINE**			

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COLOR	PALE YELLOW		
METHOD : VISUAL EXAMINATION			
SPECIFIC GRAVITY	1.005	1.003 - 1.035	
METHOD : PKA CHANGE OF POLYELECTROLYTES			
*** CHEMICAL EXAMINATION, URINE**			
PH	5.0	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : PROTEIN ERROR OF INDICATORS PRINCIPLE / SULPHOSALICYLIC ACID			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : OXIDASE-PEROXIDASE REACTION			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : NITROPRUSSIDE METHOD / ROTHERA'S TEST			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIAZO REACTION			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : EHRLICH REACTION REFLECTANCE			
*** MICROSCOPIC EXAMINATION, URINE**			
PUS CELL (WBC'S)	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
*** THYROID PANEL, SERUM**			
T3	103.1	80.00 - 200.00	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4	9.11	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE			
TSH 3RD GENERATION	1.190	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE			

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*** PAPANICOLAOU SMEAR**	RESULT PENDING		
*** LETTER**	RESULT PENDING		
*** STOOL: OVA & PARASITE**			
COLOUR	SAMPLE NOT RECEIVED		
*** ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**			
ABO GROUP	TYPE AB		
RH TYPE	POSITIVE		
*** XRAY-CHEST**			
IMPRESSION	NORMAL		
*** TMT OR ECHO**			
TMT OR ECHO	ECHO-ONCE DONE,REFER HARD COPY OF REPORTS.		
*** ECG**			
ECG	WITHIN NORMAL LIMITS		
*** MEDICAL HISTORY**			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	NOT SIGNIFICANT		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	FATHER:HYPERTHYROIDISM.		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
*** ANTHROPOMETRIC DATA & BMI**			
HEIGHT IN METERS	1.52		mts
WEIGHT IN KGS.	49		Kgs
BMI	21	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**			
PULSE	72/BPM,REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		
*** CARDIOVASCULAR SYSTEM**			
BP	117/79		mm/Hg
*** BASIC EYE EXAMINATION**			
DISTANT VISION RIGHT EYE WITH GLASSES	NORMAL		
DISTANT VISION LEFT EYE WITH GLASSES	NORMAL		

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NEAR VISION RIGHT EYE WITH GLASSES	NORMAL		
NEAR VISION LEFT EYE WITH GLASSES	NORMAL		
COLOUR VISION	NORMAL		
*** SUMMARY**			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	CHOLESTEROLEMIA.		
RELEVANT NON PATHOLOGY DIAGNOSTICS	NO ABNORMALITIES DETECTED		
REMARKS / RECOMMENDATIONS	AVOID OILY FOOD. REGULAR WALK.		
*** FITNESS STATUS**			
FITNESS STATUS	FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)		

Comments

*NOTE : NON PATHOLOGY TESTS ARE NOT NABL ACCREDITED

Radiologist/Sonologist : Dr. Naveed Ansar Noor , MBBS, MDRD.

Dental Surgeon : Dr. Abdulla Shahzad, BDS, DHM, FAGE, MD(CM).

Consulting Physician : Dr. Riteshraj, MBBS

Consulting Cardiologist: Dr. Nithin Prakash, MBBS, PGDCC.

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 - NLR-
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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition

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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"

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

References

1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

GLUCOSE, FASTING, PLASMA-

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.

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

SERUM BLOOD UREA NITROGEN-

Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• Liver disease
• SIADH.

Patient Ref. No. 777000002277336

Cert. No.

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SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
BUILDING NO 744/52,CHINTAL PLAZA,33RD CROSS,10TH MAIN, 4TH BLOCK,
JAYANAGAR,
BANGALORE, 560011
KARNATAKA, INDIA
Tel : 08041211945

PATIENT NAME : S SUJATHA /EC152874 PATIENT ID : **SSUJF050263278**

ACCESSION NO : **0278VH001368** AGE : 59 Years SEX : Female ABHA NO :

DRAWN : 08/08/2022 09:57 RECEIVED : 08/08/2022 09:29 REPORTED : 09/08/2022 10:01

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

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F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
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8800465156

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Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
THYROID PANEL, SERUM-
Triiodothyronine T3 , is a thyroid hormone. It affects 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.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. 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 INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

****
FITNESS STATUS-
Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.
Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:
• Fit (As per requested panel of tests) – SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
• Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary

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lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

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MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE

*** ULTRASOUND ABDOMEN**

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

Dr. Asha Prabhakar
Lab Head

Dr.Priya
Consultant Pathologist

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