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GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL

UHID	**12144051**	**Date**	**26/11/2022**		
Name	**Mr.Amit Tomar**	**Sex**	**Male**	**Age**	**42**
OPD	**Opthal 14**				

Drug allergy:
Sys illness:

B/B Opthal

O/E A/S WNL

Fundus exam WNL

AVn 6/6
6/6

Rx.

Eyedrop [illegible]
[illegible] 1 1 1
X 1 month

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9/12

Hiranandani HOSPITAL
A Fortis Network Hospital

UHID	12144051	Date	26/11/2022		
Name	Mr.Amit Tomar	Sex	Male	Age	42
OPD	Dental 12				

Drug allergy:
Sys illness:

Caries 6

Grossly decayed 7 | 7

missing 6

Stains ++

Calculus ++

Treatment

Adv. extraction 7 | 7

Adv. RCT + Cap 6

Adv. Implant 7 | 7

Adv. CBCT (full mouth)

Adv. oral prophylaxis

Dr Dikshu

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Hiranandani
HOSPITAL
A fortis Network Hospital

UHID	12144051	**Date**	**26/11/2022**		
Name	Mr. Amit Singh Tomar	**Sex**	**male**	**Age**	42
OPD	ENT	**Health Check-up**			

Drug allergy:
Sys illness:

Pt coming for health check up.
C/o GERD.

O/E :- Ear (N) (N)
(N) (N)
B/L TM intact

Nose
Throat } Normal.

Diag :- GERD.

Rx B

Cap Esofine DSR 1—0—0.
× 10 days
(Before meal)

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : 26/11/2022 18:15:00 RECEIVED : 26/11/2022 18:21:20 REPORTED : 27/11/2022 13:25:22

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

CLINICAL INFORMATION :

UID:12144051 REQNO-1326392
CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

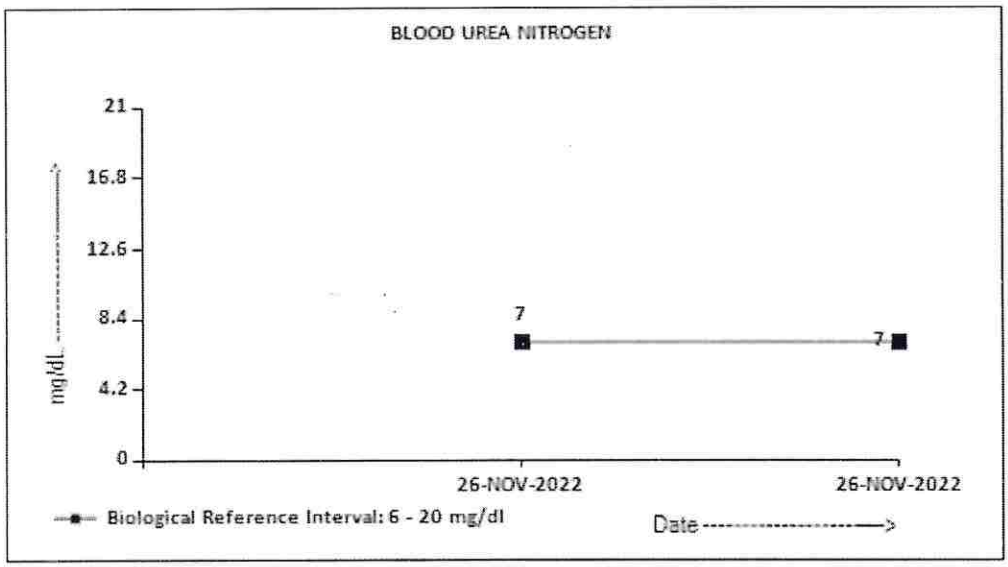
Test Report Status **Final**	Results	Biological Reference Interval	Units

KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	7	6 - 20	mg/dL

METHOD : UREASE - UV



CREATININE EGFR- EPI

CREATININE	1.05	0.90 - 1.30	mg/dL
AGE	42		years
GLOMERULAR FILTRATION RATE (MALE)	90.89	Refer Interpretation Below	mL/min/1.73r

METHOD : ALKALINE PICRATE KINETIC JAFFES

METHOD : CALCULATED PARAMETER

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

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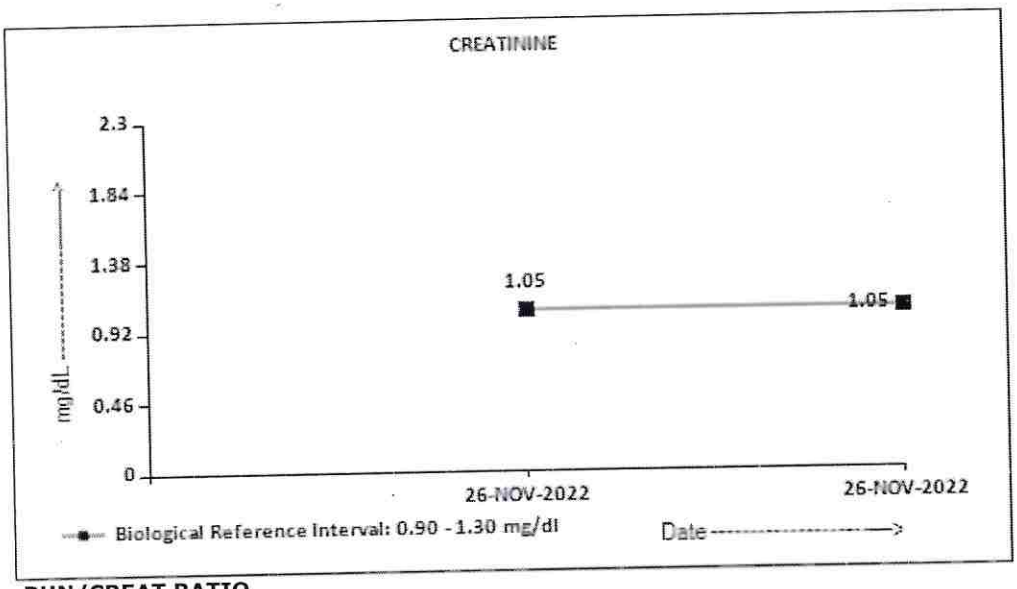

BUN/CREAT RATIO			
BUN/CREAT RATIO	6.67	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	4.6	3.5 - 7.2	mg/dL
METHOD : URICASE UV			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			
ALBUMIN	3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN			
GLOBULIN	3.6	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**132**	**Low** 136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.47	3.50 - 5.10	mmol/L

SRL Ltd
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NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,

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Scan to View Report

Patient Ref. No. 220000008

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METHOD : ISE INDIRECT CHLORIDE, SERUM METHOD : ISE INDIRECT	**96**	**Low** 98 - 107	mmol/L
Interpretation(s)			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
METHOD : PHYSICAL APPEARANCE	CLEAR		
METHOD : VISUAL			
CHEMICAL EXAMINATION, URINE			
PH	7.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION) PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE BLOOD	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	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION PUS CELL (WBC'S)	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

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EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	0-1	0-5	/HPF
CASTS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED		
BACTERIA METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
YEAST METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	
REMARKS	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

Interpretation(s)
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE EGFR- EPI-
GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
URIC ACID, SERUM-
Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome
Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

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

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HAEMATOLOGY				
CBC-5, EDTA WHOLE BLOOD				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS METHOD : FLOW CYTOMETRY	55		40 - 80	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY	34		20 - 40	%
MONOCYTES METHOD : FLOW CYTOMETRY	7		2 - 10	%
EOSINOPHILS METHOD : FLOW CYTOMETRY	4		1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY	0		0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	4.41		2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	2.72		1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.56		0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.32		0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT METHOD : CALCULATED PARAMETER	**0**	**Low**	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	1.6			
MORPHOLOGY				
RBC METHOD : MICROSCOPIC EXAMINATION	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC			
WBC METHOD : MICROSCOPIC EXAMINATION	NORMAL MORPHOLOGY			
PLATELETS METHOD : MICROSCOPIC EXAMINATION	ADEQUATE			

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

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BILLNO-150122OPCR060071
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Test Report Status **Final**	Results		Biological Reference Interval	
E.S.R METHOD : WESTERGREN METHOD	**22**	**High**	0 - 14	mm at 1 hr
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	14.5		13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.15		4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	8.01		4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	268		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	42.6		40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	**82.7**	**Low**	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	28.1		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	34.0		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	**14.2**	**High**	11.6 - 14.0	%
MENTZER INDEX	16.1			
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.9		6.8 - 10.9	fL

Interpretation(s)
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

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inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

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

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

Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS

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

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

REFERENCE :

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

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.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

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

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

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

BIO CHEMISTRY

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	192	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	125	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL

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METHOD : ENZYMATIC ASSAY				
HDL CHOLESTEROL	40		< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	129		< 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	**152**	**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				
CHOL/HDL RATIO	**4.8**	**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	**3.2**	**High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	25		</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				

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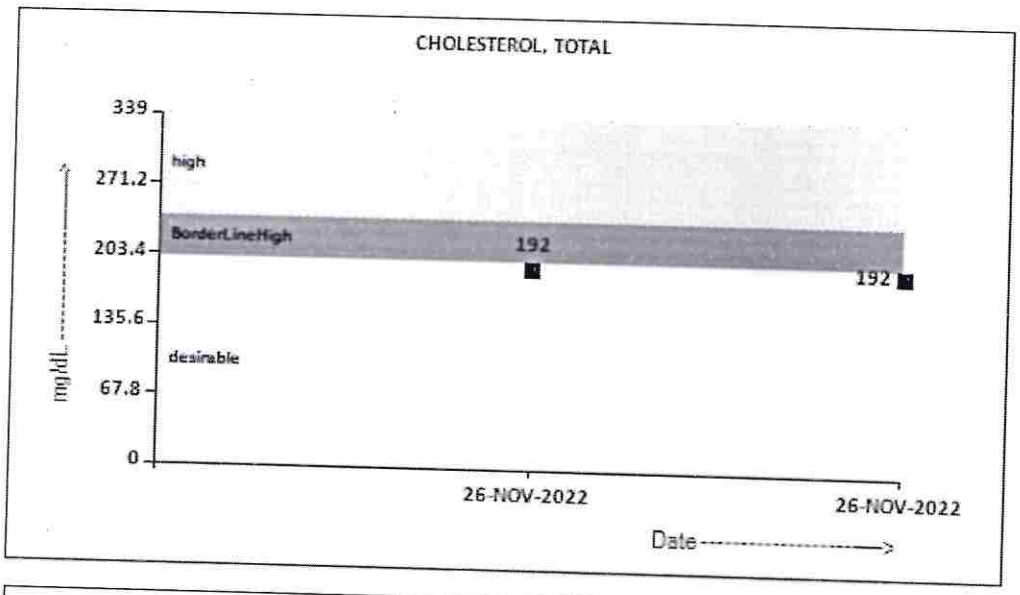
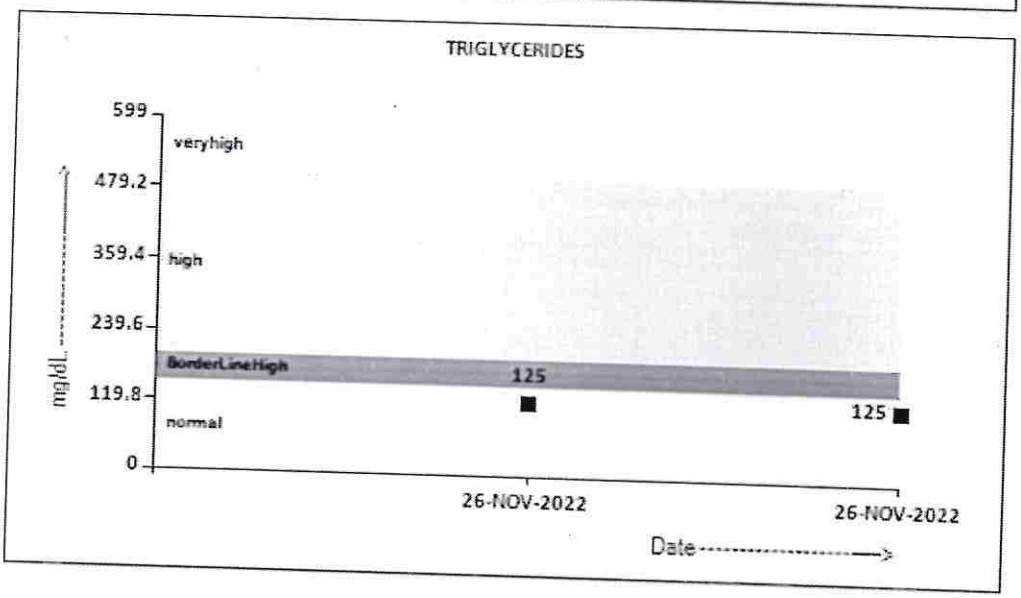




PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

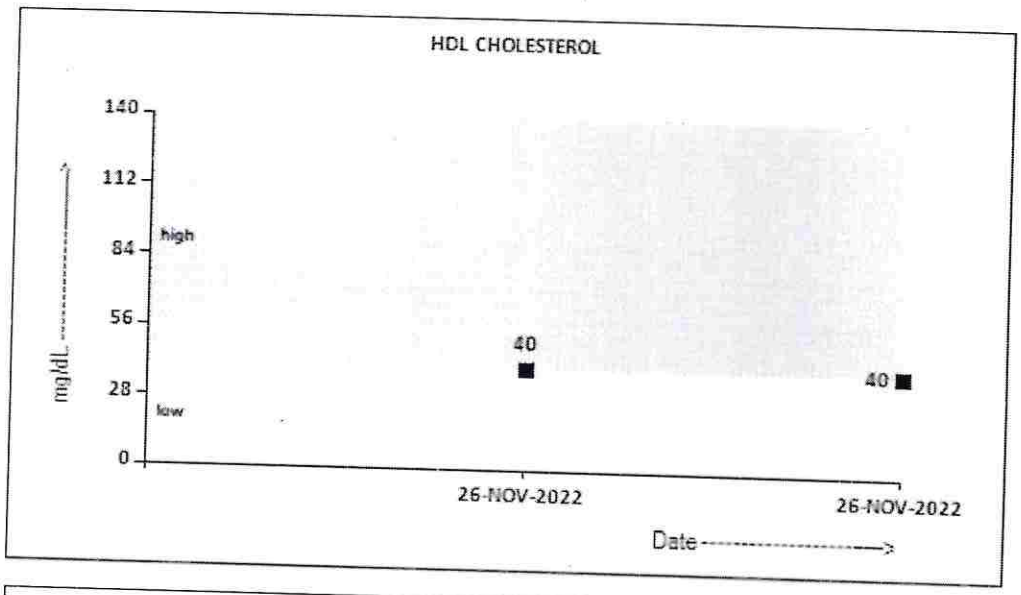
DRAWN : 26/11/2022 18:15:00 RECEIVED : 26/11/2022 18:21:20 REPORTED : 27/11/2022 13:25:22

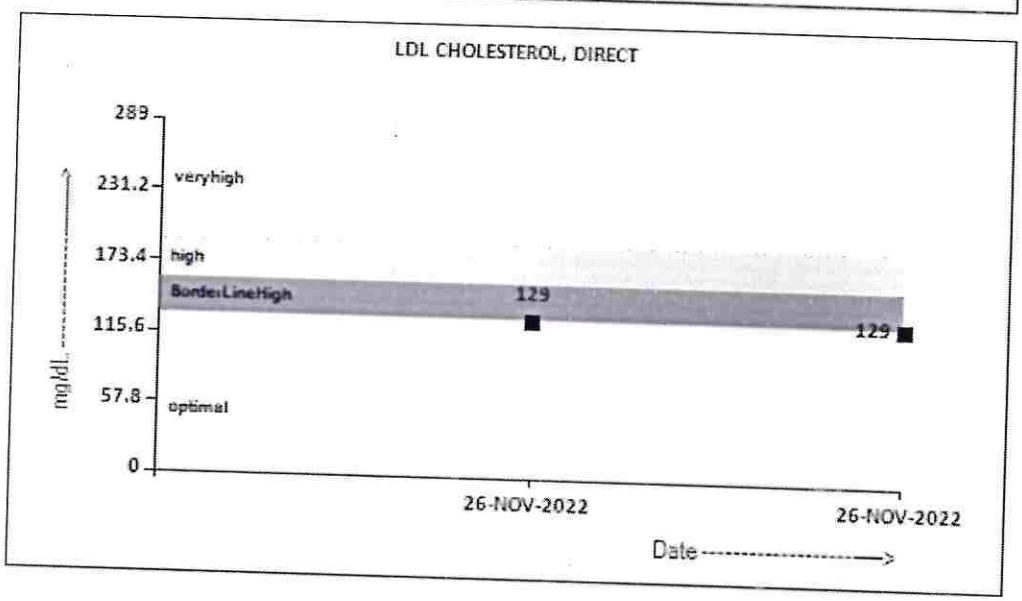
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

CLINICAL INFORMATION :

UID:12144051 REQNO-1326392
CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

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





LIVER FUNCTION PROFILE, SERUM

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

Test Report Status **Final**	Results	Biological Reference Interval	
BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.48	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.09	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.39	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.4	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.8	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.6	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT) METHOD : UV WITH P5P	16	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	32	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	102	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE	26	15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	157	100 - 190	U/L

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	99	74 - 99	mg/dL

Cert. No. MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

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CLINICAL INFORMATION :

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BILLNO-150122OPCR060071
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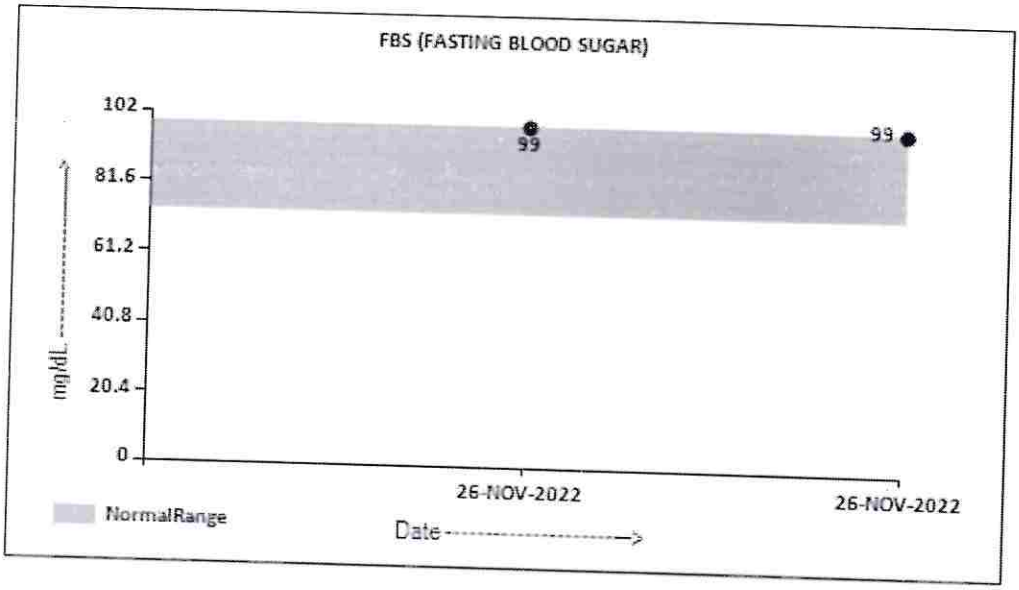
Test Report Status **Final**	Results	Biological Reference Interval



GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) METHOD : HEXOKINASE	110	70 - 139	mg/dL

LABORATORY REPORT

Cert. No. MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

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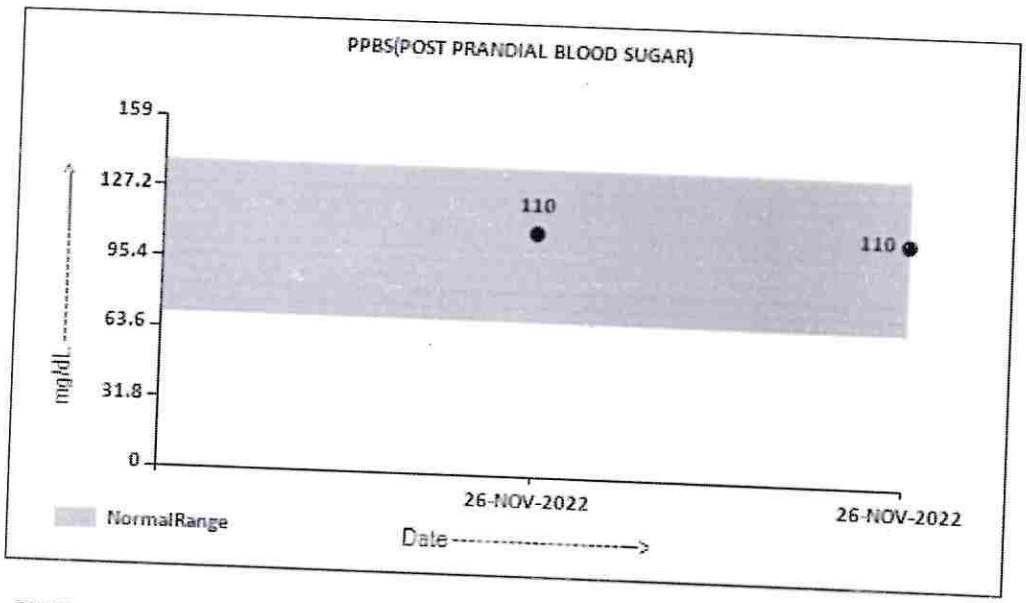
Test Report Status **Final**	Results	Biological Reference Interval



GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

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 : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	114.0	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

Interpretation(s)

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don''''''''''''''''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''''''''''''''''t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption

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Patient Ref. No. 22000000811422

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

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

CLINICAL INFORMATION :

UID:12144051 REQNO-1326392
CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

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

and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include trigiycerides and may be best used in patients for whom fasting is difficult.
LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

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

CLINICAL INFORMATION :

UID:12144051 REQNO-1326392
CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

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

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

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

****End Of Report****

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

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

LABORATORY REPORT

Cert. No. MC-2984

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

ACCESSION NO : **0022VK005989** AGE : 42 Years SEX : Male ABHA NO :

DRAWN : 26/11/2022 18:15:00 RECEIVED : 26/11/2022 18:21:20 REPORTED : 26/11/2022 20:33:11

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CORP-OPD
BILLNO-150122OPCR060071
BILLNO-150122OPCR060071

Test Report Status **Final**	Results		Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE				
THYROID PANEL, SERUM				
T3	124.4		80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
T4	5.66		5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
TSH (ULTRASENSITIVE)	**4.860**	**High**	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				

Comments

NOTE: PLEASE CORRELATE VALUES OF THYROID FUNCTION TEST WITH THE CLINICAL & TREATMENT HISTORY OF THE PATIENT.

Interpretation(s)

LABORATORY REPORT

Cert. No. MC-2984

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.AMIT SINGH TOMAR

PATIENT ID : **FH.12144051** CLIENT PATIENT ID : UID:12144051

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

SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.431	< 2.0	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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Sirmukaddam 786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

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NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
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Patient Ref. No. 22000000811422

42 Years Male 11/26/2022 3:35:00 PM

Rate 60 . Sinus rhythm.....normal P axis, V-rate 50- 99

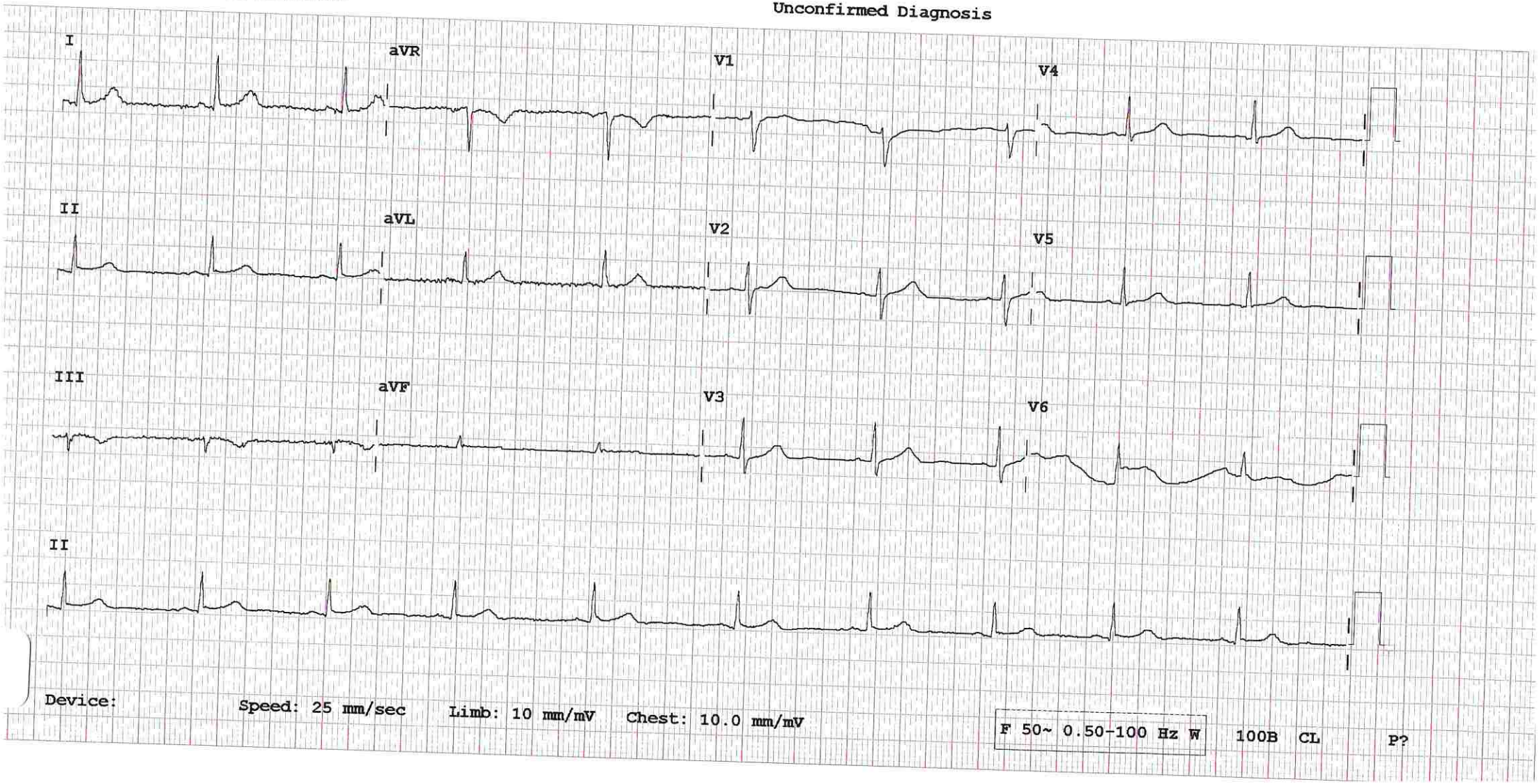
PR 128
QRSD 87
QT 384
QTc 384

--AXIS--
P 6
QRS 16
T 6

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 26/Nov/2022

DEPARTMENT OF NIC

Name: Mr. Amit Singh Tomar
Age | Sex: 42 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12144051 | 59320/22/1501
Order No | Order Date: 1501/PN/OP/2211/126071 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 14:26:48
Order Doctor Name : Dr.SELF .

TRANSTHORACIC ECHOCARDIOGRAPHY

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion

M-MODE MEASUREMENTS:

LA	32	mm
AO Root	27	mm
AO CUSP SEP	24	mm
LVID (s)	20	mm
LVID (d)	40	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	20	mm
RA	22	mm
LVEF	60	%

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www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 26/Nov/2022

Name: Mr. Amit Singh Tomar
Age | Sex: 42 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12144051 | 59320/22/1501
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Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 1.0 m/sec.
A WAVE VELOCITY:0.8 m/sec
E/A RATIO:1.2 , E/E'= 8

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	07			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	1.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.
Board Line: 022 - 39199222 I Fax: 022 - 39133220
Emergency: 022 - 39199100 I Ambulance: 1255
For Appointment: 022 - 39199200 I Health Checkup: 022 - 39199300
www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 26/Nov/2022

Name: Mr. Amit Singh Tomar
Age | Sex: 42 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12144051 | 59320/22/1501
Order No | Order Date: 1501/PN/OP/2211/126071 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 15:01:49
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Accessory azygous fissure is noted in right upper zone.

Rest of the lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)

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UHID | Episode No : 12144051 | 59320/22/1501
Order No | Order Date: 1501/PN/OP/2211/126071 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 13:07:45
Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

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 8.9 x 4.3 cm.
Left kidney measures 9.8 x 5.3 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 12.7 cc in volume.

No evidence of ascites.

IMPRESSION:

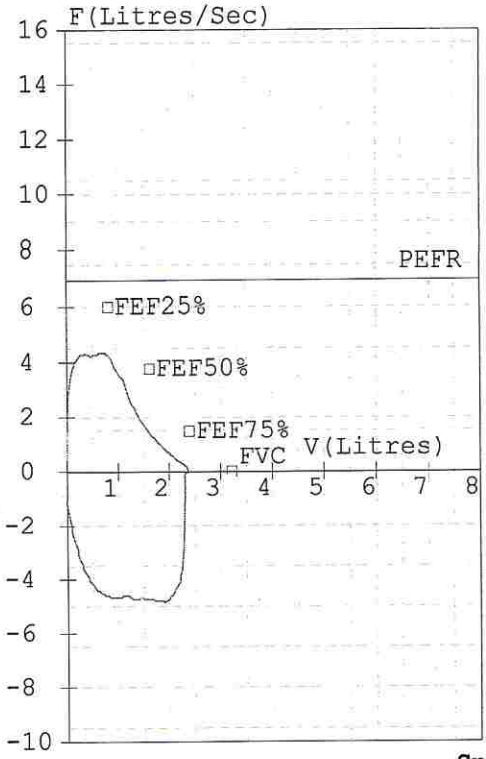
- **Grade I fatty infiltration of liver.**

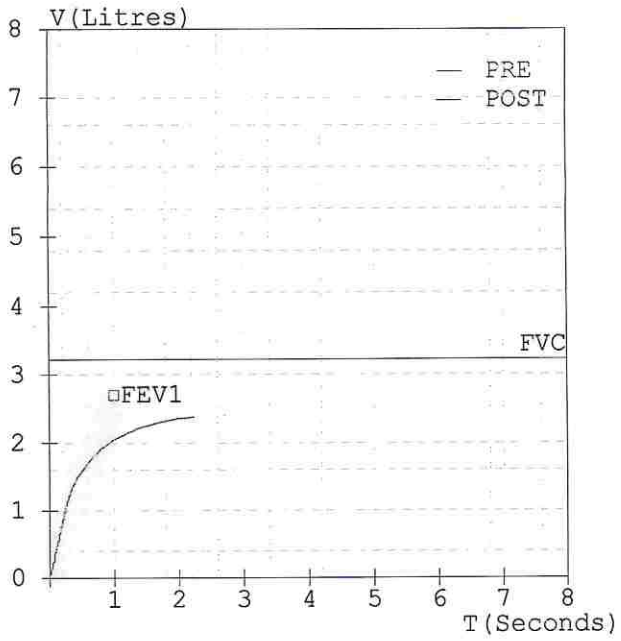
DR. CHETAN KHADKE
(MD RADIOLOGIST)

HIRANANDANI HEALTHCARE (P) ltd.

Sec-10,Vashi,Navi Mumbai-400703 022-39199222

ıtient: Mr.Amit Singh Tomar	Age : 42 Years	Gender	: Male
ɛfd. By: Bank of AMAM AHC Package	Height : 160 Cms	Smoker	: No
ɔed.Eqns: ERS 93	Weight : 71 Kgs	Eth. Corr	: 85
ıte : 26-Nov-2022 02:11 PM	ID: 12144051	Temp	:





Spirometry(FVC Results)

Parameter		Pred	M.Pre	%Pred	M.Post	%Pred	%Imp
FVC	(L)	03.22	02.38	074	-----	---	---
FEV1	(L)	02.70	02.05	076	-----	---	---
FEV1/FVC	(%)	83.85	86.13	103	-----	---	---
FEF25-75	(L/s)	03.40	02.26	066	-----	---	---
PEFR	(L/s)	06.94	04.27	062	-----	---	---
FIVC	(L)	03.34	02.46	074	-----	---	---
FEV.5	(L)	-----	01.59	---	-----	---	---
FEV3	(L)	-----	02.38	---	-----	---	---
PIFR	(L/s)	-----	04.80	---	-----	---	---
FEF75-85	(L/s)	-----	00.79	---	-----	---	---
FEF.2-1.2	(L/s)	-----	03.86	---	-----	---	---
FEF 25%	(L/s)	05.99	04.21	070	-----	---	---
FEF 50%	(L/s)	03.75	02.82	075	-----	---	---
FEF 75%	(L/s)	01.48	01.04	070	-----	---	---
FEV.5/FVC	(%)	-----	66.81	---	-----	---	---
FEV3/FVC	(%)	-----	100.00	---	-----	---	---
FET	(Sec)	-----	02.44	---	-----	---	---
ExplTime	(Sec)	-----	00.08	---	-----	---	---
Lung Age	(Yrs)	042	052	124	-----	---	---
FEV6	(L)	03.22	-----	---	-----	---	---
FIF25%	(L/s)	-----	04.73	---	-----	---	---
FIF50%	(L/s)	-----	04.62	---	-----	---	---
FIF75%	(L/s)	-----	04.02	---	-----	---	---

normal spirometry

Dr.Kumar Dudhane