NE

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NET WORK

MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. Ribi Ipe Kovoor
2. Mark of Identification	:	(Mole/Scar/any other (specify location)): Left wrist.
3. Age/Date of Birth	:	35, 12.09.1987. Gender: F F/~~M~~
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height ..... 162 ..... (cms) b. Weight ..... 80 ..... (Kgs) c. Girth of Abdomen ..... 92 ... (cms)

d. Pulse Rate ..... 70 ... (/Min) e. Blood Pressure: Systolic 110 Diastolic 80

1st Reading		
2nd Reading		

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father			
Mother	Rosy Ipe Kovoor (61)	Normal with Diabetics.	
Brother(s)	Rupi Ipe Kovoor (38)	Healthly.	
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
	N.A.	

PERSONAL HISTORY

a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. Y/N

b. Have you undergone/been advised any surgical procedure? C-section & dental implant. Y/N

c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? Covid. Y/N

d. Have you lost or gained weight in past 12 months? Y/N

Have you ever suffered from any of the following?

- Psychological Disorders or any kind of disorders of the Nervous System? Y/N
- Any disorders of Respiratory system? Y/N
- Any Cardiac or Circulatory Disorders? Y/N
- Enlarged glands or any form of Cancer/Tumour? Y/N
- Any Musculoskeletal disorder? Y/N
- Any disorder of Gastrointestinal System? Y/N
- Unexplained recurrent or persistent fever, and/or weight loss Y/N
- Have you been tested for HIV/HBsAg / HCV before? If yes attach reports Y/N
- Are you presently taking medication of any kind? Y/N

DDRC SRL Diagnostics Private Limited
Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com
Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai – 400062.

- Any disorders of Urinary System? Y/N
- Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin Y/N

FOR FEMALE CANDIDATES ONLY

a. Is there any history of diseases of breast/genital organs? Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports) Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries? Y/N

d. Do you have any history of miscarriage/ abortion or MTP Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc Y/N

f. Are you now pregnant? If yes, how many months? Y/N

CONFIDENTAIL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? Y/N
- Is there anything about the examine's health, lifestyle that might affect him/her in the near future with regard to his/her job? Y/N
- Are there any points on which you suggest further information be obtained? Y/N
- Based on your clinical impression, please provide your suggestions and recommendations below;

Medical consult

- Do you think he/she is MEDICALLY FIT or UNFIT for employment.

FIT

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

Seal of Medical Examiner :

Dr. GEORGE THOMAS
MD, FCSI, FIAE
MEDICAL EXAMINER
Reg: 86614

Name & Seal of DDRC SRL Branch :

DDRC SRL DIAGNOSTICS PVT. LTD. KADAVIL BUILDING PANAMPILLY NAGAR KOCHI-36

Date & Time : 15/03/2023

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Bank of Baroda

बैंक ऑफ़ बड़ौदा

Name RIBI IPE KOVOOR

I.C. No. 164531

उ. म प्र. को. एर्णाकुलम

DGM. RO. Ernakulam

धारक के हस्ताक्षर

LABORATORY SERVICES

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

Patient Ref. No. 666000003724465

CLIENT CODE : CA00010147 - MEDIWHEEL
CLIENT'S NAME AND ADDRESS :

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

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KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : MRS. RIBI IPE KOVOOR PATIENT ID : **RIBIF1303884126**

ACCESSION NO : **4126WC004296** AGE : 35 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 13/03/2023 08:37 REPORTED : 14/03/2023 00:47

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

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

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

TREADMILL TEST

TREADMILL TEST	TEST COMPLETED		

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MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	6	Adult(<60 yrs) : 6 to 20	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	12		
CREATININE, SERUM			
CREATININE METHOD : JAFFE KINETIC METHOD	0.50	18 - 60 yrs : 0.6 - 1.1	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
GLUCOSE, POST-PRANDIAL, PLASMA METHOD : HEXOKINASE	90	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE FASTING,FLUORIDE PLASMA			
GLUCOSE, FASTING, PLASMA METHOD : HEXOKINASE	86	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.9	Normal : 4.0 - 5.6%. Non-diabetic level : < 5.7%. Diabetic : >6.5% Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%. Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	%
MEAN PLASMA GLUCOSE	**122.6** **High**	< 116.0	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL	109	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL

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METHOD : CHOD-POD				
TRIGLYCERIDES	79		Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	**28**	**Low**	General range : 40-60	mg/dL
METHOD : DIRECT ENZYME CLEARANCE				
DIRECT LDL CHOLESTEROL	74		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	81		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	15.8		Desirable value : 10 - 35	mg/dL
CHOL/HDL RATIO	3.9		3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	2.6		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

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(Refer to " CONDITIONS OF REPORTING " Overleaf)

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Interpretation(s)

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

Serum lipid profile is measured for cardiovascular risk prediction.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	

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)

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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 TEST WITH GGT

BILIRUBIN, TOTAL METHOD : DIAZO METHOD	0.33		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.13		General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.20		0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	3.8		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	3.4		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.1		1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	28		Adults : < 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : IFCC WITHOUT PDP	37		Adults : < 34	U/L
ALKALINE PHOSPHATASE METHOD : IFCC	128		Adult (<60yrs) : 35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	12		Adult (female) : < 40	U/L

TOTAL PROTEIN, SERUM

TOTAL PROTEIN METHOD : BIURET	7.2		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL

URIC ACID, SERUM

URIC ACID	**7.0**	**High**	Adults : 2.4-5.7	mg/dL

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Test Report Status **Final**	Results			Units
METHOD : SPECTROPHOTOMETRY				
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	B			
METHOD : GEL CARD METHOD				
RH TYPE	POSITIVE			
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	**8.5**	Low	12.0 - 15.0	g/dL
METHOD : NON CYANMETHEMOGLOBIN				
RED BLOOD CELL COUNT	3.95		3.8 - 4.8	mil/µL
METHOD : IMPEDANCE				
WHITE BLOOD CELL COUNT	5.72		4.0 - 10.0	thou/µL
METHOD : IMPEDANCE				
PLATELET COUNT	379		150 - 410	thou/µL
METHOD : IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT	**27.4**	Low	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOL	**69.2**	Low	83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
MEAN CORPUSCULAR HGB.	**21.5**	Low	27.0 - 32.0	pg
METHOD : CALCULATED				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	**31.0**	Low	31.5 - 34.5	g/dL
METHOD : CALCULATED				
RED CELL DISTRIBUTION WIDTH	**18.9**	High	12.0 - 18.0	%
MENTZER INDEX	17.5			
MEAN PLATELET VOLUME	8.1		6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE				
WBC DIFFERENTIAL COUNT				
SEGMENTED NEUTROPHILS	**39**	Low	40 - 80	%
METHOD : DHSS FLOWCYTOMETRY				
LYMPHOCYTES	**49**	High	20 - 40	%
METHOD : DHSS FLOWCYTOMETRY				
MONOCYTES	8		2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
EOSINOPHILS	3		1 - 6	%
METHOD : DHSS FLOWCYTOMETRY				

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BASOPHILS METHOD : IMPEDANCE	1	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED	2.23	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED	2.80	1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED	0.46	0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED	0.17	0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0.06	0.00 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.8		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR) METHOD : WESTERGREN METHOD	**25** **High**	0 - 20	mm at 1 hr
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3 METHOD : ELECTROCHEMILUMINESCENCE	122.80	80 - 200	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE	8.37	5.1 - 14.1	µg/dl
TSH 3RD GENERATION METHOD : ELECTROCHEMILUMINESCENCE	1.770	Non-Pregnant : 0.4-4.2 Pregnant Trimester-wise : 1st : 0.1 - 2.5 2nd : 0.2 - 3 3rd : 0.3 - 3	µIU/mL

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Interpretation(s)

Triiodothyronine T3 , **Thyroxine T4,** and **Thyroid Stimulating Hormone TSH** are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.
Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3.Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism.Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

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

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association duriing pregnancy and Postpartum, 2011.
NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PHYSICAL EXAMINATION, URINE

COLOR	**AMBER**	
APPEARANCE	CLEAR	
CHEMICAL EXAMINATION, URINE		
PH	5.0	4.8 - 7.4

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Patient Ref. No. 666000003724465

CLIENT CODE : CA00010147 - MEDIWHEEL
CLIENT'S NAME AND ADDRESS :

MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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Email : customercare.ddrc@srl.in

PATIENT NAME : MRS. RIBI IPE KOVOOR PATIENT ID : **RIBIF1303884126**

ACCESSION NO : **4126WC004296** AGE : 35 Years SEX : Female ABHA NO :

DRAWN : RECEIVED : 13/03/2023 08:37 REPORTED : 14/03/2023 00:47

REFERRING DOCTOR : DR. MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED CLIENT PATIENT ID :

Test Report Status **Final**	Results		Units
SPECIFIC GRAVITY	1.025	1.015 - 1.030	
PROTEIN	**DETECTED (TRACE)**	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE	**DETECTED**	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	**5-7**	0-5	/HPF
EPITHELIAL CELLS	**8-10**	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	CALCIUM OXALATE PRESENT		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

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Test Report Status **Final**	Results	Units

Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infectionwhen present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

SUGAR URINE - FASTING

SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED

PHYSICAL EXAMINATION,STOOL

COLOUR	BROWN	
CONSISTENCY	WELL FORMED	
MUCUS	NOT DETECTED	NOT DETECTED
VISIBLE BLOOD	ABSENT	ABSENT

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LABORATORY SERVICES

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Test Report Status **Final**	Results		Units
ADULT PARASITE	NOT DETECTED		
CHEMICAL EXAMINATION,STOOL			
OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION,STOOL			
PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		

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Test Report Status **Final**	Results	Units

Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointentestinal tract like infection, malabsorption, etc.The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days.Stool specimens for parasitic examination should be collected before initiation of antidiarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects& reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

1. **Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
2. **Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
3. **Fecal Occult Blood Test(FOBT):** This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
4. **Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or waterydiarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
5. **Biofire (Film Array) GI PANEL:** In patients of Diarrhoea, Dysentry, Rice watery Stool, FDA approved, Biofire Film Array Test,(Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria,fungi,virus ,parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
6. **Rota Virus Immunoassay**: This test is recommended in severe gastroenteritis in infants & children associated with watery

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ACCESSION NO : **4126WC004296** AGE : 35 Years SEX : Female ABHA NO :

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diarrhoea, vomitting& abdominal cramps. Adults are also affected. It is highly contagious in nature.

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, 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

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
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in
Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in
Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

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

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

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PATIENT NAME : MRS. RIBI IPE KOVOOR PATIENT ID : **RIBIF1303884126**

ACCESSION NO : **4126WC004296** AGE : 35 Years SEX : Female ABHA NO :

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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.
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
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.
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, 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.
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT"S TEST
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

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Test Report Status **Final**	Results	Units

MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT

ECG WITH REPORT

REPORT

TEST COMPLETED

USG ABDOMEN AND PELVIS

REPORT

TEST COMPLETED

CHEST X-RAY WITH REPORT

REPORT

TEST COMPLETED

****End Of Report****

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

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CONSULTANT MICROBIOLOGIST

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(Refer to " CONDITIONS OF REPORTING " Overleaf)

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

NAME: MRS RIBI IPE KOVOOR	STUDY DATE 13/03/2023
AGE / SEX : 35 YRS / F	REPORTING DATE 13/03/2023
REFERRED BY : MEDIWHEEL ARCOFEMI	ACC NO : 4126WC004296

X - RAY - CHEST PA VIEW

- Both the lung fields are clear.
- B/L hila and mediastinal shadows are normal.
- Cardiac silhouette appears normal.
- Cardio – thoracic ratio is normal.
- Bilateral CP angles and domes of diaphragm appear normal.

IMPRESSION: NORMAL STUDY

Kindly correlate clinically

Navneet

Dr. NAVNEET KAUR, MBBS,MD
Consultant Radiologist.

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LABORATORY SERVICES

DDRC SRL
Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

Date...13/03/2023

OPHTHALMOLOGY REPORT

This is to certify that I have examined

~~Mr~~/ Ms : ...Rifa Ips kavoor.....Aged..25...and his / her

visual standards is as follows :

Visual Acuity:

For far vision

R: ....6/36.....

L : ....6/36.....

T CL < R 6/6
L 6/6

R : .....N6.....

For near vision

L : .....N6.....

Color Vision : .....Normal.....

.....

Nannu Elizabeth

(Optometrist)

DDRC SRL Diagnostic Services
INDIA'S LEADING DIAGNOSTICS NETWORK

NAME	**MRS RIBI IPE KOVOOR**	**AGE**	**35 YRS**
SEX	**MALE**	**DATE**	**March 13, 2023**
REFERRAL	**MEDIWHEEL ARCOFEMI**	**ACC NO**	**4126WC004296**

USG ABDOMEN AND PELVIS

LIVER
Measures ~ 13.2 cm. Bright echotexture.
Smooth margins and no obvious focal lesion within.
No IHBR dilatation. Portal vein normal in caliber .

GB
No calculus within gall bladder. Normal GB wall caliber.

SPLEEN
Measures ~ 9.7 cm, normal to visualized extent. Splenic vein normal.

PANCREAS
Normal to visualized extent. PD is not dilated.

KIDNEYS
RK: 11.5 x 3.8 cm, appears normal in size and echotexture.
LK: 11.6 x 4.4 cm, appears normal in size and echotexture.
No focal lesion / calculus within.
Maintained corticomedullary differentiation and normal parenchymal thickness.
No hydroureteronephrosis.

BLADDER
Normal wall caliber, no internal echoes/calculus within.

UTERUS
Anteverted, normal in size [7.9 x 4.1 x 5.6 cm] and echopattern.
No focal lesion seen.
ET – 12 mm.

OVARIES
RT OV: 2.6 x 2 x 2.6 cm [volume ~ 7.4 cc].
LT OV: 2.6 x 1.7 x 2.2 cm [volume ~ 5.7 cc].

NODES/FLUID
Nil to visualized extent.

BOWEL
Visualized bowel loops appear normal.

IMPRESSION
- ***Grade I fatty liver.***

Kindly correlate clinically.

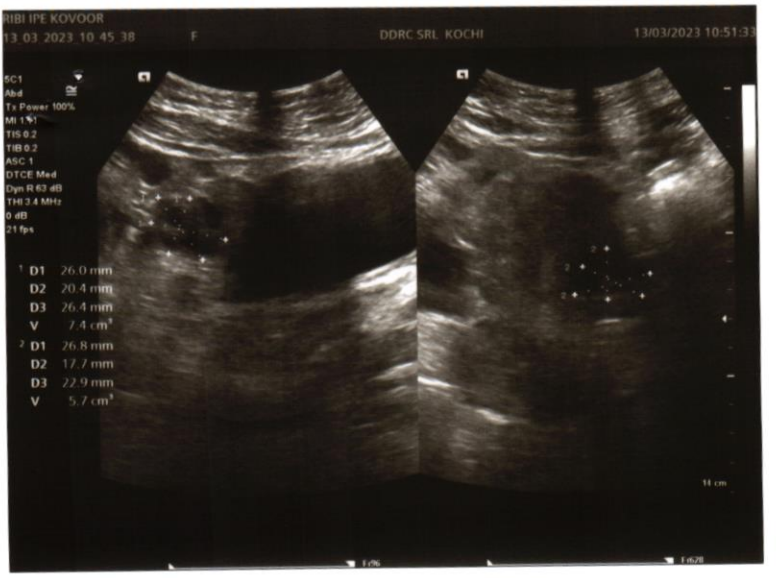
Navneet

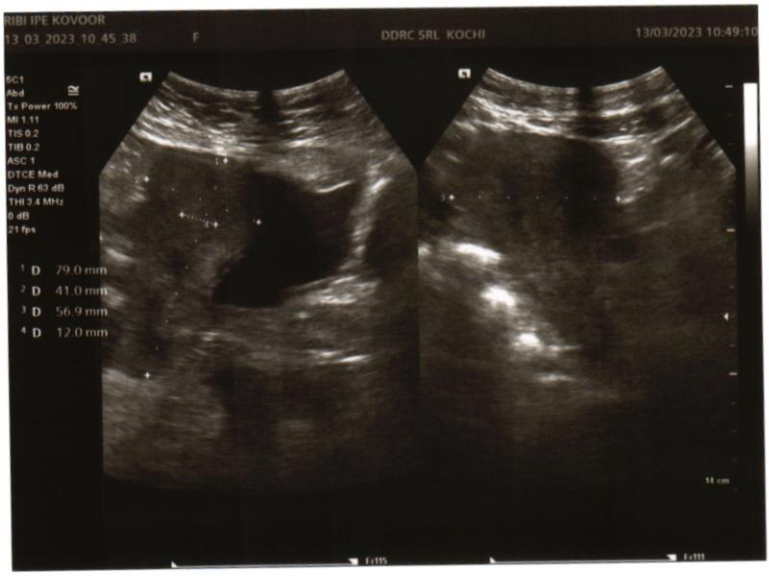
Dr. NAVNEET KAUR MBBS . MD
Consultant Radiologist

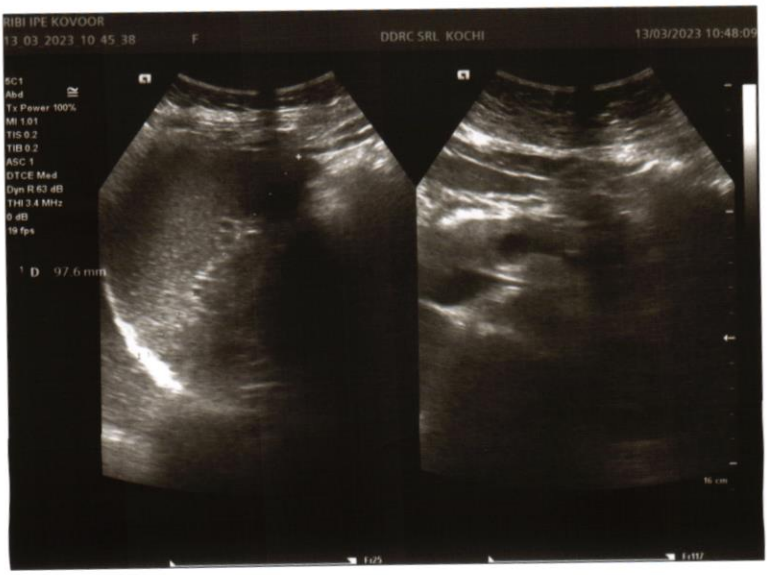
Thank you for referral. Your feedback will be appreciated.

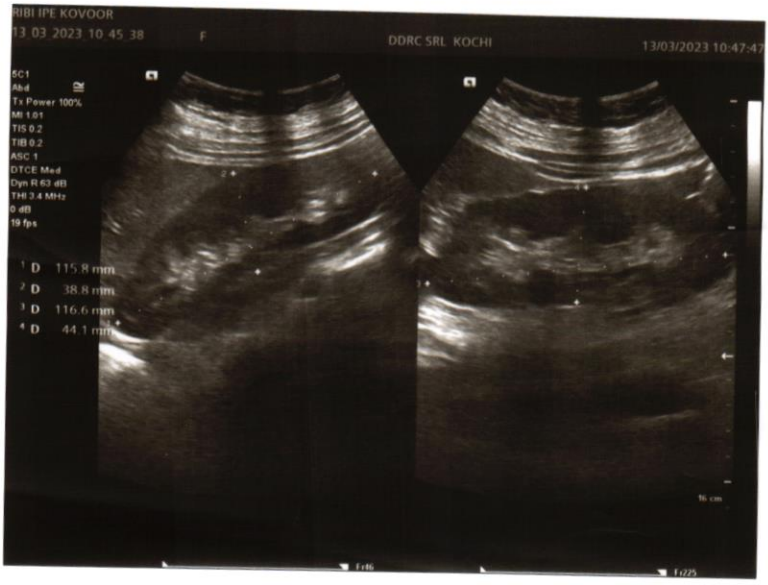
DDRC SRL DIAGNOSTICS LTD. KOCHI-35

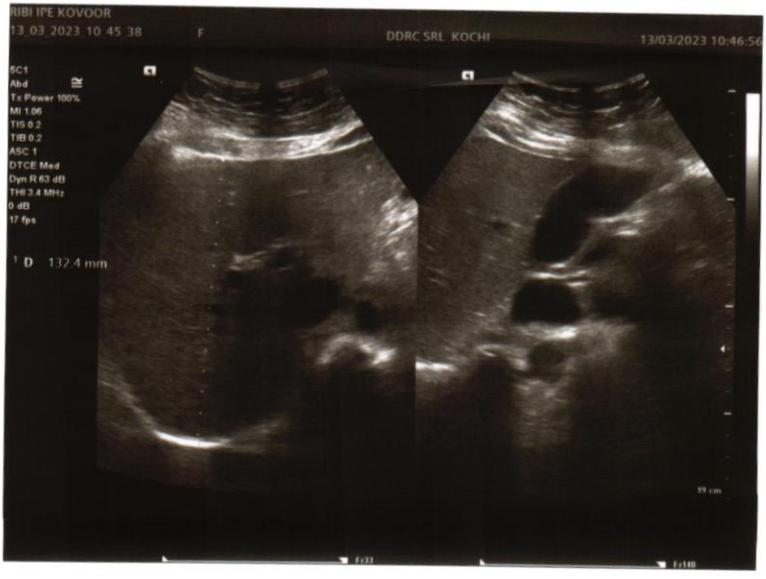
NOTE: This report is only a professional opinion based on the real time image finding and not a diagnosis by itself. It has to be correlated and interpreted with clinical and other investigation findings. Review scan is advised, If this ultrasound opinion and other clinical findings / reports don't correlate.


RIBI IPE KOVOOR
13.03.2023 10:45:38
F
DDRC SRL KOCHI
13/03/2023 10:51:33
5C1
Abd
Tx Power 100%
MI 1.91
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dyn R 63 dB
THI 3.4 MHz
0 dB
21 fps
1 D1 26.0 mm
D2 20.4 mm
D3 26.4 mm
V 7.4 cm³
2 D1 26.8 mm
D2 17.7 mm
D3 22.9 mm
V 5.7 cm³
14 cm


RIBI IPE KOVOOR
13.03.2023 10:45:38
F
DDRC SRL KOCHI
13/03/2023 10:49:10
5C1
Abd
Tx Power 100%
MI 1.11
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dyn R 63 dB
THI 3.4 MHz
0 dB
21 fps
1 D 79.0 mm
2 D 41.0 mm
3 D 56.9 mm
4 D 12.0 mm
14 cm


RIBI IPE KOVOOR
13.03.2023 10:45:38
F
DDRC SRL KOCHI
13/03/2023 10:48:09
5C1
Abd
Tx Power 100%
MI 1.01
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dyn R 63 dB
THI 3.4 MHz
0 dB
19 fps
1 D 97.6 mm
16 cm


RIBI IPE KOVOOR
13.03.2023 10:45:38
F
DDRC SRL KOCHI
13/03/2023 10:47:47
6C1
Abd
Tx Power 100%
MI 1.01
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dyn R 63 dB
THI 3.4 MHz
0 dB
19 fps
1 D 115.8 mm
2 D 38.8 mm
3 D 116.6 mm
4 D 44.1 mm
16 cm
Fr46
Fr225


RIBI IPE KOVOOR
13.03.2023 10:45:38
F
DDRC SRL KOCHI
13/03/2023 10:46:56
6C1
Abd
Tx Power 100%
MI 1.06
TIS 0.2
TIB 0.2
ASC 1
DTCE Med
Dyn R 63 dB
THI 3.4 MHz
0 dB
17 fps
1 D 132.4 mm
19 cm
Fr33
Fr148

ID: 4296
RIBI IPE KOVOOR
Female 35Years

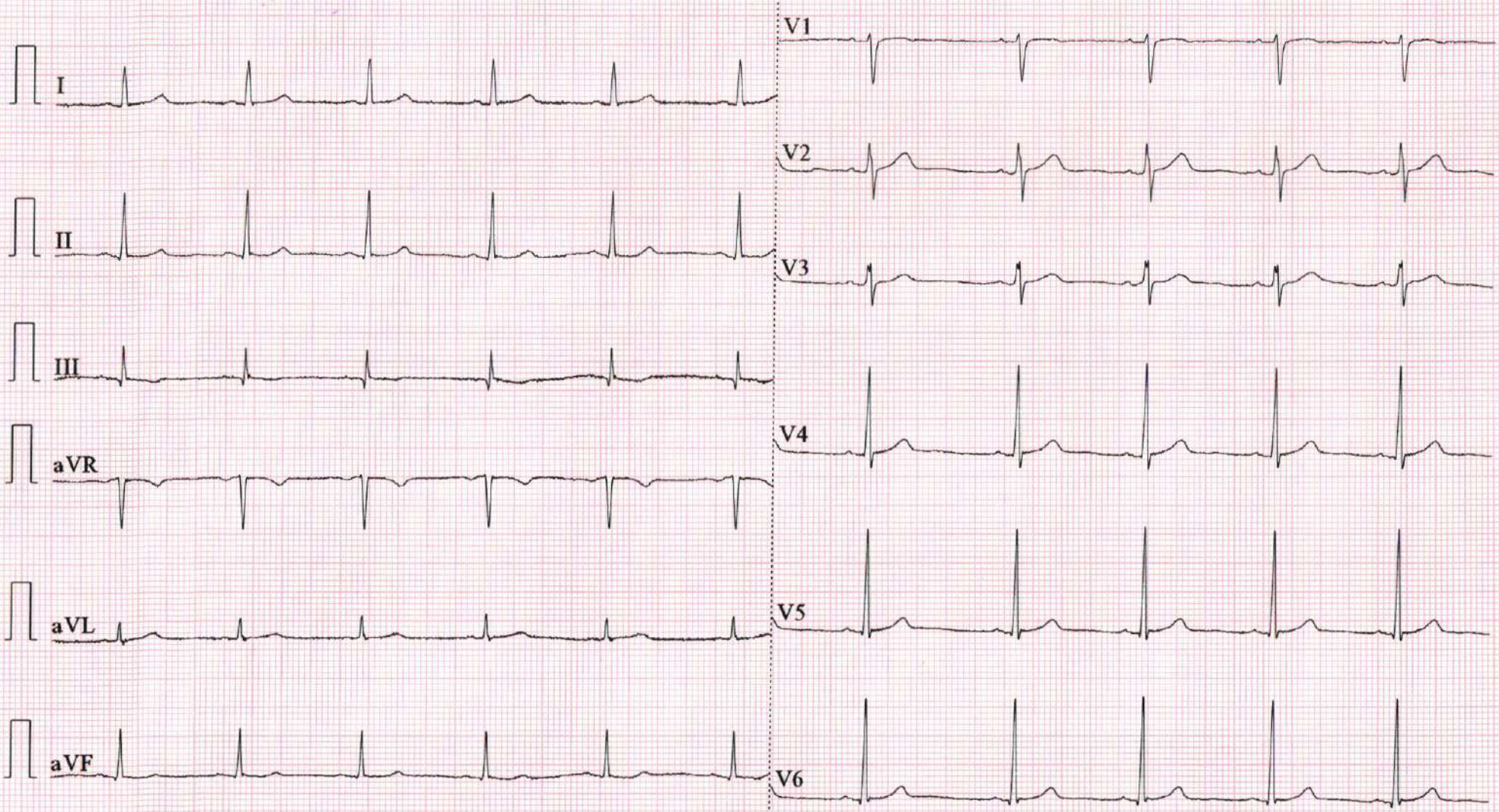
13-03-2023 10:07:18 AM

HR	: 68	bpm	
P	: 87	ms	
PR	: 130	ms	
QRS	: 79	ms	
QT/QTc	: 365/390	ms	
P/QRS/T	: 52/47/11	°	
RV5/SV1	: 1.821/0.715	mV	

Diagnosis Information:

Within normal limits
Dr. George Thomas MD,FCSI,FIAE
Cardiologist

Technician : ALEENA
Ref-Phys. : MEDIWHEEL
Report Confirmed by:



0.67~100Hz AC50 25mm/s 10mm/mV 2*5.0s ♥68 V2.2 SEMIP V1.81 DDRCSRL DIAGNOSTICS P NAGAR

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 0 m 0 s Stage Time : 0 m 46 s ***HR: 81 bpm***

Protocol: Bruce Stage: Supine Speed: 0 mph Grade: 0 % (THR: 157 bpm) B.P: 110 / 70

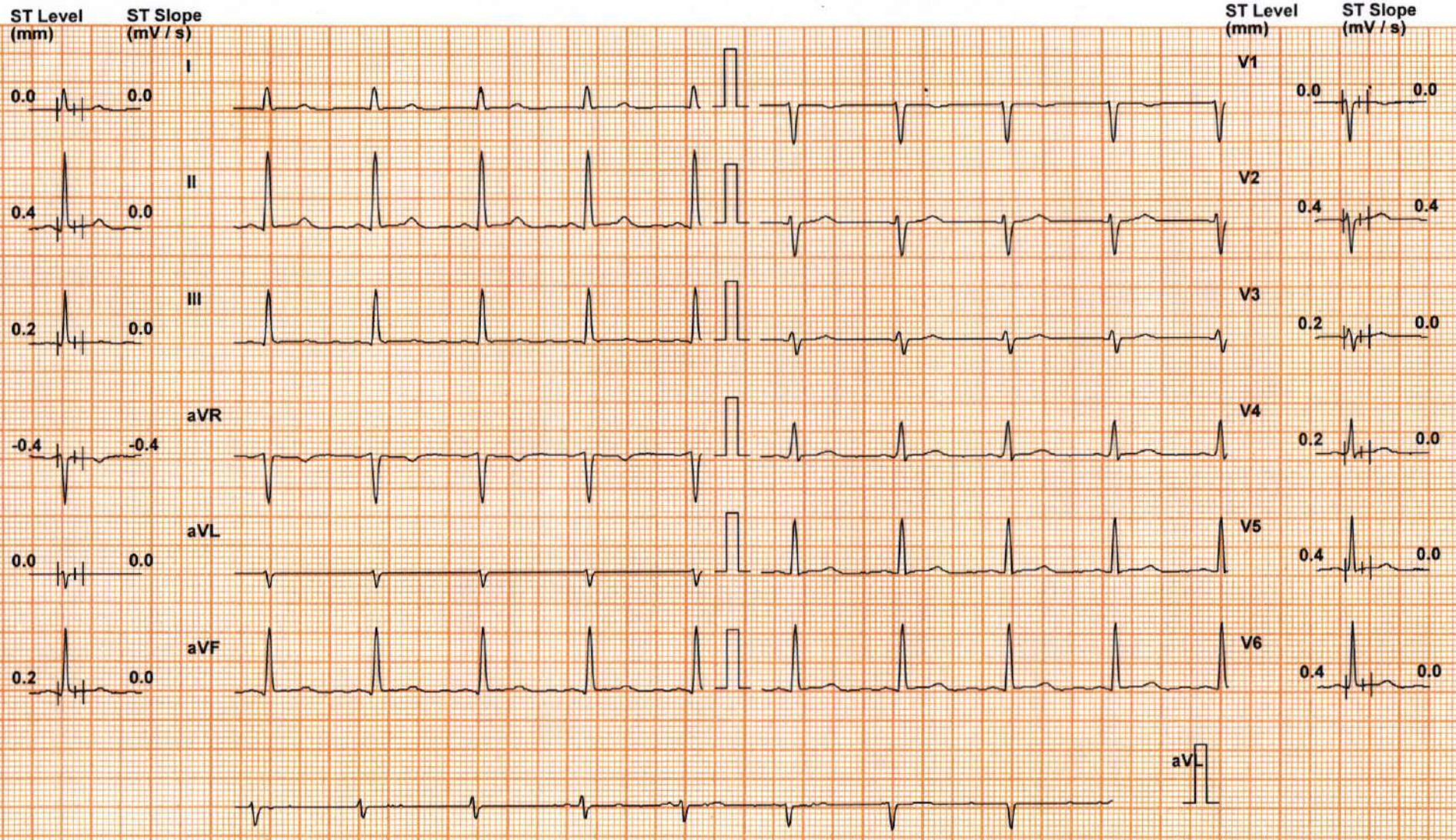


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI_ IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 0 m 0 s Stage Time : 0 m 24 s ***HR: 78 bpm***

Protocol: Bruce Stage: Standing Speed: 0 mph Grade: 0 % (THR: 157 bpm) B.P: 110 / 70

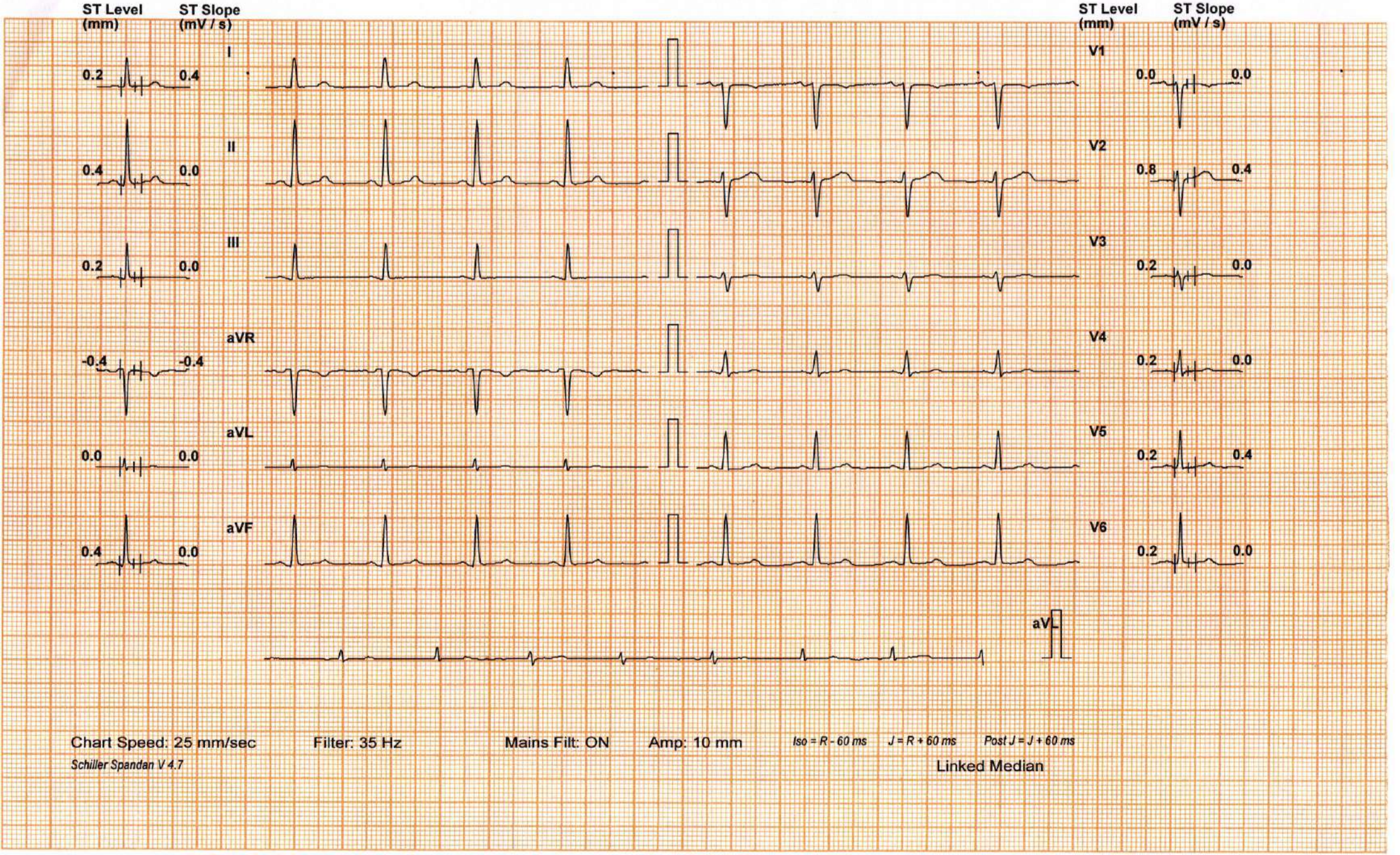


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 2 m 54 s Stage Time : 2 m 54 s ***HR: 120 bpm***

Protocol: Bruce Stage: 1 Speed: 1.7 mph Grade: 10 % (THR: 157 bpm) B.P: 120 / 70

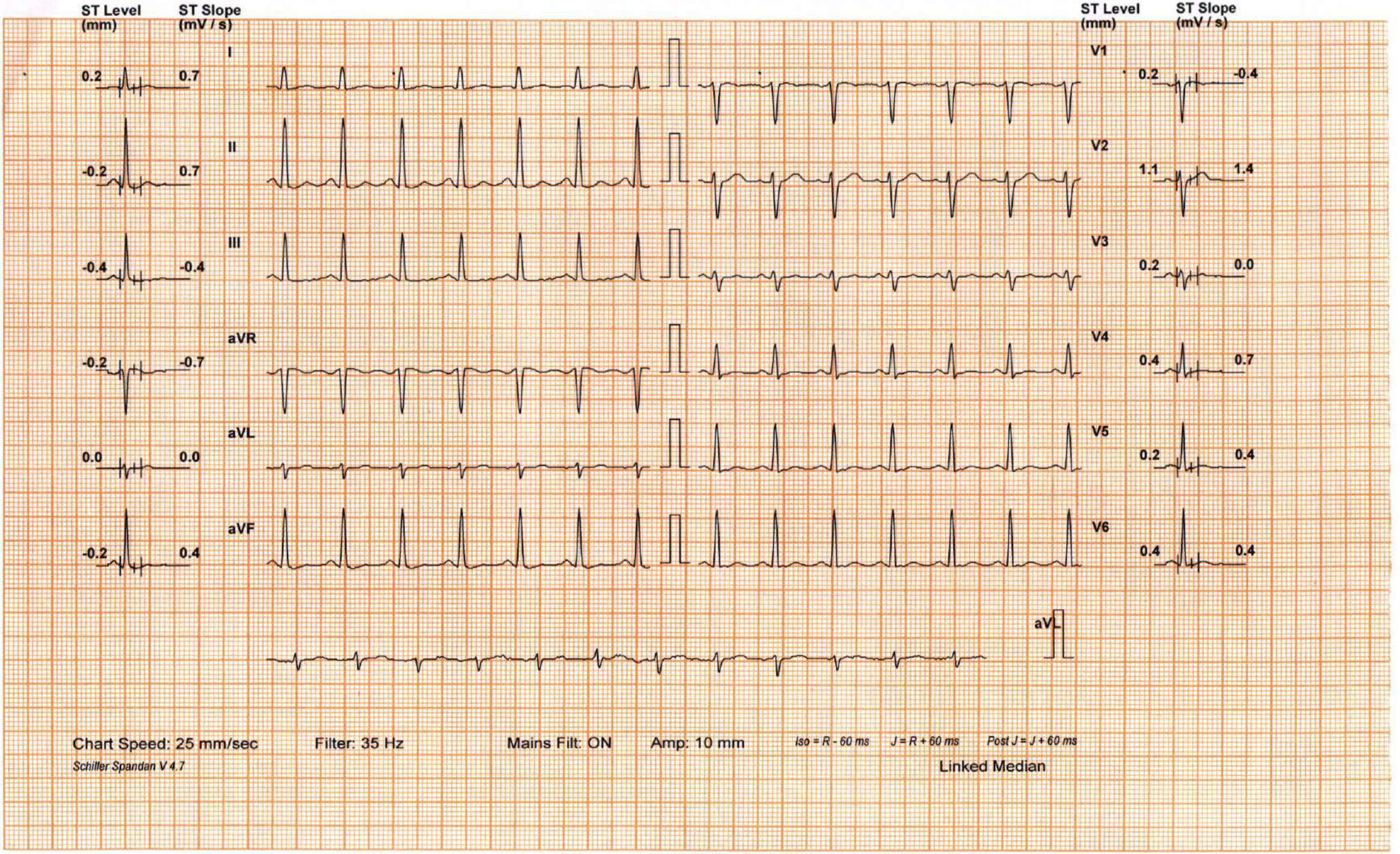


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 5 m 54 s Stage Time : 2 m 54 s ***HR: 142 bpm***

Protocol: Bruce Stage: 2 Speed: 2.5 mph Grade: 12 % (THR: 157 bpm) B.P: 130 / 70

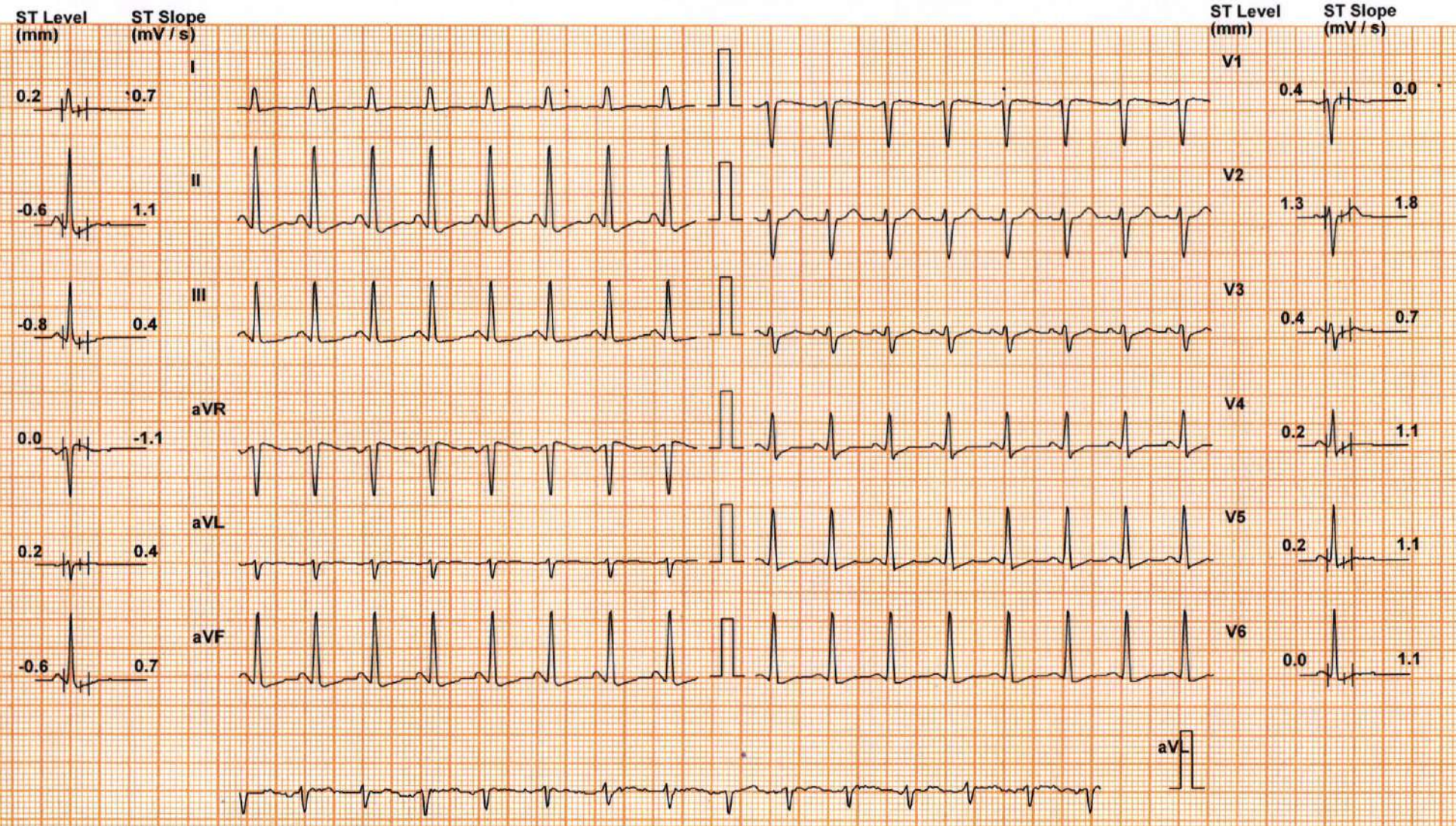


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 8 m 2 s Stage Time : 2 m 2 s ***HR: 160 bpm***

Protocol: Bruce Stage: Peak Ex Speed: 3.4 mph Grade: 14 % (THR: 157 bpm) B.P: 140 / 70

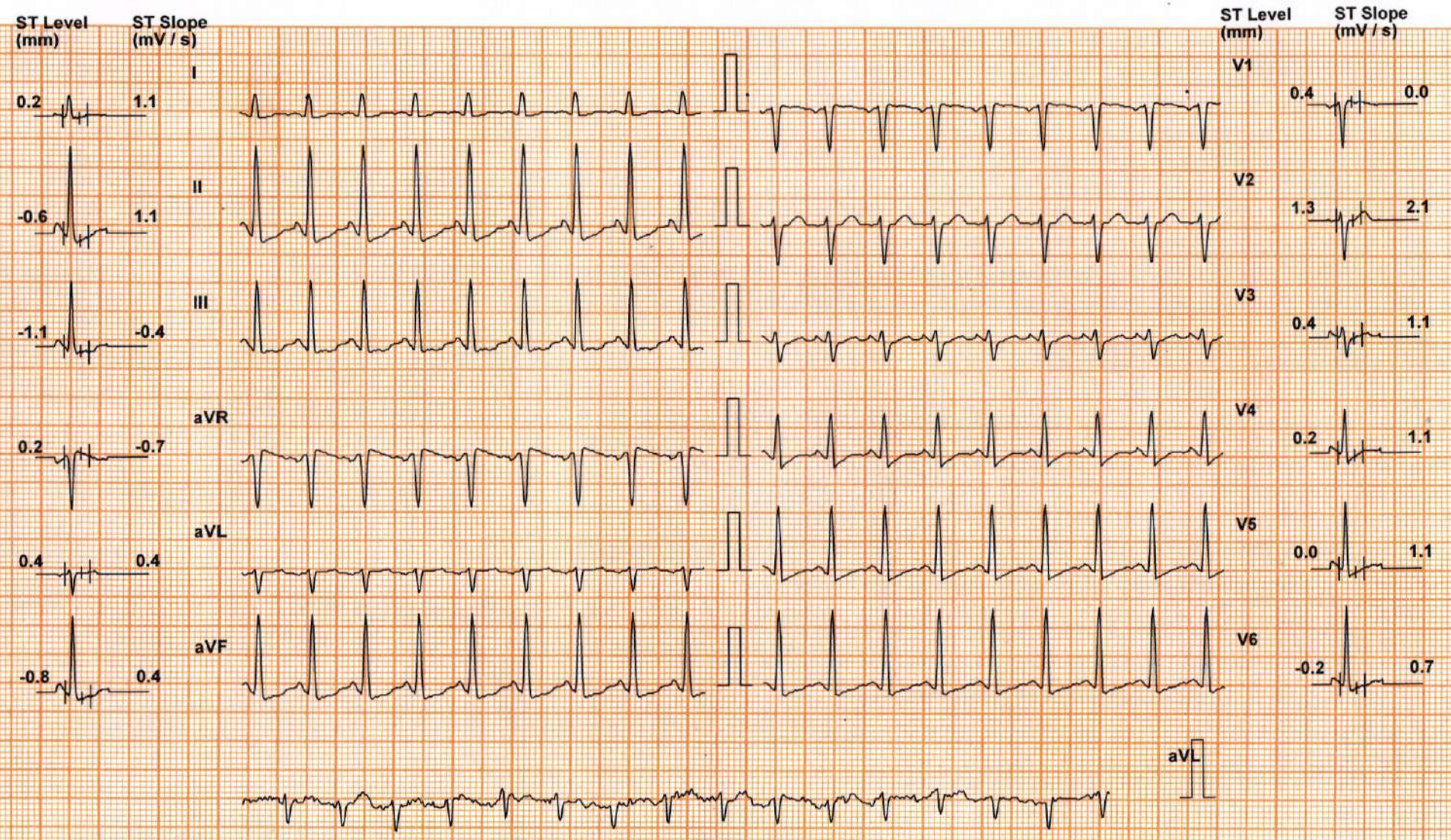


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI[illegible] IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 8 m 8 s Stage Time : 0 m 54 s ***HR: 126 bpm***

Protocol: Bruce Stage: Recovery(1) Speed: 1 mph Grade: 0 % (THR: 157 bpm) B.P: 160 / 70

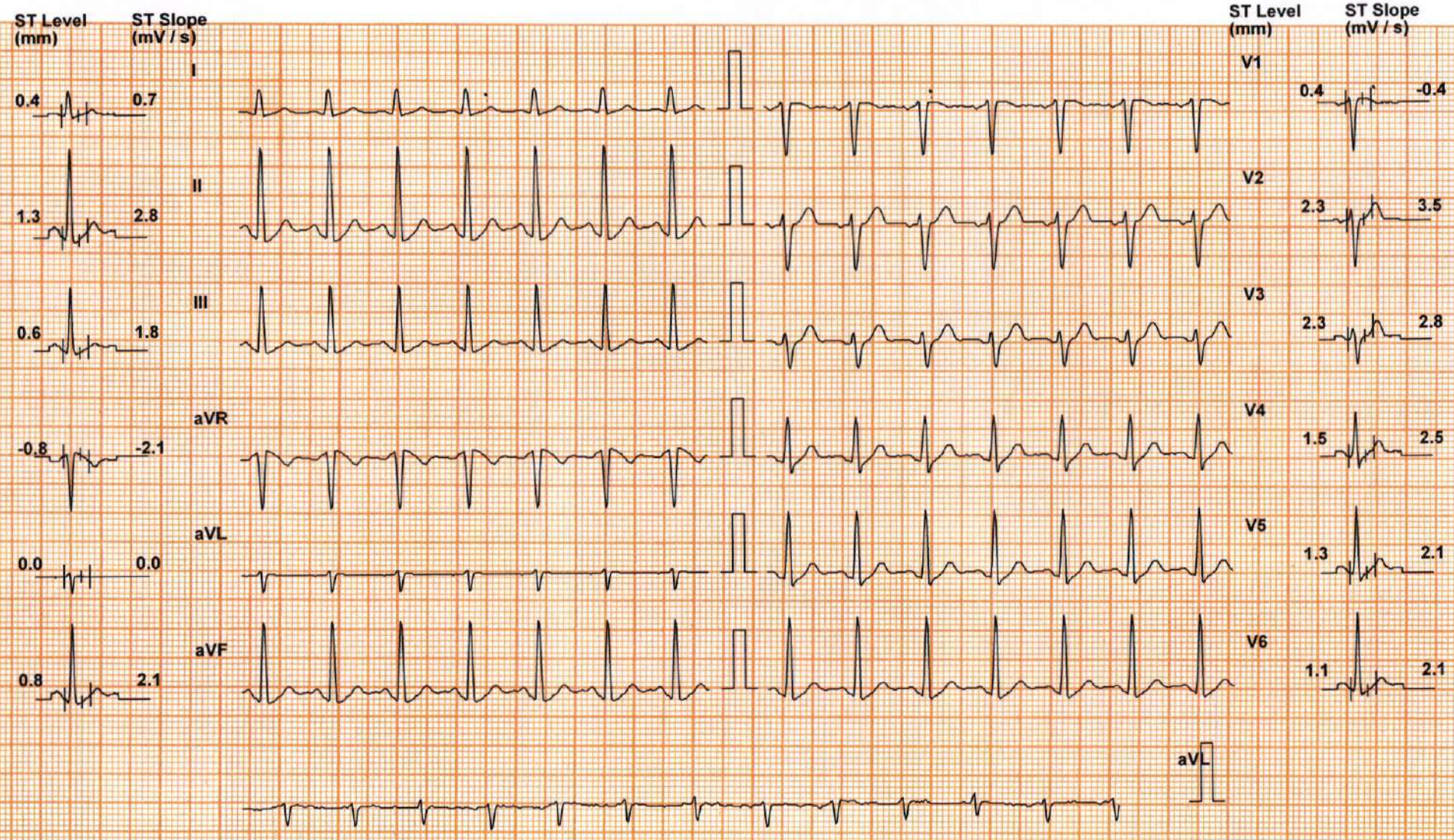


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI[illegible] IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 8 m 8 s Stage Time : 0 m 54 s ***HR: 93 bpm***

Protocol: Bruce Stage: Recovery(2) Speed: 0 mph Grade: 0 % (THR: 157 bpm) B.P: 150 / 70

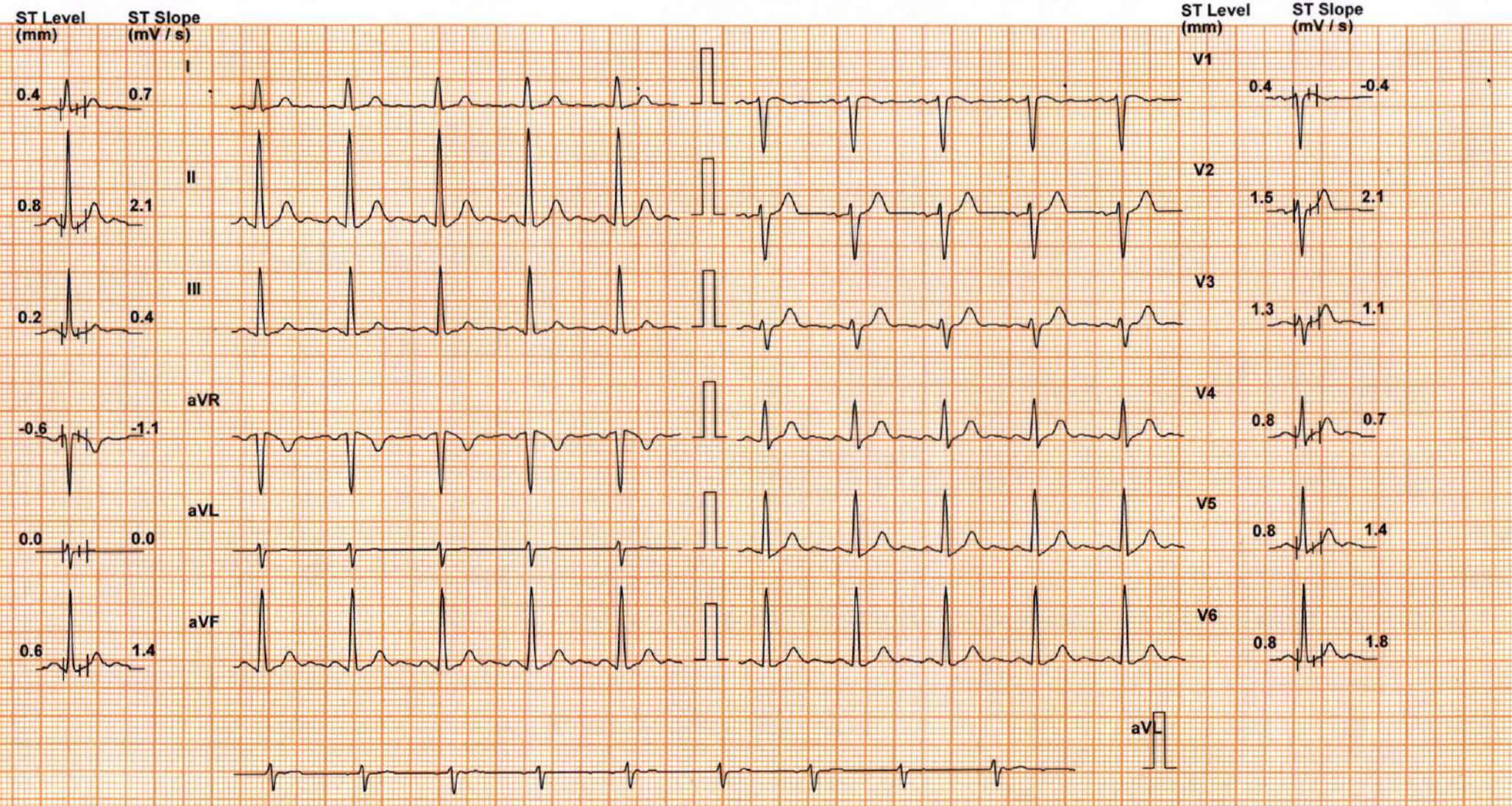


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI[illegible] IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 8 m 8 s Stage Time : 0 m 54 s ***HR: 84 bpm***

Protocol: Bruce Stage: Recovery(3) Speed: 0 mph Grade: 0 % (THR: 157 bpm) B.P: 140 / 70

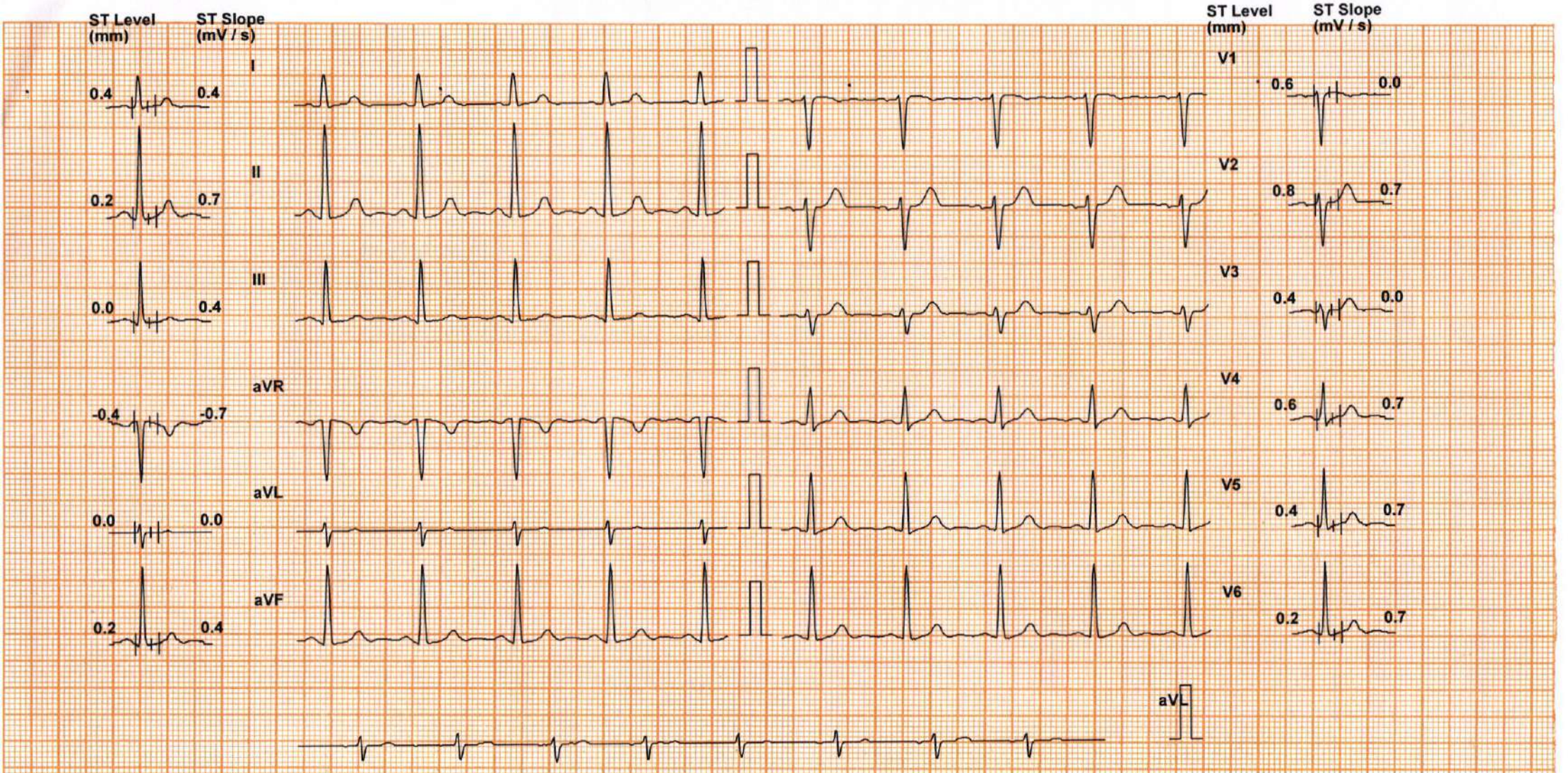


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RIBI IPE KOVOOR (35 F) ID: WC004296 Date: 13-Mar-23 Exec Time : 8 m 8 s Stage Time : 0 m 54 s ***HR: 84 bpm***

Protocol: Bruce Stage: Recovery(4) Speed: 0 mph Grade: 0 % (THR: 157 bpm) B.P: 140 / 70

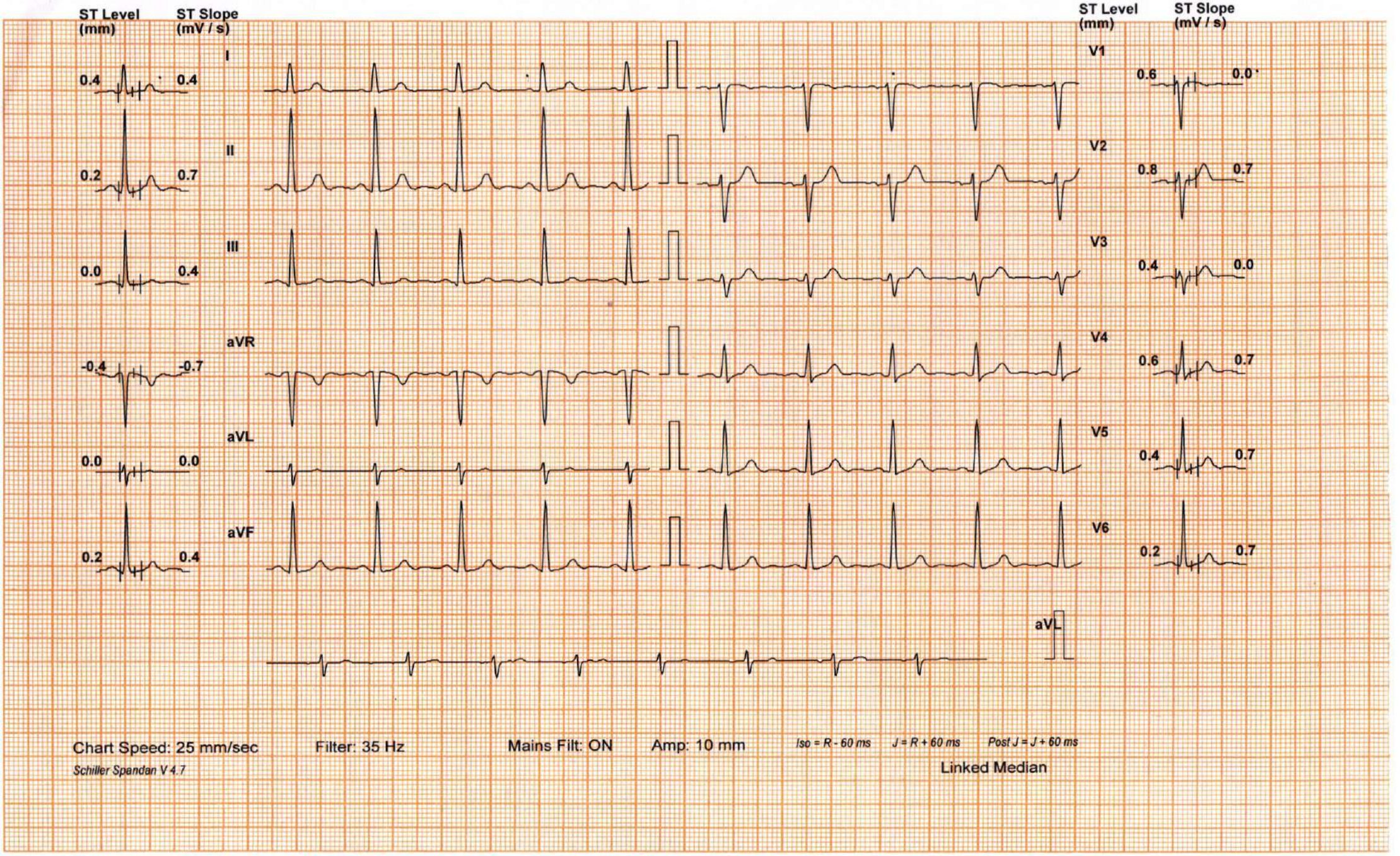


Chart Speed: 25 mm/sec Filter: 35 Hz Mains Filt: ON Amp: 10 mm *Iso = R - 60 ms* *J = R + 60 ms* *Post J = J + 60 ms*

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details **Date: 13-Mar-23** **Time: 10:19:16**

Name: RIBI IPE KOVOOR **ID:** WC004296

Age: 35 y **Sex:** F **Height:** -- cms **Weight:** -- Kgs

Clinical History: NIL

Medications:

Test Details

Protocol: Bruce **Pr.MHR:** 185 bpm **THR:** 157 (85 % of Pr.MHR) bpm

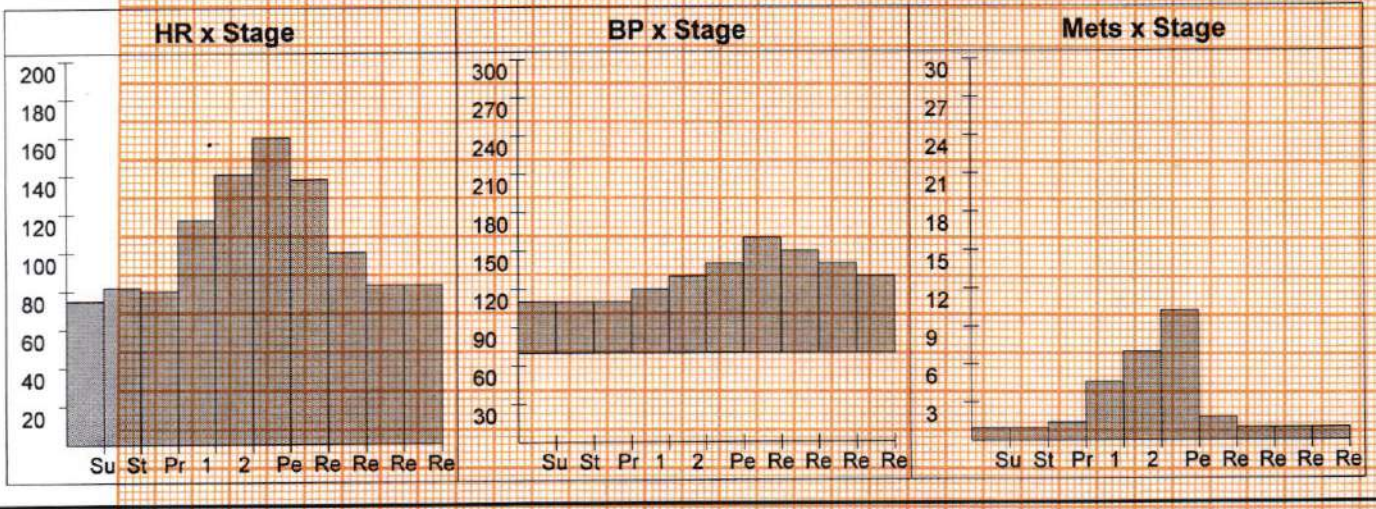
Total Exec. Time: 8 m 8 s **Max. HR:** 160 (86% of Pr.MHR)bpm **Max. Mets:** 10.20

Max. BP: 160 / 70 mmHg **Max. BP x HR:** 25600 mmHg/min **Min. BP x HR:** 5250 mmHg/min

Test Termination Criteria: Target HR attained

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 : 52	1.0	0	0	75	110 / 70	-0.42 aVR	-4.95 V1
Standing	0 : 30	1.0	0	0	82	110 / 70	-1.91 V2	-4.60 V2
1	3 : 0	4.6	1.7	10	117	120 / 70	-0.42 III	1.42 II
2	3 : 0	7.0	2.5	12	141	130 / 70	-0.85 II	1.77 V2
Peak Ex	2 : 8	10.2	3.4	14	160	140 / 70	-1.27 II	2.12 V2
Recovery(1)	1 : 0	1.8	1	0	138	160 / 70	-1.27 III	3.18 II
Recovery(2)	1 : 0	1.0	0	0	100	150 / 70	-1.06 aVR	3.54 V2
Recovery(3)	1 : 0	1.0	0	0	83	140 / 70	-0.85 aVR	2.48 V2
Recovery(4)	0 : 42	1.0	0	0	83	130 / 70	-0.64 aVR	1.42 V2



DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details **Date:** 13-Mar-23 **Time:** 10:19:16

Name: RIBI[illegible]IPE KOVOOR **ID:** WC004296

Age: 35 y **Sex:** F **Height:** -- cms **Weight:** -- Kgs

Interpretation

The patient exercised according to the Bruce protocol for 8 m 8 s achieving a work level of Max. METS : 10.20. Resting heart rate initially 75 bpm, rose to a max. heart rate of 160 (86% of Pr.MHR) bpm. Resting blood Pressure 110 / 70 mmHg, rose to a maximum blood pressure of 160 / 70 mmHg.No Angina,No Arrhythmia.

No significant ST changes
Test negative for inducible ischemia

Dr. George Thomas MD,FCSI,FIAE
Cardiologist

Ref. Doctor: MEDIWHEEL

Doctor: ------

(Summary Report edited by user)