



MC-5333

PATIENT NAME : ANKUR MITTAL**REF. DOCTOR : SELF****CODE/NAME & ADDRESS : C000049066**SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100**ACCESSION NO : 0251WA001952****PATIENT ID : ANKUM280187251****CLIENT PATIENT ID: 012301280024****ABHA NO :****AGE/SEX : 36 Years Male****DRAWN : 28/01/2023 10:06:00****RECEIVED : 28/01/2023 10:12:44****REPORTED : 28/01/2023 16:06:49**

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	15.3	13.0 - 17.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL (RBC) COUNT	5.22	4.5 - 5.5	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.80	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	344	150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	46.4	40 - 50	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	89.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.3	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.0	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.2	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	17.1		
MEAN PLATELET VOLUME (MPV)	7.9	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	44	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
LYMPHOCYTES	43 High	20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
MONOCYTES	08	2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
EOSINOPHILS	05	1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			

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JAIPUR, 302015
Rajasthan, INDIA**Patient Ref. No. 775000002221525**



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BASOPHILS		00	0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		3.43	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		3.35 High	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.62	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.39	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.0		

Interpretation(s)

BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait

(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504

This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R 05 0 - 14 mm at 1 hr

METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

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

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

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

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

False Decreased : Poikilocytosis,(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.


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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE O

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.


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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) **112 High** 74 - 99 mg/dL

METHOD : GLUCOSE OXIDASE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C **6.4 High** Non-diabetic: < 5.7 %

Pre-diabetics: 5.7 - 6.4
Diabetics: > or = 6.5
Therapeutic goals: < 7.0
Action suggested : > 8.0
(ADA Guideline 2021)

METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG) **137.0 High** < 116.0 mg/dL

METHOD : CALCULATED PARAMETER

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) **189 High** 70 - 140 mg/dL

METHOD : GLUCOSE OXIDASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL **209 High** < 200 Desirable mg/dL

200 - 239 Borderline High
>= 240 High

METHOD : CHOLESTEROL OXIDASE

TRIGLYCERIDES **184 High** < 150 Normal mg/dL

150 - 199 Borderline High
200 - 499 High
>=500 Very High

METHOD : LIPASE/GPO-PAP NO CORRECTION

HDL CHOLESTEROL **46** < 40 Low mg/dL

>=60 High

METHOD : DIRECT CLEARANCE METHOD


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CHOLESTEROL LDL **126 High** < 100 Optimal mg/dL
100 - 129
Near optimal/ above optimal
130 - 159
Borderline High
160 - 189 High
>= 190 Very High

NON HDL CHOLESTEROL **163 High** Desirable: Less than 130 mg/dL
Above Desirable: 130 - 159
Borderline High: 160 - 189
High: 190 - 219
Very high: > or = 220

METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO **36.8 High** <= 30.0 mg/dL
4.5 High 3.3 - 4.4
Low Risk
4.5 - 7.0
Average Risk
7.1 - 11.0
Moderate Risk
> 11.0
High Risk

LDL/HDL RATIO 2.7 0.5 - 3.0 Desirable/Low Risk
3.1 - 6.0 Borderline/Moderate Risk
>6.0 High Risk

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL 0.51 0 - 1 mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, DIRECT 0.15 0.00 - 0.25 mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID

BILIRUBIN, INDIRECT 0.36 0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER

TOTAL PROTEIN 7.3 6.4 - 8.2 g/dL
METHOD : BIURET REACTION, END POINT

ALBUMIN **4.5 High** 3.8 - 4.4 g/dL

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METHOD : BROMOCRESOL GREEN				
GLOBULIN	2.8	2.0 - 4.1		g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.6	1.0 - 2.1		RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	20	0 - 37		U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	35	0 - 40		U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALKALINE PHOSPHATASE	67	39 - 117		U/L
METHOD : AMP OPTIMISED TO IFCC 37° C				
GAMMA GLUTAMYL TRANSFERASE (GGT)	38	11 - 50		U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
LACTATE DEHYDROGENASE	315	230 - 460		U/L
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN	6	5.0 - 18.0		mg/dL
METHOD : UREASE KINETIC				
CREATININE, SERUM				
CREATININE	0.90	0.8 - 1.3		mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
BUN/CREAT RATIO				
BUN/CREAT RATIO	6.67			
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	6.1	3.4 - 7.0		mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.3	6.4 - 8.3		g/dL
METHOD : BIURET REACTION, END POINT				
ALBUMIN, SERUM				
ALBUMIN	4.5 High	3.8 - 4.4		g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN				
GLOBULIN	2.8	2.0 - 4.1		g/dL

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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM <small>METHOD : ION-SELECTIVE ELECTRODE</small>	140.4		137 - 145	mmol/L
POTASSIUM, SERUM <small>METHOD : ION-SELECTIVE ELECTRODE</small>	4.46		3.6 - 5.0	mmol/L
CHLORIDE, SERUM <small>METHOD : ION-SELECTIVE ELECTRODE</small>	102.1		98 - 107	mmol/L

Interpretation(s)

Interpretation(s)

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in

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

Decreased in

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

NOTE:

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

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

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

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

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

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

HbA1c Estimation can get affected due to :

I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin.

III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in

a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

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

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

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

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

Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM- Causes of Increased levels:- Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic syndrome

Causes of decreased levels- Low Zinc intake, OCP, Multiple Sclerosis

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.


Dr. Akansha Jain
Consultant Pathologist



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PERFORMED AT :

SRL Ltd
C/o Aakriti Labs Pvt. Ltd., 3, Mahatma Gandhi Marg, Gandhi Nagar Mod, Park Road
JAIPUR, 302015
Rajasthan, INDIA



Line No. 775000002221525



MC-5333

PATIENT NAME : ANKUR MITTAL

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100

ACCESSION NO : 0251WA001952

PATIENT ID : ANKUM280187251

CLIENT PATIENT ID: 012301280024

ABHA NO :

AGE/SEX : 36 Years Male

DRAWN : 28/01/2023 10:06:00

RECEIVED : 28/01/2023 10:12:44

REPORTED : 28/01/2023 16:06:49

Test Report Status	Final	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

METHOD : GROSS EXAMINATION

APPEARANCE CLEAR

METHOD : GROSS EXAMINATION

CHEMICAL EXAMINATION, URINE

PH 5.5 4.7 - 7.5

METHOD : DOUBLE INDICATOR PRINCIPLE

SPECIFIC GRAVITY <=1.005 1.003 - 1.035

METHOD : IONIC CONCENTRATION METHOD

PROTEIN NOT DETECTED NOT DETECTED

METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE

GLUCOSE DETECTED (+) NOT DETECTED

METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS

KETONES NOT DETECTED NOT DETECTED

METHOD : SODIUM NITROPRUSSIDE REACTION

BLOOD NOT DETECTED NOT DETECTED

METHOD : PEROXIDASE ANTI PEROXIDASE

BILIRUBIN NOT DETECTED NOT DETECTED

METHOD : DIPSTICK

UROBILINOGEN NORMAL NORMAL

METHOD : EHRLICH REACTION REFLECTANCE

NITRITE NOT DETECTED NOT DETECTED

METHOD : NITRATE TO NITRITE CONVERSION METHOD

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 2-3 0-5 /HPF

METHOD : DIPSTICK, MICROSCOPY

EPITHELIAL CELLS 1-2 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED


Dr. Akansha Jain
Consultant Pathologist



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Rajasthan, INDIA



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Printed By: [Name]
Lab No. 775000002221525



MC-5333

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METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

Interpretation(s)

Dr. Akansha Jain
Consultant Pathologist



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Rajasthan, INDIA



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Printed by: No. 775000002221525



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

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION,STOOL

COLOUR

SAMPLE NOT RECEIVED

METHOD : GROSS EXAMINATION

Dr. Abhishek Sharma
Consultant Microbiologist



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Test Report Status Final Results Biological Reference Interval Units

8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

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

NOTE: It is advisable to detect Free T3, Free T4 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.

****End Of Report****

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

Dr. Akansha Jain
Consultant Pathologist



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JAIPUR, 302015
Rajasthan, INDIA



Line No. 775000002221525

Name	: MR. ANKUR MITTAL	Age/Sex	: 36 Yrs/ MALE
Ref.By	: AAKRITI LABS	Date	: 28 January 2023

RADIOGRAPH OF CHEST : PA VIEW

Soft tissue and bony cage are normal.

Both lungs are normal.

Both domes of diaphragm are normal in position and contour.

Hilar shadows are normal.

Mediastinum is central.

Both costo-phrenic angles are clear.

Cardiac size and shape are within normal limits.

IMPRESSION:

- NO OBVIOUS ABNORMALITY.



DR. SHUBHAM SINGHAL
CONSULTANT RADIOLOGIST



Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563



Name : Mr. ANKUR MITTAL
Age/Gender: 36 Y/Male
Patient ID : 012301280024
BarcodeNo : 10074585
Referred By : Self

Registration No: 50907
Registered : 28/Jan/2023 10:06AM
Analysed : 28/Jan/2023 12:31PM
Reported : 28/Jan/2023 12:31PM
Panel : Medi Wheel (ArcoFemi
Healthcare Ltd)

USG: WHOLE ABDOMEN (Male)

- LIVER** : Is normal in size, shape and echogenicity.
The IHBR and hepatic radicals are not dilated.
No evidence of focal echopoor/echorich lesion seen.
Portal vein diameter and common bile duct appear normal.
- GALL** : Is normal in size, shape and echotexture. Walls are smooth and
BLADDER regular with normal thickness. There is no evidence of cholelithiasis.
- PANCREAS** : Is normal in size, shape and echotexture. Pancreatic duct is not dilated.
SPLEEN : Is normal in size, shape and echogenicity. Splenic hilum is not dilated.
- KIDNEYS** : Right Kidney:-Size: 98 x 47 mm, Left Kidney:-Size: 110 x 56 mm.
Bilateral Kidneys are normal in size, shape and echotexture,
corticomedullary differentiation is fair and ratio appears normal.
Pelvi calyceal system is normal. No evidence of hydronephrosis/ nephrolithiasis.
- URINARY** : Bladder walls are smooth, regular and normal thickness.
BLADDER : No evidence of mass or stone in bladder lumen.
- PROSTATE** : Is normal in size, shape and echotexture,
measures: 35 x 31 x 25 mm, wt: 15 gms.
Its capsule is intact and no evidence of focal lesion.
- SPECIFIC** : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.
No evidence of lymphadenopathy or mass lesion in retroperitoneum.
Visualized bowel loop appear normal. Great vessels appear normal.

IMPRESSION :- NORMAL STUDY.

*** End Of Report ***

Page 1 of 1

Dr. Neera Mehta
M.B.B.S., D.M.R.D.
RMCNO.005807/14853

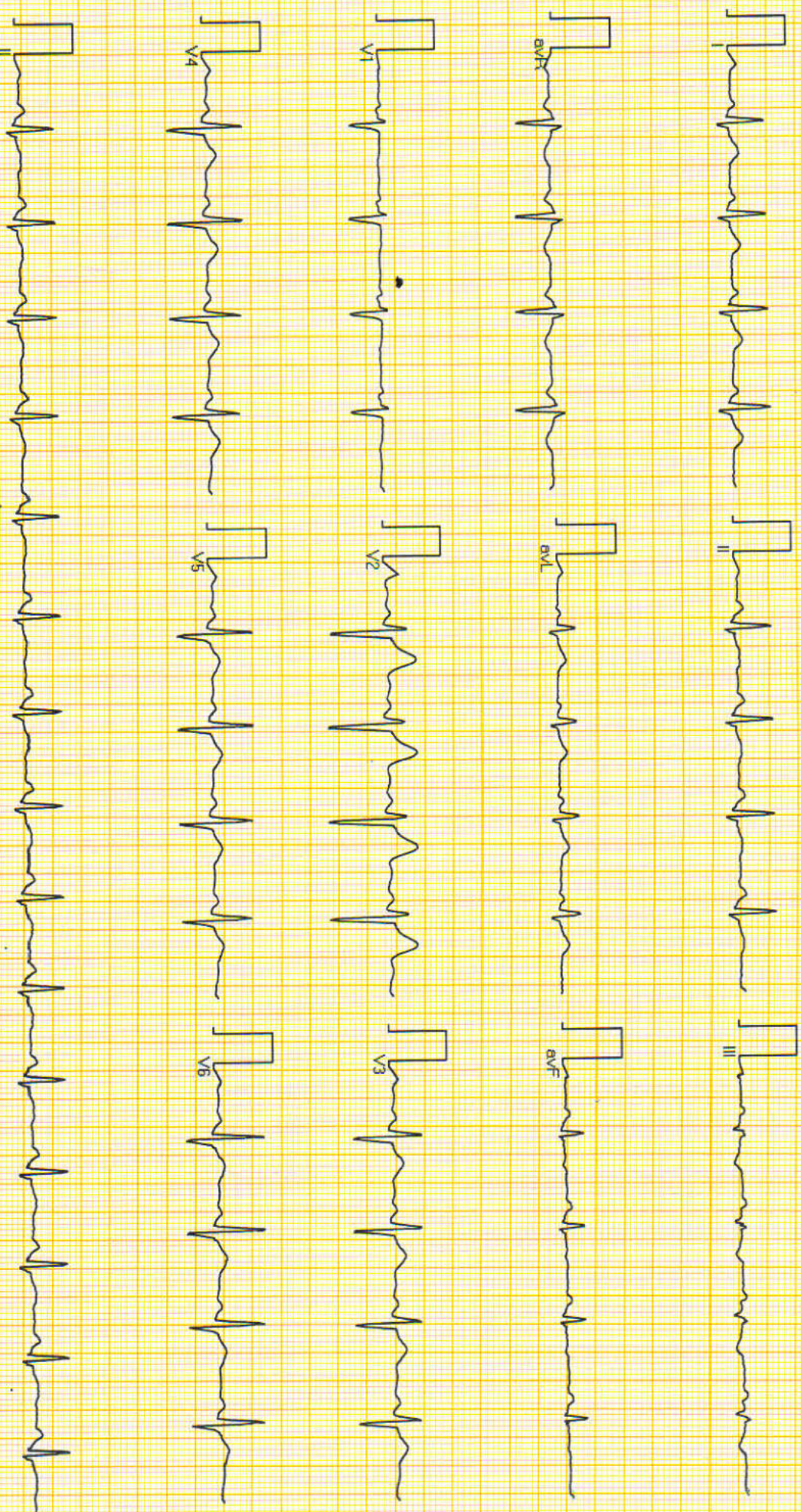


AAKRITI LABS PVT.LTD JAIPUR

48688 / MR. ANKUR MITTAL / 36 Yrs / M / Non Smoker

Heart Rate : 92 bpm / Tested On : 28-Jan-23 11:00:27 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s
/ Ref'd By : MEDI WHEEL

ECG



Vent Rate : 92 bpm
PR Interval : 132 ms
QRS Duration : 90 ms
QT/QTc Int : 342/398 ms
p-QRS-T axis : 47.00° 30.00° 1.00°
Allengers ECG (Pscses)(PIS215190517)

Reported By: *TNR*

RN
Dr. NITIZ GOYAL
M.B.B.S., M.D
RMC-023319

NAME	MR ANKUR MITTAL	AGE	36Y	SEX	MALE
REF BY	MEDIWHEEL	DATE	28/01/2022	REG NO	

ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

2D/M-MOD

IVSD mm	12.0	IVSS mm	16.5	AORTA mm	23.7
LVID mm	40.6	LVIS mm	24.7	LA mm	24.7
LVPWD mm	12.5	LVPWS mm	17.0	EF%	60%

CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	1.04/0.92	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANIMETERY)		MVA cm2 (PHT)	
MR			

AORTIC

PEAK VELOCITY m/s	1.74	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

TRICUSPID

PEAK VELOCITY m/s	0.79	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR		PASP mmHg	

PULMONARY

PEAK VELOCITY m/s	1.42	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

IMPRESSION

- NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION
- NO RWMA LVEF 60%
- NORMAL RV FUNCTION
- CONCENTRIC LVH
- NORMAL VALVULAR ECHO
- INTACT IAS / IVS
- NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.
- IVC NORMAL
- CONCLUSION : CONCENTRIC LVH,FAIR LV FUNCTION.


Cardiologist