Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 25/2/23

Name: Mr. Rupesh More Age: 35 yrs Sex: (M) / F

BP: 110/80mm Height (cms): 167 cm Weight(kgs): 72.6kg BMI: 25

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy						Overweight				Obese					Extremely Obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
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UHID	**12316598**	**Date**	**25/02/2023**		
Name	**Mr. Rupesh Dilip More**	**Sex**	**Male**	**Age**	**35**
OPD	**Opthal 14**				

Drug allergy:→ Dolo ?
Sys illness: → No

Cl. No.

V.A. D.V. (Since 3-4 yrs).

U.C.V. → Re 6/12 P
↳ Le 6/6 P.

Ref. → RE −0.50/−0.75 X 90° 6/6.
↳ Le Plano/−0.75 X 90° 6/6

N.V. → RE N6.
↳ Le N6

I.O.P. → RE 14.3.
↳ Le 15.4. (done at 9.4.P.).

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9/12

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UHID	12316598	Date	25/02/2023		
Name	Mr. Rupesh Dilip More	Sex	Male	Age	35
OPD	Dental 12				

Drug allergy:
Sys illness:

Impacted & Carious — 8/8, 8/8

Caries — 67

Missing — 6/6, 8

Stains ++ Calculus ++

Treatment

Adv. Implant — 6/6

Adv. Extraction — 8/8, 8/8

Adv. Filling — 67

Adv. Oral prophylaxis.

Adv. CBCT.

Dr Diksha Kalra

LABORATORY REPORT

Patient Ref. No. 22000000830868

Cert. No. MC-2984

CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

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

PATIENT NAME : MR.RUPESH DILIP MORE

PATIENT ID : **FH.12316598**

ACCESSION NO : **0022WB004959** AGE : 35 Years SEX : Male ABHA NO :

DRAWN : 25/02/2023 10:45:00 RECEIVED : 25/02/2023 10:45:45 REPORTED : 25/02/2023 19:14:56

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : UID:12316598

CLINICAL INFORMATION :

UID:12316598 REQNO-1377383
CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	115.00	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	8.18	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	1.570	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	**1.630**	**High**	< 1.4	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Comments

NOTE: PLEASE CORRELATE RESULTS WITH CLINICAL & THERAPEUTIC HISTORY.

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 chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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

Dr. Swapnil Sirmukaddam
Dr. Swapnil Sirmukaddam
Consultant Pathologist

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PATIENT NAME : MR.RUPESH DILIP MORE PATIENT ID : **FH.12316598**

ACCESSION NO : **0022WB004959** AGE : 35 Years SEX : Male ABHA NO :

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REFERRING DOCTOR : SELF CLIENT PATIENT ID : UID:12316598

CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results		Biological Reference Interval	Units
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN METHOD : UREASE - UV	14		6 - 20	mg/dL
CREATININE EGFR- EPI				
CREATININE METHOD : ALKALINE PICRATE KINETIC JAFFES	**0.79**	**Low**	0.90 - 1.30	mg/dL
AGE	35			years
GLOMERULAR FILTRATION RATE (MALE) METHOD : CALCULATED PARAMETER	118.81		Refer Interpretation Below	mL/min/1.73m
BUN/CREAT RATIO				
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER	**17.72**	**High**	5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID METHOD : URICASE UV	**3.3**	**Low**	3.5 - 7.2	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN METHOD : BIURET	7.7		6.4 - 8.2	g/dL
ALBUMIN, SERUM				
ALBUMIN METHOD : BCP DYE BINDING	4.1		3.4 - 5.0	g/dL
GLOBULIN				
GLOBULIN METHOD : CALCULATED PARAMETER	3.6		2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM METHOD : ISE INDIRECT	142		136 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.31		3.50 - 5.10	mmol/L

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CHLORIDE, SERUM METHOD : ISE INDIRECT	105	98 - 107	mmol/L

Interpretation(s)

PHYSICAL EXAMINATION, URINE

COLOR METHOD : PHYSICAL	PALE YELLOW		
APPEARANCE METHOD : VISUAL	CLEAR		

CHEMICAL EXAMINATION, URINE

PH METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD	5.5	4.7 - 7.5	
SPECIFIC GRAVITY METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)	>=1.030	1.003 - 1.035	
PROTEIN METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE	NOT DETECTED	NOT DETECTED	
GLUCOSE METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD	**DETECTED (+++)**	NOT DETECTED	
KETONES METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE	NOT DETECTED	NOT DETECTED	
BLOOD METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN	NOT DETECTED	NOT DETECTED	
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT	NOT DETECTED	NOT DETECTED	
UROBILINOGEN METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)	NORMAL	NORMAL	
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE	NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY	NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

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CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results	Biological Reference Interval	Units
RED BLOOD CELLS METHOD : MICROSCOPIC EXAMINATION	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : MICROSCOPIC EXAMINATION	2-3	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPIC EXAMINATION	1-2	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

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

Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis
TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

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

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HAEMATOLOGY - CBC				
CBC-5, EDTA WHOLE BLOOD				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)	15.6		13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	**6.16**	**High**	4.5 - 5.5	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	6.38		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	243		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT (PCV)	47.9		40 - 50	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	**77.8**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	**25.3**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.5		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	**15.2**	**High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	12.6			
MEAN PLATELET VOLUME (MPV)	9.6		6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT				
NEUTROPHILS	57		40 - 80	%
METHOD : FLOWCYTOMETRY				
LYMPHOCYTES	33		20 - 40	%
METHOD : FLOWCYTOMETRY				

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LABORATORY REPORT

Patient Ref. No. 22000000830868

Cert. No. MC-2275

CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

PATIENT NAME : MR.RUPESH DILIP MORE PATIENT ID : **FH.12316598**

ACCESSION NO : **0022WB004959** AGE : 35 Years SEX : Male ABHA NO :

DRAWN : 25/02/2023 10:45:00 RECEIVED : 25/02/2023 10:45:45 REPORTED : 25/02/2023 15:44:36

REFERRING DOCTOR : SELF CLIENT PATIENT ID : UID:12316598

CLINICAL INFORMATION :

UID:12316598 REQNO-1377383
CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results		Biological Reference Interval	Units
MONOCYTES	6		2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS	4		1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS	0		0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT	3.64		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT	2.11		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT	0.38		0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT	0.26		0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.7			
METHOD : CALCULATED PARAMETER				

MORPHOLOGY

RBC	NORMOCYTIC NORMOCHROMIC, MILD MICROCYTOSIS, MILD ANISOCYTOSIS
METHOD : MICROSCOPIC EXAMINATION	
WBC	NORMAL MORPHOLOGY
METHOD : MICROSCOPIC EXAMINATION	
PLATELETS	ADEQUATE
METHOD : MICROSCOPIC EXAMINATION	

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive

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CORP-OPD
BILLNO-150123OPCR011528
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Test Report Status **Final**	Results	Biological Reference Interval	Units

patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

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

METHOD : WESTERGREN METHOD

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

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: 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.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B		

METHOD : TUBE AGGLUTINATION

RH TYPE	POSITIVE		

METHOD : TUBE AGGLUTINATION

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CORP-OPD
BILLNO-150123OPCR011528
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Test Report Status **Final**	Results	Biological Reference Interval	Units

Interpretation(s)
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

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

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

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	**1.08**	**High**	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, DIRECT	0.18		0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, INDIRECT	0.90		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.7		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN	4.1		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN	3.6		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.1		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**14**	**Low**	15 - 37	U/L
METHOD : UV WITH P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	28		< 45.0	U/L
METHOD : UV WITH P5P				
ALKALINE PHOSPHATASE	116		30 - 120	U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)	21		15 - 85	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE				

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CLINICAL INFORMATION :

UID:12316598 REQNO-1377383
CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results		Biological Reference Interval	Units
LACTATE DEHYDROGENASE	147		100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**111**	**High**	74 - 99	mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**6.9**	**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 : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)	**151.3**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels 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

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LABORATORY REPORT

Patient Ref. No. 22000000830868

CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
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FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

Cert. No. MC-2275

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MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

PATIENT NAME : MR.RUPESH DILIP MORE

ACCESSION NO : **0022WB004959** AGE : 35 Years SEX : Male PATIENT ID : **FH.12316598**

DRAWN : 25/02/2023 10:45:00 RECEIVED : 25/02/2023 10:45:45 ABHA NO : REPORTED : 25/02/2023 15:44:36

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

CLIENT PATIENT ID : UID:12316598

UID:12316598 REQNO-1377383
CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

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

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: 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

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	188	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	122	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			

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ACCESSION NO : **0022WB004959** AGE : 35 Years SEX : Male ABHA NO :

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Test Report Status **Final**	Results		Biological Reference Interval	Units
HDL CHOLESTEROL	45		< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT	124		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT				
NON HDL CHOLESTEROL	**143**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	24.4		</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	4.2		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	2.8		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				

Interpretation(s)

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

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

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LABORATORY REPORT

Patient Ref. No. 22000000830918

Cert. No. MC-2275

CLIENT CODE : C000045507

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PATIENT NAME : MR.RUPESH DILIP MORE PATIENT ID : **FH.12316598**

ACCESSION NO : **0022WB005009** AGE : 35 Years SEX : Male ABHA NO :

DRAWN : 25/02/2023 13:28:00 RECEIVED : 25/02/2023 13:28:49 REPORTED : 25/02/2023 14:41:01

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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150123OPCR011528
BILLNO-150123OPCR011528

Test Report Status **Final**	Results	Biological Reference Interval	Units
BIOCHEMISTRY			
GLUCOSE, POST-PRANDIAL, PLASMA			
PPBS(POST PRANDIAL BLOOD SUGAR)	**173**	**High** 70 - 139	mg/dL
METHOD : HEXOKINASE			

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

****End Of Report****

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Dr.Akta Dubey
Counsultant Pathologist

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12316598
35 Years

RUPESH MORE
Male

2/25/2023 11:39:05 AM

HC

Rate 61 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 146
QRSD 90
QT 403
QTc 406

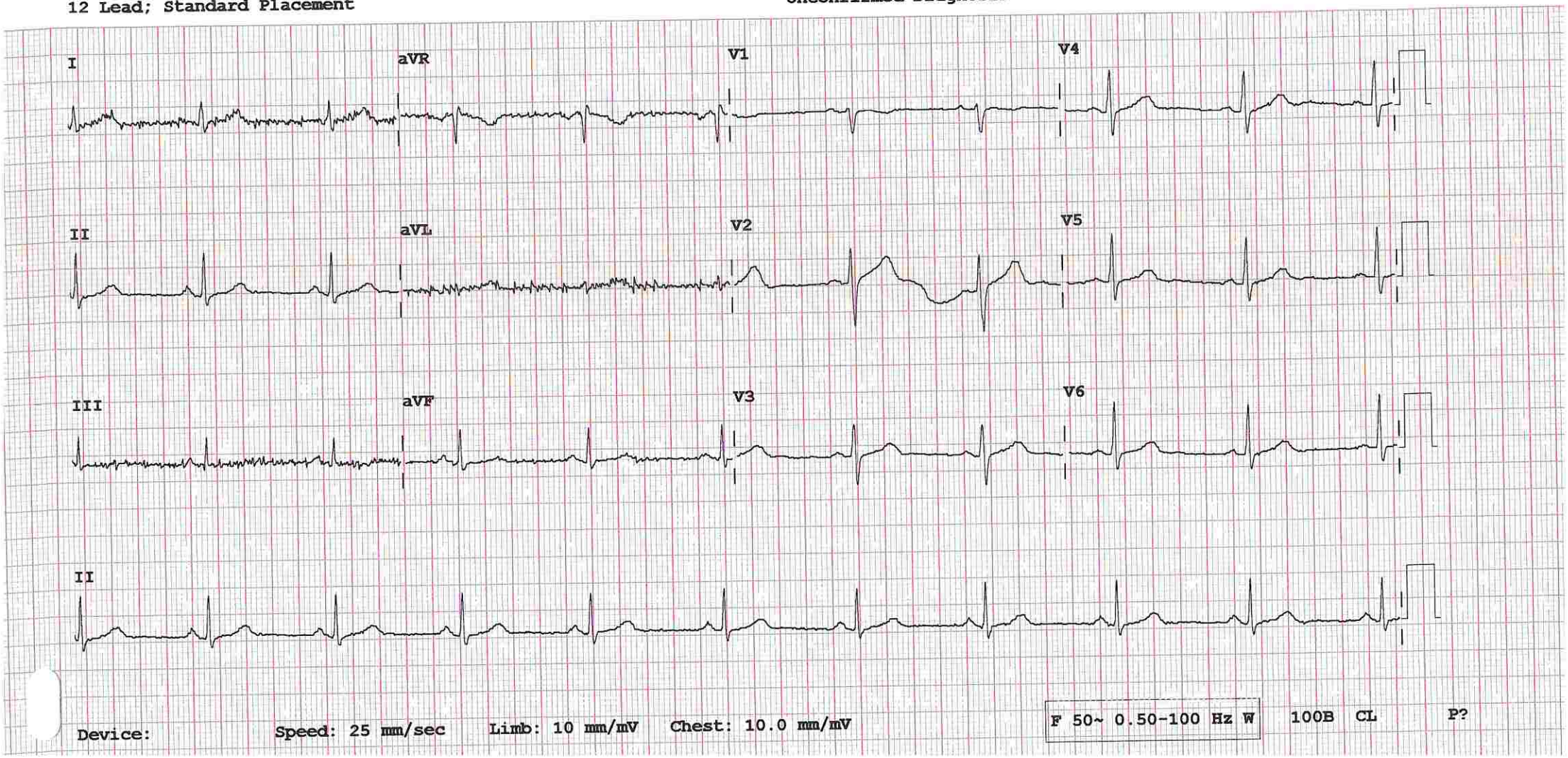
--AXIS--
P 62
QRS 68
T 35

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

Sinus rhythm



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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PAN NO : AABCH5894D

Hiranandani HOSPITA
(A Fortis Network Hospit

(For Billing/Reports & Discharge Summary only)

Date: 27/Feb/2023

DEPARTMENT OF NIC

Name: Mr. Rupesh Dilip More
Age | Sex: 35 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12316598 | 11700/23/1501
Order No | Order Date: 1501/PN/OP/2302/24291 | 25-Feb-2023
Admitted On | Reporting Date : 27-Feb-2023 13:48:36
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

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

M-MODE MEASUREMENTS:

LA	27	mm
AO Root	29	mm
AO CUSP SEP	18	mm
LVID (s)	24	mm
LVID (d)	39	mm
IVS (d)	10	mm
LVPW (d)	09	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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DOPPLER STUDY:

E WAVE VELOCITY: 1.0 m/sec.
A WAVE VELOCITY:0.6 m/sec
E/A RATIO:1.7

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	06			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

- Normal 2 Dimensional and colour doppler echocardiography study.

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

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 25/Feb/2023

Name: Mr. Rupesh Dilip More
Age | Sex: 35 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12316598 | 11700/23/1501
Order No | Order Date: 1501/PN/OP/2302/24291 | 25-Feb-2023
Admitted On | Reporting Date : 25-Feb-2023 13:06:58
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax are unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)

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Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 25/Feb/2023

Name: Mr. Rupesh Dilip More	**UHID | Episode No : 12316598 | 11700/23/1501**
Age | Sex: 35 YEAR(S) | Male	**Order No | Order Date: 1501/PN/OP/2302/24291 | 25-Feb-2023**
Order Station : FO-OPD	**Admitted On | Reporting Date : 25-Feb-2023 13:05:24**
Bed Name :	**Order Doctor Name : Dr.SELF .**

US-WHOLE ABDOMEN

LIVER is normal in size and shows moderately raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber. Few areas of focal fat sparing are seen in gall bladder fossa.

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 9.7 x 3.8 cm.
Left kidney measures 10.5 x 4.9 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 10 cc in volume.

No evidence of ascites.

IMPRESSION:

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

DR. ADITYA NALAWADE
M.D. (Radiologist)