



Patient Ref. No. 775000001774379

CLIENT CODE : C000138376

## CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
F-703, LADO SARAI, MEHRAULI  
SOUTH WEST DELHI  
NEW DELHI 110030  
DELHI INDIA  
8800465156

SRL Ltd  
PLOT NO.160,POCKET D-11 SECTOR 8, ROHINI

NEW DELHI, 110085  
NEW DELHI, INDIA  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956  
Email : customercare.pitampura@srl.in

PATIENT NAME : RAKESH

PATIENT ID : RAKEM10028762

ACCESSION NO : 0062VJ001158

AGE : 35 Years

SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 22/10/2022 10:21:22

REPORTED : 26/10/2022 13:17:13

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

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

HEMOGLOBIN	13.5		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	<b>6.65</b>	<b>High</b>	4.5 - 5.5	mil/ $\mu$ L
WHITE BLOOD CELL COUNT	<b>10.50</b>	<b>High</b>	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	155		150 - 410	thou/ $\mu$ L

**RBC AND PLATELET INDICES**

HEMATOCRIT	44.9		40 - 50	%
MEAN CORPUSCULAR VOL	<b>68.0</b>	<b>Low</b>	83 - 101	fL
MEAN CORPUSCULAR HGB.	<b>20.3</b>	<b>Low</b>	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	<b>30.0</b>	<b>Low</b>	31.5 - 34.5	g/dL
MENTZER INDEX	10.2			
RED CELL DISTRIBUTION WIDTH	<b>14.8</b>	<b>High</b>	11.6 - 14.0	%
MEAN PLATELET VOLUME	<b>13.7</b>	<b>High</b>	6.8 - 10.9	fL

**WBC DIFFERENTIAL COUNT - NLR**

NEUTROPHILS	59		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	6.20		2.0 - 7.0	thou/ $\mu$ L
LYMPHOCYTES	35		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	<b>3.68</b>	<b>High</b>	1.0 - 3.0	thou/ $\mu$ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.7			
EOSINOPHILS	3		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.32		0.02 - 0.50	thou/ $\mu$ L
MONOCYTES	3		2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.32		0.2 - 1.0	thou/ $\mu$ L
BASOPHILS	0		0 - 2	%
ABSOLUTE BASOPHIL COUNT	<b>0</b>	<b>Low</b>	0.02 - 0.10	thou/ $\mu$ L

DIFFERENTIAL COUNT PERFORMED ON: EDTA SMEAR

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

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



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**GLUCOSE FASTING,FLUORIDE PLASMA**

**FBS (FASTING BLOOD SUGAR)** **109** **High** 74 - 99 mg/dL

METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

**HBA1C** TEST NOT PERFORMED  
 Non-diabetic Adult < 5.7 %  
 Pre-diabetes 5.7 - 6.4  
 Diabetes diagnosis: > or = 6.5  
 Therapeutic goals: < 7.0  
 Action suggested : > 8.0  
 (ADA Guideline 2021)

**Comments**

INVALID RESULT.  
 THE HBA1c ASSAY METHODOLOGY USED IS CAPILLARY ELECTROPHORESIS.THE EDTA SAMPLE CHROMATOGRAPH SHOWS A HB VARIANT PEAK OF AROUND 82% WHICH IS SUGGESTIVE OF A HOMOZYGOUS HAEMOGLOBINOPATHY IN THE PATIENT.  
 ADVICE:- HEMOGLOBIN VARIANT ANALYSIS TO RULE OUT THE PRESENCE OF ABNORMAL VARIANTS OF HEMOGLOBIN.HBA1c TO BE DETERMINED BY ALTERNATE METHODOLOGY LIKE BORONATE AFFINITY METHOD.

**GLUCOSE, POST-PRANDIAL, PLASMA**

**PPBS(POST PRANDIAL BLOOD SUGAR)** **153** **High** 70 - 139 mg/dL

**CORONARY RISK PROFILE, SERUM**

**CHOLESTEROL, TOTAL** 153 < 200 Desirable mg/dL  
 200 - 239 Borderline High  
 >/= 240 High

METHOD : CHOD-POD

**TRIGLYCERIDES** 67 < 150 Normal mg/dL  
 150 - 199 Borderline High  
 200 - 499 High  
 >/=500 Very High

METHOD : LIPASE / GLUCOSE DEHYDROGENASE

**HDL CHOLESTEROL** **38** **Low** < 40 Low mg/dL  
 >/=60 High



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CHOLESTEROL LDL		102	High < 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
NON HDL CHOLESTEROL		115	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO		4.0	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	
VERY LOW DENSITY LIPOPROTEIN		13.4	<= 30.0	mg/dL
<b>LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.74	0.2 - 1.0	mg/dL
METHOD : SULPH ACID DPL/CAFF-BENZ				
BILIRUBIN, DIRECT		0.24	High 0.0 - 0.2	mg/dL
METHOD : SULPH ACID DPL/CAFF-BENZ				
BILIRUBIN, INDIRECT		0.50	0.1 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY, MODIFIED DIAZO METHOD (JENDRASSIK AND GROF)				
TOTAL PROTEIN		7.7	6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRIC				
ALBUMIN		4.2	3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRIC				
GLOBULIN		3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO		1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				



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ASPARTATE AMINOTRANSFERASE (AST/SGOT)	<b>62</b>	<b>High</b>	15 - 37	U/L
METHOD : SPECTROPHOTOMETRIC-IFCC WITH UV WITH PYRIDOXAL-5-PHOSPHATE				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	<b>142</b>	<b>High</b>	< 45.0	U/L
METHOD : SPECTROPHOTOMETRIC-IFCC WITH UV WITH PYRIDOXAL-5-PHOSPHATE				
ALKALINE PHOSPHATASE	92		30 - 120	U/L
METHOD : SPECTROPHOTOMETRIC				
GAMMA GLUTAMYL TRANSFERASE (GGT)	54		15 - 85	U/L
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
LACTATE DEHYDROGENASE	<b>197</b>	<b>High</b>	100 - 190	U/L
METHOD : SPECTROPHOTOMETRIC				
<b>BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN	12		6 - 20	mg/dL
METHOD : UREASE KINETIC				
<b>CREATININE, SERUM</b>				
CREATININE	<b>0.63</b>	<b>Low</b>	0.90 - 1.30	mg/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO	<b>19.05</b>	<b>High</b>	5.00 - 15.00	
<b>URIC ACID, SERUM</b>				
URIC ACID	5.4		3.5 - 7.2	mg/dL
METHOD : URICASE/CATALASE UV				
<b>TOTAL PROTEIN, SERUM</b>				
TOTAL PROTEIN	7.7		6.4 - 8.2	g/dL
METHOD : BIURET				
<b>ALBUMIN, SERUM</b>				
ALBUMIN	4.2		3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
<b>GLOBULIN</b>				
GLOBULIN	3.5		2.0 - 4.1	g/dL
METHOD : SPECTROPHOTOMETRY, O-CRESOLPHTHALEIN COMPLEXONE				
<b>ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM	140		136 - 145	mmol/L
METHOD : ISE INDIRECT				



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POTASSIUM		4.41	3.50 - 5.10	mmol/L
CHLORIDE		103	98 - 107	mmol/L
METHOD : ISE INDIRECT				
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		PALE YELLOW		
APPEARANCE		CLEAR		
SPECIFIC GRAVITY		1.025	1.003 - 1.035	
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		5.5	4.7 - 7.5	
PROTEIN		NOT DETECTED	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		NOT DETECTED	NOT DETECTED	
<b>MICROSCOPIC EXAMINATION, URINE</b>				
PUS CELL (WBC'S)		0-1	0-5	/HPF
EPITHELIAL CELLS		2-3	0-5	/HPF
ERYTHROCYTES (RBC'S)		NOT DETECTED	NOT DETECTED	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	
REMARKS		NOTE:- MICROSCOPIC EXAMINATION OF URINE IS PERFORMED BY CENTRIFUGE URINARY SEDIMENT.		
<b>THYROID PANEL, SERUM</b>				
T3		122.20	80.00 - 200.00	ng/dL
T4		6.78	5.10 - 14.10	µg/dL
TSH 3RD GENERATION		2.590	0.270 - 4.200	µIU/mL





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**STOOL: OVA & PARASITE**

COLOUR	YELLOW			
CONSISTENCY	SEMI FORMED			
ODOUR	FAECAL			
MUCUS	ABSENT	NOT DETECTED		
VISIBLE BLOOD	ABSENT	ABSENT		
POLYMPHONUCLEAR LEUKOCYTES	0 - 1	0 - 5		/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED		/HPF
MACROPHAGES	NOT DETECTED	NOT DETECTED		
CHARCOT-LEYDEN CRYSTALS	NOT DETECTED	NOT DETECTED		
TROPHOZOITES	NOT DETECTED	NOT DETECTED		
CYSTS	NOT DETECTED	NOT DETECTED		
OVA	NOT DETECTED			
LARVAE	NOT DETECTED	NOT DETECTED		
ADULT PARASITE	NOT DETECTED			
OCCULT BLOOD	NOT DETECTED	NOT DETECTED		

**Comments**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

**ABO GROUP** TYPE AB

METHOD : TUBE AGGLUTINATION

**RH TYPE** POSITIVE

METHOD : TUBE AGGLUTINATION

**XRAY-CHEST**

>>>	BOTH THE LUNG FIELDS ARE CLEAR
>>>	BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR
>>>	BOTH THE HILA ARE NORMAL
>>>	CARDIAC AND AORTIC SHADOWS APPEAR NORMAL
>>>	BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL
>>>	VISUALIZED BONY THORAX IS NORMAL





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IMPRESSION

NORMAL

## TMT OR ECHO

TMT OR ECHO

NEGATIVE

## ECG

ECG

WITHIN NORMAL LIMITS

## MEDICAL HISTORY

RELEVANT PRESENT HISTORY

KNEE PAIN (01 YRS)

RELEVANT PAST HISTORY

NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY

MARRIED, 01 CHILD, EGG.

RELEVANT FAMILY HISTORY

NOT SIGNIFICANT

OCCUPATIONAL HISTORY

OFFICE BOY / GD

HISTORY OF MEDICATIONS

? ANALGESICS

## ANTHROPOMETRIC DATA &amp; BMI

HEIGHT IN METERS

1.57

mts

WEIGHT IN KGS.

65.85

Kgs

BMI

27

BMI & Weight Status as follows: kg/sqmts  
Below 18.5: Underweight  
18.5 - 24.9: Normal  
25.0 - 29.9: Overweight  
30.0 and Above: Obese

## GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE

NORMAL

PHYSICAL ATTITUDE

NORMAL

GENERAL APPEARANCE / NUTRITIONAL STATUS

HEALTHY

BUILT / SKELETAL FRAMEWORK

AVERAGE

FACIAL APPEARANCE

NORMAL

SKIN

NORMAL

UPPER LIMB

NORMAL

LOWER LIMB

NORMAL

NECK

NORMAL

NECK LYMPHATICS / SALIVARY GLANDS

NOT ENLARGED OR TENDER

THYROID GLAND

NOT ENLARGED



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CAROTID PULSATION		NORMAL		
BREAST (FOR FEMALES)		NORMAL		
TEMPERATURE		NORMAL		
PULSE		63/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE		NORMAL		
<b>CARDIOVASCULAR SYSTEM</b>				
BP		119/78 MM HG (SITTING)		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		S1, S2 HEARD NORMALLY		
MURMURS		ABSENT		
<b>RESPIRATORY SYSTEM</b>				
SIZE AND SHAPE OF CHEST		NORMAL		
MOVEMENTS OF CHEST		SYMMETRICAL		
BREATH SOUNDS INTENSITY		NORMAL		
BREATH SOUNDS QUALITY		VESICULAR (NORMAL)		
ADDED SOUNDS		ABSENT		
<b>PER ABDOMEN</b>				
APPEARANCE		NORMAL		
VENOUS PROMINENCE		ABSENT		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		
HERNIA		ABSENT		
ANY OTHER COMMENTS		NIL		
<b>CENTRAL NERVOUS SYSTEM</b>				
HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		
CEREBELLAR FUNCTIONS		NORMAL		
SENSORY SYSTEM		NORMAL		
MOTOR SYSTEM		NORMAL		



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REFLEXES

NORMAL

**MUSCULOSKELETAL SYSTEM**

SPINE

NORMAL

JOINTS

NORMAL

**BASIC EYE EXAMINATION**

CONJUNCTIVA

NORMAL

EYELIDS

NORMAL

EYE MOVEMENTS

NORMAL

CORNEA

NORMAL

DISTANT VISION RIGHT EYE WITHOUT GLASSES

6/9

DISTANT VISION LEFT EYE WITHOUT GLASSES

6/6

NEAR VISION RIGHT EYE WITHOUT GLASSES

N/6

NEAR VISION LEFT EYE WITHOUT GLASSES

N/6

COLOUR VISION

NORMAL

**BASIC ENT EXAMINATION**

EXTERNAL EAR CANAL

NORMAL

TYMPANIC MEMBRANE

NORMAL

NOSE

NO ABNORMALITY DETECTED

SINUSES

NORMAL

THROAT

NORMAL

TONSILS

NOT ENLARGED

**BASIC DENTAL EXAMINATION**

TEETH

OTHERS

GUMS

BLEEDING

ANY OTHER COMMENTS

STAINS++/CALCULUS++.  
ADV- ORAL PROPHYLAXIS.**SUMMARY**

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

BL. SUGAR, SGOT/ PT - ABOVE NORMAL LIMITS

RELEVANT NON PATHOLOGY DIAGNOSTICS

NO ABNORMALITIES DETECTED



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**DIAGNOSTIC REPORT**

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PLOT NO.160,POCKET D-11 SECTOR 8, ROHININEW DELHI, 110085  
NEW DELHI, INDIA  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956  
Email : customercare.pitampura@srl.in**PATIENT NAME : RAKESH**PATIENT ID : **RAKEM10028762**ACCESSION NO : **0062VJ001158**

AGE : 35 Years

SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 22/10/2022 10:21:22

REPORTED : 26/10/2022 13:17:13

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	<u>Final</u>	Results	Biological Reference Interval	Units
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REMARKS / RECOMMENDATIONS

MONITOR BL SUGAR, LIVER ENZYMES; DENTAL TREATMENT

**FITNESS STATUS**

FITNESS STATUS

FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)



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Patient Ref. No. 775000001774379

CLIENT CODE : C000138376

## CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD ( MEDIWHEEL )  
F-703, LADO SARAI, MEHRAULI  
SOUTH WEST DELHI  
NEW DELHI 110030  
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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

PENDING

**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.

WBC DIFFERENTIAL COUNT - NLR-

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

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504 This ratio element is a calculated parameter and out of NABL scope.

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**

**Increased** 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: 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.

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; sulfonyleureas,tolbutamide, and other oral hypoglycemic agents.

**NOTE:**

Hypoglycemia is defined as a glucose of < 50 mg/dL in men and < 40 mg/dL in women.

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

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



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

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
  - Diagnosing diabetes.
  - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
  - eAG gives an evaluation of blood glucose levels for the last couple of months.
  - eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

**HbA1c Estimation can get affected due to :**

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
  - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
  - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
  - 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

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)



**DIAGNOSTIC REPORT**



**Patient Ref. No. 775000001774379**



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**PATIENT NAME :** RAKESH

**PATIENT ID :** RAKEM10028762

**ACCESSION NO :** 0062VJ001158 **AGE :** 35 Years **SEX :** Male **ABHA NO :**

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Lower than normal level may be due to:

- Myasthenia Gravis
  - Muscular dystrophy
- URIC ACID, SERUM-**  
 Causes of Increased levels  
 Dietary
- High Protein Intake.
  - Prolonged Fasting,
  - Rapid weight loss.
- Gout  
 Lesch nyhan syndrome.  
 Type 2 DM.  
 Metabolic syndrome.

Causes of decreased levels

- Low Zinc Intake
- OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High Fibre foods
- Vit C Intake
- Antioxidant rich foods

**TOTAL PROTEIN, SERUM-**

Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease  
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

**ALBUMIN, SERUM-**

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

**ELECTROLYTES (NA/K/CL), SERUM-**

Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism, liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion. Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfunction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,

**MICROSCOPIC EXAMINATION, URINE-**

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders  
 Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever  
 Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.  
 Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.  
 Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.  
 Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.  
 Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.  
 pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.  
 Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.  
 Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.



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Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

THYROID PANEL, SERUM-Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

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

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

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

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.

Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

**Reference:**

- Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
- Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
- Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

**STOOL: OVA & PARASITE-**

Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-**

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

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

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

**MEDICAL HISTORY-**

\*\*\*\*\* THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS. \*\*\*\*\*

**FITNESS STATUS-**

Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for. These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) - SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as



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height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.

• Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.

• Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

**\*\*End Of Report\*\***Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

**Dr. Kamlesh I Prajapati**  
Consultant Pathologist

**CONDITIONS OF LABORATORY TESTING & REPORTING**

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
  - i. Specimen received is insufficient or inappropriate
  - ii. Specimen quality is unsatisfactory
  - iii. Incorrect specimen type
  - iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

**SRL Limited**

Fortis Hospital, Sector 62, Phase VIII,  
Mohali 160062



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