



NABH



No.1



Out Patient Record

Patient Name : Mr.MANJUNATH M

UHID : UHJA24006718

Age / Sex : 37 Years / Male

OP NO/Reg Dt : 17-10-2024 09:05 AM

Spouse / Father Name : -

Department :

Address : , , Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Ashmitha Padma MBBS, MD
(GENERAL MEDICINE), PGDCC,FEM
KMC No. : 02M1087

Complaints / Findings / Observations :

Ht - 179cm.
wt - 69.5kg
BP - 136/84.
PR - 92b/min
SpO2 - 98%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

UNITED HOSPITAL (A Unit of United Brothers Healthcare Services Private Limited)

United Hospital

No.110 (30), Madhavan Park Circle, 10th Main Rd.

T: 080 4566 6666

E: appointments@unitedhospital.in



NABH



No.1

DEPARTMENT OF RADIODIAGNOSIS

Name	Manjunath M	Date	17/10/24
Age	37 years	Hospital ID	UHJA24006718
Sex	Male	Ref.	Health check

ULTRASOUND ABDOMEN AND PELVIS
FINDINGS:

Liver is enlarged in size (15.1 cms) and shows mild increased echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (8.4 x 3.7 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (8.8 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 11.2 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- Mild hepatomegaly with mild fatty infiltration (Grade I).
- No other definite sonological abnormality detected.



Dr. Elluru Santosh Kumar
 Consultant Radiologist



NABH



No.1



DEPARTMENT OF RADIODIAGNOSIS

Name	Manjunath M	Date	17/10/24
Age	37 years	Hospital ID	UHJA24006718
Sex	Male	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- No radiographic abnormality.

Dr. Elluru Santosh Kumar
Consultant Radiologist

EXERCISE STRESS TEST REPORT

Patient Name: MR. MANJUNATH M,
Patient ID: 24006718
Height: 179 cm
Weight: 69.5 kg

DOB: 26.05.1987
Age: 37yrs
Gender: Male
Race: Indian

Study Date: 17.10.2024
Test Type: TRERADMILL STRESS TEST
Protocol: BRUCE

Referring Physician: DR. RAHUL S PATIL
Attending Physician: DR. RAHUL S PATIL
Technician: YAMINI/THABITHA

Medications:

--

Medical History:
NO H/O DM & HTN

Reason for Exercise Test:
SCREENING FOR CAD

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	00:18	0.00	0.00	96	130/80	
	STANDING	00:06	0.00	0.00	101	130/80	
	HYPERV.	00:03	0.00	0.00	104	130/80	
	WARM-UP	00:17	0.00	0.00	96	130/80	
EXERCISE	STAGE 1	03:00	1.70	10.00	127	130/80	
	STAGE 2	03:00	2.50	12.00	157	140/80	
	STAGE 3	02:02	3.40	14.00	171	150/90	
RECOVERY		03:11	0.00	0.00	130	150/90	

The patient exercised according to the BRUCE for 8:01 mins, achieving a work level of Max. METS: 10.10. The resting heart rate of 97 bpm rose to a maximal heart rate of 173 bpm. This value represents 94 % of the maximal, age-predicted heart rate. The resting blood pressure of 130/80 mmHg, rose to a maximum blood pressure of 150/90 mmHg. The exercise test was stopped due to Target heart rate achieved.

Interpretation

Summary: Resting ECG: normal.
Functional Capacity: normal.
HR Response to Exercise: appropriate.
BP Response to Exercise: normal resting BP - appropriate response.
Chest Pain: none.
Arrhythmias: none.
ST Changes: none.
Overall impression: Normal stress test.

Conclusions

GOOD EFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Physician _____

Technician _____

MR. MANJUNATH M,
Patient ID 24006718
17.10.2024 Male 179 cm 69.5 kg
37yrs Indian
Meds

Test Reason: SCREENING FOR CAD
Medical History: NO H/O DM & HTN

BRUCE: Total Exercise Time 08:01
Max HR: 173 bpm 94% of max predicted 183 bpm HR at rest: 97
Max BP: 150/90 mmHg BP at rest: 130/80 Max RPP: 25650 mmHg* bpm
Maximum Workload: 10.10 METS
Max. ST: -2.50 mm, 0.00 mV/s in II; EXERCISE STAGE: 3 07:00
Arrhythmia: A:30, PVC:1
ST/HR index: 2.66 μ V/bpm

Ref. MD: DR. RAHUL S PATIL Ordering MD: DR. RAHUL S PATIL
Technician: YAMINI/THABITHA Test Type: TREADMILL STRES
Reasons for Termination: Target heart rate achieved
Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall

BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY	BASELINE EXERCISE	MAX. ST EXERCISE	PEAK EXERCISE EXERCISE	TEST END RECOVERY
96 bpm 130/80 mmHg	171 bpm 150/90 mmHg	171 bpm 150/90 mmHg	133 bpm 150/90 mmHg	96 bpm 130/80 mmHg	171 bpm 150/90 mmHg	171 bpm 150/90 mmHg	133 bpm 150/90 mmHg
I 0.30 mV 0.49 mV/s	I -0.05 1.70	I 0.15 1.86	I 0.55 1.40	V1 0.20 -0.87	V1 0.70 -0.30	V1 0.85 -0.84	V1 0.00 -1.57
II -0.25 0.21	II -2.50 0.30	II -2.05 0.79	II 0.05 1.58	V2 0.90 0.73	V2 0.20 1.59	V2 0.85 1.74	V2 0.85 0.96
III -0.50 -0.64	III -2.40 -1.50	III -2.20 -0.98	III -0.55 -0.29	V3 -0.20 -0.53	V3 -0.90 -0.25	V3 -0.70 -0.30	V3 -0.25 -0.42
aVR 0.00 -1.05	aVR 1.25 -0.89	aVR 1.00 -1.34	aVR -0.30 -2.12	V4 -0.30 -0.16	V4 -2.10 0.41	V4 -1.80 0.27	V4 0.00 0.77
aVL 0.40 0.38	aVL 1.15 1.58	aVL 1.15 1.43	aVL 0.50 0.56	V5 -0.25 0.04	V5 -2.05 0.58	V5 -1.65 0.61	V5 0.05 1.00
aVF -0.40 -0.16	aVF -2.50 -0.63	aVF -2.10 -0.07	aVF -0.25 0.69	V6 -0.30 0.10	V6 -1.90 0.56	V6 -1.40 0.78	V6 0.00 0.90

Unconfirmed

GE CASE V6.73 (2)
10mm/mV 50Hz 0.01-20Hz S+ HEART V5.4

Attending MD: DR. RAHUL S PATIL

MR. MANJUNATH M,

Patient ID 24006718

17.10.2024

11:43:26am

Male 179 cm 69.5 kg

37yrs Indian

Meds:

Test Reason: SCREENING FOR CAD

Medical History: NO H/O DM & HTN

Ref. MD: DR. RAHUL S PATIL Ordering MD: DR. RAHUL S PATIL
Technician: YAMINI/THABITHA Test Type: TRERADMILL STRES

Comment:

BRUCE: Total Exercise Time 08:01
Max HR: 173 bpm 94% of max predicted 183 bpm HR at rest: 97
Max BP: 150/90 mmHg BP at rest: 130/80 Max RPP: 25650 mmHg*bpm
Maximum Workload: 10.10 METS
Max ST: -2.50 mm, 0.00 mV/s in II: EXERCISE STAGE 3 07:00
Arrhythmia: A:30, PVC:1
ST/HR index: 2.66 μ V/bpm

Reasons for Termination: Target heart rate achieved

Summary: Resting ECG: normal. Functional Capacity: normal. HR Response to
Exercise: appropriate. BP Response to Exercise: normal resting BP - appropriate
response. Chest Pain: none. Arrhythmias: none. ST Changes: none. Overall
impression: Normal stress test

Conclusion: GOODEFFORT TOLERANCE
NORMAL HR AND BP RESPONSE
NO ANGINA OR ARRHYTHMIAS NOTED
NO SIGNIFICANT ST-T CHANGES NOTED DURING EXERCISE AND
RECOVERY

IMPRESSION:- STRESS TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA
Location Number: * 0 *

GE CASE V6.73 (2)

Unconfirmed

AW CE

Attending MD: DR. RAHUL S PATIL

100 bpm
130/80 mmHg

LINKED MEDIANS

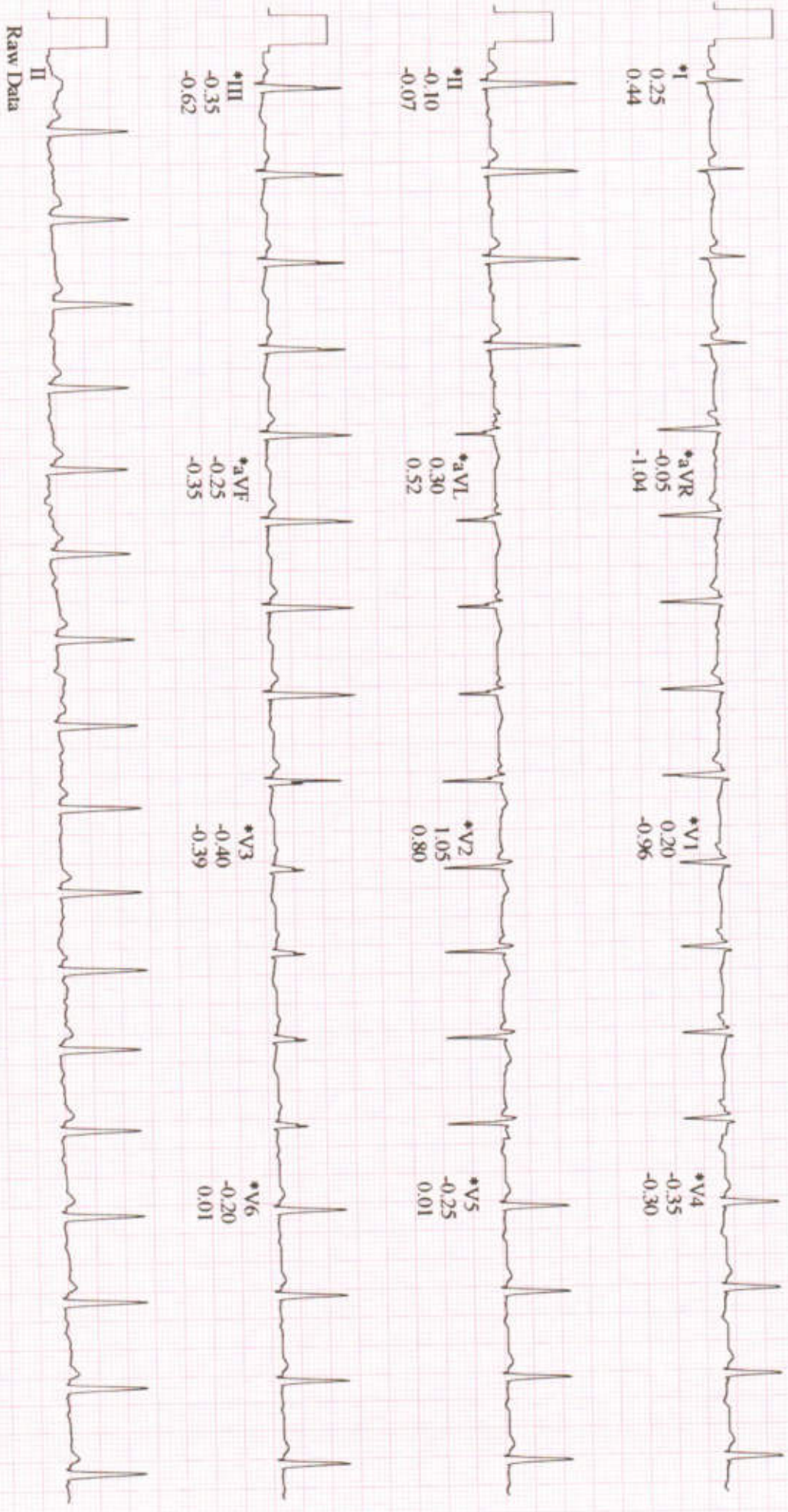
PRETEST
STANDING
00:21

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



*Computer Synthesized Rhythms

Start of Test: 11:43:26am

MR. MANJUNATH N
Patient ID: 24006718
17.10.2024
11:44:03am

100 bpm
130/80 mmHg

LINKED MEDIANS

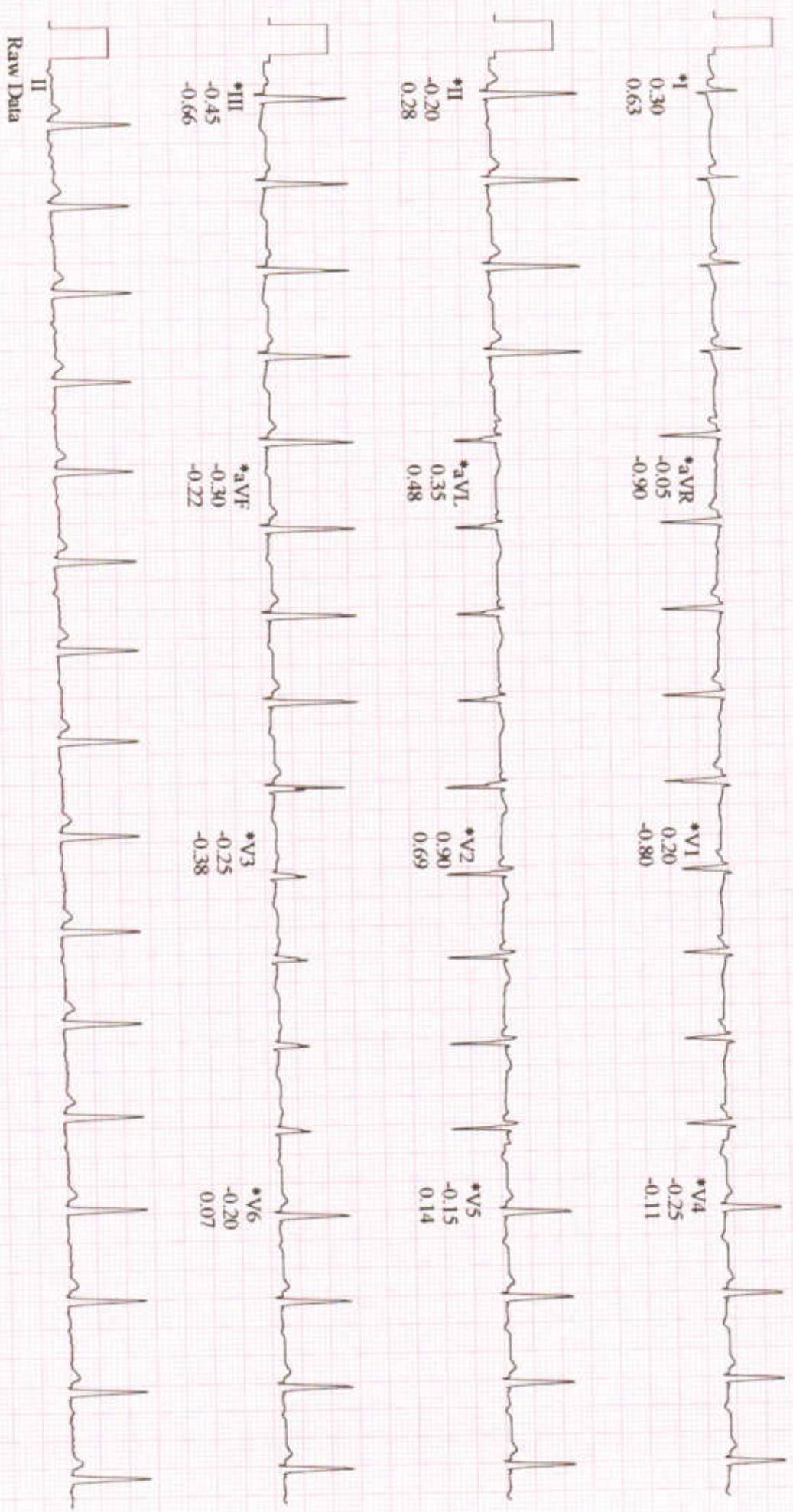
PRETEST
WARM-UP
00:37

BRUCE
0.0 mph
0.0 %

UNITED HOSPITAL

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(II,V6)

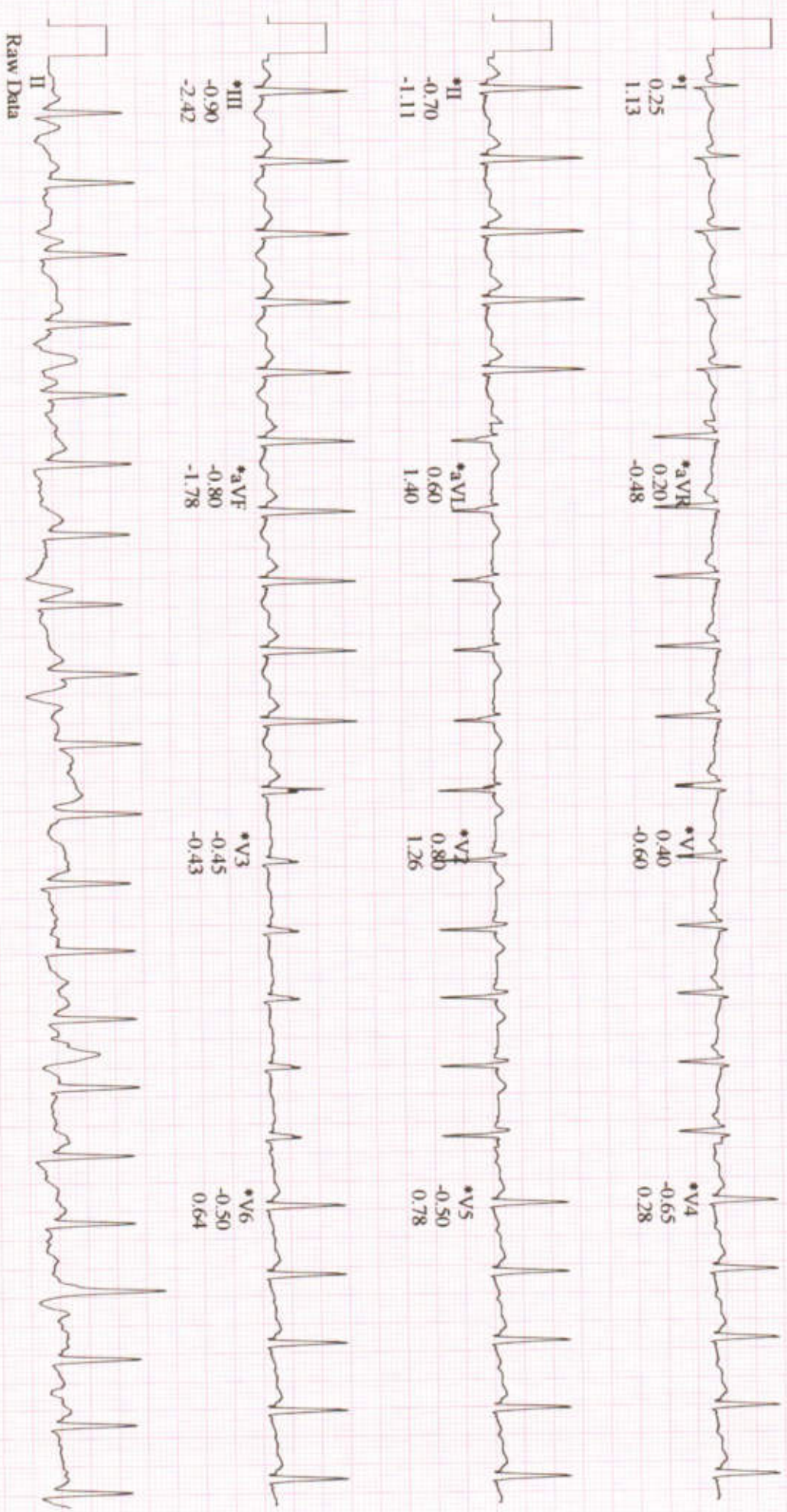
Start of Test: 11:43:26am

125 bpm
130/80 mmHg
EXERCISE
STAGE 1
02:50

BRUCE
1.7 mph
10.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

MR. MANJUNATH N
Patient ID: 24006718
17.10.2024
11:49:57am

157 bpm
140/80 mmHg

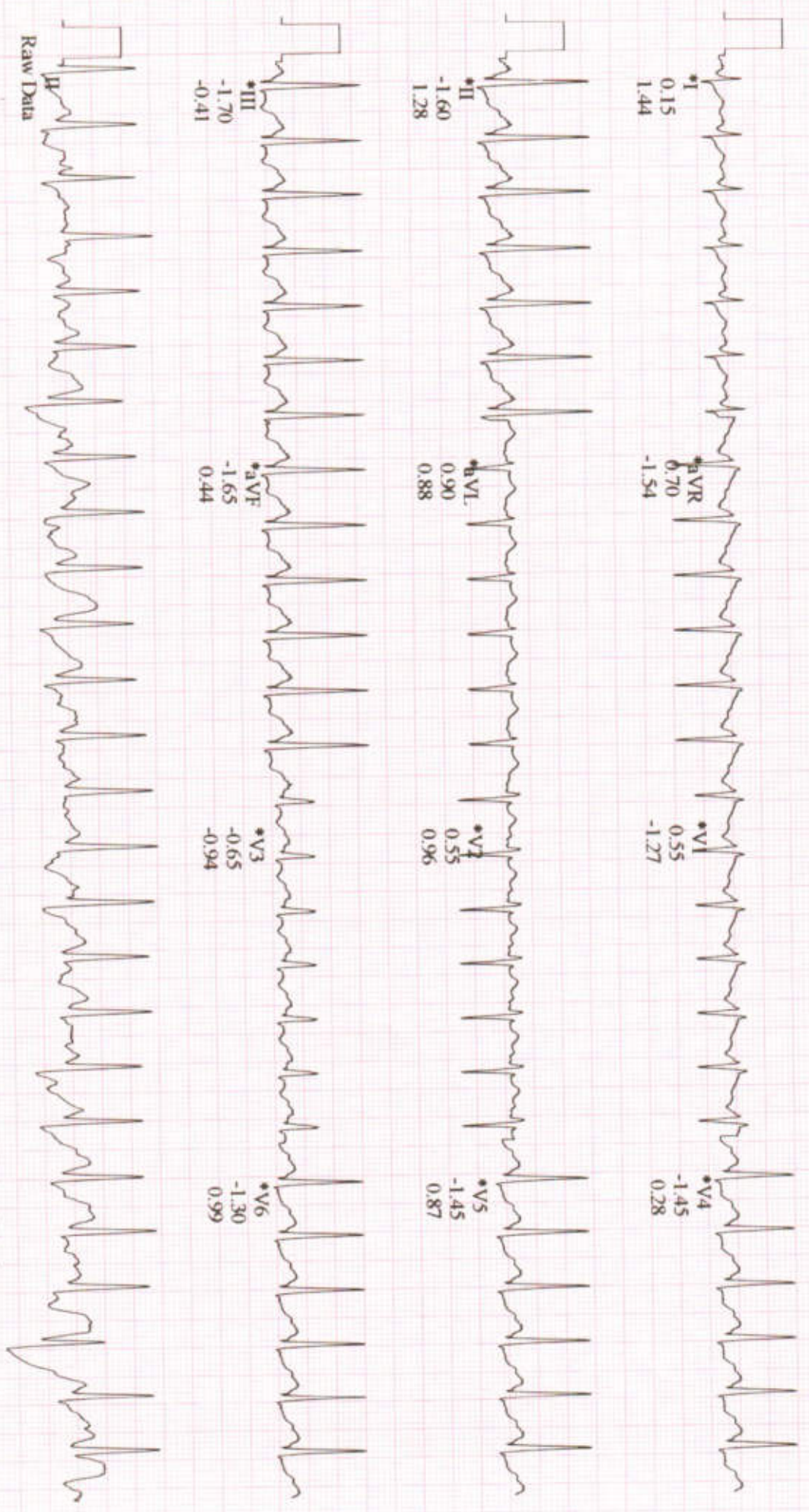
LINKED MEDIAN
EXERCISE
STAGE 2
05:50

BRUCE
2.5 mph
12.0 %

UNITED HOSPITAL

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



Raw Data

*Computer Synthesized Rhythms

MR. MANJUNATH N
Patient ID: 24006718
17.10.2024
11:52:07am

171 bpm
150/90 mmHg

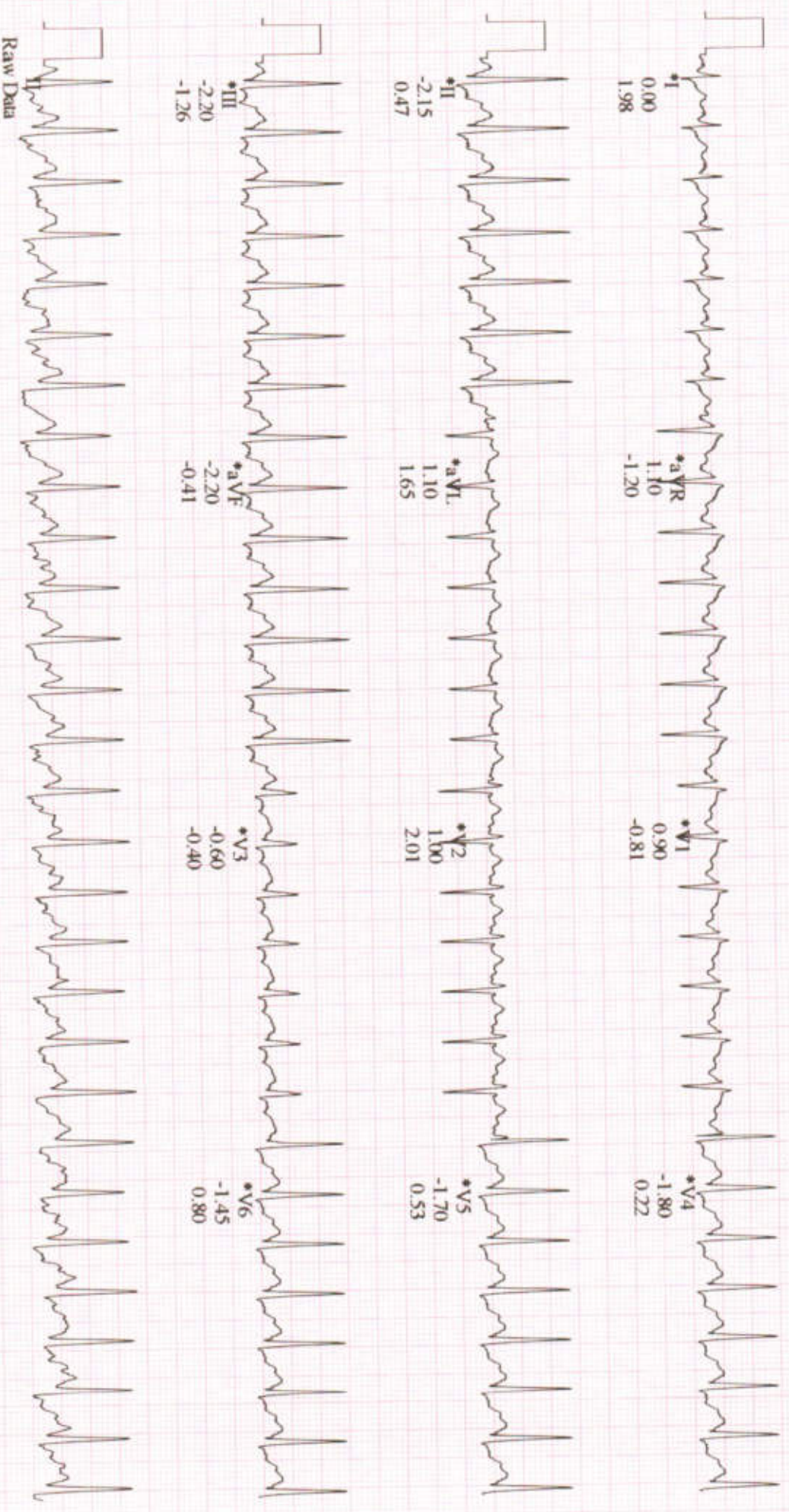
LINKED MEDIANS
EXERCISE
STAGE 3
08:00

BRUCE
3.4 mph
14.0 %

UNITED HOSPITAL

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(LL,V6) CE

Start of Test 11:43:26am

MR. MANJUNATH M
Patient ID: 24006718
17.10.2024
11:52:58am

LINKED MEDIANS

UNITED HOSPITAL

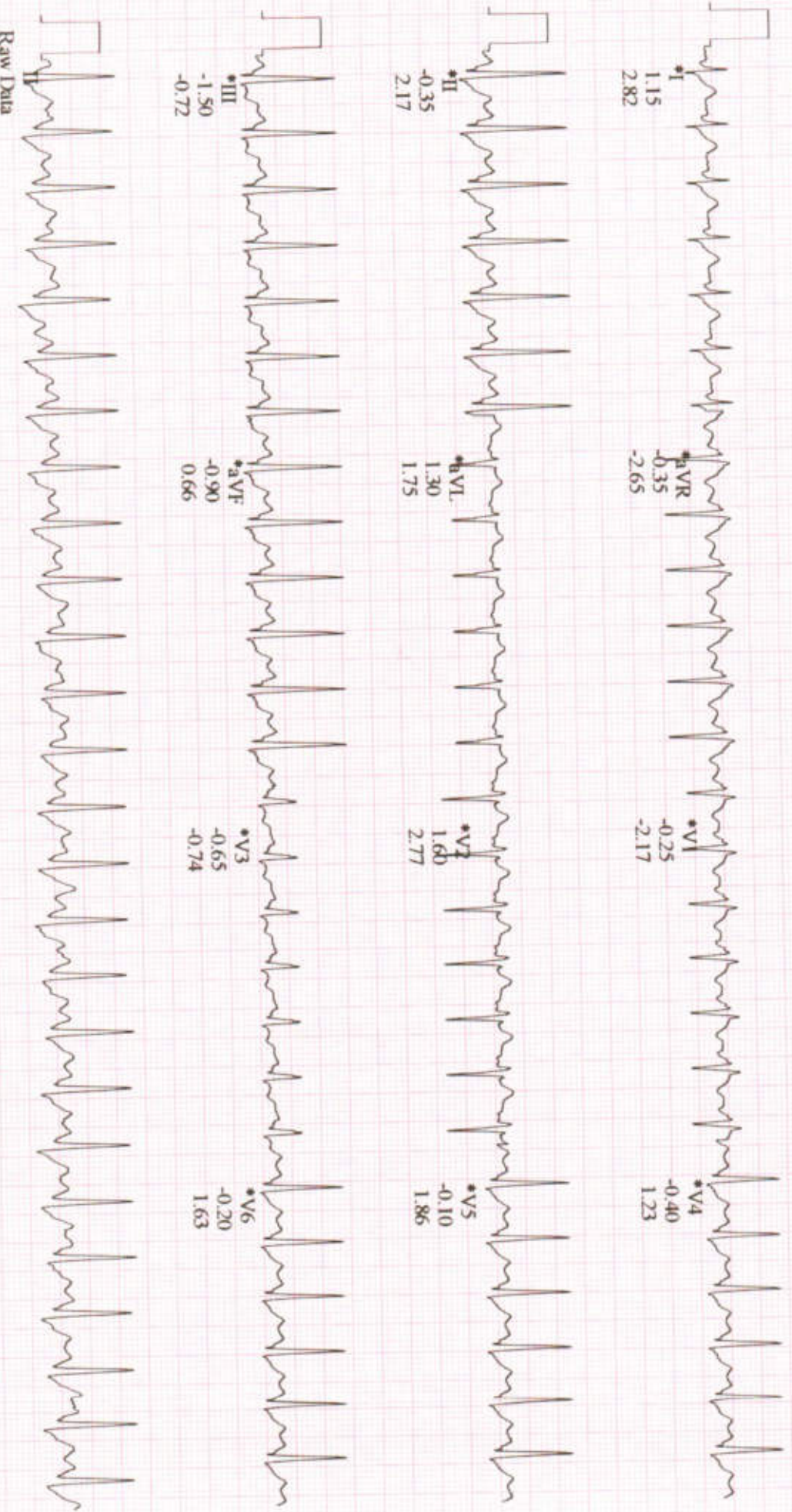
157 bpm
150/90 mmHg

RECOVERY
#1
00:50

BRUCE
1.5 mph
0.0 %

Lead
ST Level (mm)
ST Slope (mV/s)

ST @ 10mm/mV
60 ms post J



Raw Data

*Computer Synthesized Rhythms

GE
CASE V6.73
25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(LL.V6) CE

Start of Test: 11:43:26am

MR. MANJUNATH #1
Patient ID: 24006718
17.10.2024
11:53:58am

141 bpm
150/90 mmHg

RECOVERY
#1
01:50

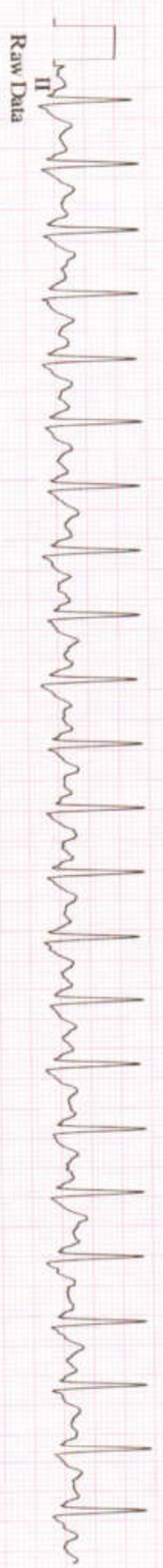
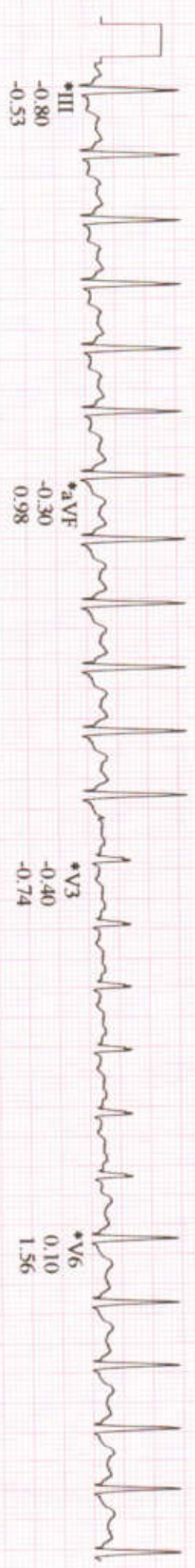
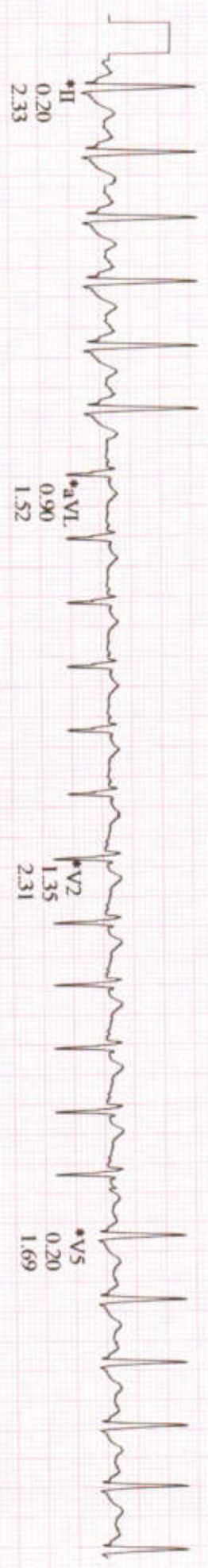
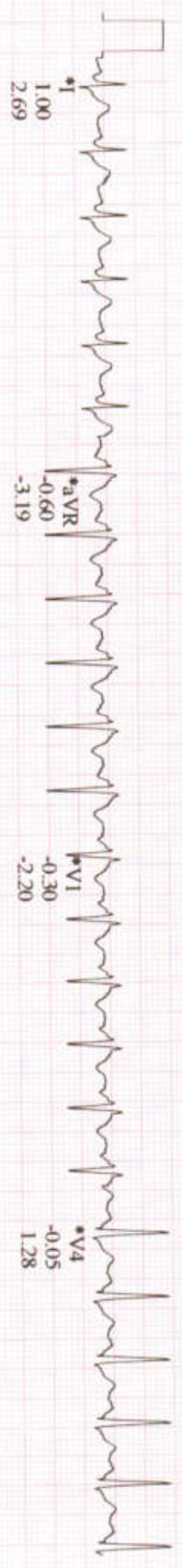
BRUCE
1.5 mph
0.0%

LINKED MEDIAN

UNITED HOSPITAL

ST @ 10mm/mV
60 ms post J

Lead
ST Level (mm)
ST Slope (mV/s)



*Computer Synthesized Rhythms

GE
CASE V6.73

25 mm/s 10 mm/mV 50Hz 0.01 - 20Hz S+ HR(LL.V6) CE

Start of Test: 11:43:26am

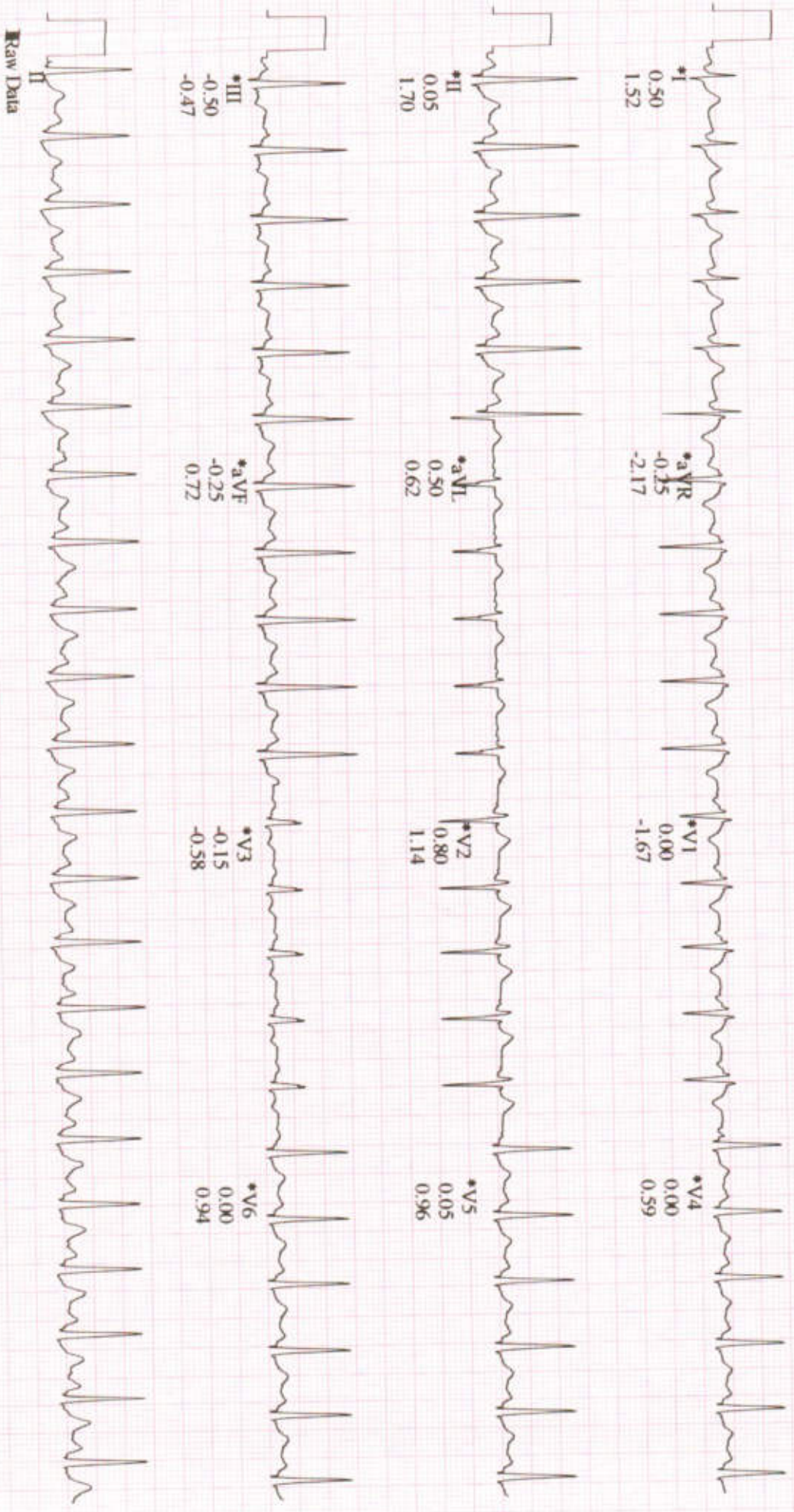
130 bpm
 150/90 mmHg

RECOVERY
 #1
 02:50

BRUCE
 0.0 mph
 0.0 %

Lead
 ST Level (mm)
 ST Slope (mV/s)

ST @ 10mm/mV
 60 ms post J



Raw Data

*Computer Synthesized Rhythms

ID: 24006718

Name: manjunath m

Birth date: / /

kg mmHg

Indication:

lyptoms:

istory:

nt. rate

R int

RS dur

T/QTc(E) int

/QRS/T axis

V5/SV1 amp

V5+SV1 amp

87 bpm

132 ms

88 ms

306/ 350 ms

45/ 55/ -30 *

1.52/ 0.76 mV

2.28 mV

37 years

1100 Sinus rhythm

4164 T wave abnormality, possible anterior ischemia [negative T (V3, V4)]

8305 Short QTc interval [QTc int. < 360 ms]

9150 ** abnormal ECG **

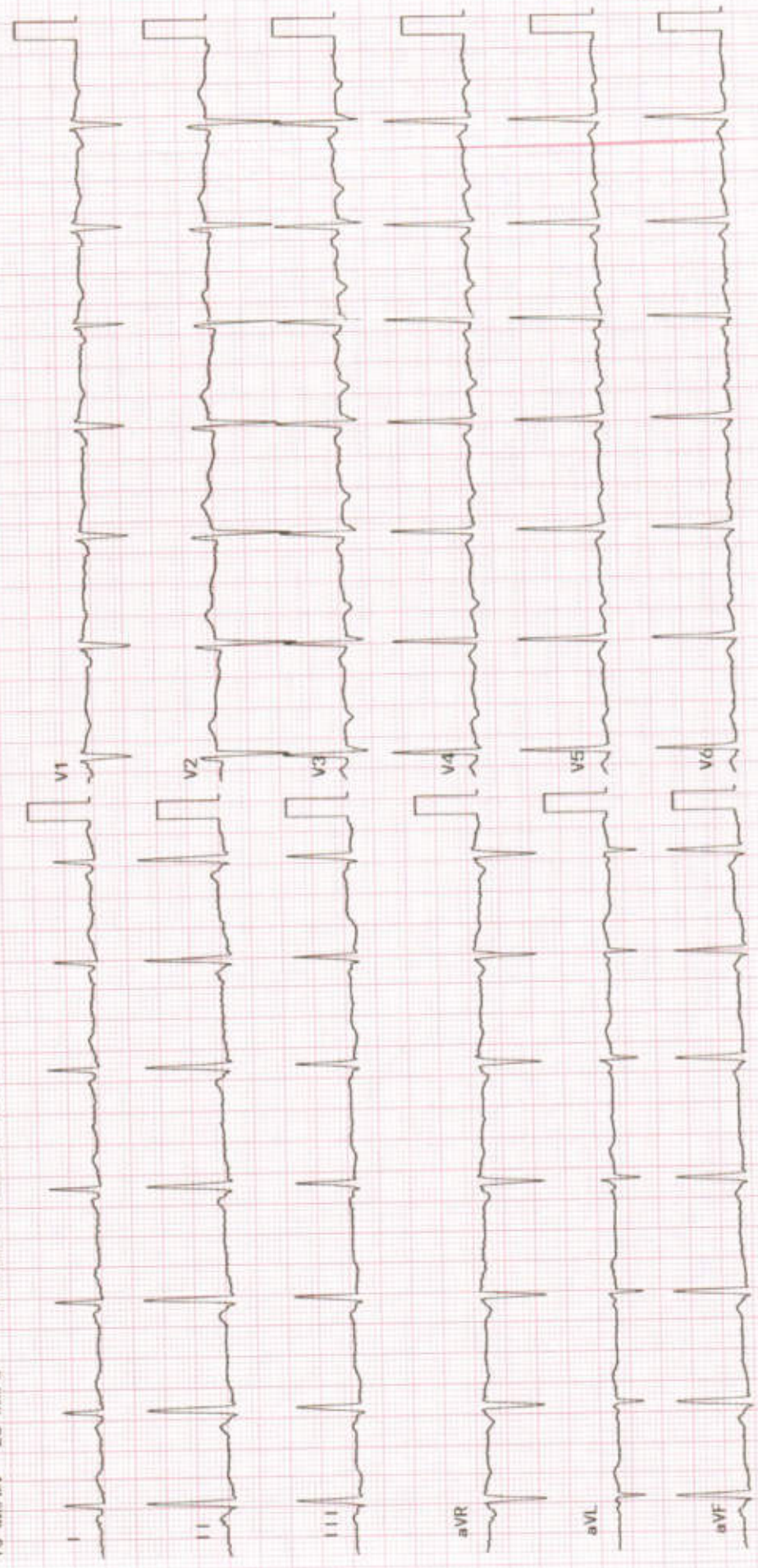
Unconfirmed Report

Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s



DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. MANJUNATH M	Order No : 1000099469
UHID : UHJA24006718	Registered On : 17/10/2024 09:05:16 AM
Age/Sex : 37/Years Male	Collected On : 17/10/2024 09:27:42 AM
Ward / Bed No :	Reported On : 17/10/2024 02:26:48 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJA240009214
Station : Corp	Mobile No : 8147515521
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

FASTING GLUCOSE (Method: Hexokinase)	95	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	112	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	4.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	94	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.98	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	9.51	µg/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	2.54	µIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	232	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	402	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	44.4	mg/dL	< 40 - Low ≥ 60 - High

DEPARTMENT OF LABORATORY MEDICINE

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	107.20	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	80.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.23		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.41		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	187.60	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.9	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.88	mg/dL	0.9-1.3
LIVER FUNCTION TEST			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.78	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.12	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.66	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.1	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.53	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.57	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.76		2:1

Sample: Serum

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. MANJUNATH M	Order No	: 1000099469
UHID	: UHJA24006718	Registered On	: 17/10/2024 09:05:16 AM
Age/Sex	: 37/Years Male	Collected On	: 17/10/2024 09:27:42 AM
Ward / Bed No	:	Reported On	: 17/10/2024 02:26:48 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240009214
Station	: Corp	Mobile No	: 8147515521
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	18	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	15	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	22	U/L	50-116
GGT (Method:IFCC)	29	U/L	< 55

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. MANJUNATH M	Order No : 1000099469
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Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.27	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.6	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5240	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	58.46	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.82	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.39	%	0-6
MONOCYTES (Method:Optical/Impedance)	5.01	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.32	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.96	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	91.9	fL	78-100
MCH (Method: Calculated)	30.8	pg	27-31
MCHC (Method: Calculated)	33.5	g/dL	31-37
RDW - CV (Method: Calculated)	12.8	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.02	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.23	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	16.7	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	3060	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	130	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1770	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	260	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	08	mm/hour	1-15

BLOOD GROUPING & RH TYPING

ABO Group (Method:Agglutination Method)	A
Rh Factor (Method:Agglutination Method)	Positive

Interpretation Notes

Note: Both forward and reverse grouping performed

Sample: Whole blood (EDTA)

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KMC No : 103567

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. MANJUNATH M	Order No : 1000099469
UHID : UHJA24006718	Registered On : 17/10/2024 09:05:16 AM
Age/Sex : 37/Years Male	Collected On : 17/10/2024 09:27:42 AM
Ward / Bed No :	Reported On : 17/10/2024 02:26:48 PM
Reference : Dr. Ashmitha Padma	Bill No : OPBJA240009214
Station : Corp	Mobile No : 8147515521
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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CLINICAL PATHOLOGY

**URINE EXAMINATION, ROUTINE
PHYSICAL EXAMINATION**

Sample: Urine

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.015		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative

MICROSCOPIC EXAMINATION

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mr. MANJUNATH M	Order No : 1000099469
UHID : UHJA24006718	Registered On : 17/10/2024 09:05:16 AM
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Station : Corp	Mobile No : 8147515521
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	0-2	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Rashmita

---End of Report---



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