Hosp. Reg. No.: TMC - Zone C - 386

INDUSTRIAL HEALTH SERVICES

13/01/2024

Saraswati Kumani 40 yrs / female

Ht - 199, weigw - 52 BMI - 23.4 kg1m2, Normal bodyache &

Brided shoulder pain &

KILLO - Hypothyroidism

On & T. Thyrox 100 meg.

PIN- HIO fall from bike

in 2021

injury to & shoulder and & knee.

Cervical spondylosis in 2022,

MIN-20/12/23, regular.

FIH- NAD.

OIH- G2P2Ao12Do. female- Fyrs, FTND, healthy

BP- 120/70 mm/s

Male-10 yrs, LSCS, healthy.

P- 70/1 min

SP02- 964

Pt is fit and resume her normal duties.











Imaging Department

Name - Mrs. Saraswati Kumari Doppler	Age/4D 48SY/F
Ref by Dr Siddhivinayak Hospital	Date - 13/01/2024

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size (12.3 cm). It appears normal in morphology with normal echogenicity. No evidence of intrahepatic ductal dilatation.

The GB-gallbladder is distended normal. Tiny gall bladder polyp is seen measuring 2.5 mm along anterior wall

The CBD- common bile duct is normal. The portal vein is normal.

The pancreas appears normal in morphology.

The **spleen** is normal in size (9.8 cm) and morphology

Both ${\bf kidneys}$ demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 9.1 x 3.9 cm.

The left kidney measures 8.9 x 4.6 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus: normal in size and morphology. Size: 8.6 x 4.8 x 4.5 cm.

Endometrium: 7.6 mm, it appears normal in morphology.

Right ovary- Simple cyst of size 32×27 mm.

Left ovary is normal in size and morphology.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Tiny gall bladder polyp.
- Right ovarian simple cyst

DR. AMOL BENDRE

MBBS; DMRE
CONSULTANT RADIOLOGIST









Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

Name - Mrs. Saraswati Kumari	Age - 40 Y/F
Ref by Dr Siddhivinayak Hospital	Date - 13/01/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. MOHAMMAD SOHAIB
MBBS; DMRE

CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





OPTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

SARASWATI KUMARI

AGE

40

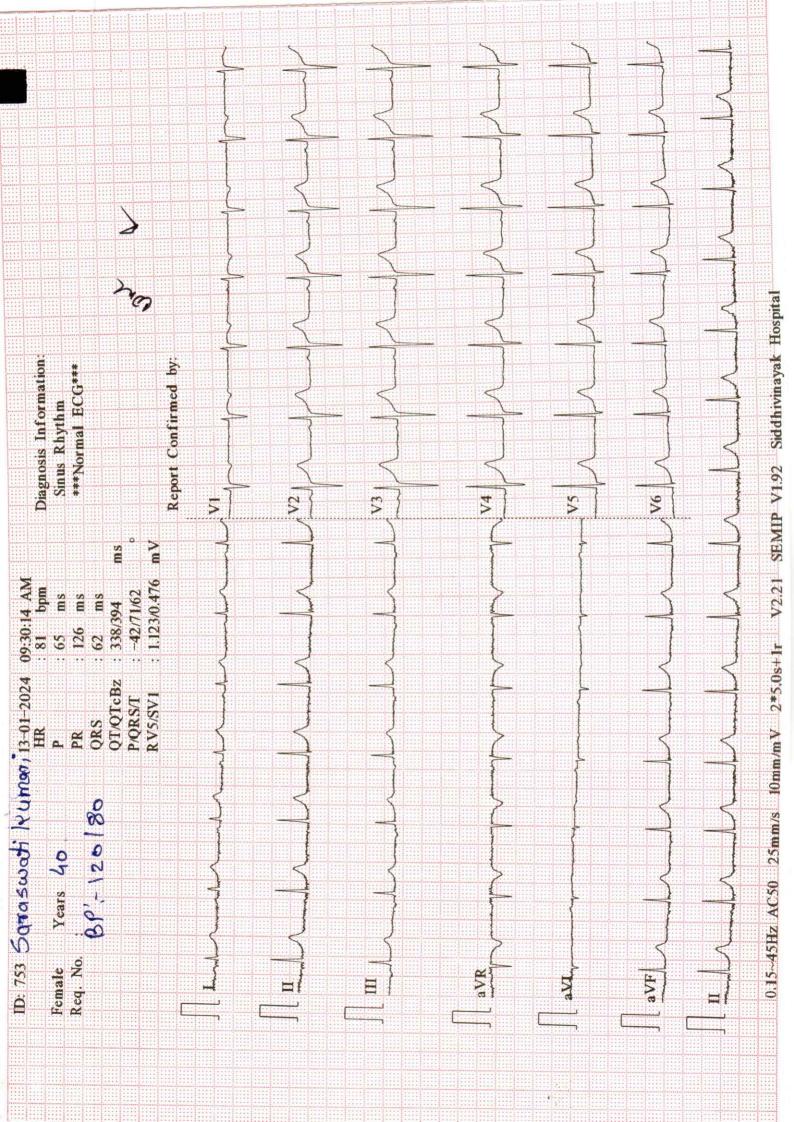
DATE -

13.01.2024

Spects: Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/12	6/6
Color Blind Test	NORMAL	









Imaging Department
Sonography | Colour Doppler | 3D / 4D USG

ECHOCARDIOGRAM

NAME	MRS. SARASWATI KUMARI
AGE/SEX	40 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	13/01/2024

2D/M-MODE ECHOCARDIOGRAPHY

VALVES:	CHAMBERS:
MITRAL VALVE:	LEFT ATRIUM: Normal
AML: Normal	Left atrial appendage: Normal
 PML: Normal Sub-valvular deformity: Absent 	LEFT VENTRICLE: Normal
	• RWMA: No
AORTIC VALVE: Normal	Contraction: Normal
• No. of cusps: 3	RIGHT ATRIUM: Normal
PULMONARY VALVE: Normal	RIGHT VENTRICLE: Normal
TRICUSPID VALVE: Normal	RWMA: No Contraction: Normal
GREAT VESSELS:	SEPTAE:
AORTA: Normal	IAS: Intact
 PULMONARY ARTERY: Normal 	IVS: Intact
CORONARIES: Proximal coronaries normal	<u>VENACAVAE</u> ;
	SVC: Normal
CORONARY SINUS: Normal	IVC: Normal and collapsing >20% with respiration
PULMONARY VEINS: Normal	PERICARDIUM: Normal

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	20 mm	Left atrium	31 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	45.0 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	26.1 mm	RVEF	%
Ascending aorta	mm	IVSd	8.0 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	8.0 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	73 %	RVOT	mm
Abdominal aorta	mm	LVOT	mm	IVC	13.2 mm





COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

	MRS. SARASWATI KUMARI	
NAME	WING. STATE	
AGE/SEX	40 YRS/F	
REFERRED BY	SIDDHIVINAYAK HOSPITAL	
	13/01/2024	
DATE OF EXAMINATION	13/01/2024	

	T. Company	TRICUSPID	AORTIC	PULMONARY
	MITRAL	TRICCSITO	1.38	0.95
FLOW VELOCITY (m/s)				
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)		TRJV= m/s		
REGURGITATION		PASP= mmHg		
	1.35			
E/A	8.2		_	
E/E'	0.2			

FINAL IMPRESSION: NORMAL STUDY

- No RWMA
- Normal LV systolic function (LVEF 73 %)
- Good RV systolic function
- Normal diastolic function
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Nil

ECHQCARDIOGRAPHER:

Dr. ANA TMUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde MBBS, DNB, DM (Cardiology) Reg. No. 2005021228





: Mrs. SARASWATI KUMARI (A) **Collected On** : 13/1/2024 11:27 am Name

. 13/1/2024 11:37 am Lab ID. Received On : 180466

: 14/1/2024 1:06 pm Reported On Age/Sex : 40 Years / Female

Report Status : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

*LIPID PROFILE

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE,ESTERASE,PEROXIDA SE)	182.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	52.6	mg/dL	Major risk factor for heart :<30 mg/dl. Negative risk factor for heart disease :>=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	76.1	mg/dL	Desirable level: <161 mg/dl. High:>= 161 - 199 mg/dl. Borderline High: 200 - 499 mg/dl. Very high:>499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	15	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	114	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High: 160 - 189mg/dl. Very high: >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.17		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	3.46		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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Lab ID. : 180466

: 14/1/2024 1:06 pm Reported On Age/Sex : 40 Years / Female

: SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

Report Status : FINAL

Received On

. 13/1/2024 11:37 am

COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	10.7	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	32.1	%	36 - 46
RBC COUNT	3.63	x10^6/uL	4.5 - 5.5
MCV	88	fl	80 - 96
MCH	29.5	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	14.9	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	4270	/cumm	4000 - 11000
DIFFERENTIAL COUNT			
NEUTROPHILS	60	%	40 - 80
LYMPHOCYTES	35	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	03	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	222000	/ cumm	150000 - 450000
MPV	12.4	fl	6.5 - 11.5
PDW	15.9	%	9.0 - 17.0
PCT	0.280	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normo	ochromic, Reduced red	blood cells count
WBC MORPHOLOGY	Normal		
PLATELETS ON SMEAR	Adequate		
Method · FDTA Whole Blood- Tests of	done on Automated Six	Part Cell Counter RBC :	and Platelet count by

Method: EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method). Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By

Priyanka_Deshmukh

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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. 13/1/2024 11:37 am Lab ID. : 180466 Received On

Reported On : 14/1/2024 1:06 pm Age/Sex : 40 Years / Female

Report Status : FINAL Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

URINE ROUTINE EXAMINATION

TEST NAME UNIT REFERENCE RANGE **RESULTS**

URINE ROUTINE EXAMINATION

PHYSICAL EXAMINATION

VOLUME 10 ml

COLOUR Pale Yellow Pale Yellow

APPEARANCE Silghtly Hazy Clear

CHEMICAL EXAMINATION

REACTION Acidic Acidic

(methyl red and Bromothymol blue indicator)

1.005 - 1.022 SP. GRAVITY 1.015

(Bromothymol blue indicator)

PROTEIN Absent Absent

(Protein error of PH indicator)

BLOOD Present (Trace) Absent

(Peroxidase Method)

SUGAR Absent Absent

(GOD/POD)

KETONES Absent Absent

(Acetoacetic acid)

BILE SALT & PIGMENT Absent Absent

(Diazonium Salt)

UROBILINOGEN Normal Normal

(Red azodye)

LEUKOCYTES Absent Absent

(pyrrole amino acid ester diazonium salt)

Present (+) Negative

(Diazonium compound With tetrahydrobenzo quinolin 3-phenol)

MICROSCOPIC EXAMINATION

RED BLOOD CELLS 4-6/HPF Absent **PUS CELLS** 2-4 / HPF 0 - 5 **EPITHELIAL** 3-5 / HPF 0 - 5

CASTS Absent

Checked By

pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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Name : Mrs. SARASWATI KUMARI (A) **Collected On** : 13/1/2024 11:27 am

. 13/1/2024 11:37 am Lab ID. Received On : 180466

: 14/1/2024 1:06 pm Reported On Age/Sex : 40 Years / Female

Report Status : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Calcium oxalate (few)		
BACTERIA	Present (+)		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent
REMARK	Result relates to sample	tested. Kindly corr	relate with clinical findings.

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja_jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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Lab ID. : 180466

Reported On : 14/1/2024 1:06 pm Age/Sex : 40 Years / Female

Report Status : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

: FINAL

Received On

. 13/1/2024 11:37 am

IMMUNO ASSAY

				LINITT	DEEEDENCE DANCE	
TEST NAME		RESULTS		UNIT	REFERENCE RANGE	
<u>TFT (THYROID</u>	FUNCTION T	EST)				
SPACE				Space	-	
SPECIMEN		Serum				
Т3		131.0		ng/dl	84.63 - 201.8	
T4		13.49		µg/dl	5.13 - 14.06	
TSH		0.270		μIU/ml	0.270 - 4.20	
T3 (Triido Thyro hormone)	onine)	T4 (Thyroxine	e)	TSH(Th	yroid stimulating	
AGE	RANGE	AGE	RANGES	AGE	RANGES	
1-30 days	100-740	1-14 Days	11.8-22.6	0-14 D	ays 1.0-39	
1-11 months	105-245	1-2 weeks	9.9-16.6	2 wks -5	months 1.7-9.1	
1-5 yrs	105-269	1-4 months	7.2-14.4	6 mont	hs-20 yrs 0.7-6.4	
6-10 yrs	94-241	4 -12 months	7.8-16.5	Pregna	incy	
11-15 yrs	82-213	1-5 yrs	7.3-15.0	1st Tri	mester	
0.1-2.5						
15-20 yrs	80-210	5-10 yrs	6.4-13.3	2nd Tr	imester	
0.20-3.0						
		11-15 yrs	5.6-11.7	3rd T	rimester	
0.30-3.0						

INTERPRETATION:

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By Pathologist

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

Name : Mrs. SARASWATI KUMARI (A) **Collected On** : 13/1/2024 11:27 am

Lab ID. : 180466

. 13/1/2024 11:37 am Received On

Reported On : 14/1/2024 1:06 pm

Age/Sex : 40 Years / Female

Report Status : FINAL

HAEMATOLOGY

UNIT REFERENCE RANGE TEST NAME **RESULTS**

BLOOD GROUP

Ref By

SPECIMEN WHOLE BLOOD EDTA & SERUM

* ABO GROUP '0'

RH FACTOR **POSITIVE**

Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT ----

Checked By pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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Lab ID. : 180466

Reported On : 14/1/2024 1:06 pm Age/Sex : 40 Years / Female

Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / **Report Status** : FINAL

Received On

. 13/1/2024 11:37 am

*RENAL FUNCTION TEST TEST NAME UNIT REFERENCE RANGE **RESULTS BLOOD UREA** 28.9 mg/dL 13 - 40 (Urease UV GLDH Kinetic) **BLOOD UREA NITROGEN** 13.50 mg/dL 5 - 20 (Calculated) S. CREATININE 0.68 0.6 - 1.4mg/dL (Enzymatic) S. URIC ACID 6.00 2.6 - 6.0 mg/dL (Uricase) S. SODIUM 137 - 145 136.0 mEq/L (ISE Direct Method) S. POTASSIUM 4.49 mEq/L 3.5 - 5.1(ISE Direct Method) S. CHLORIDE 98.0 mEq/L 98 - 110 (ISE Direct Method) S. PHOSPHORUS 3.84 mg/dL 2.5 - 4.5(Ammonium Molybdate) S. CALCIUM 9.30 8.6 - 10.2 mg/dL (Arsenazo III) **PROTEIN** 7.50 6.4 - 8.3 g/dl (Biuret) S. ALBUMIN 4.07 g/dl 3.2 - 4.6 (BGC) **S.GLOBULIN** 3.43 1.9 - 3.5 g/dl (Calculated) A/G RATIO 1.19 0 - 2calculated NOTE BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200)

Result relates to sample tested, Kindly correlate with clinical findings.

ANALYZER.

Checked By

pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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. 13/1/2024 11:37 am Lab ID. Received On 180466

: 14/1/2024 1:06 pm Reported On Age/Sex : 40 Years / Female

Report Status : FINAL : SIDDHIVINAYAK HOSPITAL CGHS /ESIS / Ref By

Peripheral smear examination

TEST NAME RESULTS

SPECIMEN RECEIVED Whole Blood EDTA

RBC Normocytic Normochromic

WBC Total leucocyte count is normal on smear.

> Neutrophils:59 % Lymphocytes:35 % Monocytes:04 % Eosinophils:02 % Basophils:00 % Adequate on smear. No parasite seen.

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja jadhav

PLATELET

HEMOPARASITE

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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Name : Mrs. SARASWATI KUMARI (A) **Collected On**

: 13/1/2024 11:27 am

Lab ID.

: 180466

Received On Reported On

Report Status

. 13/1/2024 11:37 am

Age/Sex

: 40 Years

/ Female

: 14/1/2024 1:06 pm : FINAL

Ref By

: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
TOTAL BILLIRUBIN	0.53	mg/dL	0.0 - 2.0	
(Method-Diazo)				
DIRECT BILLIRUBIN	0.22	mg/dL	0.0 - 0.4	
(Method-Diazo)				
INDIRECT BILLIRUBIN	0.31	mg/dL	0 - 0.8	
Calculated				
SGOT(AST)	17.0	U/L	0 - 37	
(UV without PSP)				
SGPT(ALT)	12.1	U/L	UP to 40	
UV Kinetic Without PLP (P-L-P)				
ALKALINE PHOSPHATASE	90.0	U/L	42 - 98	
(Method-ALP-AMP)				
S. PROTIEN	7.50	g/dl	6.4 - 8.3	
(Method-Biuret)				
S. ALBUMIN	4.07	g/dl	3.5 - 5.2	
(Method-BCG)				
S. GLOBULIN	3.43	g/dl	1.90 - 3.50	
Calculated				
A/G RATIO	1.19		0 - 2	
Calculated				

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja_jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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: SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

Name : Mrs. SARASWATI KUMARI (A) **Collected On** : 13/1/2024 11:27 am

Lab ID. : 180466

. 13/1/2024 11:37 am Received On

Ref By

: 14/1/2024 1:06 pm Reported On

Age/Sex : 40 Years / Female

Report Status : FINAL

НΔ	EM	ΔΤ	OI	O	GY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE	
<u>ESR</u>				
ESR	50	mm/1hr.	0 - 20	

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja_jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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: 13/1/2024 11:27 am Name : Mrs. SARASWATI KUMARI (A) Collected On

Lab ID. 180466

Reported On : 14/1/2024 1:06 pm Age/Sex : 40 Years / Female

Received On

Report Status Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

: FINAL

. 13/1/2024 11:37 am

BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
GAMMA GT	20.9	U/L	5 - 55
BLOOD GLUCOSE FASTING & PP			
BLOOD GLUCOSE FASTING	98.4	mg/dL	70 - 110
BLOOD GLUCOSE PP	124.0	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

- 1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
- 2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl

- Impaired Fasting glucose (IFG): 110-125 mg/dl

- Diabetes mellitus : >=126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance: 70-139 mg/dl - Impaired glucose tolerance: 140-199 mg/dl

- Diabetes mellitus : >=200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose >=126 mg/dl
- Classical symptoms +Random plasma glucose >=200 mg/dl
- Plasma glucose >=200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin > 6.5%

GLYCOCELATED HEMOGLOBIN (HBA1C)

HBA1C (GLYCOSALATED	5.6	%	Hb A1c
HAEMOGLOBIN)			> 8 Action suggested
			< 7 Goal
			< 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	114.0	mg/dL	65.1 - 136.3

METHOD Particle Enhanced Immunoturbidimetry

Checked By

pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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^{***}Any positive criteria should be tested on subsequent day with same or other criteria.



. 13/1/2024 11:37 am Lab ID. Received On : 180466

Reported On : 14/1/2024 1:06 pm Age/Sex Years : 40 / Female

Report Status : FINAL Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS /

BIOCHEMISTRY

UNIT REFERENCE RANGE TEST NAME **RESULTS**

HbA1c: Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes. Average Blood Glucose (A.B.G) is calculated value from HbA1c: Glycosylated hemoglobin concentration in whole Blood. It indicates average blood sugar level over past three months.

Result relates to sample tested, Kindly correlate with clinical findings.

Checked By pooja jadhav

DR. SMITA RANVEER. M.B.B.S.M.D. Pathology(Mum) **Consultant Histocytopathologist**

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