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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL

UHID	12143798	Date	26/11/2022
Name	Mr.Sarang Battalwar	Sex	Male Age 37
OPD	Opthal 14	Health Check Up	

Drug allergy:
Sys illness:

O/B ophthal.

K/c/o DM since 5 yrs; on Rx

A/S : A/S - WNL

Fundus examn - WNL

Vn R -0.75 sph → 6/6
L -0.50-0.50x110° → 6/6

Rx. eyedrop REFTEARS 1-1-1-1 (CBD) x 1 mnth

F/up for dilated retina examn & OCT scan (CBD)

[signature]

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9112.

Hiranandani HOSPITAL

UHID	**12143798**	**Date**	**26/11/2022**		
Name	**Mr.Sarang Battalwar**	**Sex**	**Male**	**Age**	**37**
OPD	**Dental 12**	**Health Check Up**			

Drug allergy:
Sys illness:

deep caries $\frac{87 \mid 7}{7 \mid 7}$

Stains +

Calculus +

Treatment

Adv filling $\frac{87 \mid 7}{7 \mid 7}$

Adv. Oral prophylaxis.

Dr Diksha Kaka

LABORATORY REPORT

Cert. No. MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005845** AGE : 37 Years SEX : Male ABHA NO :

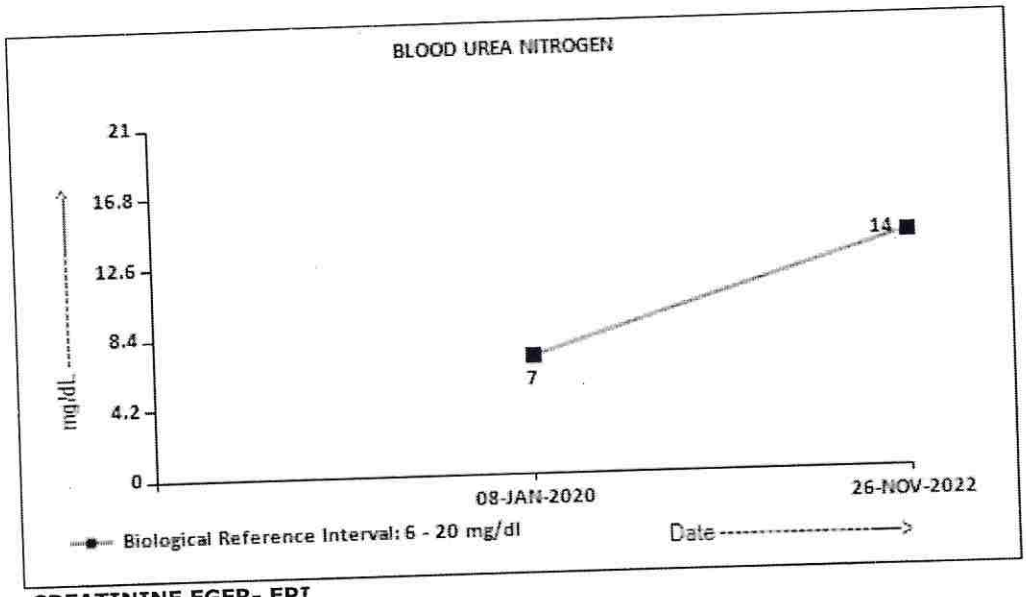
DRAWN : 26/11/2022 11:19:00 RECEIVED : 26/11/2022 11:19:12 REPORTED : 26/11/2022 13:38:54

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. Sejal Gandhi

CLINICAL INFORMATION :

UID:5615811 REQNO-1326177
CORP-OPD
BILLNO-150122OPCR059898
BILLNO-150122OPCR059898

Test Report Status **Final**	Results	Biological Reference Interval	Units
KIDNEY PANEL - 1			
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	14	6 - 20	mg/dL
METHOD : UREASE - UV			



CREATININE EGFR- EPI			
CREATININE	0.98	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	37		years
GLOMERULAR FILTRATION RATE (MALE)	101.85	Refer Interpretation Below	mL/min/1.7
METHOD : CALCULATED PARAMETER			

PATIENT NAME : MR. MR.SARANG BATTALWAR

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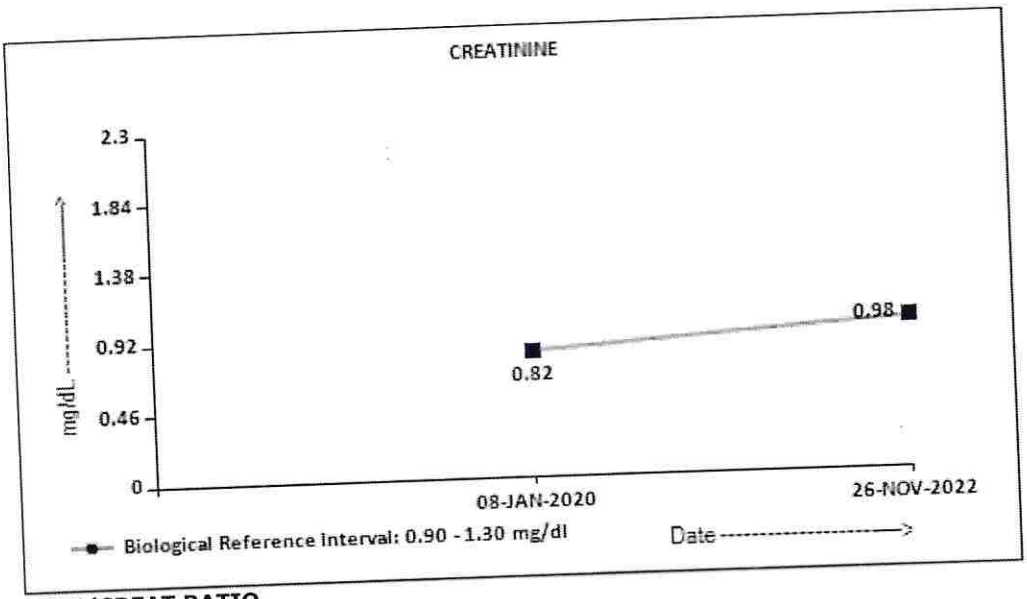

BUN/CREAT RATIO			
BUN/CREAT RATIO	14.29	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	5.0	3.5 - 7.2	mg/dL
METHOD : URICASE UV			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	6.9	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			
ALBUMIN	3.7	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN			
GLOBULIN	3.2	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	137	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.62	3.50 - 5.10	mmol/L

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Patient Ref. No. 220000008

PATIENT NAME : MR. MR.SARANG BATTALWAR

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METHOD : ISE INDIRECT			
CHLORIDE, SERUM	99	98 - 107	mmol/L
METHOD : ISE INDIRECT			
Interpretation(s)			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
METHOD : PHYSICAL			
APPEARANCE	CLEAR		
METHOD : VISUAL			
CHEMICAL EXAMINATION, URINE			
PH	7.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	**DETECTED (+++)**	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			

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CLINICAL INFORMATION :

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Test Report Status **Final**	Results	Biological Reference Interval	Units
EPITHELIAL CELLS	1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
YEAST	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
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
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-5, EDTA WHOLE BLOOD

MORPHOLOGY

RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION			
WBC	NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS	ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION			

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	10		0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD				

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	16.7		13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	**5.85**	**High**	4.5 - 5.5	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	9.29		4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT	309		150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE				

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	49.9		40 - 50	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOLUME (MCV)	85.3		83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.5		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.4		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				

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BILLNO-150122OPCR059898
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Test Report Status **Final**	Results	Biological Reference Interval	
RED CELL DISTRIBUTION WIDTH (RDW)	12.6	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	14.6		
MEAN PLATELET VOLUME (MPV)	9.6	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	68	40 - 80	%
METHOD : FLOW CYTOMETRY			
LYMPHOCYTES	21	20 - 40	%
METHOD : FLOW CYTOMETRY			
MONOCYTES	9	2 - 10	%
METHOD : FLOW CYTOMETRY			
EOSINOPHILS	2	1 - 6	%
METHOD : FLOW CYTOMETRY			
BASOPHILS	00	0 - 2	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	6.32	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.95	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.84	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.19	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)	3.2		
METHOD : CALCULATED PARAMETER			

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) th 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.

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Patient Ref. No. 2200000081

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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.
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B		
METHOD : TUBE AGGLUTINATION			
RH TYPE	POSITIVE		
METHOD : TUBE AGGLUTINATION			

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

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

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

BIO CHEMISTRY

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	**244**	**High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
TRIGLYCERIDES	**515**	**High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL

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METHOD : ENZYMATIC ASSAY HDL CHOLESTEROL	**33**	**Low** < 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG LDL CHOLESTEROL, DIRECT	112	< 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	**211**	**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 CHOL/HDL RATIO	**7.4**	**High** 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	**3.4**	**High** 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER VERY LOW DENSITY LIPOPROTEIN	**103.0**	**High** </= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			

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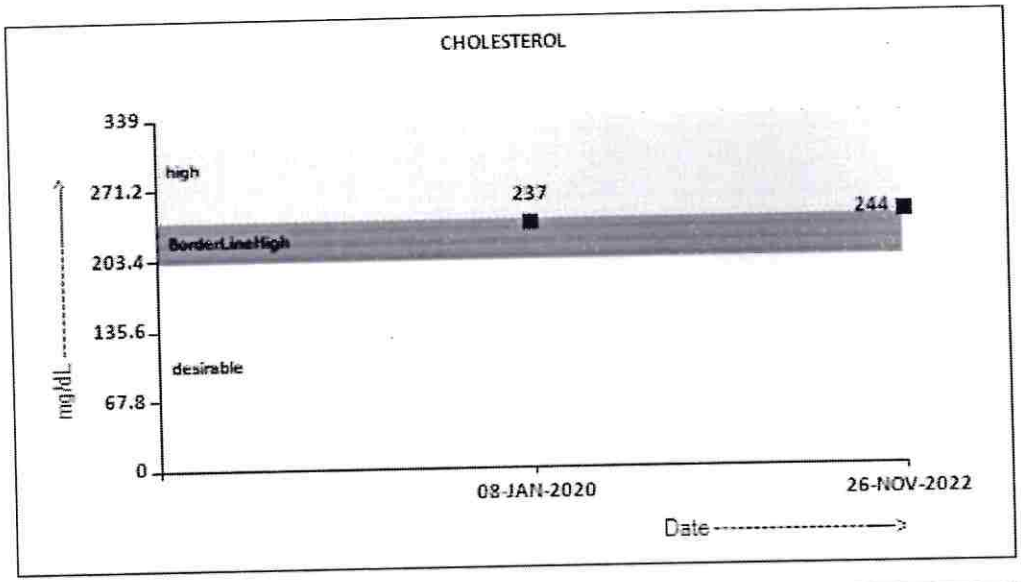

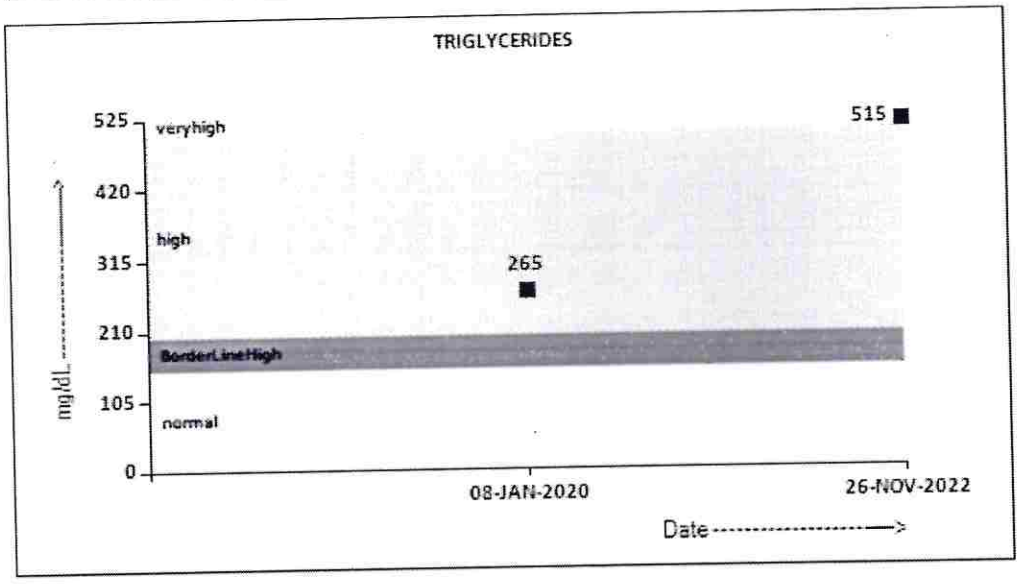

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PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005845** AGE : 37 Years SEX : Male ABHA NO :

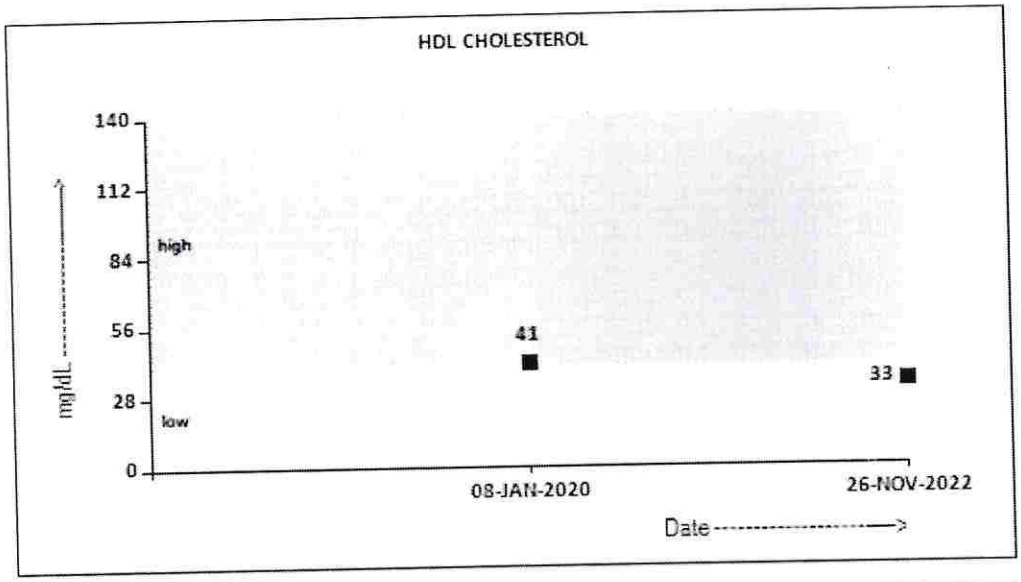
DRAWN : 26/11/2022 11:19:00 RECEIVED : 26/11/2022 11:19:12 REPORTED : 26/11/2022 13:38:54

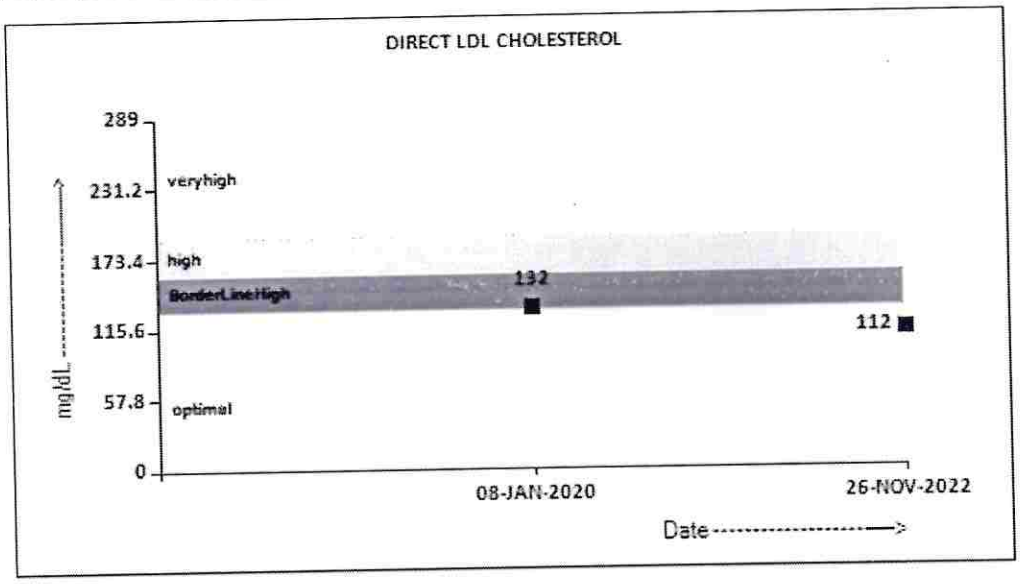
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. Sejal Gandhi

CLINICAL INFORMATION :

UID:5615811 REQNO-1326177
CORP-OPD
BILLNO-150122OPCR059898
BILLNO-150122OPCR059898

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





LIVER FUNCTION PROFILE, SERUM

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005845** AGE : 37 Years SEX : Male ABHA NO :

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Test Report Status **Final**	Results		Biological Reference Interval	
BILIRUBIN, TOTAL	**1.27**	**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	**1.09**	**High**	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	6.9		6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN	3.7		3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN	3.2		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.2		1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	18		15 - 37	U/L
METHOD : UV WITH P5P				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	39		< 45.0	U/L
METHOD : UV WITH P5P				
ALKALINE PHOSPHATASE	111		30 - 120	U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)	30		15 - 85	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE				
LACTATE DEHYDROGENASE	168		100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)	**183**	**High**	74 - 99	mg/dL
METHOD : HEXOKINASE				

PATIENT NAME : MR. MR.SARANG BATTALWAR

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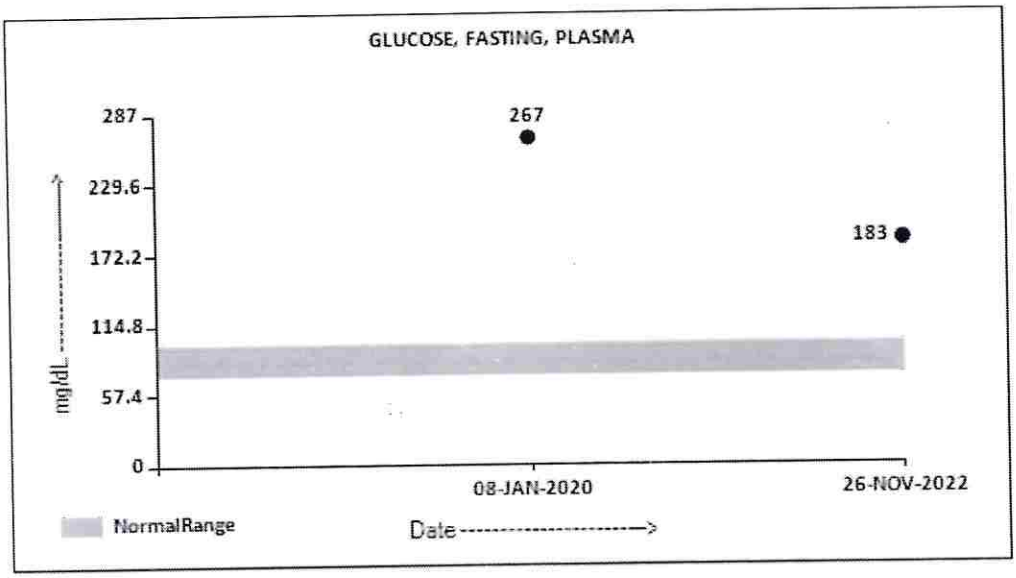
Test Report Status **Final**	Results	Biological Reference Interval



GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				
HBA1C	**9.4**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)	**223.1**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				

PATIENT NAME : MR. MR.SARANG BATTALWAR

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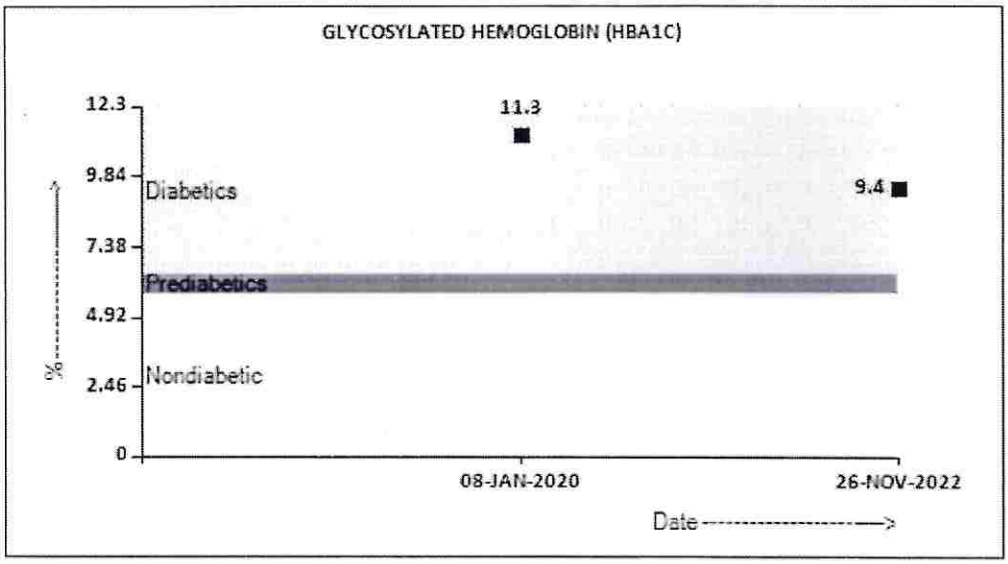

Interpretation(s)
LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don''''''''''t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn''''''''''t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

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CLINICAL INFORMATION :

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

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

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 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:

Hypoglycemia is defined as a glucoseof < 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 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.)

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

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

****End Of Report****

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

Dr.Akta Dubey
Counsultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

LABORATORY REPORT

Cert. No. MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005944** AGE : 37 Years SEX : Male ABHA NO :

DRAWN : 26/11/2022 14:30:00 RECEIVED : 26/11/2022 14:30:12 REPORTED : 26/11/2022 15:55:27

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. Sejal Gandhi

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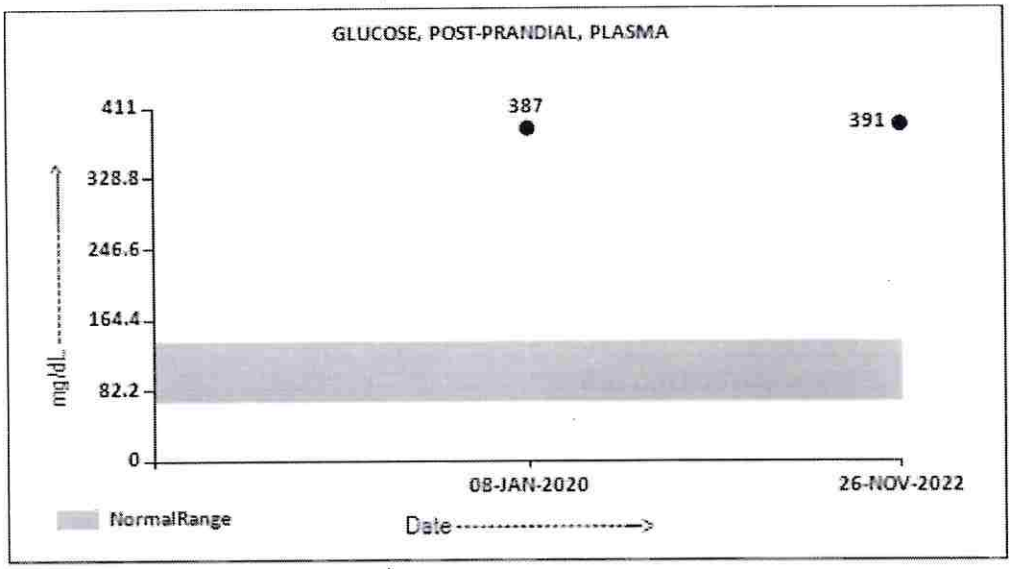
Test Report Status **Final**	Results	Biological Reference Interval	Units

BIO CHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	**391**	**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****

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

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SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
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Patient Ref. No. 22000000811377

LABORATORY REPORT

Cert. No. MC-2275

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005944** AGE : 37 Years SEX : Male ABHA NO :

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

Dr.Akta Dubey
Counsultant Pathologist

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

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Patient Ref. No. 2200000081137

LABORATORY REPORT

Cert. No. MC-2984

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.SARANG BATTALWAR

PATIENT ID : **FH.5615811** CLIENT PATIENT ID : UID:5615811

ACCESSION NO : **0022VK005845** AGE : 37 Years SEX : Male ABHA NO :

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** DR. Sejal Gandhi

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Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	131.7	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	12.23	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	2.310	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

LABORATORY REPORT

Cert. No. MC-2984

Fortis | SRL Diagnostics

PATIENT NAME : MR. MR.SARANG BATTALWAR

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.302	< 1.4	ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

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

****End Of Report****

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

Sirmukaddam 786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

37 Years Male 11/26/2022 2:23:16 PM

ECG

Rate 117 . Sinus tachycardia.....rate> 99

PR 144
QRSD 83
QT 330
QTc 461

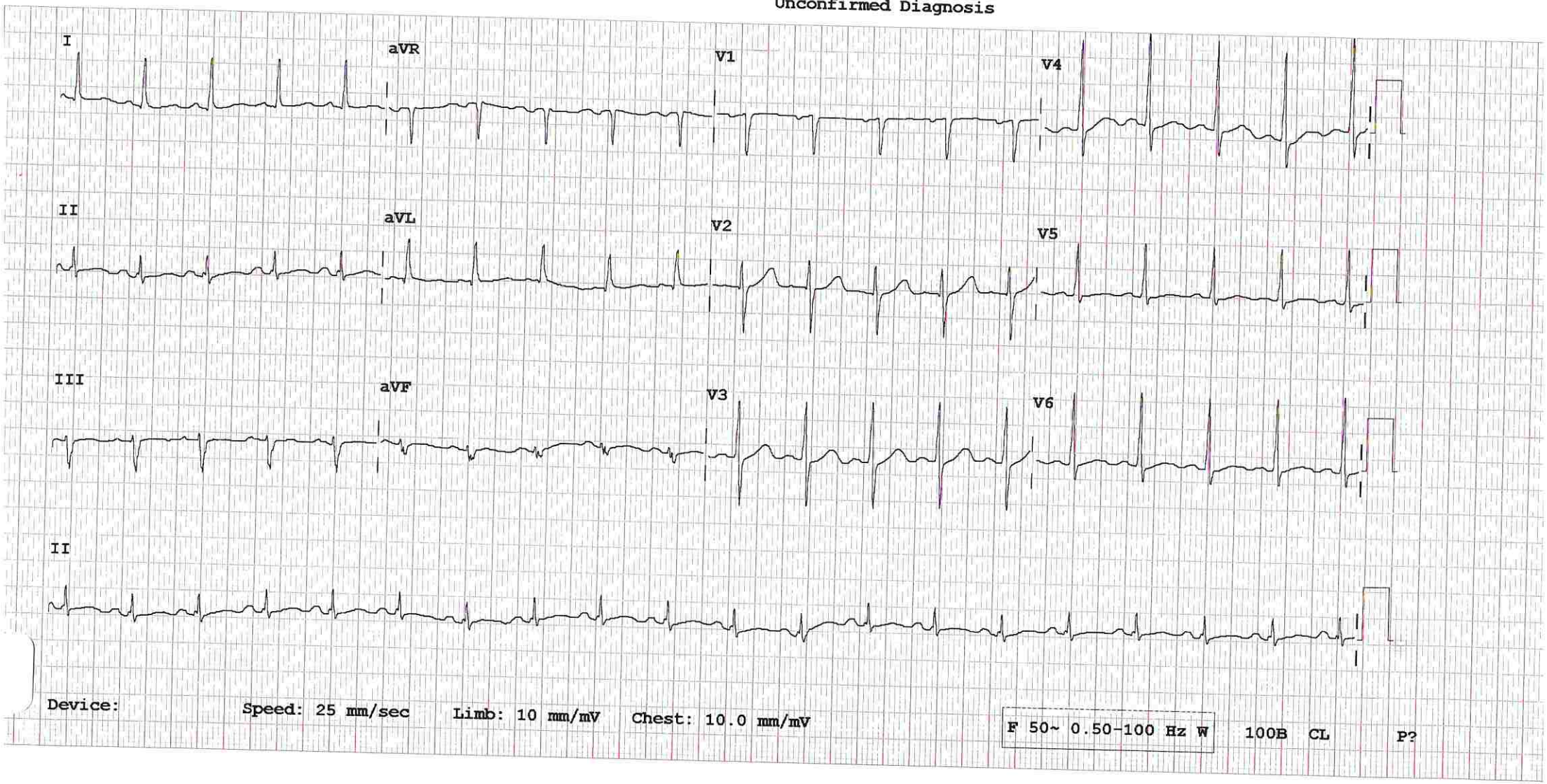
--AXIS--
P 53
QRS -11
T 49

Sinus tachycardia
Correlate Clinical
0

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.
Board Line: 022 - 39199222 I Fax: 022 - 39133220
Emergency: 022 - 39199100 I Ambulance: 1255
For Appointment: 022 - 39199200 I Health Checkup: 022 - 39199300
www.fortishealthcare.com I vashi@fortishealthcare.com
CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

Date: 26/Nov/2022

DEPARTMENT OF NIC

Name: Mr. Sarang Battalwar
Age | Sex: 37 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5615811 | 59312/22/1501
Order No | Order Date: 1501/PN/OP/2211/126046 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 16:13:12
Order Doctor Name : Dr.Sejal Gandhi

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	36	mm
AO Root	33	mm
AO CUSP SEP	24	mm
LVID (s)	37	mm
LVID (d)	44	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	23	mm
RA	29	mm
LVEF	60	%

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PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

DEPARTMENT OF NIC

Date: 26/Nov/2022

Name: Mr. Sarang Battalwar
Age | Sex: 37 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5615811 | 59312/22/1501
Order No | Order Date: 1501/PN/OP/2211/126046 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 16:13:12
Order Doctor Name : Dr.Sejal Gandhi

DOPPLER STUDY:

E WAVE VELOCITY: 1.0 m/sec.
A WAVE VELOCITY:0.7 m/sec
E/A RATIO:1.3

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			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: 26/Nov/2022

Name: Mr. Sarang Battalwar
Age | Sex: 37 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5615811 | 59312/22/1501
Order No | Order Date: 1501/PN/OP/2211/126046 | 26-Nov-2022
Admitted On | Reporting Date : 26-Nov-2022 14:30:16
Order Doctor Name : Dr.Sejal Gandhi

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)

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Admitted On | Reporting Date : 26-Nov-2022 13:00:50
Order Doctor Name : Dr.Sejal Gandhi

US-WHOLE ABDOMEN

LIVER is normal in size and shows moderately raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

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. Right kidney measures 11.1 x 6.1 cm. No evidence of calculi/hydronephrosis. Left kidney measures 10.5 x 6.2 cm. A 2.9 mm sized non-obstructing calculus is noted at mid pole calyx of left kidney. No evidence of hydronephrosis.

PANCREAS: Head and body of pancreas appear unremarkable. Rest of the pancreas is obscured.

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

PROSTATE is normal in size & echogenicity. It measures ~ 17.5 cc in volume.

No evidence of ascites.

IMPRESSION:

- **Grade II fatty infiltration of liver.**
- **Left renal non-obstructing calculus.**

DR. CHETAN KHADKE
(MD RADIOLOGIST)