

**DIAGNOSTIC REPORT**



Cert. No. MC-5320



**CLIENT CODE :** C000138358

**CLIENT'S NAME AND ADDRESS :**  
SWETA KUMARI

SRL DIAGNOSTICS  
Veda Ranghaa Nivas, No:22/97,Dr.Ambedkar Road, Ashok Nagar,4th Avenue  
CHENNAI, 600083  
TAMIL NADU, INDIA

**PATIENT NAME :** SWETA KUMARI

**PATIENT ID :** SWETF111193323

**ACCESSION NO :** 0323VL005970 **AGE :** 29 Years **SEX :** Female

**ABHA NO :**

**DRAWN :** 24/12/2022 09:08

**RECEIVED :** 24/12/2022 09:10

**REPORTED :** 28/12/2022 13:10

**REFERRING DOCTOR :** SELF

**CLIENT PATIENT ID :**

Test Report Status	Final	Results	Biological Reference Interval	Units
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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**

**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)	<b>10.9</b>	<b>Low</b>	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT	4.11		3.8 - 4.8	mil/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT	5.59		4.0 - 10.0	thou/ $\mu$ L
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	<b>135</b>	<b>Low</b>	150 - 410	thou/ $\mu$ L
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY				

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)	<b>33.5</b>	<b>Low</b>	36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOLUME (MCV)	<b>81.7</b>	<b>Low</b>	83 - 101	fL
METHOD : ELECTRICAL IMPEDANCE				
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>26.5</b>	<b>Low</b>	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	32.5		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
RED CELL DISTRIBUTION WIDTH (RDW)	<b>17.3</b>	<b>High</b>	11.6 - 14.0	%
METHOD : ELECTRICAL IMPEDANCE				
MENTZER INDEX	19.9			
METHOD : CALCULATED				
MEAN PLATELET VOLUME (MPV)	<b>13.7</b>	<b>High</b>	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS	67		40 - 80	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
LYMPHOCYTES	27		20 - 40	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
MONOCYTES	5		2 - 10	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
EOSINOPHILS	1		1 - 6	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
BASOPHILS	0		0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				



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ABSOLUTE NEUTROPHIL COUNT		3.75	2.0 - 7.0	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		1.51	1 - 3	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.28	0.20 - 1.00	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.06	0.02 - 0.50	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY & CALCULATED				
ABSOLUTE BASOPHIL COUNT		<b>0.01</b>	<b>Low</b> 0.02 - 0.10	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY & CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.5		
METHOD : CALCULATED				
<b>* ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD</b>				
E.S.R		<b>21</b>	<b>High</b> < 20	mm at 1 hr
<b>* GLUCOSE FASTING,FLUORIDE PLASMA</b>				
FBS (FASTING BLOOD SUGAR)		95	74 - 99	mg/dL
METHOD : HEXOKINASE				
<b>* GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD</b>				
HBA1C		4.9	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG)		93.9	< 116.0	mg/dL
<b>* GLUCOSE, POST-PRANDIAL, PLASMA</b>				
PPBS(POST PRANDIAL BLOOD SUGAR)		97	70 - 140	mg/dL
METHOD : HEXOKINASE				
<b>LIPID PROFILE, SERUM</b>				
CHOLESTEROL, TOTAL		175	Desirable: < 200 BorderlineHigh: 200 - 239 High: > or = 240	mg/dL
TRIGLYCERIDES		84	Desirable: < 150 BorderlineHigh: 150 - 199 High: 200 - 499 Very High: > or = 500	mg/dL
HDL CHOLESTEROL		60	Low < 40 High > or = 60	mg/dL



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CHOLESTEROL LDL		98	Optimal : < 100 Near optimal/above optimal : 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	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		2.9		
LDL/HDL RATIO		1.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		16.8		mg/dL
<b>* LIVER FUNCTION PROFILE, SERUM</b>				
BILIRUBIN, TOTAL		0.82	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		<b>0.27</b>	<b>High</b> Upto 0.2	mg/dL
BILIRUBIN, INDIRECT		0.55	UPTO 0.6	mg/dL
TOTAL PROTEIN		6.7	6.4 - 8.3	g/dL
ALBUMIN		4.7	3.5 - 5.2	g/dL
GLOBULIN		2.0	1.8 - 3.6	g/dL
ALBUMIN/GLOBULIN RATIO		2.4		RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		12	0 - 32	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		13	0 - 33	U/L
ALKALINE PHOSPHATASE		67	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		10	5 - 36	U/L
LACTATE DEHYDROGENASE		149	135 - 214	U/L
<b>* BLOOD UREA NITROGEN (BUN), SERUM</b>				
BLOOD UREA NITROGEN		<b>5</b>	<b>Low</b> 6 - 20	mg/dL
<b>* CREATININE, SERUM</b>				
CREATININE		<b>0.47</b>	<b>Low</b> 0.60 - 1.10	mg/dL
<b>BUN/CREAT RATIO</b>				
BUN/CREAT RATIO		10.64	5.0 - 15.0	
<b>* URIC ACID, SERUM</b>				
URIC ACID		3.4	2.4 - 5.7	mg/dL
<b>* TOTAL PROTEIN, SERUM</b>				



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TOTAL PROTEIN		6.7	6.4 - 8.3	g/dL
<b>* ALBUMIN, SERUM</b>				
ALBUMIN		4.7	3.5 - 5.2	g/dL
<b>GLOBULIN</b>				
GLOBULIN		2.0	1.8 - 3.6	g/dL
<b>* ELECTROLYTES (NA/K/CL), SERUM</b>				
SODIUM, SERUM		136	136 - 145	mmol/L
POTASSIUM, SERUM		4.37	3.5 - 5.1	mmol/L
CHLORIDE, SERUM		101	98 - 107	mmol/L
<b>PHYSICAL EXAMINATION, URINE</b>				
COLOR		PALE YELLOW		
METHOD : AUTOMATED-COLORIMETRY				
APPEARANCE		CLEAR		
METHOD : AUTOMATED-COLORIMETRY				
<b>CHEMICAL EXAMINATION, URINE</b>				
PH		6.5	4.5 - 8.0	
METHOD : PH INDICATOR				
SPECIFIC GRAVITY		1.010	1.010 - 1.025	
METHOD : AUTOMATED-REFRACTOMETRY				
PROTEIN		NOT DETECTED	NOT DETECTED	
METHOD : PROTEIN- ERROR INDICATOR				
GLUCOSE		NOT DETECTED	NOT DETECTED	
METHOD : GOD-POD METHOD				
KETONES		NOT DETECTED	NOT DETECTED	
METHOD : NITROPRUSSIDE REACTION				
BLOOD		<b>DETECTED (TRACE)</b>	NOT DETECTED	
METHOD : PEROXIDASE-LIKE ACTIVITY OF HEMOGLOBIN				
BILIRUBIN		NOT DETECTED	NOT DETECTED	
METHOD : AZO COUPLING METHOD				
UROBILINOGEN		NORMAL	NORMAL	
METHOD : AZO COUPLING METHOD				
NITRITE		NOT DETECTED	NOT DETECTED	
METHOD : GRIESS TEST				
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
METHOD : ESTERASE HYDROLYSIS ACTIVITY				
<b>* MICROSCOPIC EXAMINATION, URINE</b>				



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RED BLOOD CELLS		<b>DETECTED (OCCASIONAL)</b>	NOT DETECTED	/HPF
PUS CELL (WBC'S)		0-1	0-5	/HPF
EPITHELIAL CELLS		1-2	0-5	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	
<b>* THYROID PANEL, SERUM</b>				
T3		111.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
T4		7.36	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)		<b>4.620</b>	<b>High</b> Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL



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**Interpretation(s)**

**Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH** are thyroid hormones which affect 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. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of 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. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1)Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3)Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2.Guidlines of the American Thyroid association during pregnancy and Postpartum, 2011.

**NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.**TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

**PAPANICOLAOU SMEAR**

**TEST METHOD**

CONVENTIONAL GYNEC CYTOLOGY.

PAP NO :- 414/2022

**SPECIMEN TYPE**

TWO PAPANICOLAOU SMEARS PREPARED.  
TWO UNSTAINED CERVICAL SMEARS RECEIVED.



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REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY.
SPECIMEN ADEQUACY	SMEARS ARE SATISFACTORY FOR EVALUATION.
MICROSCOPY	TRANSFORMATION ZONE CELLS PRESENT. SMEARS STUDIED SHOW SUPERFICIAL AND INTERMEDIATE SQUAMOUS CELLS IN A BACKGROUND OF NEUTROPHILS.
INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

**Comments**

PAP SMEAR COMMENTS.

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SUGGESTIONS / GUIDELINES : (REF: THE BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY , 2014 , 3 RD EDITION)

1) PLEASE NOTE PAPANICOLALOU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS, HENCE SHOULD BE INTERPRETED WITH CAUTION.

2) NO CYTOLOGIC EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

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

ABO GROUP	AB
RH TYPE	Positive

**\* XRAY-CHEST**

IMPRESSION NO ABNORMALITY DETECTED

**TMT OR ECHO**

TMT OR ECHO	ECHO : -  NO REGIONAL WALL MOTION ABNORMALITY. NORMAL LEFT VENTRICULAR SYSTOLIC AND DIASTOLIC FUNCTION. NORMAL RIGHT VENTRICULAR FUNCTION. NORMAL VALVES. INTACT SEPTAE.
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**\* ECG**

ECG	WITHIN NORMAL LIMITS
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**MEDICAL HISTORY**

RELEVANT PRESENT HISTORY	NOT SIGNIFICANT
RELEVANT PAST HISTORY	H/O : LSCS 2020
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT
RELEVANT FAMILY HISTORY	FATHER - DM + SHT
OCCUPATIONAL HISTORY	NOT SIGNIFICANT
HISTORY OF MEDICATIONS	NOT SIGNIFICANT

**ANTHROPOMETRIC DATA & BMI**

HEIGHT IN METERS	1.53	mts
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WEIGHT IN KGS.	56			Kgs
BMI	24			
			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
CAROTID PULSATION	NORMAL
TEMPERATURE	98.4F
PULSE	101/MIN
RESPIRATORY RATE	16/MIN

**CARDIOVASCULAR SYSTEM**

BP	129/79	mm/Hg
PERICARDIUM	NORMAL	
APEX BEAT	NORMAL	
HEART SOUNDS	S1, S2 HEARD NORMALLY	
MURMURS	ABSENT	

**RESPIRATORY SYSTEM**

SIZE AND SHAPE OF CHEST	NORMAL
MOVEMENTS OF CHEST	SYMMETRICAL
BREATH SOUNDS INTENSITY	NORMAL
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)
ADDED SOUNDS	ABSENT

**PER ABDOMEN**

APPEARANCE	NORMAL
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VENOUS PROMINENCE		ABSENT		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		
HERNIA		ABSENT		
<b>BASIC EYE EXAMINATION</b>				
CONJUNCTIVA		NORMAL		
EYELIDS		NORMAL		
EYE MOVEMENTS		NORMAL		
CORNEA		NORMAL		
DISTANT VISION RIGHT EYE WITHOUT GLASSES		REFRACTIVE ERROR TO BE CORRECTED.		
DISTANT VISION LEFT EYE WITHOUT GLASSES		REFRACTIVE ERROR TO BE CORRECTED.		
NEAR VISION RIGHT EYE WITHOUT GLASSES		NORMAL		
NEAR VISION LEFT EYE WITHOUT GLASSES		NORMAL		
COLOUR VISION		NORMAL		
<b>BASIC ENT EXAMINATION</b>				
EXTERNAL EAR CANAL		NORMAL		
TYMPANIC MEMBRANE		NORMAL		
NOSE		NO ABNORMALITY DETECTED		
SINUSES		NORMAL		
THROAT		NO ABNORMALITY DETECTED		
TONSILS		NOT ENLARGED		
<b>BASIC DENTAL EXAMINATION</b>				
TEETH		NORMAL		
GUMS		HEALTHY		
<b>SUMMARY</b>				
RELEVANT HISTORY		NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS		NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS		HAEMOGLOBIN , PCV, MCV, MCH, PLATELETS COUNTS IS DECREASED. MICROCYTIC HYPOCHROMIC ANAEMIA IS NOTED.		
RELEVANT NON PATHOLOGY DIAGNOSTICS		NO ABNORMALITIES DETECTED		



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**DIAGNOSTIC REPORT**

Patient Ref. No. 323000001149353



Cert. No. MC-5320



CLIENT CODE : C000138358

CLIENT'S NAME AND ADDRESS :  
SWETA KUMARISRL DIAGNOSTICS  
Veda Ranghaa Nivas, No:22/97,Dr.Ambedkar Road, Ashok Nagar,4th  
Avenue  
CHENNAI, 600083  
TAMIL NADU, INDIA

PATIENT NAME : SWETA KUMARI

PATIENT ID : SWETF111193323

ACCESSION NO : 0323VL005970 AGE : 29 Years SEX : Female

ABHA NO :

DRAWN : 24/12/2022 09:08

RECEIVED : 24/12/2022 09:10

REPORTED : 28/12/2022 13:10

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

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

ADVISED REFRACTIVE ERROR TO BE CORRECTED.

HAEMOGLOBIN , PCV, MCV,MCH, PLATELETS COUNTS IS DECREASED.  
MICROCYTIC HYPOCHROMIC ANAEMIA IS NOTED.  
ADVISED TO TAKE IRON RICH FOOD.**FITNESS STATUS**

FITNESS STATUS

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

**Comments**

OUR PANEL OF DOCTORS :

GENERAL PHYSICIANS - DR.MOHAMMED NAWAZ M.B.B.S

RADIOLOGIST - DR.SIVALINGAM.MD(RADIODIAGNOSIS),DMRD

SONOLOGIST -DR. UMALAKSHMI.G M.B.B.S

PULMONOGISTS - DR.M.VASANTHA KUMAR MBBS,DTCD

ENT PHYSICIANS - DR.NIRAJ JOSHI MBBS,MS,DLO.

OPHTHALMOLOGISTS - DR.K RAVIKUMAR., MBBS,MS(OPHTHALMOLOGY),FRCS.

CARDIOLOGISTS - DR ARUN R M.D;DM

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

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(&gt;13)

(&lt;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 &lt; 49.5 years old and NLR &lt; 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



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Page 10 Of 14



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(sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

**TEST INTERPRETATION**

**Increase** in: Infections, Vasculitides, 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 sulfonylureas,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.

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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.

2. eAG gives an evaluation of blood glucose levels for the last couple of months.

3. eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

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

I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).

III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in

a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

c. HbF > 25% on alternate 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



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SRL DIAGNOSTICS  
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TAMIL NADU, INDIA

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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, 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)

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, 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.

**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.



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Page 13 Of 14



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**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****\* ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

NORMAL STUDY.

**\*\*End Of Report\*\***Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession  
TEST MARKED WITH '\*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.Dr. S.Nalina Priya  
Consultant PathologistDr.C.N.Srinivas  
Vice President – Technical &  
Head of HLA & TI**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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Page 14 Of 14



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