



CLIENT CODE : CA00010147 CLIENT'S NAME AND ADDRESS : MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 DELHI INDIA 8800465156 8800465156

DDRC SRL DIAGNOSTICS
Phoenix Tower, Near Central Park Hotel,
Prathibha Junction, Kadappakada,
KOLLAM, 691008
KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in

Test Report Status <u>Final</u>	Results	Biological Reference Interval Units
REFERRING DOCTOR : SELF		CLIENT PATIENT ID :
DRAWN :	RECEIVED : 26/11/2022 12:17	REPORTED : 26/11/2022 17:22
ACCESSION NO : 4071VK006059	AGE: 30 Years SEX: Male	
PATIENT NAME : SABARI PRAKA	PATIENT ID : SABAM1309924071	

MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

OPTHAL	
OPTHAL	REPORTED
TREADMILL TEST	
TREADMILL TEST	REPORTED
PHYSICAL EXAMINATION	
PHYSICAL EXAMINATION	REPORTED





		LABORA	TORY SERVICES
DDRC SRL Diagnostic Services	Patient Ref. No. 66600002450977		
CLIENT CODE: CA00010147 CLIENT'S NAME AND ADDRESS: MEDIWHEEL ARCOFEMI HEALTHCARE LIMI F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 DELHI INDIA 8800465156	TED Phoer Prathi KOLL KERA Tel : 9	SRL DIAGNOSTICS ix Tower, Near Central Park Hotel, bha Junction, Kadappakada, AM, 691008 LA, INDIA 93334 93334 : customercare.ddrc@srl.in	
PATIENT NAME : SABARI PRAKAS	SAM	PATIENT ID : SABAN	11309924071
ACCESSION NO : 4071VK006059	AGE : 30 Years SEX : Male		
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Test Report Status <u>Final</u>	Results		Units
MEDIWHEEL HEALTH CHEKUP BEI	<u>OW 40(M)TMT</u>		
BUN/CREAT RATIO	0.6		
BUN/CREAT RATIO	9.6		
CREATININE, SERUM CREATININE	1.01	19 60 17	ma/dl
	1.01	18 - 60 yrs : 0.9 - 1.3	mg/dL
GLUCOSE, POST-PRANDIAL, PLAS GLUCOSE, POST-PRANDIAL, PLASMA		Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE, FASTING, PLASMA			
GLUCOSE, FASTING, PLASMA	83	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
GLYCOSYLATED HEMOGLOBIN(HE BLOOD	BA1C), EDTA WHOLE		
GLYCOSYLATED HEMOGLOBIN (HBA1	C) 5.7	Normal : 4.0 - 5.6% Non-diabetic level : < 5.7%. Diabetic : >6.5%	%
		Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%.	
		Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	
MEAN PLASMA GLUCOSE	116.9		mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL	191	Borderline : 200-239	mg/dL
TRIGLYCERIDES	139	High : >or= 240 Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	30		mg/dL







F701A, LADO SARAI, NEW DELHI,

SOUTH DELHI, DELHI, SOUTH DELHI 110030

DELHI INDIA

8800465156

DRAWN :

CLIENT CODE : CA00010147 CLIENT'S NAME AND ADDRESS : MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

PATIENT NAME : SABARI PRAKASAM



DDRC SRL DIAGNOSTICS Phoenix Tower, Near Central Park Hotel, Prathibha Junction, Kadappakada, KOLLAM, 691008 KERALA, INDIA Tel: 93334 93334

Email : customercare.ddrc@srl.in

PATIENT ID : SABAM1309924071

ACCESSION NO : **4071VK006059** AGE: 30 Years SEX : Male RECEIVED : 26/11/2022 12:17

26/11/2022 17:22 REPORTED :

CLIENT PATIENT ID :

REFERRING DOCTOR : SELF

Test Report Status	<u>Final</u>	Results			Units
DIRECT LDL CHOLESTEF	ROL	140		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROI	-	161	High	Desirable: Less than 130 Above Desirable: $130 - 159$ Borderline High: $160 - 189$ High: $190 - 219$ Very high: $> or = 220$	mg/dL
CHOL/HDL RATIO		6.4	High	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO		4.7	High	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate >6.0 High Risk	Risk
VERY LOW DENSITY LIP	OPROTEIN	27.8		Desirable value : 10 - 35	mg/dL
LIVER FUNCTION TES	T WITH GGT			10 55	
BILIRUBIN, TOTAL		0.55		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT		0.18		General Range : < 0.2	mg/dL
BILIRUBIN, INDIRECT		0.37		0.00 - 0.60	mg/dL
TOTAL PROTEIN		7.5		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN		4.8		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN		2.7		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RA	TIO	1.8		1.0 - 2.0	RATIO
ASPARTATE AMINOTRAN	ISFERASE (AST/SGOT)	36		Adults : < 40	U/L
ALANINE AMINOTRANSF	ERASE (ALT/SGPT)	52		Adults : < 45	U/L
ALKALINE PHOSPHATAS	E	69		Adult(<60yrs): 40 -130	U/L
GAMMA GLUTAMYL TRAI	NSFERASE (GGT)	39		8 - 61	U/L
TOTAL PROTEIN, SER	UM				
TOTAL PROTEIN		7.5		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM					
URIC ACID		6.4		Adults : 3.4-7	mg/dL
ABO GROUP & RH TYP	PE, EDTA WHOLE BLOOD				







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SOUTH DELHI 110030

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PATIENT NAME : SABARI PRAKASAM PATIENT ID : SABAM1309924071 4071VK006059 30 Years ACCESSION NO : AGE : SEX : Male DRAWN : RECEIVED : 26/11/2022 12:17 **REPORTED** : 26/11/2022 17:22 REFERRING DOCTOR : SELF CLIENT PATIENT ID : **Test Report Status** Results Units <u>Final</u> ABO GROUP TYPF A RH TYPE POSITIVE **BLOOD COUNTS, EDTA WHOLE BLOOD** 15.6 13.0 - 17.0 g/dL HEMOGLOBIN RED BLOOD CELL COUNT 5.23 4.5 - 5.5 mil/µL WHITE BLOOD CELL COUNT 5.73 4.0 - 10.0 thou/µL PLATELET COUNT 293 150 - 410 thou/µL **RBC AND PLATELET INDICES** HEMATOCRIT 46.7 40 - 50 % MEAN CORPUSCULAR VOL 89.2 83 - 101 fl MEAN CORPUSCULAR HGB. 29.9 27.0 - 32.0 pg MEAN CORPUSCULAR HEMOGLOBIN 33.5 31.5 - 34.5 g/dL CONCENTRATION RED CELL DISTRIBUTION WIDTH 13.5 11.6 - 14.0 % MENTZER INDEX 17.1 MEAN PLATELET VOLUME 8.6 6.8 - 10.9 fL WBC DIFFERENTIAL COUNT SEGMENTED NEUTROPHILS 49 40 - 80 % 46 High 20 - 40 % I YMPHOCYTES MONOCYTES 03 % 2 - 10EOSINOPHILS 02 % 1 - 6 ABSOLUTE NEUTROPHIL COUNT 2.81 2.0 - 7.0 thou/µL ABSOLUTE LYMPHOCYTE COUNT 2.64 1.0 - 3.0 thou/µL Low 0.2 - 1.0 ABSOLUTE MONOCYTE COUNT 0.17 thou/µL ABSOLUTE EOSINOPHIL COUNT 0.02 - 0.50 0.11 thou/µL NEUTROPHIL LYMPHOCYTE RATIO (NLR) 1.1 **ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE** BLOOD SEDIMENTATION RATE (ESR) 04 0 - 14mm at 1 hr SUGAR URINE - POST PRANDIAL SUGAR URINE - POST PRANDIAL NOT DETECTED NOT DETECTED **THYROID PANEL, SERUM** 80 - 200 Т3 147.60 ng/dL Т4 8.21 5.1 - 14.1 µg/dl 1.900 TSH 3RD GENERATION 21-50 yrs : 0.4 - 4.2 µIU/mL





DDRC SRL Diagnostic Services	Patient Ref. No. 666000002450977		LABORATORY SERVICE
CLIENT COAND CAANAGETICA NET WORK CLIENT'S NAME AND ADDRESS : MEDIWHEEL ARCOFEMI HEALTHCARE LI F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 DELHI INDIA 8800465156	MITED Phoenix Prathibh KOLLAM KERALA Tel : 93	RL DIAGNOSTICS Tower, Near Central Park Hotel, la Junction, Kadappakada, l, 691008 , INDIA 334 93334 customercare.ddrc@srl.in	
PATIENT NAME : SABARI PRAK	ASAM	PATIENT ID :	SABAM1309924071
ACCESSION NO : 4071VK006059	AGE : 30 Years SEX : Male		
DRAWN :	RECEIVED : 26/11/2022 12:17	REPORTED : 26/11/2022	2 17:22
REFERRING DOCTOR : SELF		CLIENT PATIENT ID	:
Test Report Status <u>Final</u>	Results		Units
PHYSICAL EXAMINATION, URIN	IE		
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URI	NE		
PH	6.0	4.8 - 7.4	
SPECIFIC GRAVITY	1.020	1.015 - 1.030	
PROTEIN	NOT DETECTED	NOT DETECTED	
GLUCOSE	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION,	URINE		
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NIL		
CRYSTALS	NIL		
BACTERIA	NOT DETECTED	NOT DETECTED	
SERUM BLOOD UREA NITROGEN	i		
BLOOD UREA NITROGEN	10	Adult(<60 yrs) : 6 to 20	mg/dL
SUGAR URINE - FASTING			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	

Interpretation(s) 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 • Drohlems during regrapacy (such as conjunce (or languein)) or high blood prossure co

• 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

• Muscular dystrophy GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes. GLUCOSE, FASTING, PLASMA-ADA 2012 guidelines for adults as follows:



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PATIENT NAME : SABARI PRAKA	SAM	PATIENT ID : SABAM1309924071

Pre-diabetics: 100 - 125 mg/dL Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines) 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.) c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is 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 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.

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.

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

OTAL 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 alobulin

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. URIC ACID, SERUM-

Causes of Increased levels



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INDIA'S LEADING DIAGNOSTICS NET WORK					
CLIENT CODE :	CA00010147				
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PATIENT NAME : SABARI PRAKASAM				PA	TIENT ID :	SABAM1309924071
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Test Report Status	s <u>Final</u>	F	Results			Units

Dietary • High Protein Intake. Prolonged Fasting, Rapid weight loss Gout Lesch nyhan syndrome. Type 2 DM. Metabolic syndrome. Causes of decreased levels

Low Zinc Intake
OCP's

Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

Drink plenty of fluids

 Limit animal proteins High Fibre foods

Vit C Intake

Antioxidant rich foods

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.

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(>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. ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-

(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 SR.

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 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.

Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, 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 :

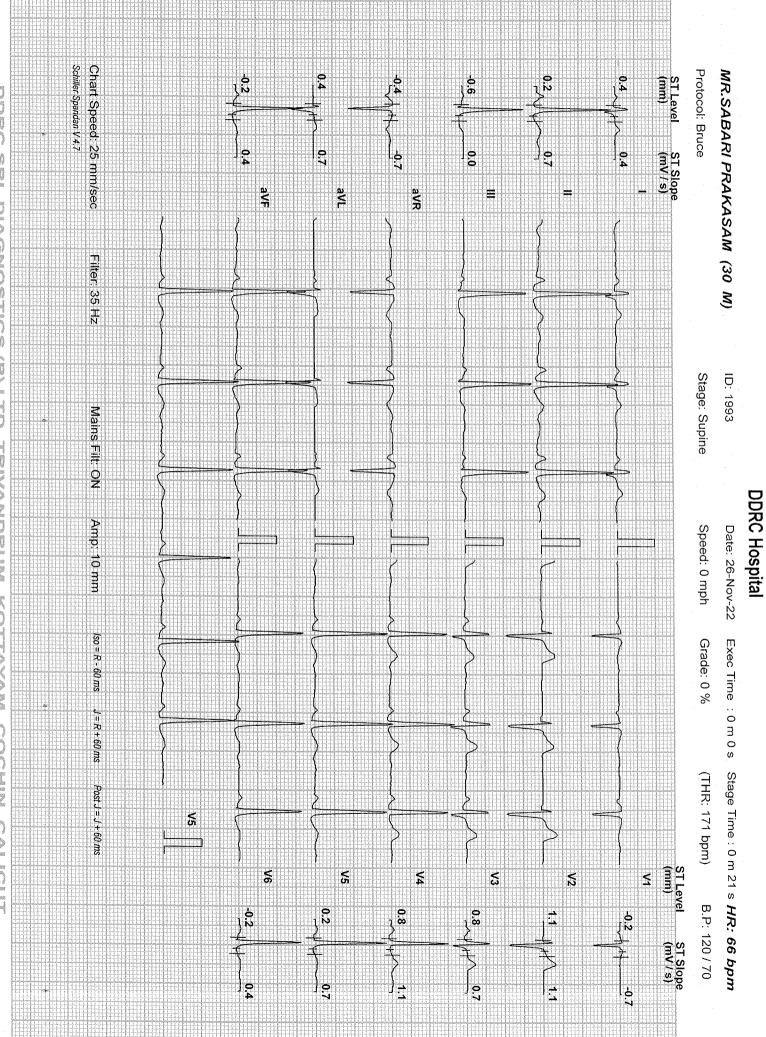
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition. SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST THYROID PANEL, SERUM-



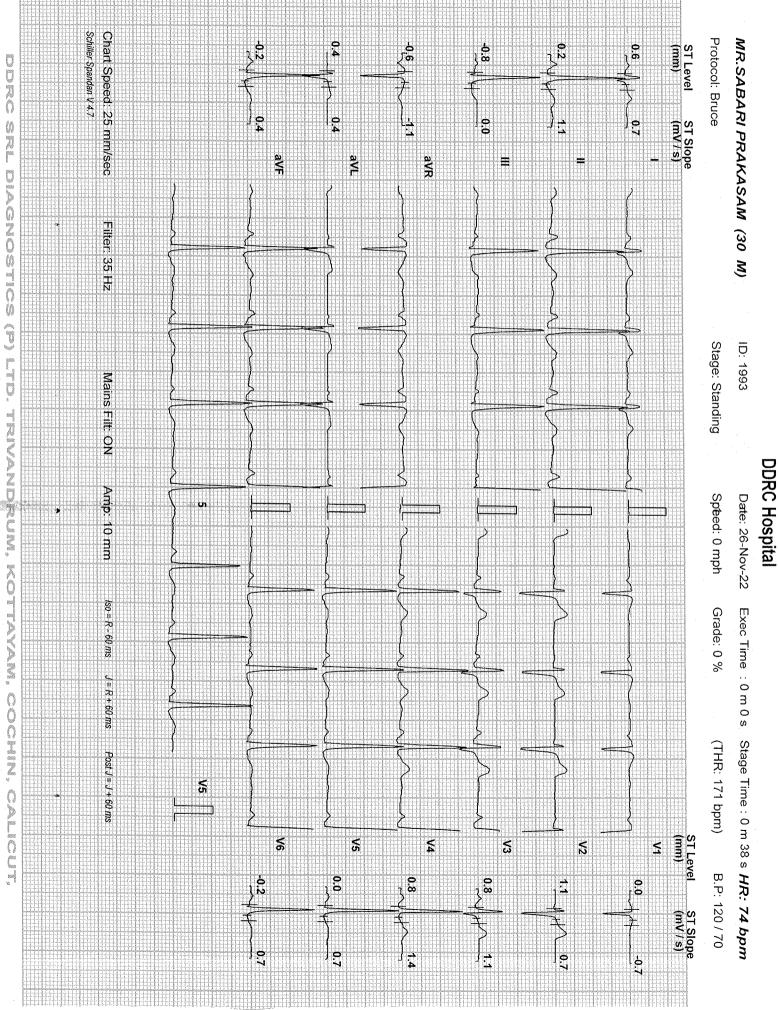


DDRC SRL			LABORATORY SERVICES
Diagnostic Services	Patient Ref. No. 666000002450977		
MUCH LEADING DURANGOTICA MET WORK CLIENT CODE : CA00010147 CLIENT'S NAME AND ADDRESS : MEDIWHEEL ARCOFEMI HEALTHCARE LIMI F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 DELHI INDIA 8800465156	ITED Phoen Prathii KOLLA KERAL Tel : S	SRL DIAGNOSTICS ix Tower, Near Central Park Hotel, bha Junction, Kadappakada, M, 691008 A, INDIA 93334 93334 : customercare.ddrc@srl.in	
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heart rate. Production of T3 and its prohormone to concentrations of T3, and T4 in the blood inhibit Thyroxine T4, Thyroxine's principal function is to hyperthyroidism, and deficient secretion is called circulating hormone is free and biologically active In primary hypothyroidism, TSH levels are signifi- Below mentioned are the guidelines for Pregnanc Levels in TOTAL T4 TSH30 Pregnancy (µg/dL) (µUU/ First Trimester 6.6 - 12.4 0.1 - 2 2nd Trimester 6.6 - 15.5 0.2 - 3 3rd Trimester 6.6 - 15.5 0.3 - 3 Below mentioned are the guidelines for age relate T3 T4 (ng/dL) (µg/dL) New Born: 75 - 260 1-3 day: 8.2 - 19 . 19 Week: 6.0 - 15.9 NOTE: TSH concentrations in apparently normal of documented in the pediatric population including Kindly note: Method specific reference ranges are Reference: 1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz te: 2. Gowenlock A.H. Varley's Practical Clinical Bioct 3. Behrman R.E. Kilegman R.M., Jenson H. B. Ne SERUM BLOOD UREA NITROGEN- Causes of Increased levels Pre renal • High protein diet, Increased protein catabolism • Renal Failure Post Renal • Malignancy, Nephrolithiasis, Prostatism Causes of decreased levels • Liver disease • SIADH. SUGAR URINE - FASTING-METHOD: DIPSTICK/B	stimulate the metabolism of all cells and tissues in hypothyroidism. Most of the thyroid hormone in blo cantly elevated, while in secondary and tertiary hyp y related reference ranges for Total T4, TSH & Tota G TOTAL T3 nL) (ng/dL) 2.5 81 - 190 3.0 100 - 260 3.0 100 - 260 ed reference ranges for T3 and T4. .9 euthyroid subjects are known to be highly skewed, the infant age group. e appearing on the report under biological reference ktbook of Clinical Chemistry and Molecular Diagnost nemistry, 6th Edition. Ison Text Book of Pediatrics, 17th Edition h, GI haemorrhage, Cortisol, Dehydration, CHF R ENEDICT'S TEST **End Of Report**	prmone (TSH), which is released from ti the body. Excessive secretion of thyrox bod is bound to transport proteins. Only nothyroidism, TSH levels are low. I T3 with a strong tailed distribution towards range. ics, 4th Edition.	he pituitary gland. Elevated ine in the body is a very small fraction of the
Please visit v	www.srlworld.com for related Test Info	rmation for this accession	
SREELEKSHMI S LAB TECHNICIAN	DR.AMJAD A CONSULTANT PATHOLOGIST	RAJI R RAJI R LAB TECHNICIAN	Vareeniya p LAB TECHNICIAN
			Page 8 Of 8 回れ来の第回

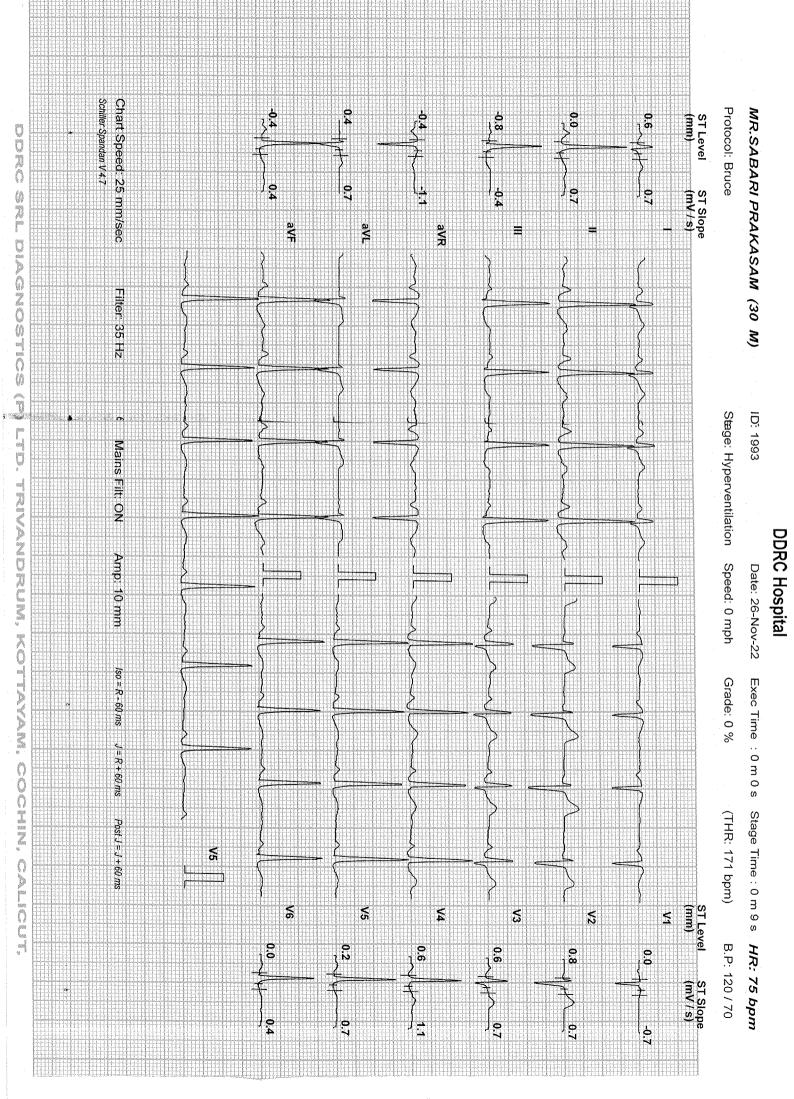


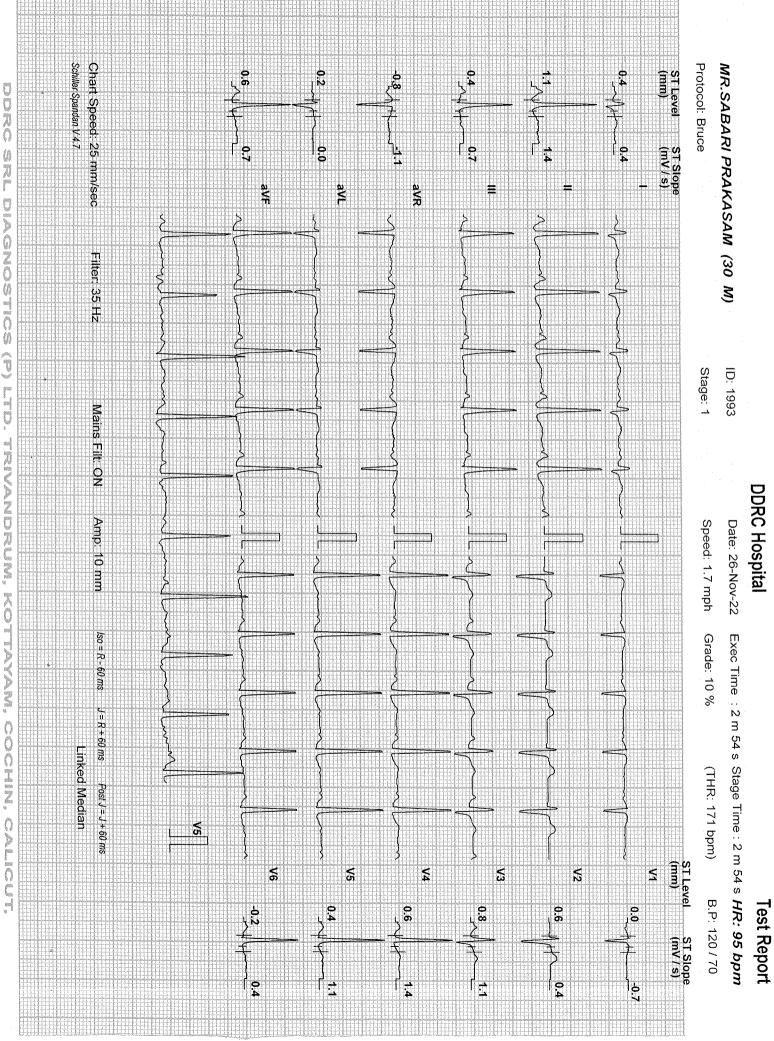


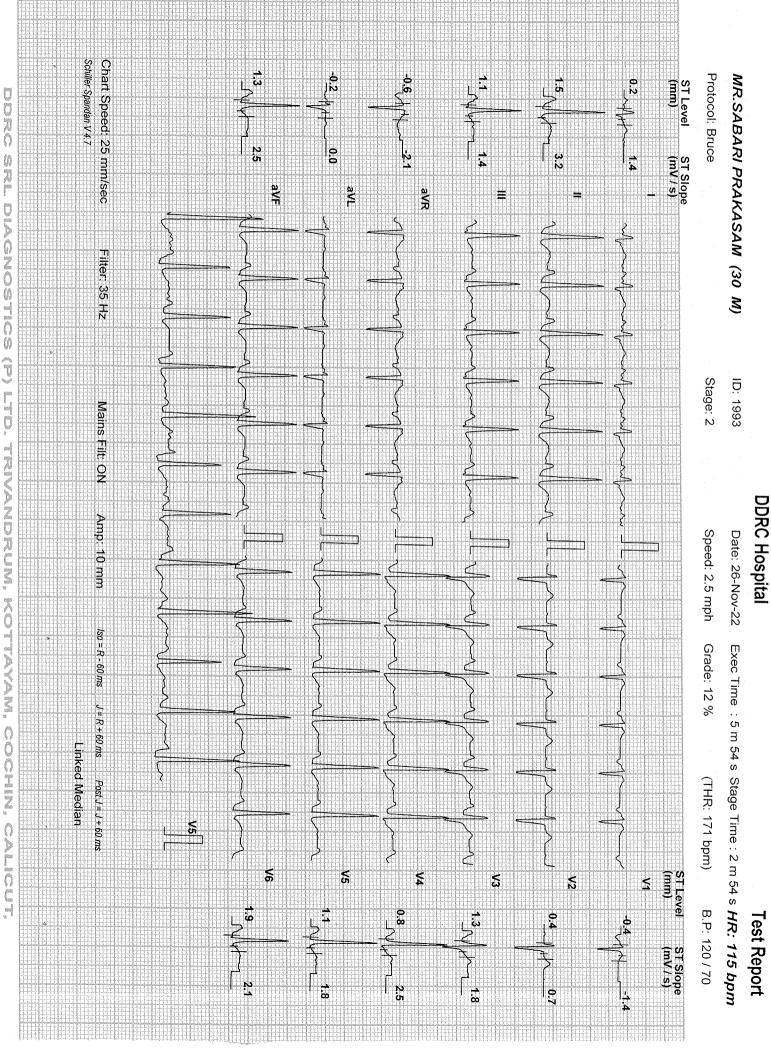
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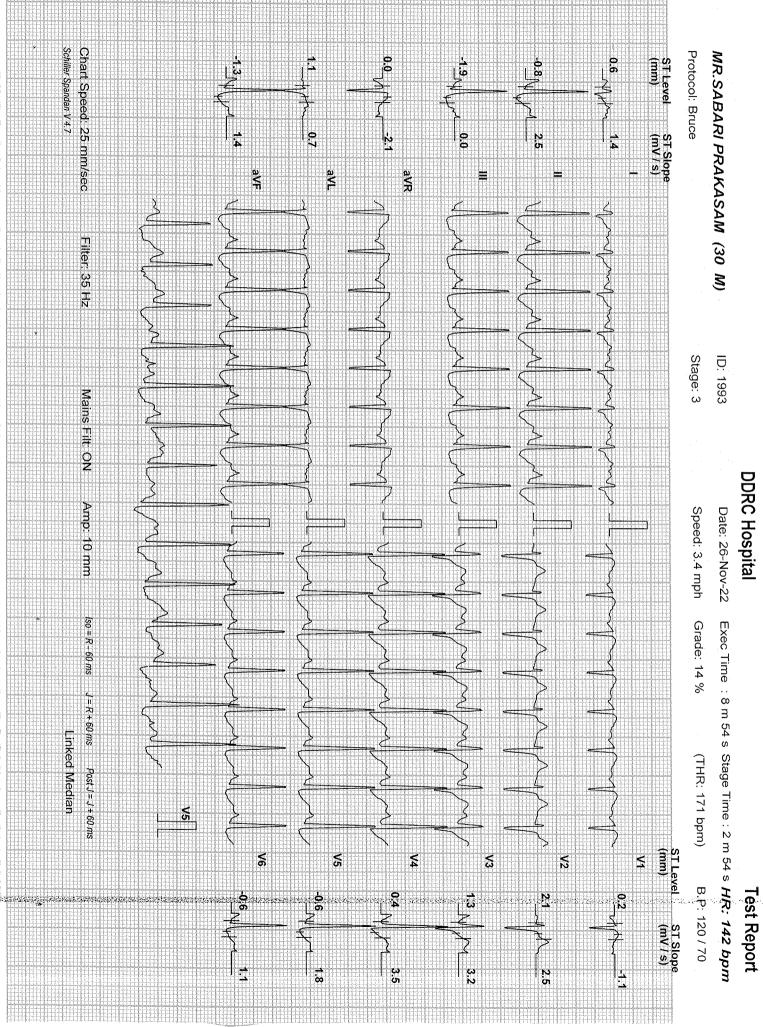
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