



NE

**MEDICAL EXAMINATION REPORT (MER)**

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. <b>NIRUPAMA VARCHESE</b>
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	<b>38 26/10/1983</b> Gender: <b>F/M</b>
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

**PHYSICAL DETAILS:**

a. Height <b>159</b> (cms)	b. Weight <b>78</b> (Kgs)	c. Girth of Abdomen <b>99</b> (cms)
d. Pulse Rate <b>70</b> (/Min)	e. Blood Pressure:	Systolic Diastolic
	1 <sup>st</sup> Reading	<b>120 80</b>
	2 <sup>nd</sup> Reading	

**FAMILY HISTORY:**

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father		/ NS -	
Mother			
Brother(s)			
Sister(s)			

**HABITS & ADDICTIONS:** Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
—	—	—

**PERSONAL HISTORY**

- a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. **DM, HT** **Y/N**
- b. Have you undergone/been advised any surgical procedure? **LSCS** **Y/N**
- c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? **Y/N**
- d. Have you lost or gained weight in past 12 months? **Y/N**

**Have you ever suffered from any of the following?**

- Psychological Disorders or any kind of disorders of the Nervous System? **Y/N**
- Any disorders of Respiratory system? **Y/N**
- Any Cardiac or Circulatory Disorders? **Y/N**
- Enlarged glands or any form of Cancer/Tumour? **Y/N**
- Any Musculoskeletal disorder? **Y/N**
- Any disorder of Gastrointestinal System? **Y/N**
- Unexplained recurrent or persistent fever, and/or weight loss **Y/N**
- Have you been tested for HIV/HBsAg / HCV before? If yes attach reports **Y/N**
- Are you presently taking medication of any kind? **Y/N**

*Insulin OHA  
Telm. Gluc*

• Any disorders of Urinary System?

Y/N

• Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin

Y/N

**FOR FEMALE CANDIDATES ONLY**

a. Is there any history of diseases of breast/genital organs?

Ovarian cyst

Y/N

d. Do you have any history of miscarriage/abortion or MTP

Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports)

Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc

Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries?

Y/N

f. Are you now pregnant? If yes, how many months?

Y/N

**CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER**

➤ Was the examinee co-operative?

Y/N

➤ Is there anything about the examinee's health, lifestyle that might affect him/her in the near future with regard to his/her job?

Y/N

➤ Are there any points on which you suggest further information be obtained?

Y/N

➤ Based on your clinical impression, please provide your suggestions and recommendations below;

Medical consult

➤ Do you think he/she is MEDICALLY FIT or UNFIT for employment.

FIT

**MEDICAL EXAMINER'S DECLARATION**

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

*[Signature]*

Seal of Medical Examiner :

Dr. GEORGE THOMAS  
MD, FCSI, FIAE  
MEDICAL EXAMINER  
Reg: 86614

Name & Seal of DDRC SRL Branch :

Date & Time :



19/09/2022

**DDRC SRL Diagnostics Private Limited**

Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036  
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai - 400062.

आपका आधार क्रमांक / Your Aadhaar No. :

**4712 3701 1692**

मेरा आधार, मेरी पहचान



भारत सरकार

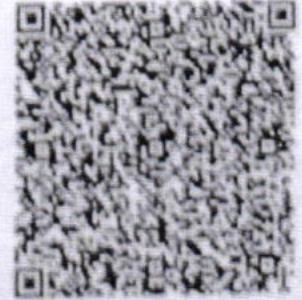
Government of India



Nirupama Varghese

DOB : 26/10/1983

Female



**4712 3701 1692**

मेरा आधार, मेरी पहचान

CS Scanned with CamScanner

Attachments:

CamScanner 02-20-2021 21.09.30\_4.jpg

235 KB

*Handwritten signature*  
17/9/22





**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

DDRC SRL DIAGNOSTICS  
DDRC SRL Tower, G-131, Panampilly Nagar,  
PANAMPALLY NAGAR, 682036  
KERALA, INDIA  
Tel : 93334 93334  
Email : customercare.ddrc@srl.in

**PATIENT NAME :** MRS. NIRUPAMA VARGHESE

**PATIENT ID :** NIRUF1709844126

**ACCESSION NO :** 4126VI005409 **AGE :** 38 Years **SEX :** Female

**DRAWN :** **RECEIVED :** 17/09/2022 08:37 **REPORTED :** 17/09/2022 17:01

**REFERRING DOCTOR :** DR. BANK OF BARODA

**CLIENT PATIENT ID :**

Test Report Status	Final	Results	Units
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**MEDIWHEEL HEALTH CHECKUP BELOW 40(F)TMT**

**SERUM BLOOD UREA NITROGEN**

BLOOD UREA NITROGEN 7 6 - 20 mg/dL  
METHOD : UREASE - UV

**BUN/CREAT RATIO**

BUN/CREAT RATIO 11.7

**CREATININE, SERUM**

CREATININE 0.63 0.60 - 1.1 mg/dL  
METHOD : JAFFE KINETIC METHOD

**GLUCOSE, POST-PRANDIAL, PLASMA**

GLUCOSE, POST-PRANDIAL, PLASMA **381** **High** Diabetes Mellitus : > or = 200 mg/dL  
mg/dL.  
Impaired Glucose tolerance/  
Prediabetes : 140 to 199 mg/dL.  
Hypoglycemia : < 55 mg/dL.  
METHOD : HEXOKINASE

**GLUCOSE, FASTING, PLASMA**

GLUCOSE, FASTING, PLASMA **245** **High** Diabetes Mellitus : > or = 126 mg/dL  
mg/dL.  
Impaired fasting Glucose/  
Prediabetes : 101 to 125 mg/dL.  
Hypoglycemia : < 55 mg/dL.  
METHOD : HEXOKINASE

**GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD**

GLYCOSYLATED HEMOGLOBIN (HBA1C) **10.5** **High** Normal : 4.0 - 5.6 %  
Non-diabetic level : < 5.7%.  
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 254.6 mg/dL

**CORONARY RISK PROFILE (LIPID PROFILE), SERUM**

CHOLESTEROL 200 Desirable cholesterol level < 200 mg/dL  
Borderline high cholesterol 200 - 239  
High cholesterol > / = 240



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TRIGLYCERIDES		95	mg/dL
		Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High: > 499	
HDL CHOLESTEROL		54	mg/dL
METHOD : DIRECT ENZYME CLEARANCE			
DIRECT LDL CHOLESTEROL		<b>116</b>	mg/dL
		<b>High</b> Adult Optimal : < 100 Near optimal : 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : > or = 190	
NON HDL CHOLESTEROL		<b>146</b>	mg/dL
		<b>High</b> Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	
CHOL/HDL RATIO		3.7	
		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		1.6	
		0.5 - 3.0 Desirable/ Low Risk 3.1-6.0 Borderline /Moderate Risk > 6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		19.0	mg/dL
		Desirable value : 10 - 35	
<b>LIVER FUNCTION TEST WITH GGT</b>			
BILIRUBIN, TOTAL		0.48	mg/dL
		< 1.1	
BILIRUBIN, DIRECT		0.21	mg/dL
		< 0.31	
METHOD : DIAZO METHOD			
BILIRUBIN, INDIRECT		0.27	mg/dL
		0.00 - 0.60	
TOTAL PROTEIN		6.8	g/dL
		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	
ALBUMIN		4.2	g/dL
		3.5 - 5.2	
GLOBULIN		2.6	g/dL
		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	
ALBUMIN/GLOBULIN RATIO		1.6	RATIO
		1.00 - 2.00	
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		<b>51</b>	U/L
		<b>High</b> < 33	
ALANINE AMINOTRANSFERASE (ALT/SGPT)		<b>104</b>	U/L
		<b>C.High</b> < 34	
METHOD : IFCC WITHOUT PDP			
ALKALINE PHOSPHATASE		85	U/L
		35 - 105	
METHOD : IFCC			



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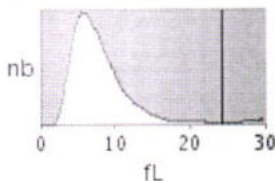
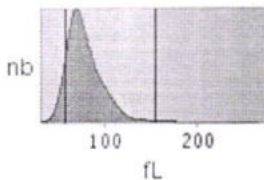
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GAMMA GLUTAMYL TRANSFERASE (GGT)	<b>78</b>	<b>High</b> < 40	U/L
<b>TOTAL PROTEIN, SERUM</b>			
TOTAL PROTEIN	6.8	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
METHOD : BIURET			
<b>URIC ACID, SERUM</b>			
URIC ACID	3.6	2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY			
<b>ABO GROUP &amp; RH TYPE, EDTA WHOLE BLOOD</b>			
ABO GROUP	B		
METHOD : GEL CARD METHOD			
RH TYPE	POSITIVE		
<b>BLOOD COUNTS</b>			
HEMOGLOBIN	12.7	12.0 - 15.0	g/dL
METHOD : NON CYANMETHHEMOGLOBIN			
RED BLOOD CELL COUNT	<b>4.89</b>	<b>High</b> 3.8 - 4.8	mil/ $\mu$ L
METHOD : IMPEDANCE			
WHITE BLOOD CELL COUNT	8.40	4.0 - 10.0	thou/ $\mu$ L
METHOD : IMPEDANCE			
PLATELET COUNT	265	150 - 410	thou/ $\mu$ L
METHOD : IMPEDANCE			



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**RBC AND PLATELET INDICES**

HEMATOCRIT	38.1	36 - 46	%
METHOD : CALCULATED			
MEAN CORPUSCULAR VOL	<b>78.0</b>	<b>Low</b> 83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN CORPUSCULAR HGB.	<b>25.9</b>	<b>Low</b> 27.0 - 32.0	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.2	31.5 - 34.5	g/dL
METHOD : CALCULATED			
RED CELL DISTRIBUTION WIDTH	<b>16.8</b>	<b>High</b> 11.6 - 14.0	%
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN PLATELET VOLUME	7.9	6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			

**WBC DIFFERENTIAL COUNT - NLR**

SEGMENTED NEUTROPHILS	54	40 - 80	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	4.54	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED			
LYMPHOCYTES	37	20 - 40	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE LYMPHOCYTE COUNT	<b>3.11</b>	<b>High</b> 1 - 3	thou/ $\mu$ L
METHOD : CALCULATED			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.5		
EOSINOPHILS	2	1 - 6	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE EOSINOPHIL COUNT	0.17	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED			
MONOCYTES	7	2 - 10	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE MONOCYTE COUNT	0.59	0.20 - 1.00	thou/ $\mu$ L
METHOD : CALCULATED			
BASOPHILS	0	0 - 1	%
METHOD : IMPEDANCE			
ABSOLUTE BASOPHIL COUNT	<b>0</b>	<b>Low</b> 0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED			



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CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)



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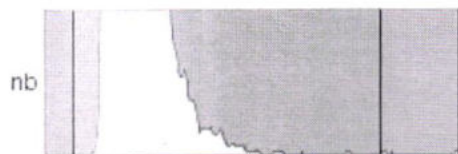
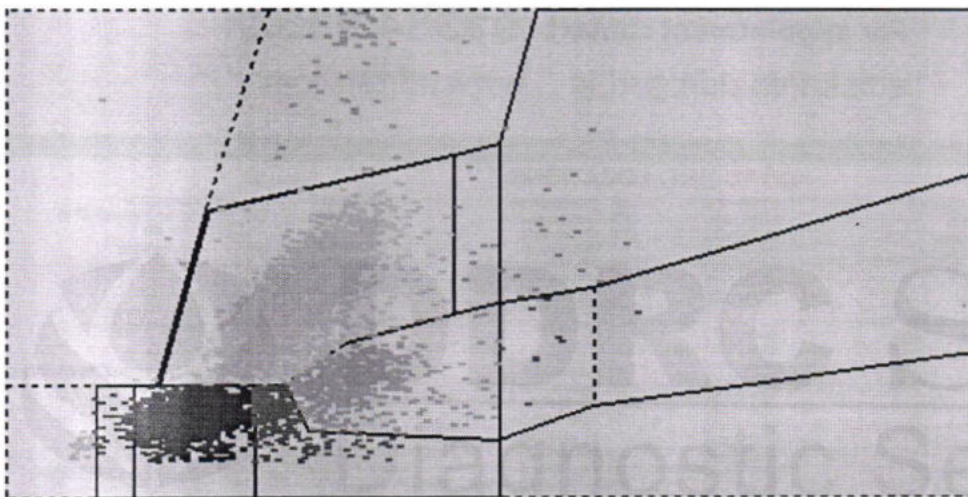
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**ERYTHRO SEDIMENTATION RATE, BLOOD**
**SEDIMENTATION RATE (ESR)**

17

0 - 20

mm at 1 hr

METHOD : WESTERNGREN METHOD

**STOOL: OVA & PARASITE**
**COLOUR**

BROWN

**CONSISTENCY**

WELL FORMED

**ODOUR**

FAECAL

**MUCUS**

NOT DETECTED

NOT DETECTED

**VISIBLE BLOOD**

ABSENT

ABSENT

**POLYMORPHONUCLEAR LEUKOCYTES**

1-2

0 - 5

/HPF

**RED BLOOD CELLS**

NOT DETECTED

NOT DETECTED

/HPF

**CYSTS**

NOT DETECTED

NOT DETECTED

**OVA**

NOT DETECTED







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**\* SUGAR URINE - POST PRANDIAL**SUGAR URINE - POST PRANDIAL **DETECTED (++++)** NOT DETECTED**URINALYSIS**

COLOR	<b>AMBER</b>		
APPEARANCE	CLEAR		
PH	5.0	4.8 - 7.4	
SPECIFIC GRAVITY	1.025	1.015 - 1.030	
GLUCOSE	<b>DETECTED (++++)</b>	NOT DETECTED	
PROTEIN	<b>DETECTED (TRACE)</b>	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	
WBC	<b>10-15</b>	0-5	/HPF
EPITHELIAL CELLS	<b>20-30</b>	0-5	/HPF
RED BLOOD CELLS	<b>2 - 3</b>	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	AMORPHOUS URATES PRESENT		
BACTERIA	NOT DETECTED	NOT DETECTED	

**THYROID PANEL, SERUM**

T3	111.00	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4	10.29	5.1 - 14.1	µg/dl
METHOD : ELECTROCHEMILUMINESCENCE			
TSH 3RD GENERATION	0.771	Non-Pregnant : 0.4-4.2	µIU/mL

Pregnant Trimester-wise :  
 1st : 0.1-2.5  
 2nd : 0.2-3  
 3rd : 0.3-3

METHOD : ELECTROCHEMILUMINESCENCE

Interpretation(s)  
 SERUM BLOOD UREA NITROGEN-  
 Causes of Increased levels  
 Pre renal



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- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
- Renal Failure
- Post Renal
- Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- 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

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:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: &gt; or = 126 mg/dL

(Ref: Tietz 4th Edition &amp; ADA 2012 Guidelines)

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycosylated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycosylated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycosylated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

## References

1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R. Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
  2. Forsham PH. Diabetes Mellitus: A rational plan for management. Postgrad Med 1982, 71, 139-154.
  3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
- CORONARY RISK PROFILE (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.



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CIN : U85190MH2006PTC161480

(Refer to "CONDITIONS OF REPORTING" overleaf)



Cert. No. MC-2354

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

 DDRC SRL DIAGNOSTICS  
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 PANAMPALLY NAGAR, 682036  
 KERALA, INDIA  
 Tel : 93334 93334  
 Email : customercare.ddrc@srl.in

**PATIENT NAME : MRS. NIRUPAMA VARGHESE**
**PATIENT ID : NIRUF1709844126**
**ACCESSION NO : 4126VI005409** AGE : 38 Years SEX : Female

DRAWN : RECEIVED : 17/09/2022 08:37 REPORTED : 17/09/2022 17:01

**REFERRING DOCTOR : DR. BANK OF BARODA**

CLIENT PATIENT ID :

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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 triglycerides and may be best used in patients for whom fasting is difficult.

**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.

**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'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-**

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-**

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.

**WBC DIFFERENTIAL COUNT - NLR-**

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.

**ERYTHRO SEDIMENTATION RATE, BLOOD-**

Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure





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and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

Reference :

- Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
  - Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin
  - 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  
URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders  
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever  
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.  
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.  
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.  
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.  
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.  
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.  
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.  
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.  
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
- THYROID PANEL, SERUM-
- Triiodothyronine T3, is a thyroid hormone. It affects 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.
- Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called 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.
- In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
- Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3
- | Levels in     | TOTAL T4<br>(µg/dL) | TSH3G<br>(µIU/mL) | TOTAL T3<br>(ng/dL) |
|---------------|---------------------|-------------------|---------------------|
| Pregnancy     | 6.6 - 12.4          | 0.1 - 2.5         | 81 - 190            |
| 1st Trimester | 6.6 - 15.5          | 0.2 - 3.0         | 100 - 260           |
| 2nd Trimester | 6.6 - 15.5          | 0.3 - 3.0         | 100 - 260           |
| 3rd Trimester |                     |                   |                     |
- Below mentioned are the guidelines for age related reference ranges for T3 and T4.
- |           | T3<br>(ng/dL) | T4<br>(µg/dL)       |
|-----------|---------------|---------------------|
| New Born: | 75 - 260      | 1-3 day: 8.2 - 19.9 |
|           |               | 1 Week: 6.0 - 15.9  |

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.  
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:

- Burtis C.A., Ashwood E. R. Bruns D.E. Teltz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
- Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
- Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

**\*\*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.



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DR. HARI SHANKAR, MBBS MD  
HEAD - Biochemistry &  
Immunology

DR. VIJAY K N, MD (PATH)  
HEAD-HAEMATOLOGY &  
CLINICAL PATHOLOGY

DR. SMITHA PAULSON, MD  
(PATH), DPB  
LAB DIRECTOR & HEAD-  
HISTOPATHOLOGY &  
CYTOLOGY



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Date...17.09.2022

**OPHTHALMOLOGY REPORT**

This is to certify that I have examined

Mr / Ms : Nityama. Vaghese.....Aged...38.....and his / her

visual standards is as follows :

**Visual Acuity:**

For far vision

R: .....6/12P.....  
L: .....6/9.....  
*EPUR 6/6P  
L 6/6P*

For near vision

R: .....N8.....  
L: .....N8.....  
*EPUR N6  
L N6*

Color Vision : .....Normal.....



Nannu Elizabeth  
**Nannu Elizabeth**  
**(Optometrist)**

NAME: MRS NIRUPAMA VARGHESE	STUDY DATE:17/09/2022
AGE / SEX :38 YRS / M	REPORTING DATE :17/09/2022
REFERRED BY :BOB MEDIWHEEL ARCOFEMI	ACC NO : 4126VI005409

### X - RAY - CHEST PA VIEW

- Both the lung fields are clear.
- B/L hila and mediastinal shadows are normal.
- Cardiac silhouette appears normal.
- Cardio – thoracic ratio is normal.
- Bilateral CP angles and domes of diaphragm appear normal.

**IMPRESSION: NORMAL STUDY**



**Dr. Sandeep S MD  
Consultant Radiologist.**



ID: 5409

17-09-2022 11:37:37 AM 12

NIRUPAMA VARGHESE

Female 38Years

HR : 76 bpm

P : 82 ms

PR : 133 ms

QRS : 97 ms

QT/QTc : 390/439 ms

P/QRS/T : 56/-30/27 °

RV5/SV1 : 0.630/0.630 mV

Diagnosis Information:

*Left axis deviation*

*DR GEORGE THOMAS*  
MD, FCSI, FIAE  
CARDIOLOGIST

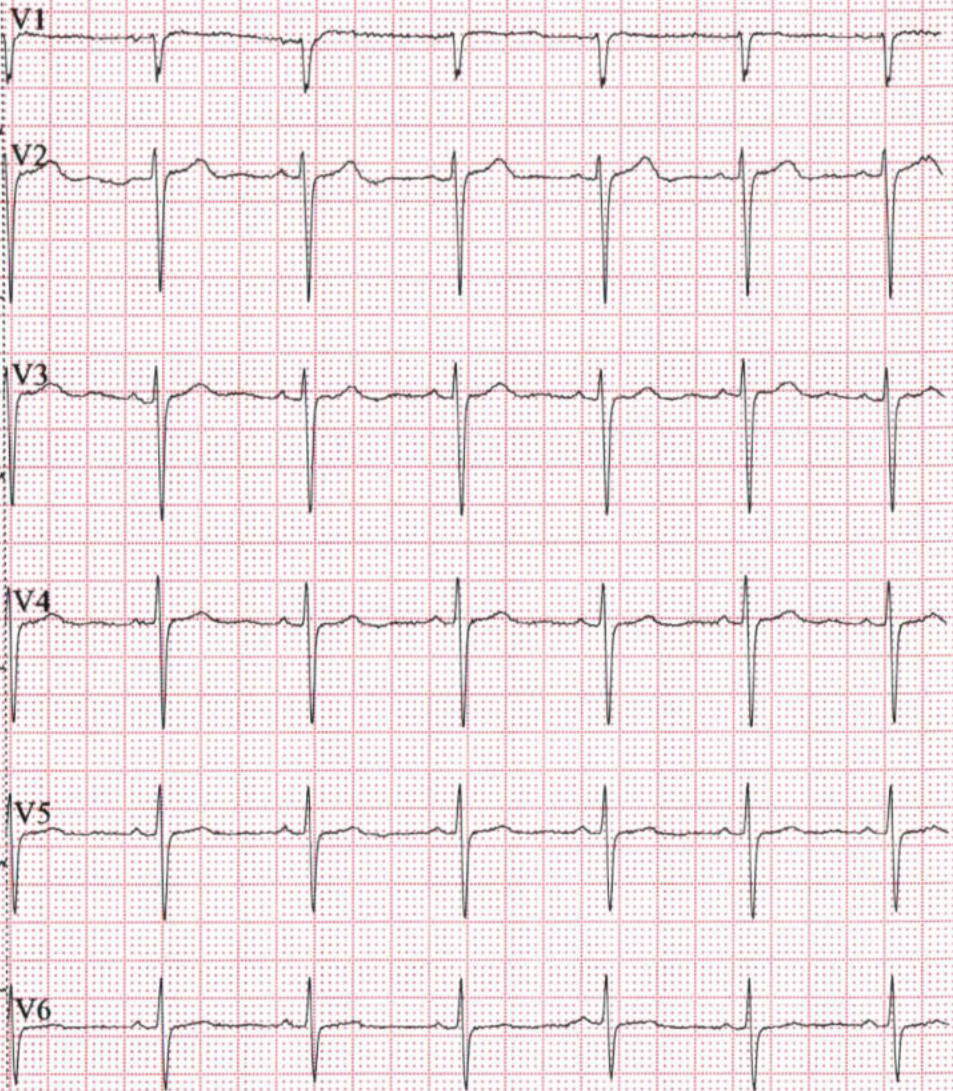
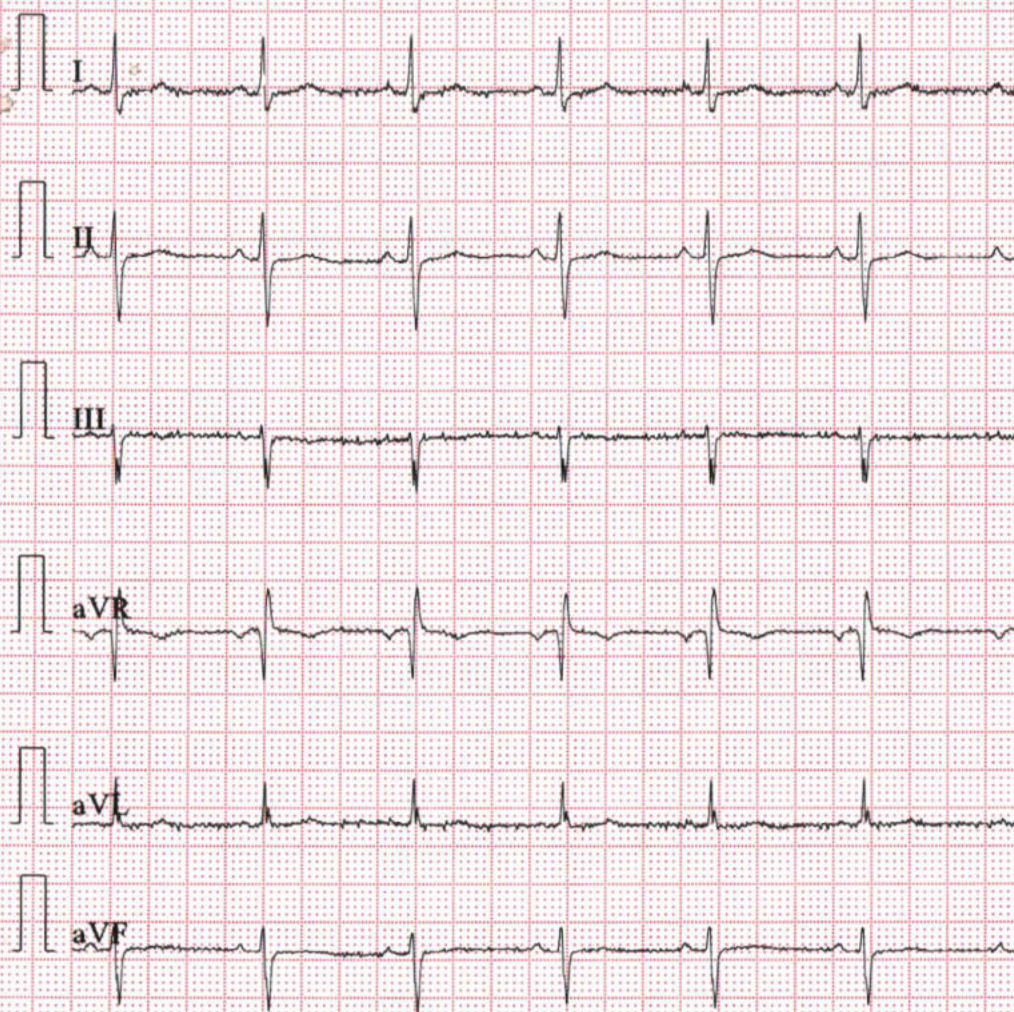
Technician : ARDRA

Ref-Phys. : BOB

Report Confirmed by:



*Bob*





NAME	MRS NIRUPAMA VARGHESE	AGE	38 YRS
SEX	FEMALE	DATE	September 17, 2022
REFERRAL	MEDIWHEEL ARCOFEMI	ACC NO	4126VI005409

**USG ABDOMEN AND PELVIS**

<b>LIVER</b>	<b>Measures ~ 18 cm. Enlarged size and increased echoes.</b> Smooth margins and no obvious focal lesion within. No IHBR dilatation. Portal vein normal in caliber.
<b>GB</b>	Partially distended.
<b>SPLEEN</b>	Normal to visualized extent. Splenic vein normal.
<b>PANCREAS</b>	Normal to visualized extent. PD is not dilated.
<b>KIDNEYS</b>	RK: 11.8 x 3.6 cm, appears normal in size and echotexture. LK: 10.3 x 5.6 cm, appears normal in size and echotexture. No focal lesion / calculus within. Maintained corticomedullary differentiation and normal parenchymal thickness. No hydroureteronephrosis.
<b>BLADDER</b>	Normal wall caliber, no internal echoes/calculus within.
<b>UTERUS</b>	Retroverted, normal in size [6.7 x 4.7 x 5.7 cm] and echopattern. No obvious focal lesion within. ET - 13 mm. Multiple nabothian cyst noted in cervix
<b>OVARIES</b>	RT OV: 2.7 x 2.5 cm. LT OV: 3.1 x 2.4 cm . no dominant follicle.
<b>NODES/FLUID</b>	Nil to visualized extent.
<b>BOWEL</b>	Visualized bowel loops appear normal.
<b>IMPRESSION</b>	<b>⚡ Hepatomegaly with grade I fatty change</b> Kindly correlate clinically.



**Dr. Sandeep S MBBS . MD**  
**Consultant Radiologist**

*Thank you for referral. Your feedback will be appreciated.*

NOTE: This report is only a professional opinion based on the real time image finding and not a diagnosis by itself. It has to be correlated and interpreted with clinical and other investigation findings.  
Review scan is advised, If this ultrasound opinion and other clinical findings / reports don't correlate.



