

**PATIENT NAME : KHAJURIA NITISH**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000138383**

**ACCESSION NO : 0080WB009140**

**AGE/SEX : 33 Years Male**

PROVISIONAL REPORT

**PATIENT ID : KHAJM25029080**

**DRAWN :**

**CLIENT PATIENT ID:**

**RECEIVED : 25/02/2023 08:30:59**

**ABHA NO :**

**REPORTED : 25/02/2023 18:38:16**

**Test Report Status Final**

**Results**

**Biological Reference Interval Units**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**THYROID PANEL, SERUM**

T3 METHOD : COMPETITIVE (ECLIA)	126.5	80.00 - 200.00	ng/dL
T4 METHOD : COMPETITIVE (ECLIA)	9.04	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : SANDWICH (ECLIA)	<b>4.710 High</b>	0.270 - 4.200	µIU/mL

**Interpretation(s)**



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24 SCO, SECTOR 11 D  
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PUNJAB, INDIA  
Tel : 9111591115,  
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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	14.0	13.0 - 17.0	g/dL
METHOD : CYANMETHEMOGLOBIN METHOD			
RED BLOOD CELL (RBC) COUNT	<b>5.55 High</b>	4.5 - 5.5	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT	5.60	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	262	150 - 410	thou/ $\mu$ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	44.0	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV)	<b>79.3 Low</b>	83.0 - 101.0	fL
METHOD : DERIVED PARAMETER FROM RBC HISTOGRAM			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>25.3 Low</b>	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	31.9	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.9	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	14.3		
MEAN PLATELET VOLUME (MPV)	8.5	6.8 - 10.9	fL
METHOD : DERIVED PARAMETER FROM PLATELET HISTOGRAM			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	50	40 - 80	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
LYMPHOCYTES	39	20 - 40	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
MONOCYTES	8	2.0 - 10.0	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
EOSINOPHILS	3	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
METHOD : LIGHT ABSORBANCE OF CYTCHEMICAL STAINED CELLS IMPEDENCE			
ABSOLUTE NEUTROPHIL COUNT	2.8	2.0 - 7.0	thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT	2.18	1.0 - 3.0	thou/ $\mu$ L



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ABSOLUTE MONOCYTE COUNT		0.45	0.2 - 1.0	thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT		0.17	0.02 - 0.50	thou/ $\mu$ L
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.3		
METHOD : CALCULATED PARAMETER				

**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(>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.



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**HAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R 05 0 - 14 mm at 1 hr

METHOD : MODIFIED WESTERGREN

**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) 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.



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**IMMUNOHAEMATOLOGY**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

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

**ABO GROUP**

**TYPE B**

METHOD : SLIDE AGGLUTINATION

**RH TYPE**

**POSITIVE**

METHOD : SLIDE 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.



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**BIOCHEMISTRY**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**GLUCOSE FASTING, FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR) 97 74 - 106 mg/dL

METHOD : HEXOKINASE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C 5.5 Non-diabetic Adult < 5.7 %

Pre-diabetes 5.7 - 6.4

Diabetes diagnosis: > or = 6.5

Therapeutic goals: < 7.0

Action suggested : > 8.0

(ADA Guideline 2021)

ESTIMATED AVERAGE GLUCOSE(EAG) 111.2 < 116.0 mg/dL

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR) 99 Non-Diabetes mg/dL

70 - 140

METHOD : HEXOKINASE

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL 152 < 200 Desirable mg/dL

200 - 239 Borderline High

>/= 240 High

METHOD : CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES 78 < 150 Normal mg/dL

150 - 199 Borderline High

200 - 499 High

>/= 500 Very High

METHOD : ENZYMATIC ASSAY

HDL CHOLESTEROL 51 < 40 Low mg/dL

>/=60 High

METHOD : DIRECT MEASURE - PEG



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CHOLESTEROL LDL	85	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
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METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

NON HDL CHOLESTEROL	101	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
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METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN	15.6	Desirable value : 10 - 35	mg/dL
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METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO	<b>3.0 Low</b>	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk
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METHOD : CALCULATED PARAMETER

LDL/HDL RATIO	1.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk Risk >6.0 High Risk
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METHOD : CALCULATED PARAMETER

**Interpretation(s)**

**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.22	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.08	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	0.14	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.0	6.6 - 8.7	g/dL

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**Patient Ref. No. 8000001385505**

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METHOD : BIURET

ALBUMIN	4.5	3.97 - 4.94	g/dL
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METHOD : BROMOCRESOL GREEN

GLOBULIN	2.5	2.0 - 4.0	g/dL
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Neonates -  
Pre Mature:  
0.29 - 1.04

METHOD : CALCULATED PARAMETER

ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
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METHOD : CALCULATED PARAMETER

ASPARTATE AMINOTRANSFERASE (AST/SGOT)	15	0 - 40	U/L
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ALANINE AMINOTRANSFERASE (ALT/SGPT)	25	0 - 41	U/L
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METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE

ALKALINE PHOSPHATASE	58	40 - 129	U/L
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METHOD : PNPP - AMP BUFFER

GAMMA GLUTAMYL TRANSFERASE (GGT)	19	8 - 61	U/L
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METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE

LACTATE DEHYDROGENASE	107 Low	135 - 225	U/L
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METHOD : LACTATE -PYRUVATE

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	9	6 - 20	mg/dL
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METHOD : UREASE - UV

**CREATININE, SERUM**

CREATININE	0.88	0.70 - 1.20	mg/dL
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METHOD : ALKALINE PICRATE-KINETIC

**BUN/CREAT RATIO**

BUN/CREAT RATIO	10.23	5.00 - 15.00	
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METHOD : CALCULATED PARAMETER

**URIC ACID, SERUM**

URIC ACID	6.1	3.4 - 7.0	mg/dL
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METHOD : URICASE, COLORIMETRIC

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	7.0	6.6 - 8.7	g/dL
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METHOD : BIURET

**ALBUMIN, SERUM**

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ALBUMIN	4.5	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			

**GLOBULIN**

GLOBULIN	2.5	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM	140	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.05	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	105	98 - 107	mmol/L
METHOD : ISE INDIRECT			

**Interpretation(s)**

**Interpretation(s)**

**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; sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:** 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 :**

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic



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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 addition 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 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

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.



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SRL Ltd  
24 SCO, SECTOR 11 D  
CHANDIGARH, 160011  
PUNJAB, INDIA  
Tel : 9111591115,  
CIN - U74899PB1995PLC045956

PATIENT NAME : KHAJURIA NITISH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138383

ACCESSION NO : 0080WB009140

AGE/SEX : 33 Years Male

PROVISIONAL REPORT

PATIENT ID : KHAJM25029080

DRAWN :

CLIENT PATIENT ID:

RECEIVED : 25/02/2023 08:30:59

ABHA NO :

REPORTED : 25/02/2023 18:38:16

Test Report Status	Final	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5

METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY 1.030 1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY (PKA CHANGE OF PRETREATED POLY ELECTROLYTES)

PROTEIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY (PROTEIN-ERROR-OF-INDICATORS PRINCIPLE)

GLUCOSE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY(GLUCOSE OXIDAE/PEROXIDASE METHOD)

KETONES NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY (SODIUM NITROPRUSSIDE REACTION)

BLOOD NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY (PEROXIDASE METHOD)

BILIRUBIN NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)

UROBILINOGEN NORMAL NORMAL

METHOD : REFLECTANCE SPECTROPHOTOMETRY - EHRlich REACTION

NITRITE NOT DETECTED NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED

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

EPITHELIAL CELLS 0-1 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS NOT DETECTED

CRYSTALS NOT DETECTED



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**Test Report Status** Final

**Results**

**Biological Reference Interval** **Units**

METHOD : MICROSCOPIC EXAMINATION

**BACTERIA**

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

**YEAST**

NOT DETECTED

NOT DETECTED

**Interpretation(s)**



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**CLINICAL PATH - STOOL ANALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**PHYSICAL EXAMINATION,STOOL**

COLOUR	BROWN		
CONSISTENCY	SEMI FORMED		
MUCUS	ABSENT	NOT DETECTED	
VISIBLE BLOOD	ABSENT	ABSENT	
ADULT PARASITE	NOT DETECTED		

METHOD : MICROSCOPIC EXAMINATION

**CHEMICAL EXAMINATION,STOOL**

STOOL PH 6.5

**MICROSCOPIC EXAMINATION,STOOL**

PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	

**Interpretation(s)**

**\*\*End Of Report\*\***

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**Patient Ref. No. 8000001385505**