



भारत सरकार

Government of India



Issue Date: 17/07/2018



मृणालिनी

Mrinalini

जन्म तिथि/DOB: 17/10/1988

महिला/ FEMALE

9490 5069 3604

VID : 9154 6046 3637 5541

मेरा आधार, मेरी पहचान

Download Date: 10/06/2020

## MEDICAL EXAMINATION FORM

Confidential without Prejudice Report. To Be Filled In Strictly By the Physician/Diagnostic Center

### PART I: GENERAL DETAILS

NAME OF THE PATIENT Meinalini  
 D.O.B. \_\_\_\_\_ Age: 36 Sex: F Phone number 7874134747

### PART II: MEDICAL EXAMINATION REPORT (Strictly to be filled by Medical Examiner)

(Kindly tick wherever applicable)

#### A. PERSONAL HISTORY:

##### 1. Previous history if any:

Disease	Yes/ No	Medicine & Surgery Details	Disease	Yes/ No	Medicine & Surgery Details
Diabetes Mellitus	} No		Cancer	} No	
Hypertension			Tumor/Benign		
IHD			Genital urinary disorder		
Stroke			Rheumatic joint diseases or symptoms		
Surgeries			Asthma		
Tuberculosis			Pulmonary Disease		
Congenital Disease			Anemia		
Arrhythmia			Bleeding disease or Disorder		
Aids (HIV)			Mental Stress		

##### 2. Habits:

Diet	<u>Mixed</u>	Alcohol	<u>No</u>	Tobacco/Smoking	<u>No</u>	Medicine	<u>No</u>
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3. Major complaints/Relevant past history if any: N/A

4. Previous Illness (Hospitalization Investigation, consultation): N/A

5. Family history: N/A

**B. MEDICAL EXAMINERS FINDING AND ASSESSMENT 1:** (Please answer each question and where appropriate provide particulars. You are asked not to give any information to the person, insured, about the results)

**1. Anthropometry:**

Height	155 cm	Weight	76 kg	BMI	
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**2. Vital Parameters:**

(i)

Respiratory Rate	22 min	Pulse Rate	95 bpm
------------------	--------	------------	--------

(ii) Blood Pressure (Three consecutive Reading):

Systolic	120		
Diastolic	80		
Further readings at 10 minute interval if the first reading exceeds 140/90	mmhg		

**3. Skin**

Is there any evidence of:

Chronic Ulcers:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Eczema	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Swelling	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Varicose Veins	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
Skin Discoloration	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO	Psoriasis	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

Any Other skin problem and specific location describe \_\_\_\_\_

**EXAMINATION FINDINGS DETAILS**

**4. Cardiovascular System:**

TMT - Positive .

**5. Genito-Urinary System:**

**6. Respiratory System:**

SIS2



7. Gastro-Entrology System:

(a) Oropharyngeal:

(b) Abdomen:



Evidence of Hernia, Hydrocele, Fissure, Fistula & piles,

If yes, please describe

8. Nervous System:

Conscious, Well - Oriented

9. Eye Check-up

Report Attached .

10. ENT

(N)

12. For Female Clients Only:

- 1. Is there any disease of breast?       No
- 2. (i) Is there any evidence of pregnancy?       No
- (ii) If Pregnant, are any complications to be expected?       No
- 3. Do you suspect any disease of uterus, cervix or ovaries?       No
- 4. Any menstrual complaints?       No

C. SUMMARY of the examination findings:

Positive Findings if any: (Please Specify)

Treadmill Test - Positive.

Advice:

Consult a Cardiologist.

Conclusion on the fitness of the client:

Clinically fit.

D. DOCTOR'S DECLARATION:

I confirm that I have examined this CLIENT and the findings stated above are true and correct to the best of my knowledge.

1. Name of the Medical Examiner: Dr. Anand gaur

Signature of the Medical Examiner: 

Stamp of the Medical Examiner

DR. ANAND PRAKASH  
MBBS, GCMH, CCBB  
(Consulting Physician)  
MMC Reg. No.  
200510210966

Registration Number

Date of medicals conducted: 24/2/24

Place: ghansoli

2. Name of the Client:

Signature of the Client: 

NOTE: NAME AND SIGNATURE OF MEDICAL EXAMINER AND THE CLIENT IS MANDATORY ON THIS FORM





### Ophthalmology Case Paper

Reg. No. : \_\_\_\_\_ Date: 24/2/24

Patient Name Mr./Mrs: Meinali

Age 36 Sex F Address: \_\_\_\_\_

Mobile No: 7874134747

Systemic Illness:	<u>NAD</u>
Allergies:	<u>no allergies</u>

	Right Eye	Left Eye
Color Vision	<u>N</u>	<u>N</u>
Distance	<u><math>\frac{6}{6}</math> N</u>	<u><math>\frac{6}{6}</math> N</u>
Near	<u>6N</u>	<u>6N</u>

Doctor's Sign and Stamp  
Dr. Ashish Gaur  
MBBS, GMC, CCEBDM  
(Consulting Physician)  
M.M. Reg. No.  
2005/02/0965

RADIOLOGY | PATHOLOGY | LABORATORY | HEALTH LEDGER





# JUMBO DIAGNOSTIC CENTER

## THE DIAGNOSTIC SPECIALISTS

Patient Name : MARINALINI

Patient ID:4780

Age /Gender : 33 yrs/MALE

Date : 24/02/2024

### X-RAY CHEST PA

Plain P.A. Radiograph of chest shows :-  
The hilar shadows are normal in size, position and density.  
Both Cardiophrenic and Costophrenic angles are clear.  
The Cardiac silhouette is within normal limits.  
Aortic shadow is normal.  
Rest of the visualized mediastinum shadows are normal.  
Both domes of diaphragms are normal.  
The visualised bony thorax is normal.

**CONCLUSION :**

**NO SIGNIFICANT ABNORMALITY DETECTED**

DR. Nikunj Kothia  
MBBS, DMRD Reg-2009093218

CT SCAN | USG | 2D ECHO | X-RAY | PATHOLOGY | ECG | DOPPLER |

36 cloud, Plot No.6, Sector -11, New Palm Beach Road, Chansoli, Navi Mumbai, Maharashtra-400701

JumboLabhub@gmail.com  
+917718032706



Scanned with OKEN Scanner





PATIENT'S NAME	MRS. MRINALINI	AGE :- 36 y/F
REFERRED BY	CREDENCE CARE HOSPITAL	DATE : 24/02/2024

**USG WHOLE ABDOMEN & PELVIS**

LIVER is normal in size, normal in shape and echotexture. No evidence of any focal lesion seen. The portal vein appears normal & shows normal hepato-petal flow.No evidence of intra-hepatic biliary duct dilatation.

GALL BLADDER appears well distended with normal wall thickness. There is no calculus or pericholecystic collection. CBD appears normal.

Visualised parts of head & body of PANCREAS appear normal. PD is not dilated.

SPLEEN is normal in size and echotexture. No focal lesion seen. Splenic vein is normal.

Both kidneys are normal in size, shape and echotexture with normal parenchymal reflectivity and maintained cortico-medullary differentiation. No hydronephrosis calculi or mass seen.

URINARY BLADDER is empty.

UTERUS is normal in size, shape and echotexture.

Both ovaries and adnexa are normal.

Visualised bowel loops appear normal. There is no free fluid seen in abdomen and pelvis.

**IMPRESSION :**

- **No Significant abnormality is detected.**

THIS REPORT IS NOT TO BE USED FOR MEDICOLEGAL PURPOSE.THE CONTENTS OF THIS REPORT REQUIRE CLINICAL CO-RELATION BEFORE ANY APPLICATION.

DR SAGAR GARGE  
(consultant Radiologist)

OPCRENCE HOSPITAL  
GHANSOLI  
NAVI MUMBAI

Station  
Telephone:

## EXERCISE STRESS TEST REPORT

Patient Name: MRS. MRINALINI ,  
Patient ID: 91464  
Height:  
Weight:

DOB: 17.10.1988  
Age: 35yrs  
Gender: Female  
Race:

Study Date: 24.02.2024  
Test Type: --  
Protocol: BRUCE

Referring Physician: --  
Attending Physician: --  
Technician: --

Medications:  
--

Medical History:  
--

Reason for Exercise Test:  
--

### Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	02:08	0.00	0.00	109	120/80	
	STANDING	00:22	0.00	0.00	111		
	HYPERV.	00:24	0.50	0.00	107		
EXERCISE	STAGE 1	03:00	1.70	10.00	137	130/80	
	STAGE 2	03:00	2.50	12.00	155	150/80	
	STAGE 3	01:02	3.40	14.00	166	160/80	
RECOVERY		07:34	0.00	0.00	116		

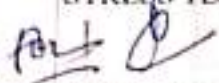
The patient exercised according to the BRUCE for 7:01 min:s, achieving a work level of Max. METS: 8.50. The resting heart rate of 114 bpm rose to a maximal heart rate of 169 bpm. This value represents 91 % of the maximal, age-predicted heart rate. The resting blood pressure of 120/80 mmHg, rose to a maximum blood pressure of 160/80 mmHg. The exercise test was stopped due to Target heart rate achieved, breathlessness..

### Interpretation

Summary: Resting ECG: normal.  
Functional Capacity: normal.  
HR Response to Exercise: appropriate.  
BP Response to Exercise: normal resting BP - appropriate response.  
Chest Pain: none.  
Arrhythmias: none.  
ST Changes: ST depression noted in inferolateral leads during study.  
Overall impression: Positive stress test typical of ischemia.

### Conclusions

STRESS TEST IS POSITIVE FOR EXERCISE INDUCED MYOCARDIAL ISCHEMIA.

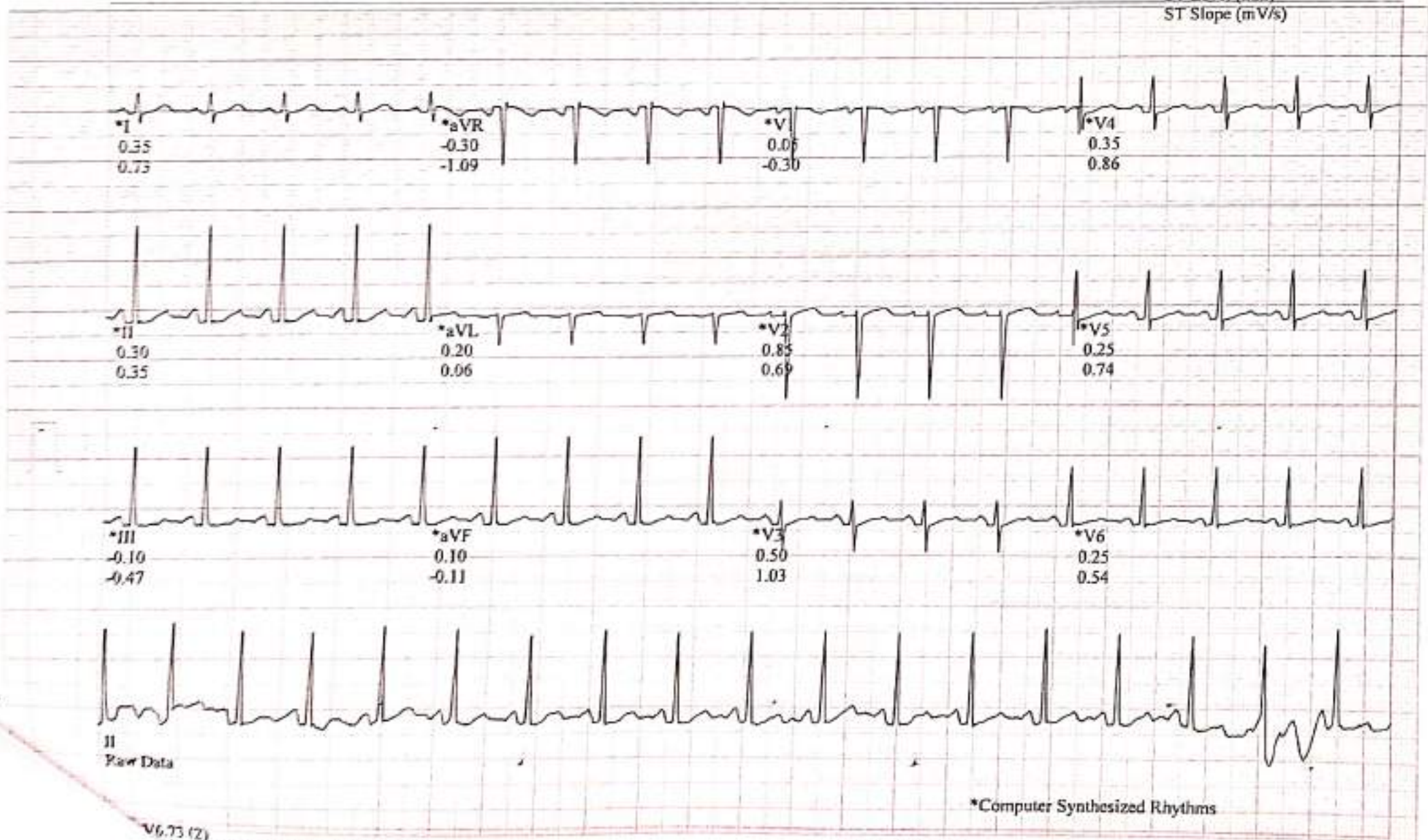


DR. KUMAR RAJEEV  
M.D, DNB, CARDIOLOGY

DR. KUMAR RAJEEV, REG. NO. 89099  
MD(MED), DNB(CARD)



Lead  
ST Level (mm)  
ST Slope (mV/s)



II  
Raw Data

\*Computer Synthesized Rhythms

V6.73 (2)  
V 50Hz 0.01 - 40Hz S+ HR(V2,II)

Start of Test: 11:35:59am

Page 1



MRS. MRINALINI ,  
Patient ID: 91464  
24.02.2024  
11:38:09am

109 bpm

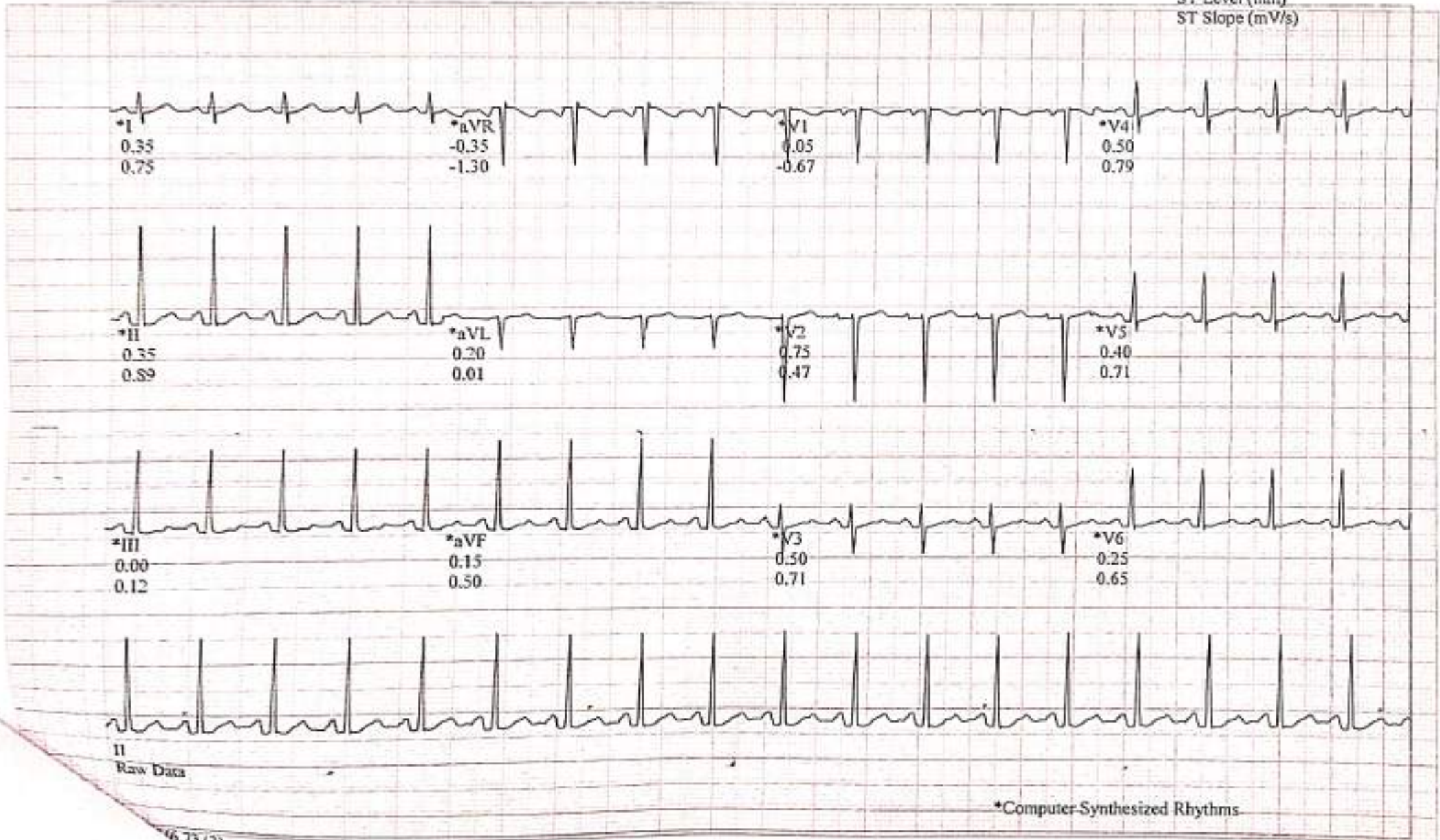
Linked Medians

PRETEST  
STANDING  
02:08

BRUCE  
0.0 mph  
0.0 %

-0pCREDENCE HOSPITAL

Lead  
ST Level (mm)  
ST Slope (mV/s)



II  
Raw Data

\*Computer-Synthesized Rhythms

6.75 (2)  
50Hz 0.01 - 40Hz 5- HR/V/2 III

Start of Test: 11:35:59am

Page 2



MRS. MRINALINI ,  
Patient ID 91464  
24.02.2024  
11:38:30am

Linked Medians

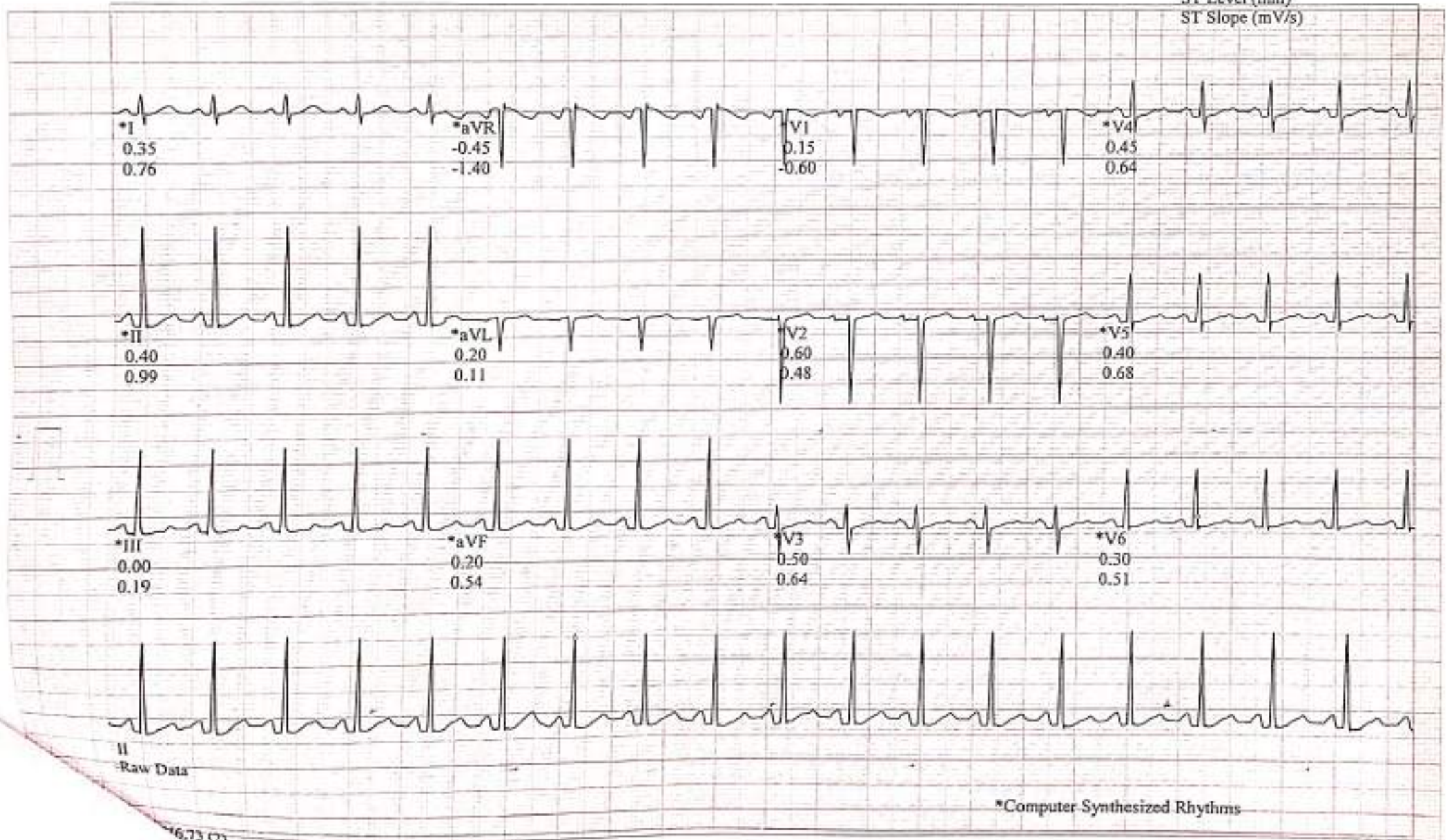
PRETEST  
HYPERV.  
02:29

BRUCE  
0.0 mph  
0.0 %

-0pCREDENCE HOSPITAL

111 bpm

Lead  
ST Level (mm)  
ST Slope (mV/s)



II  
Raw Data

\*Computer Synthesized Rhythms

16.73 (2)  
50Hz 0.01 - 40Hz S+ HR(V2.II)

Start of Test: 11:35:59am

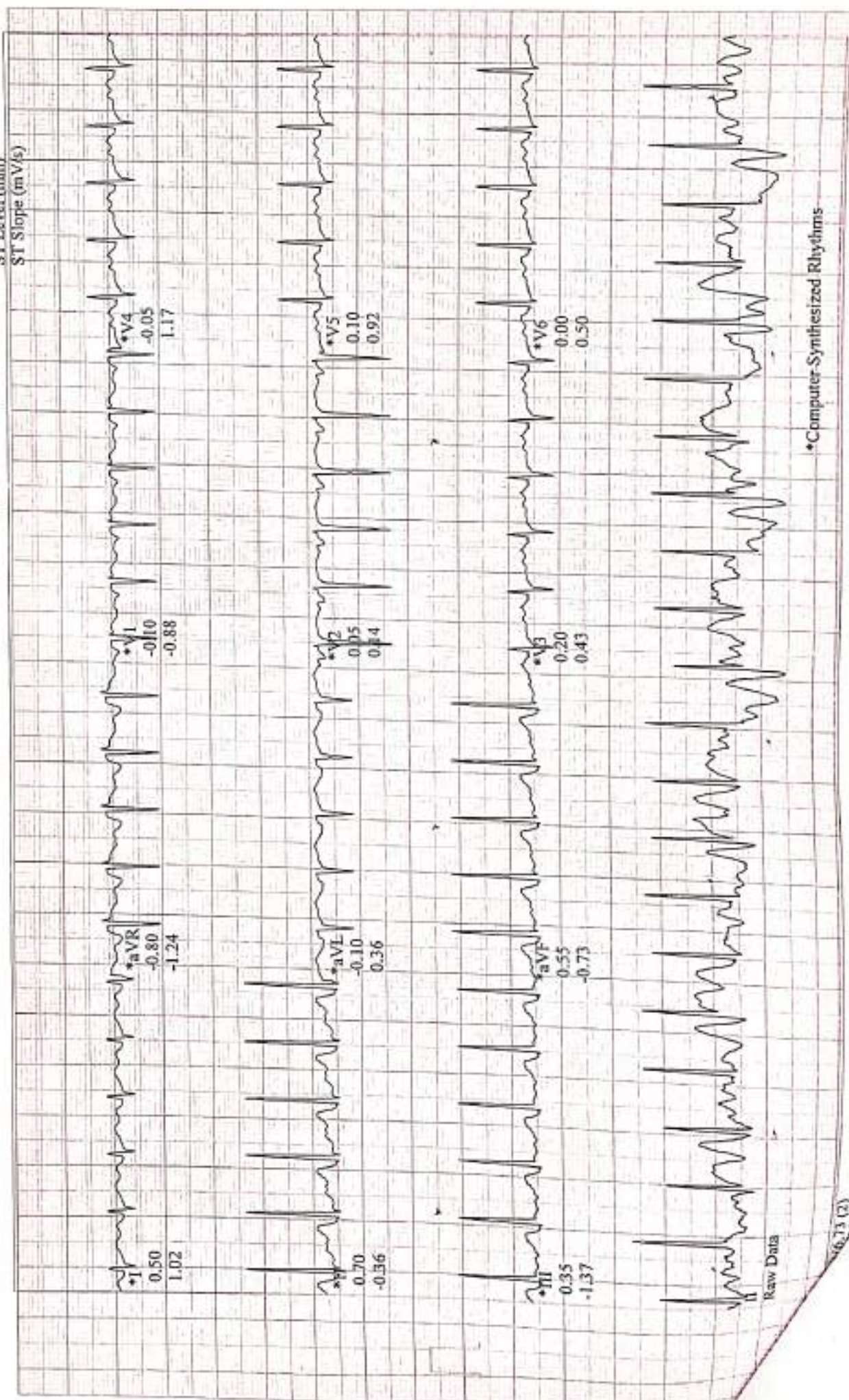
Page 2



MRS. MRINALINI  
Patient ID 91464  
24.02.2024  
11:40:46am

BRUCE  
EXERCISE STAGE 1  
01:54  
133 bpm  
130/80 mmHg

Lead  
ST Level (mm)  
ST Slope (mV/s)



Raw Data

\*Computer-Synthesized Rhythms

50Hz 0.01 - 40Hz S+ HR(V2.II)

Start of Test: 11:35:59am



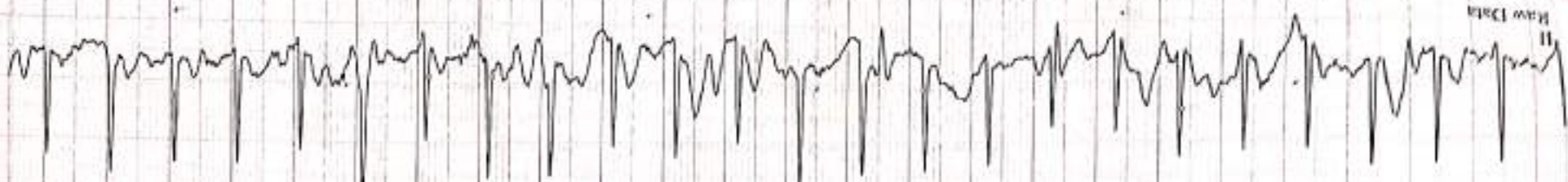
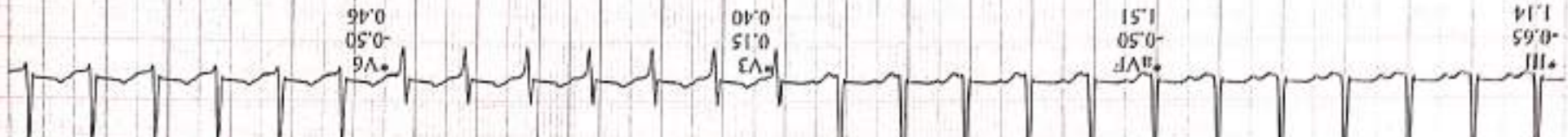
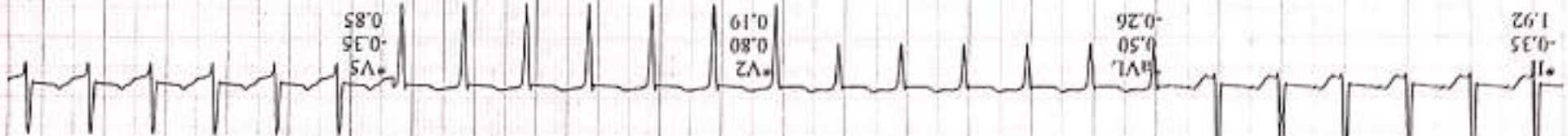
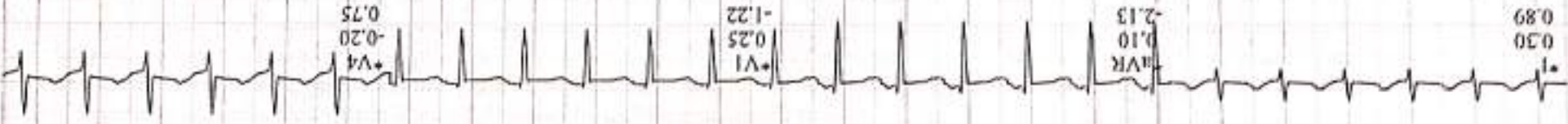
MRS. MRINALINI  
Patient ID 91464  
24.02.2024  
11:43:12am

Linked Medians  
EXERCISE  
STAGE 2  
04:20  
148 bpm  
140/80 mmHg

BRI/CE  
2.5 mph  
12.0 %

APCREDENCE HOSPITAL

Lead  
ST Level (mm)  
ST Slope (mV/s)



\*Computer Synthesized Rhythms

Start of Test: 11:35:59am

16.73.17  
V 5012 001 - 4012 S4 HRV2 II

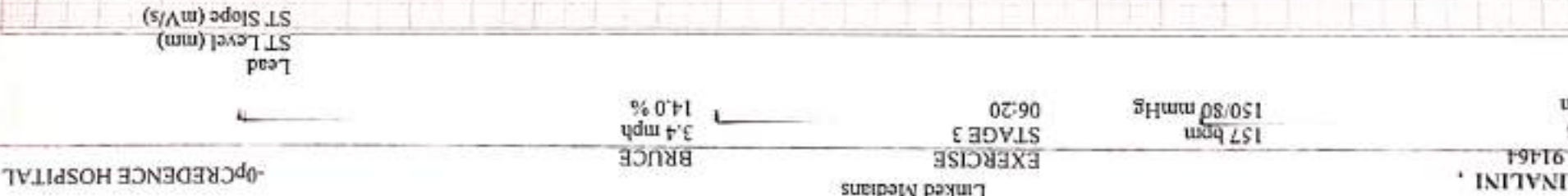
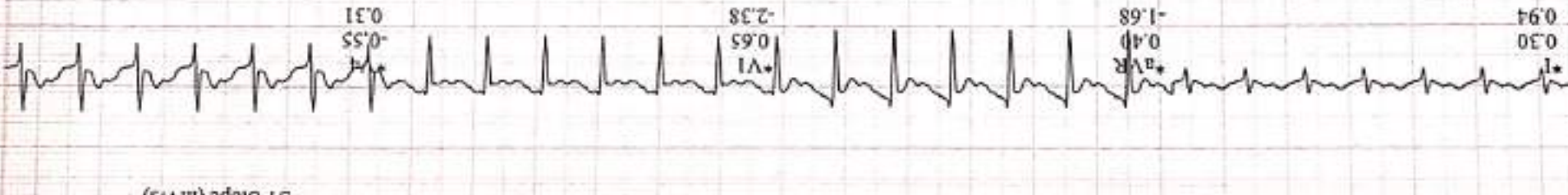
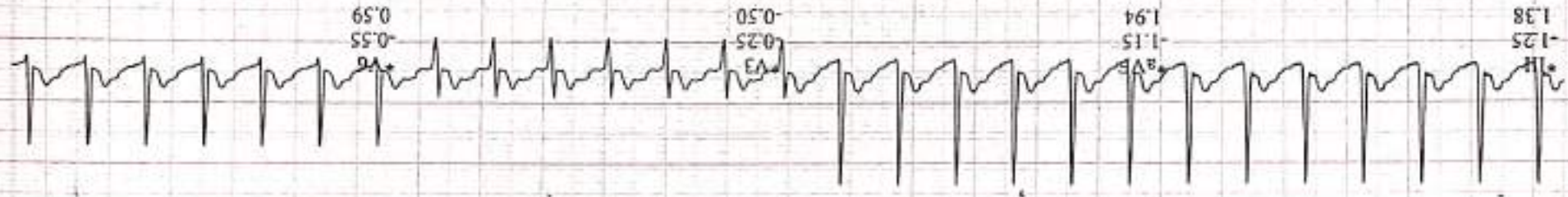
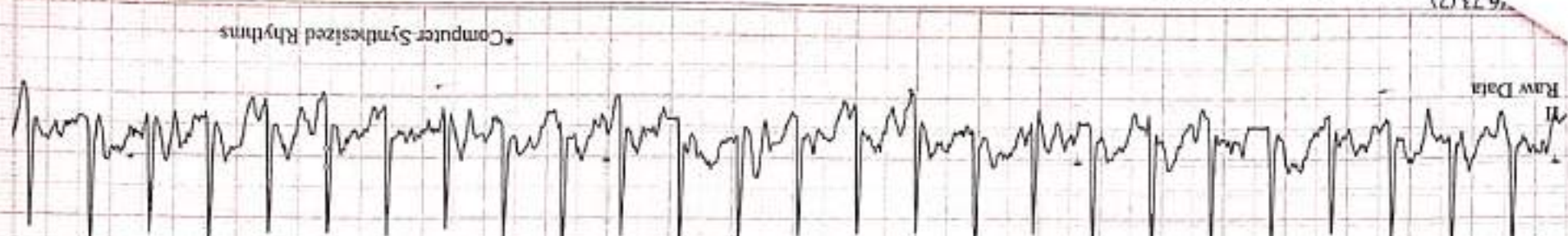
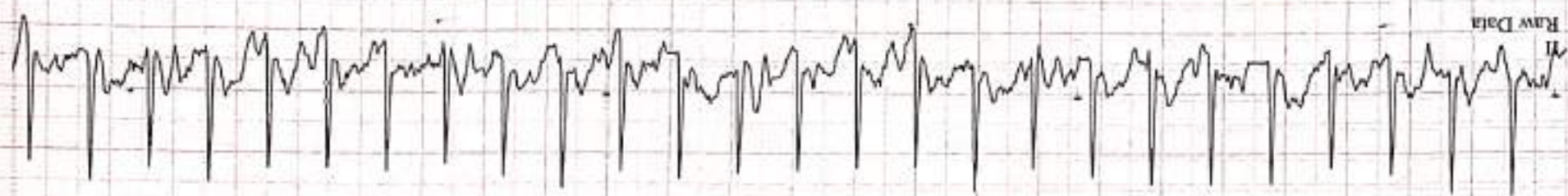
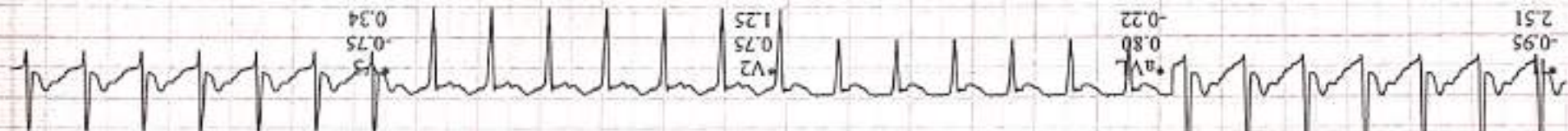
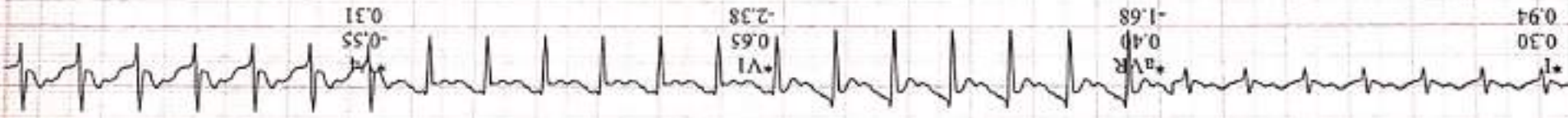
MRS. MIRNALINI,  
Patient ID 91464  
24.02.2024  
11:45:12am

157 bpm  
150/80 mmHg  
EXERCISE  
STAGE 3  
06:20  
Linked Medians

BRUCE  
3.4 mph  
14.0 %

OPCRENDENCE HOSPITAL

Lead  
ST Level (mm)  
ST Slope (mV/s)



\*Computer Synthesized Rhythms

Raw Data

50Hz 0.01 - 40Hz 5 + HR(V2,II)  
6.73 (2)

Start of Test: 11:35:59am



MRS. MRINALINI,  
Patient ID: 91464  
24.02.2024  
11:45:31am

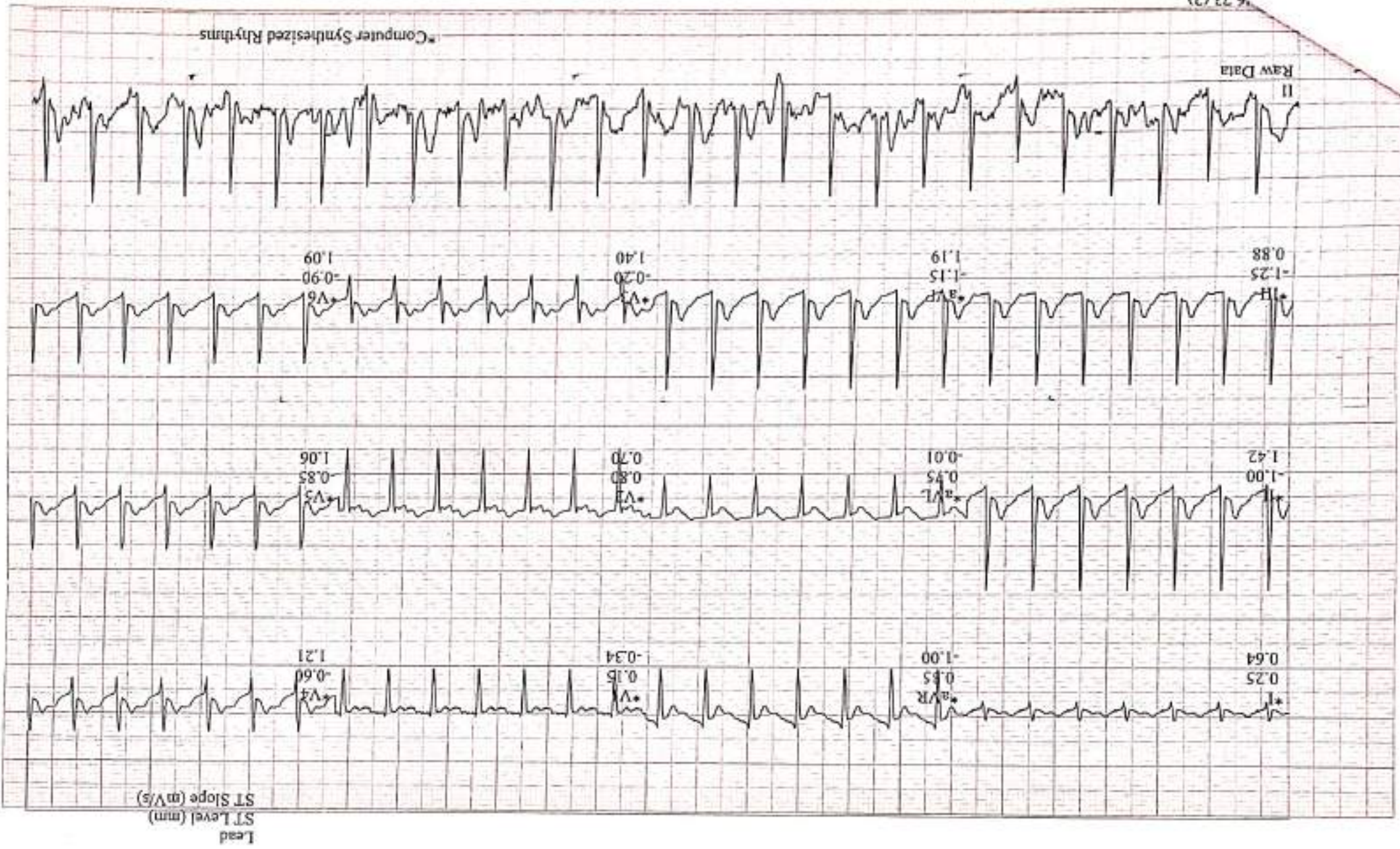
164 bpm

EXERCISE  
STAGE 3  
06:39

BRUCE  
3.4 mph  
14.0 %

Linked Medians

-OPCRENCE HOSPITAL





MRS. MRINALINI

Patient ID 91464

24.02.2024

11:45:33am

166 bpm  
160/80 mmHg

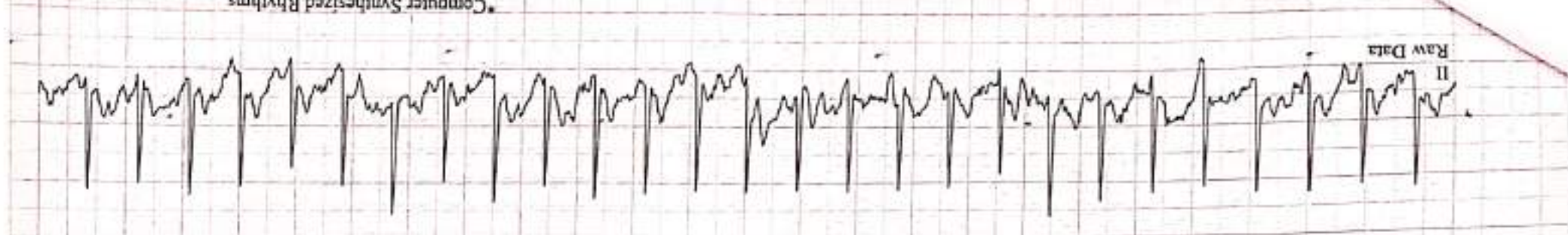
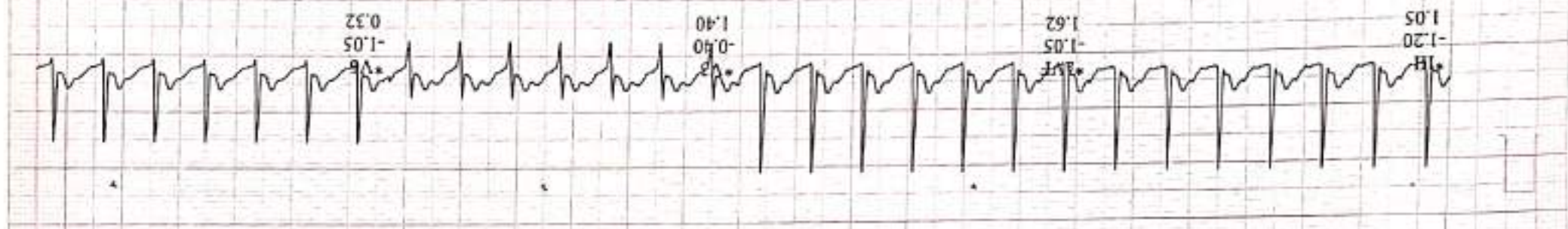
STAGE 3  
07:02

3.4 mph  
14.0 %

EXERCISE  
BRUCE  
Linked Medians (PEAK EXERCISE)

-OPCRENDENCE HOSPITAL

Lead	ST Level (mm)	ST Slope (mV/s)
V6	1.20	-0.80
V1	-0.73	0.15
V4R	-1.81	0.35
V1	0.15	0.88
V4	0.90	2.23
V6	-1.05	1.05
V2	0.55	0.04
V2	-0.40	1.40
V4	-1.05	1.62
V6	-1.20	1.05



\*Computer Synthesized Rhythms

Raw Data

II

50Hz 0.01 - 40Hz S - HR(V2,II)



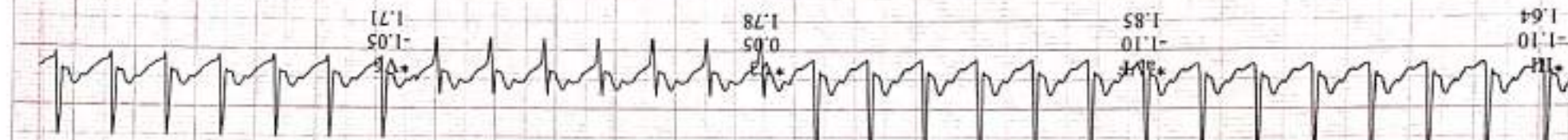
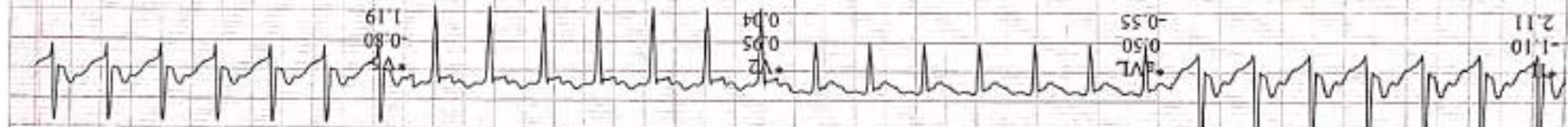
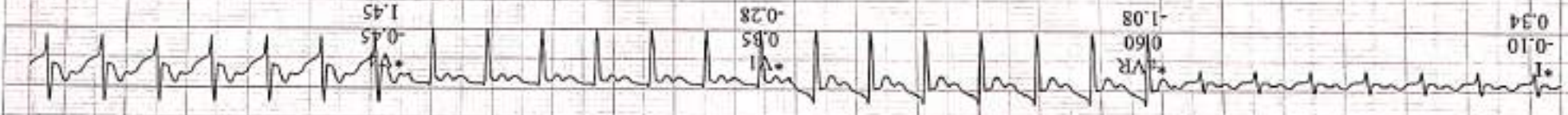
MRS. MRINALINI  
Patient ID 91464  
24.02.2024  
11:46:03am

Linked Medians  
RECOVERY #1  
166 bpm  
160/80 mmHg  
00:11

BRUCE  
1.5 mph  
0.0 %

OPCREDESCENCE HOSPITAL

Lead  
ST Level (mm)  
ST Slope (mV/s)



\*Computer Synthesized Rhythms

Start of Test: 11-35-58am

11:46:03am



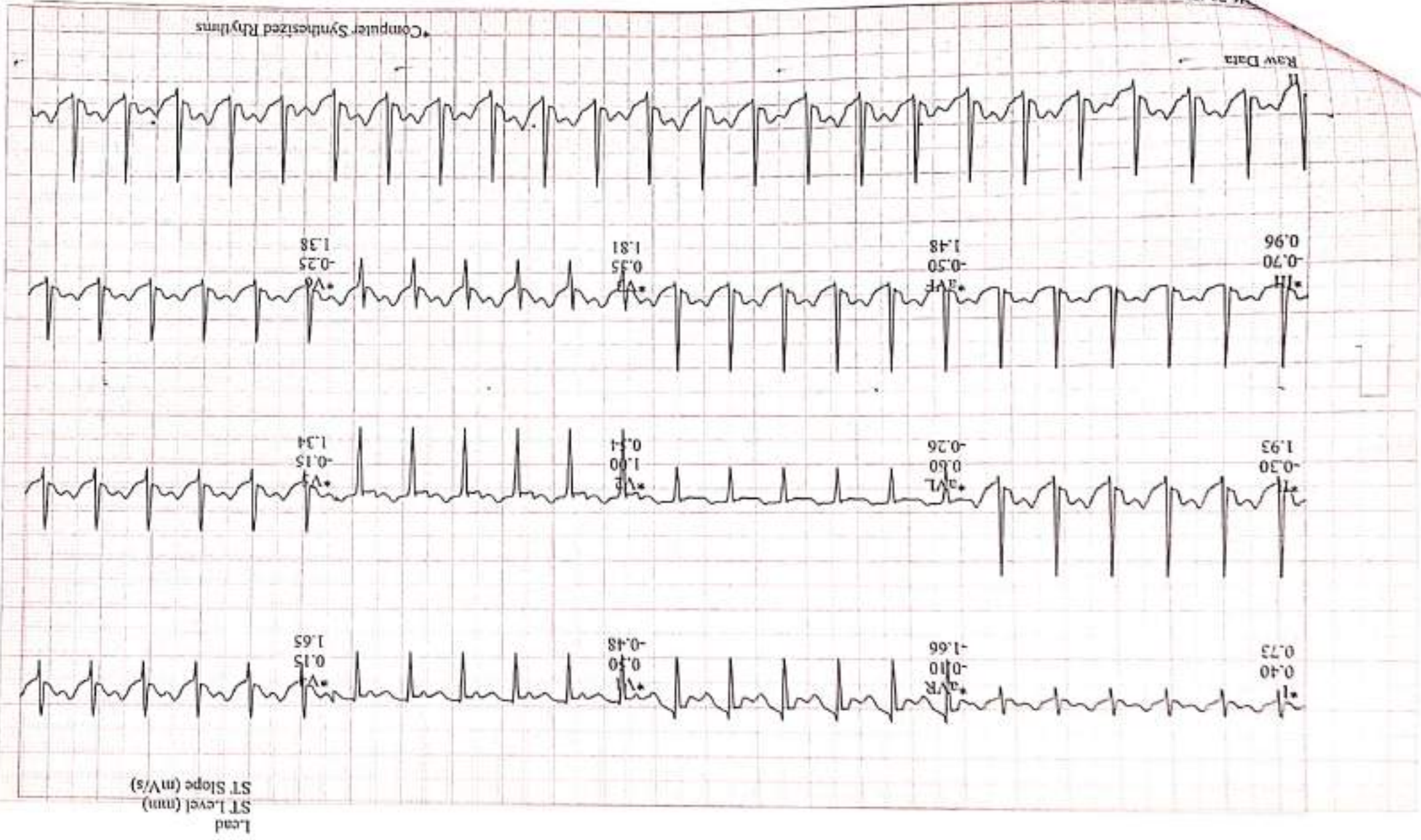
MRS. MIRNALINI,  
Patient ID 81464  
24.02.2024  
11:40:58am

142 bpm

Linked Medians  
RECOVERY  
#1  
01:06

BRUCE  
0.0 mph  
0.0%

-dpCREDENCE HOSPITAL





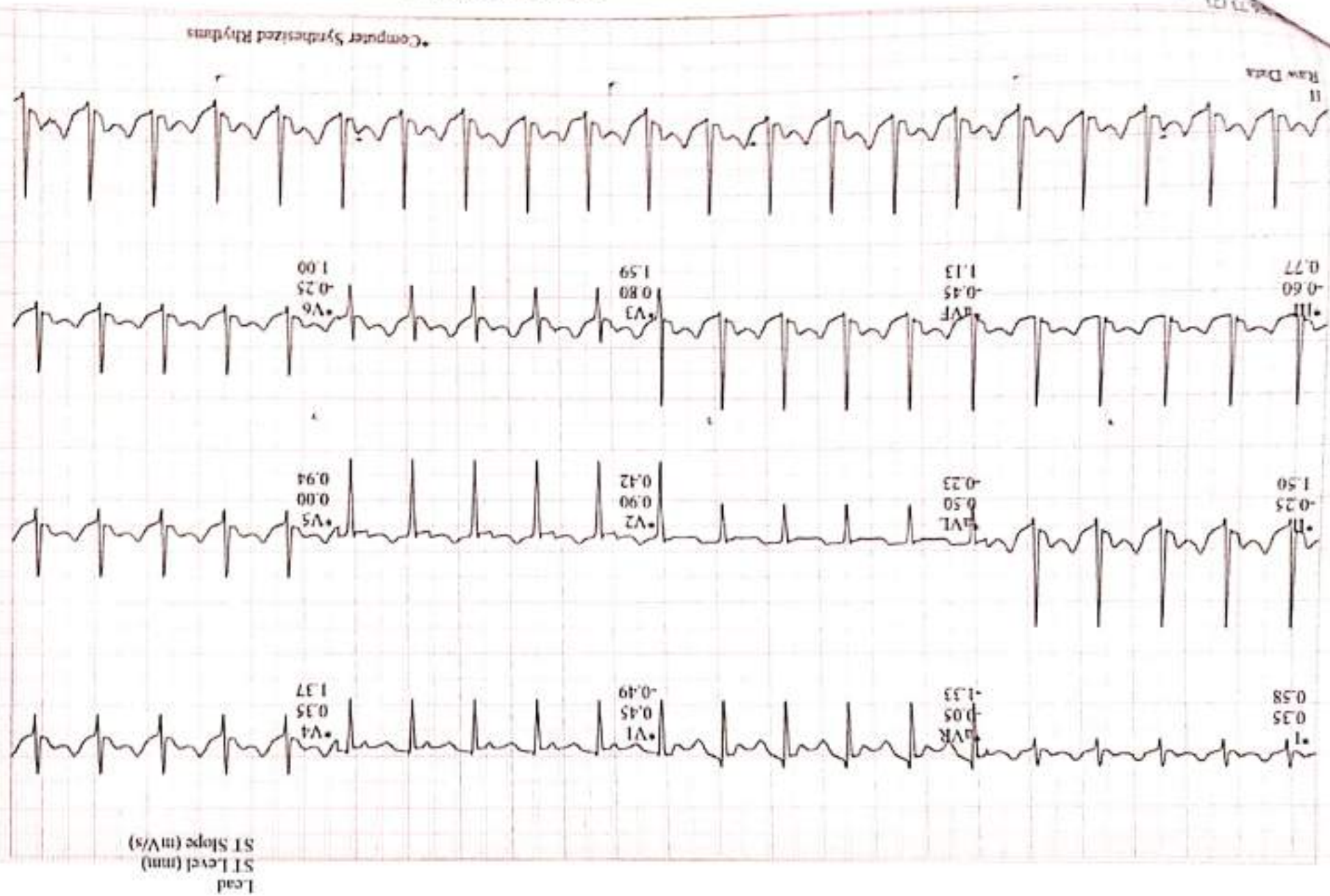
MRS. MIRNALINI,  
 Patient ID 91464  
 24.02.2024  
 11:47:39am

126 bpm

Linked Medians  
 RECOVERY #1  
 01:46

BRI/CI  
 0.0 mph  
 0.0 %

OPCRENCE HOSPITAL



Start of Test 11:35:59am

6.73 CI  
 0.01 - 40Hz S - HR(V2))

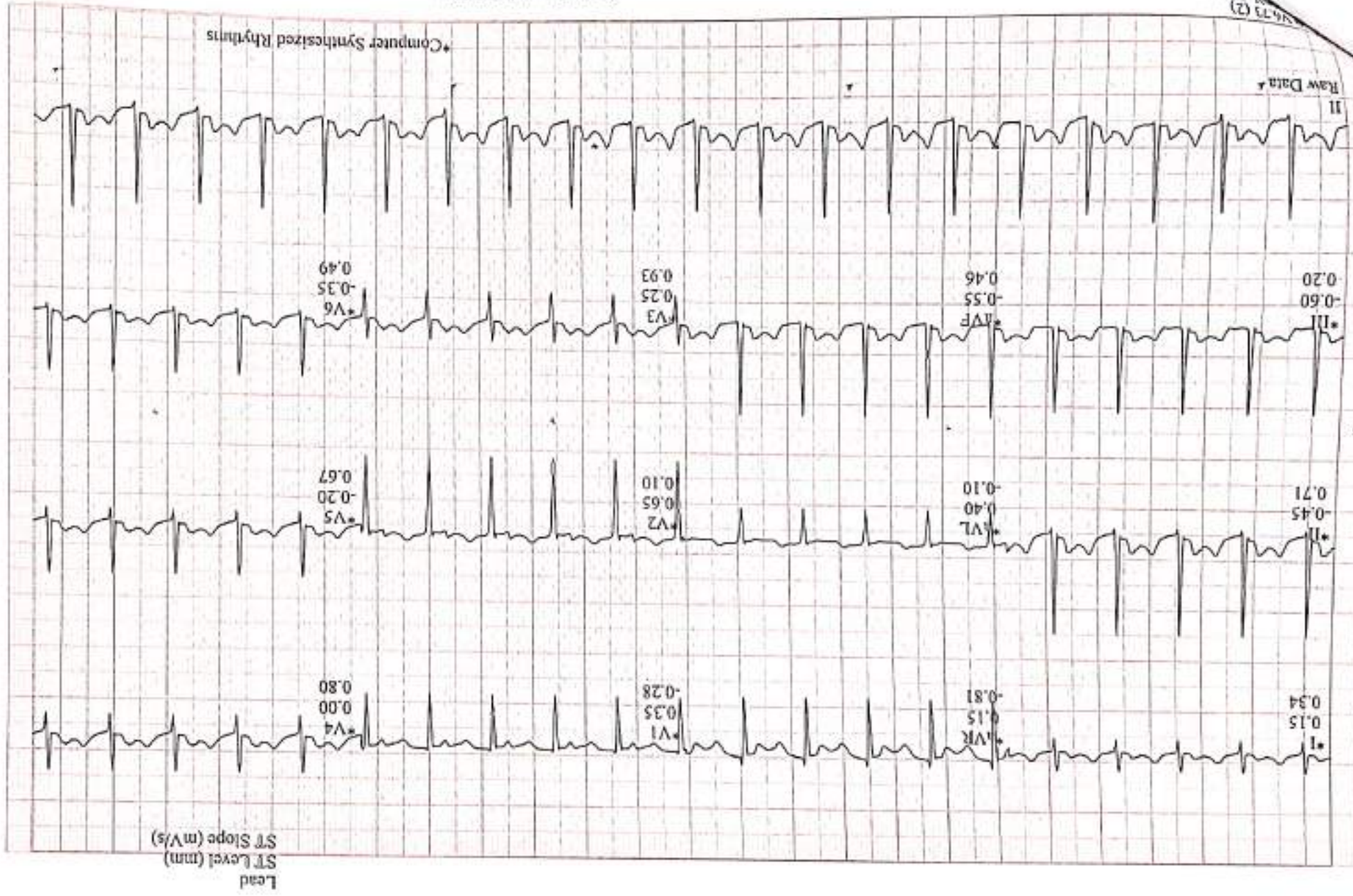
MRS. MIRINALINI  
Patient ID: 91464  
24.02.2024  
11:49:11am

123 bpm

Linked Medians  
RECOVERY #1  
03:18

BRUCE  
0.0 mph  
0.0 %

-OPCREDESCENCE HOSPITAL



Start of Test: 11:35:59am  
SINUS BRADYCARDIA 0.01 - 40Hz S+ HR(V2 II)  
SINUS BRADYCARDIA 0.01 - 40Hz S+ HR(V2 II)




Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHECK UP

Collection Date : 24/02/2024 01:44 PM

Pt.Type / ID : OPD/  629

Reporting Date : 24/02/2024 06:28 PM

**Complete Blood Count (CBC)**

Test Description	Value(s)	Unit	Reference Range
Hemoglobin	11.9	gms/dl	12 - 15
RBC Count	3.98	mil./cmm	3.8 - 5.8
Haematocrit (HCT)	33.0	%	37 - 47
<b>RBC Indices</b>			
MCV	82.91	fL	80 - 100
MCH	29.90	pg	27 - 34
MCHC	36.06	gm/dl	32 - 36
RDW-CV	12.0	%	11 - 16
Total WBC Count	9100	/uL	4000 - 10000
<b>DIFFERENTIAL COUNT</b>			
Neutrophil	60	%	40 - 70
Lymphocytes	35	%	20 - 40
Eosinophil	02	%	1 - 6
Monocytes	03	%	2 - 8
Basophils	00	%	0 - 1
<b>Platelet Indices</b>			
Platelet Count	210000	/cmm.	150000 - 450000
RBC Morphology	Normocytic Normochromic		
WBC Morphology	Within Normal Limits		
Platelet	Adequate on smear		

Done on fully Automated cell counter-ERBA H360



Checked By

Authenticity Check

Dr. Harshal Thorat

MD (Path)


Reg No. 2014/10/4438

Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHECK UP

Collection Date : 24/02/2024 01:44 PM

Pt.Type / ID : OPD/  629

Reporting Date : 24/02/2024 06:28 PM

**ESR (ERYTHROCYTE SEDIMENTATION RATE)**

Test Description	Value(s)	Unit	Reference Range
Erythrocyte Sedimentation Rate Wintrobe method	08	mm/hr	< 20

**Interpretation:** It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Checked By



Authenticity Check

Dr. Harshal Thorat

MD (Path)

Reg No. 2014/10/4438




Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHECK UP

Collection Date : 24/02/2024 01:44 PM

Pt.Type / ID : OPD/  629

Reporting Date : 24/02/2024 06:28 PM

**BLOOD GROUP (BG)**

Test Description	Value(s)	Unit	Reference Range
------------------	----------	------	-----------------

Sample Type : WHOLE BLOOD EDTA

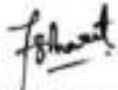
Blood Group : A Rh Positive

METHOD : Monoclonal blood grouping (Agglutination test) by slide method

KIT : Span diagnostics.

Checked By




  
**Dr. Harshal Thorat**  
MD (Path)  
Reg No. 2014/10/4438

Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHECK UP

Collection Date : 24/02/2024 01:44 PM

Pt.Type / ID : OPD/   
629

Reporting Date : 24/02/2024 06:28 PM

**BLOOD GLUCOSE LEVEL ( FASTING & POST PRANDIAL )**

Test Description	Value(s)	Unit	Reference Range
Glucose Fasting (Plasma)	91.0	mg/dl	70 - 110
Glucose Urine	Absent		
Glucose PP (Plasma)	105.0	mg/dl	90 - 150

Interpretation : Fasting Blood Sugar more than 126 mg/dl on more than one occasion can indicate Diabetes Mellitus.

Checked By



Authenticity Check

**Dr. Harshal Thorat**

MD (Path)

Reg No. 2014/10/4438




Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHECK UP

Collection Date : 24/02/2024 01:44 PM

Pt.Type / ID : OPD/  629

Reporting Date : 24/02/2024 06:28 PM

**GLYCOSYLATED HAEMOGLOBIN ( GHB / HBA1c )**

Test Description	Value(s)	Unit	Reference Range
HbA1c H.P.L.C	5.7	%	Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control Above 10% - Poor Control

**Interpretation:** Glycosylated Haemoglobin is accurate and true index of the " Mean Blood Glucose Level in the body for the previous 2-3 months. HbA1c is an indicator of glycemic control. HbA1c represent average glycemia over the past six to eight weeks. Glycation of hemoglobin occurs the entire 120 days life span of the red blood cell, but within this 120 days. Recent glycemia has the largest influence on the HbA1c value. Clinical studies suggest that a patient in stable control will have 50% of their HbA1c formed in the month before sampling, 25% in the month before that, and the remaining 25% in months 2-4.

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Authenticity Check

**Dr. Harshal Thorat**

MD (Path)


Reg No. 2014/10/4438

Patient Name : MRS. MRINALINI

Age / Gender : 33 Years / Female

Referral Doctor: HEALTH CHRCK UP

Collection Date : 24/02/2024 01:44 PM

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**THYROID FUNCTION TEST ( TFT )**

Test Description	Value(s)	Unit	Reference Range
<b>TOTAL TRIIODOTHYRONINE (T3)</b> Competitive Chemi Luminescent Immuno Assay	132.0	ng/dl	60 - 181
<b>TOTAL THYROXINE (T4)</b> Competitive Chemi Luminescent Immuno Assay	5.8	µg/dL	4.5 - 12.6
<b>THYROID STIMULATING HORMONE (TSH)</b> SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY	3.5	uIU/mL	0.3 - 5.5


**SANDWICH CHEMI LUMINESCENT IMMUNO ASSAY**

Reference range for < 18 years

TEST	1 - 3 D	4 - 30 D	31 - 60 D	61 D - 12 M	1 - 5 Y	6 - 10 Y	11 - 14 Y	15 - 18 Y
TSH	0.1-9.2	0.2-8.5	0.2-7.8	0.30-5.9	0.4-4.8	0.5-4.7	0.5-4.6	0.6-4.5
T3	41.7-272.1	48.2-272.1	54.7-272.1	76.8-272.1	89.2-246.7	87.2-218.1	86.6-199.8	85.3-188.8
T4	4.9-15.8	5-15.3	5.2-14.8	5.7-13.3	5.7-11.7	5.4-10.7	5.2-10	5.1-9.6
FT3	1.5-5.3	1.6-5.2	1.6-5.1	1.8-4.8	2-4.5	2.1-4.4	2.3-4.4	2.3-4.3
FT4	0.84-2.08	0.85-1.98	0.85-1.89	0.89-1.62	0.89-1.48	0.85-1.46	0.84-1.45	0.84-1.45

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**LIPID PROFILE**

Test Description	Value(s)	Unit	Reference Range
Total Cholesterol	141.0	mg/dl	Low < 125 Desirable : < 200 Borderline High : 201 - 240 High : > 240
Triglycerides	101.0	mg/dl	Low < 25 Normal : < 150 Borderline High : 151 - 199 High : > 200
HDL Cholesterol	41.0	mg/dl	< 35 Low >80 High
Non HDL Cholesterol	100.00	mg/dl	Desirable : < 130 Boderline high : 130 - 159 High : > 160
LDL Cholesterol	79.80	mg/dl	Low < 85 Optimal : <100 Near/Above Optimal : 101 - 129 Borderline High : 130 - 159 High : >160
VLDL Cholesterol	20.20	mg/dl	Below 40
TOTAL CHOL/HDL Ratio	3.44	-	Desirable/Low Risk : 3.3 - 4.4 Borderline/Middle Risk : 4.5 - 7.1 Elevated/High Risk : 7.2 - 11.0
LDL/HDL Ratio	1.95	-	Desirable/Low Risk : 0.5 - 3.0 Borderline/Middle Risk : 3.1 - 6.0 Elevated/High Risk : >6.1
Appearance of Serum	Clear		

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URIC ACID

Test Description	Value(s)	Unit	Reference Range
Uric Acid	5.0	mg/dl	2.6 - 6.0

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**BLOOD UREA NITROGEN**

Test Description	Value(s)	Unit	Reference Range
BUN* Serum,Calculated	9.1	mg/dL	7 - 18.0



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**CREATININE**

Test Description	Value(s)	Unit	Reference Range
CREATININE Jaffe IDMS	0.8	mg/dl	0.6 - 1.4



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**BUN/CREATININE RATIO**

Test Description	Value(s)	Unit	Reference Range
BUN/CREATININE RATIO	11.4	Mg/dL	5 - 20

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Reporting Date : 24/02/2024 06:28 PM

**LIVER FUNCTION TEST ( LFT )**

Test Description	Value(s)	Unit	Reference Range
Bilirubin Total	0.72	mg/dL	0.3 - 1.5
Bilirubin Direct	0.32	mg/dL	0.0 - 0.5
Bilirubin Indirect	0.4	mg/dL	0.2 - 0.9
SGOT (AST)	20.0	U/L	0 - 45
SGPT (ALT)	29.0	U/L	0 - 45
Alkaline Phosphatase	172.0	U/L	80 - 306
Protein Total	6.9	g/dL	6 - 8
Albumin	3.8	g/dL	3.2 - 5.0
Globulin	3.10	g/dL	2.5 - 3.3
A/G Ratio	1.23	-	1.0 - 2.1

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**GAMMA GT**

Test Description	Value(s)	Unit	Reference Range
Gamma Glutaryl Trans Peptidase	18.0	U/L	5 - 40

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**URINE ROUTINE REPORT**

Test Description	Value(s)	Unit	Reference Range
<b>Physical Examination</b>			
Quantity	20	ml	-
Colour	Pale Yellow		Pale yellow / Yellow
Appearance	Clear		Clear
Specific Gravity	1.010		1.005-1.030
pH	Acidic		Acidic
Deposit	Absent		Absent
<b>Chemical Examination</b>			
Protein	Trace		Absent
Sugar	Absent		Absent
Ketones	Absent		Absent
Bile Salt	Absent		Absent
Bile Pigment	Absent		Absent
Urobilinogen	Normal		Normal
<b>Microscopic Examination (/hpf)</b>			
Pus Cell	1-2		Upto 5
Epithelial Cells	1-2		Upto 5
Red Blood Cells	Absent		Absent
Casts	Absent		Absent
Crystals	Absent		Absent
Bacteria	Absent		Absent

**\*\*END OF REPORT\*\***



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