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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Jyoti on 11/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	✓
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____ recommended	
• Unfit	

Dr. _____
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

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DATE- 09/03/24

NAME - Jyoti | PHONE - 9911350753

AGE/GENDER - 58 Y/F | ADDRESS -

EMAIL - | CORPORATE NAME -

1. **Past medical history & medications**:-

   GALL BLADDER REMOVAL
   MIGRANE PATIENT

2. **Any existing disease: -**

   THYROID.

3. **Current medications :-**

   THYROID.

4. **VITALS** - (To be filled by medical personnel)

   - BLOOD PRESSURE - 150/90 mm
   - PULSE RATE - 65bpm
   - TEMPERATURE - 97.5 F
   - SPO2 – 99%
   - BLOOD SUGAR (RANDOM) – .....
   - HEIGHT – 155 cm.
   - WEIGHT – 57.4 K.g.
   - BMI – .....

Vision- Both Eye- 6/6.
Colour vision- Normal.

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5. **FINDINGS**: -

LAB INVESTIGATION: - Hb- 13.5
Deranged Lipid profile.

CARDIOLOGY INVESTIGATIONS: - ECG- Normal.

RADIOLOGY INVESTIGATIONS: - CXR- Normal

6. **DOCTOR REMARKS:** – Abnormal Lipid Profile

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

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Patient's name:- MRS JYOTI	**Date:- 17-03-2024**
Referred by:- HEALTH CHECK UP	**Age/Sex:- 58Y/F**

ULTRASOUND WHOLE ABDOMEN

CLINICAL PROFILE – General check up

The movements of both the domes of diaphragm are normal.

The liver is normal in size, outline and parenchymal echotexture. No focal lesion is seen. The portal vein is normal in calibre and course.

The gall bladder is not seen- consistent with previous surgical removal. The intra hepatic biliary radicals and CBD are normal.

The pancreas and spleen are normal.

Both the kidneys are normal in size, outline and parenchymal echopattern. No calculus, hydronephrosis or any other abnormality is seen on either side.

No free fluid is seen in the peritoneal cavity.

No lymphadenopathy is seen.

The urinary bladder is normal in outline.

The uterus is bulky, and shows lobulated outline. This is due to the presence of multiple intramural and subserosal fibroids, largest one being39x38mm along anterior fundus, subserosal in location. The endometrial lining is central, 4.2mm. The myo-endometrial interface is preserved.

Both ovaries appear normal

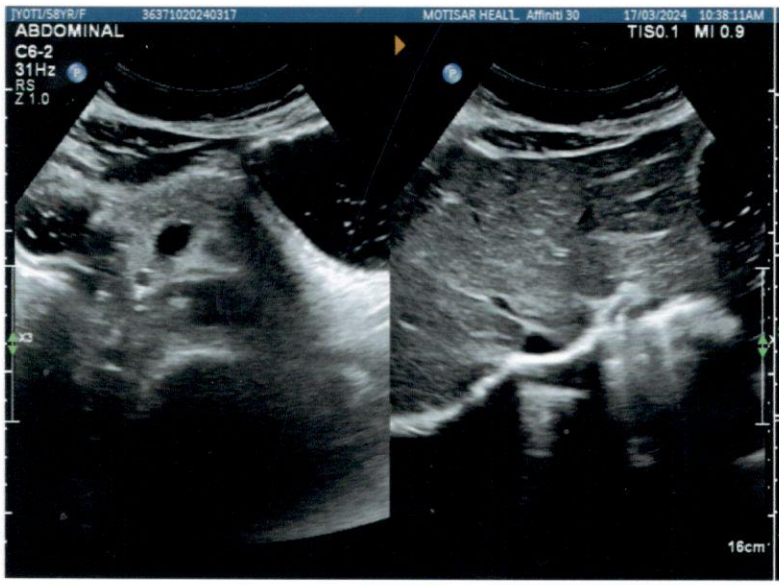
No adnexal mass or collection is seen

IMPRESSION:

BULKY UTERUS WITH FIBROIDS

CLINICAL CORRELATION /TVS EXAMINATION IS NECESSARY .

DR. RAJNISH JUNEJA
MBBS, DNB RADIODIAGNOSIS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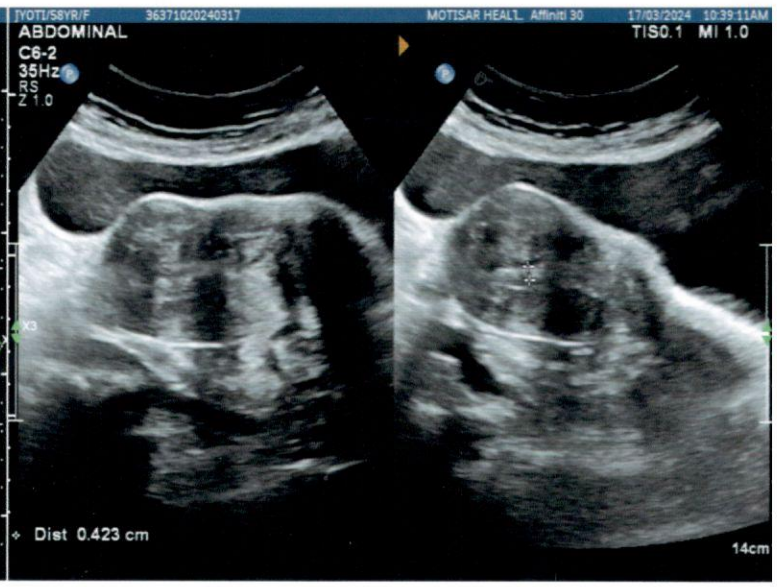
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 0.9
16cm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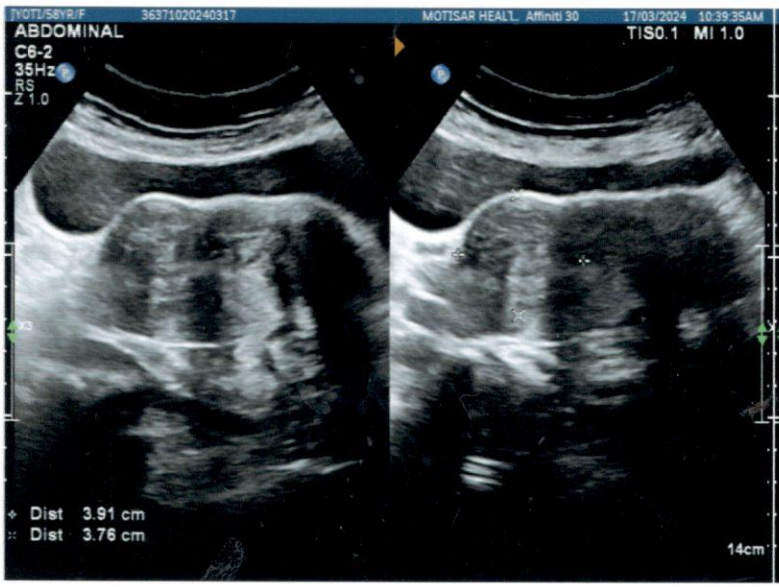
C6-2
35Hz
RS
Z 1.0
TIS0.1 MI 1.0
Dist 0.423 cm
14cm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C6-2
35Hz
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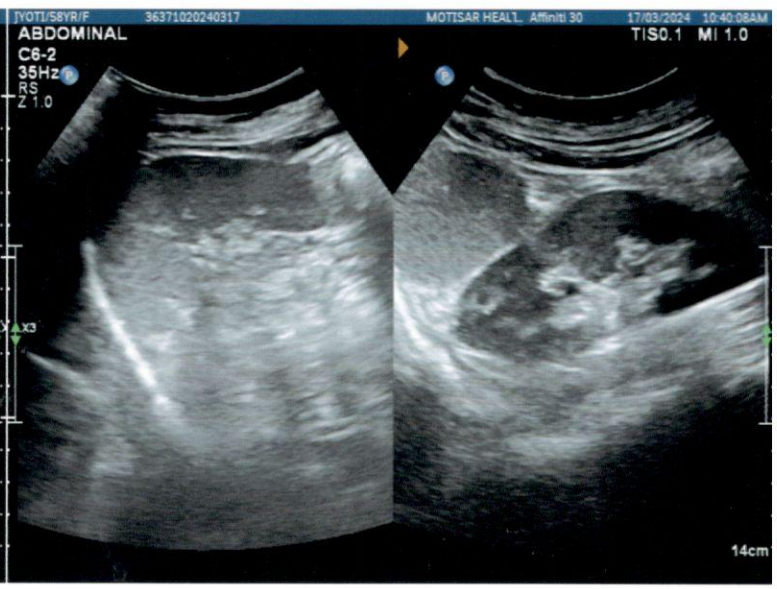
TIS0.1 MI 1.0
Dist 3.91 cm
Dist 3.76 cm
14cm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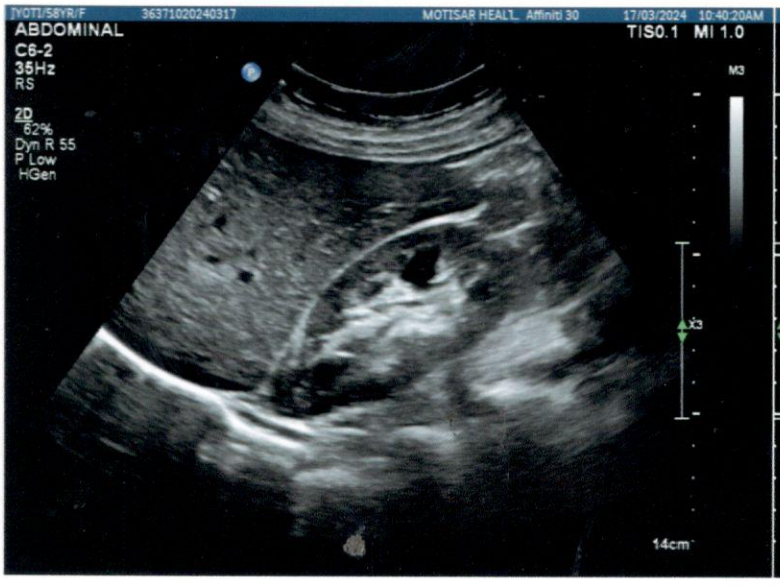
C6-2
35Hz
RS
Z 1.0
TIS0.1 MI 1.0
14cm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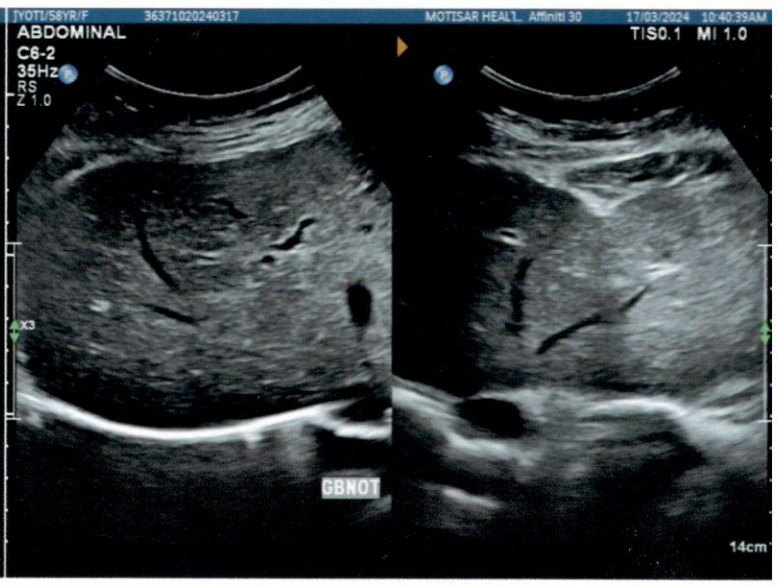
ABDOMINAL
C6-2
35Hz
RS
2D
62%
Dyn R 55
P Low
HGen
TIS0.1 MI 1.0
M3
14cm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ABDOMINAL
C6-2
35Hz
RS
Z 1.0
TIS0.1 MI 1.0
GBNOT
14cm

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ECHOCARDIOGRAPHY REPORT

Patient's Name	MRS JYOTI	Date	13-03-2024
Referred by	HEALTH CHECK UP	Age &Sex	58Yrs/F

MITRAL VALVE

Morphology **AML** - **Normal** / Thickening/Calcification/ Flutter/ Vegetation/ Prolapse/ SAM/ Doming
PML - **Normal**/ Thickening/ Calcification/ Mild Prolapse/ Paradoxical motion/ fixed.
Sub valvular deformity Present/ **Absent** Score: .....

Doppler **Normal**/Abnormal **E>A** A>E
Mitral Stenosis Present/**Absent** RR interval.....msec
EDG.....mmHg MDG.....mmHg MVA.....cm^2
Mitral Regurgitation Absent /Trivial/**Mild**/Moderate/Severe

TRICUSPID VALVE

Morphology **Normal**/ Atresia/Thickening/ Calcification/ Prolapse/ Vegetation/ Doming
Doppler **Normal**/ Abnormal
Tricuspid Stenosis Present/ **Absent** RR interval.....
EDG.....mmHg MDG.....mmHg
Tricuspid Regurgitation: **Absent**/ Trivial/ Mild/ Moderate/ Severe Fragmented signals
Velocity.....m/sec

PULMONARY VALVE

Morphology **Normal**/ Atresia/ Thickening/ Doming/ Vegetation
Doppler **Normal**/ Abnormal
Pulmonary Stenosis Present/**Absent** Level Valvular and Sub valvular
PV Max = **0.88 m/sec** PSG.....mmHg Pulmonary annulus.....mm
Pulmonary Regurgitation Present/ **Absent**
Early diastolic gradient.....mmHg. End Diastolic Gradient.....mmHg

AORTIC VALVE

Morphology **Normal**/ Thickening/ Tip Calcification/ Restricted Opening/ Flutter vegetation
No. of cusps 1/2/**3**/4

Doppler **Normal**/ Abnormal
Aortic Stenosis: Present/**Absent**
AV Max = **1.7** m/sec Aortic Annulus.....mm
Aortic Regurgitation **Absent**/ Trivial/ Mild/Moderate/ Severe

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Measurements	Normal Values	Measurements	Normal Values
Aorta- 2.5	(2.0-3.7 cm)	LAes- 3.4	(1.9-4.0 cm)
LVes- 2.6	(2.2-4.0 cm)	LVed- 4.1	(3.7-5.6 cm)
IVSed-1.4	(0.6-1.1 cm)	PW (LV) 0.8	(0.6-1.1 cm)
RV ed	(0.7-2.6 cm)	RV anterior wall	(up to 5 mm)
LVVd (ml)		LVVs (ml)	
EF **60-65 %**	(54%-76%)	IVS motion	**Normal**/ Flat/ Paradoxical

CHAMBERS:

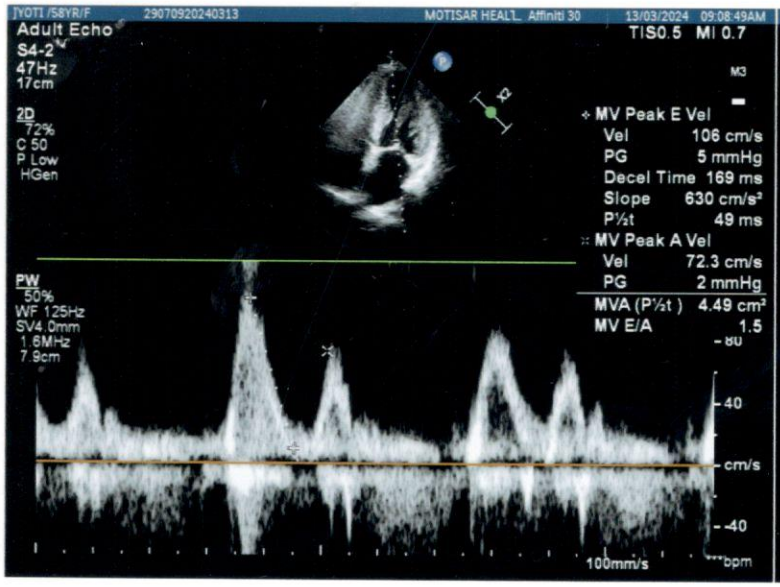
LV	**Normal** / Enlarged/ Clear/ Thrombus/hypertrophy Contraction **Normal** / Reduced
LA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RV	**Normal**/ Enlarged/ **Clear**/ Thrombus
Pericardium	**Normal**/ Thickening/ Calcification/ Effusion

COMMENTS AND SUMMARY

- **ALL FOUR CHAMBERS NORMAL IS SIZE AND SHAPE**
- **ALL FOUR VALVES NORMAL IN MORPHOLOGY**
- **MILD MR**
- **NO AR/TR**
- **NO AORTIC STENOSIS**
- **NORMAL LV DIASTOLIC FUNCTION**
- **NO CLOT/MASS/PE SEEN**
- **NORMAL LV SYSTOLIC FUNCTION, LVEF= 60-65%**

Kindly correlate clinically

DR. ROHIT GOEL
M.D, D.M (Cardiology)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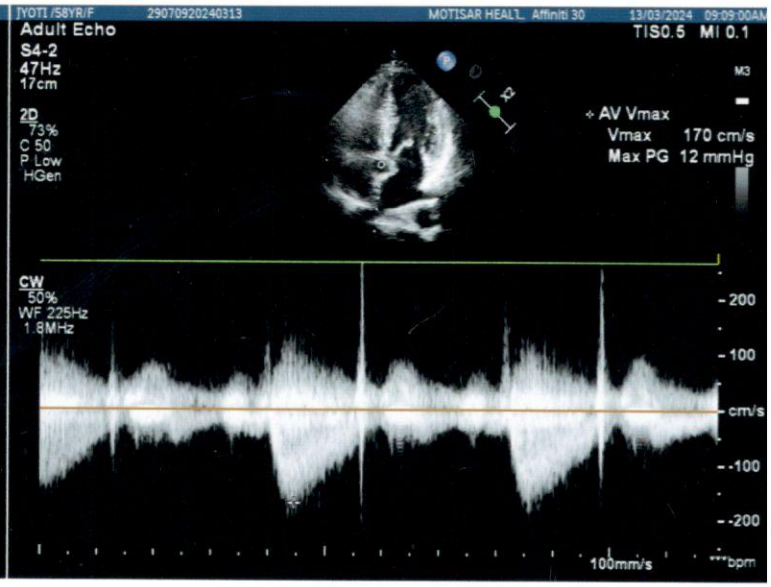
Adult Echo
TIS0.5 MI 0.7
S4-2
47Hz
17cm
2D
72%
C 50
P Low
HGen
MV Peak E Vel
Vel 106 cm/s
PG 5 mmHg
Decel Time 169 ms
Slope 630 cm/s²
P½t 49 ms
MV Peak A Vel
Vel 72.3 cm/s
PG 2 mmHg
MVA (P½t) 4.49 cm²
MV E/A 1.5
PW
50%
WF 125Hz
SV4.0mm
1.6MHz
7.9cm
40
cm/s
-40
100mm/s
***bpm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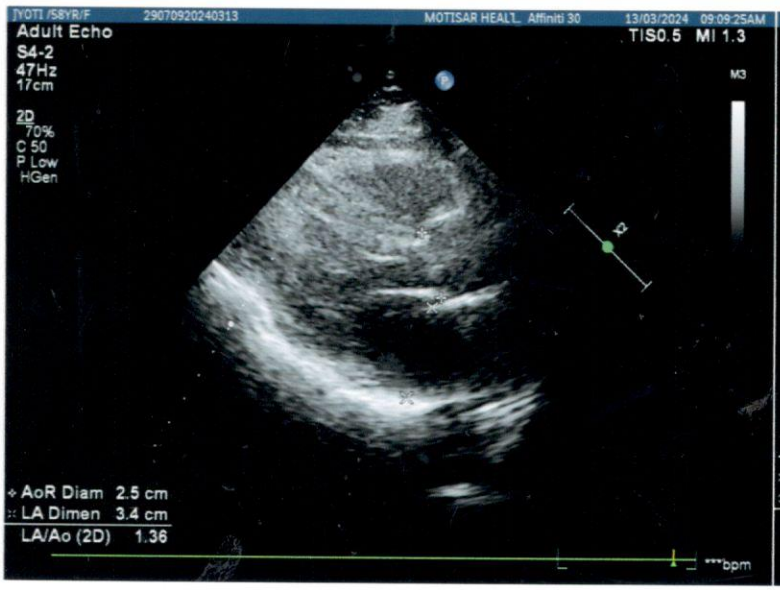
Adult Echo
TIS0.5 MI 0.1
S4-2
47Hz
17cm
2D
73%
C 50
P Low
HGen
AV Vmax
Vmax 170 cm/s
Max PG 12 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm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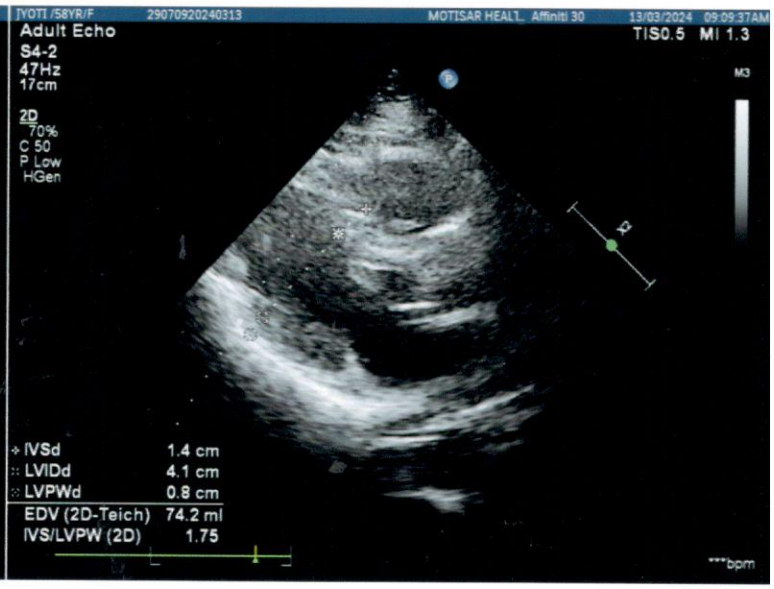
Adult Echo
TIS0.5 MI 1.3
S4-2
47Hz
17cm
2D
70%
C 50
P Low
HGen
AoR Diam 2.5 cm
LA Dimen 3.4 cm
LA/Ao (2D) 1.36
***bpm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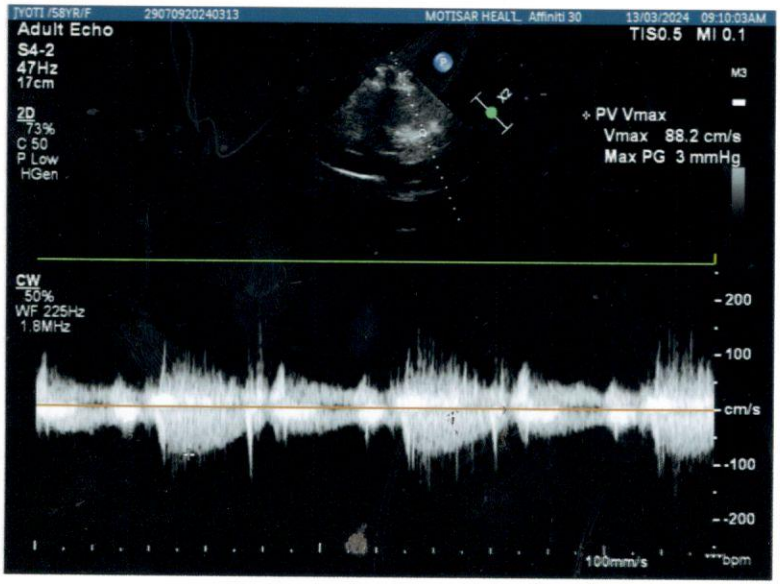
Adult Echo
TIS0.5 MI 1.3
S4-2
47Hz
17cm
2D
70%
C 50
P Low
HGen
IVSd 1.4 cm
LVIDd 4.1 cm
LVPWd 0.8 cm
EDV (2D-Teich) 74.2 ml
IVS/LVPW (2D) 1.75
***bpm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Adult Echo
TIS0.5 MI 0.1
S4-2
47Hz
17cm
2D
73%
C 50
P Low
HGen
PV Vmax
Vmax 88.2 cm/s
Max PG 3 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm

Name - -
Patient ID **Jyoti**

09.03.2024 11:27:12
Standard 12-Lead

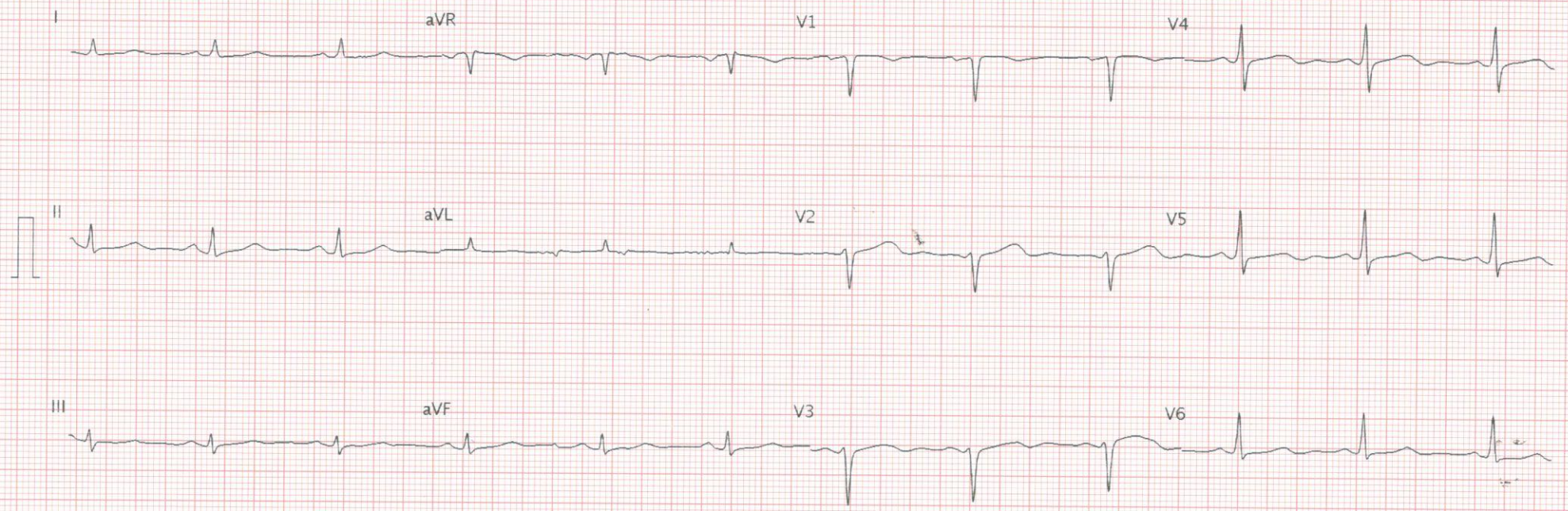
Date of birth		**Visit ID**	
Gender	Undefined	**Room**	
Height		**Medication**	
Weight		**Order ID**	
Ethnicity	Undefined	**Ord. prov.**	
Pacemaker	Unknown	**Ord. prot.**	

Indication
Remark

HR	69 bpm	**RR**	864 ms	Sinus rhythm
		P	104 ms	Normal electrical axis
		PR	146 ms	Low limb lead voltage
P axis	60 °	**QRS**	82 ms	Nonspecific T abnormality
QRS axis	33 °	**QT**	415 ms	Borderline ECG
T axis	56 °	**QTcB**	446 ms	

Unconfirmed report

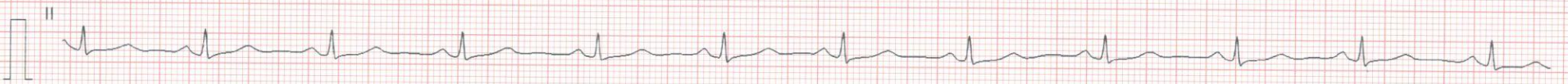
Borderline



25 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

AT-102 G2 1.2.0 (1080.009830)

Printed on 09.03.2024 11:27:24

SCHILLER

Part No.2.157048M CE 0123 O.BD

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Patient's Name:-	MS. JYOTI	Date	:- 09/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 58Y/F

Radiograph of Chest (PA View)

Prominent broncho vascular marking are seen in bilateral lung fields.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

Dr Arushi Gupta
MBBS, DNB (Radio – Diagnosis)
Radiologist

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Jyoti Vats AGE/SEX: 58 / F DATE: 9 March 24

Through health checkup

O/E Dental caries 8/

Decayed 6.

Chr. gen. gingivitis

Advice → scaling & polishing

→ Ext^n of 8/

→ Ext^n & placement of implant /

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Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

TO BOOK AN APPOINTMENT
08079 838383

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	**13.00**	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	**4.6**	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	**41.5**	%	42-52	Calculated
MCV	90.30	fL	78-100	Electrical Impedence
MCH	28.2	pg	27-31	Calculated
MCHC	**31.2**	gm/dL	32-36	Calculated
RDW-SD	**13.6**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	4160	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	56	%	40-80	VCSn Technology
LYMPHOCYTE	37	%	20-40	VCSn Technology
MONOCYTE	06	%	2-10	VCSn Technology
EOSINOPHIL	01	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	153	10^3/ul	150 - 450	Electrical Impedence
MPV	**13.9**	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	16.3	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	2.33	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	**1.54**	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.25	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.04**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	**22**	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. 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.

BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	AB			Gel Columns agglutination
Rh Typing	**POSITIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:46PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.80	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.25	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.55	mg/dL	0.1 - 1.0	Calculated
SGPT	20.10	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	26.50	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	1.32	Ratio	0.7 - 1.4	
GGT	36	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	**152.00**	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.70	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.40	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.3	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.33	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

Dr. Sarita Prasad
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Sr. Consultant (HMC.9669)

Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:46PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

Prasad

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Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:45PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	**233.00**	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	**189.10**	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	51.40	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	143.78	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	**181.6**	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	37.82	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	4.53	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	2.8	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.36	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

Prasad

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:45PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

Dr. Sarita Prasad
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Sr. Consultant (HMC.9669)

Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:58PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.1	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	99.67	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	96.8	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	93.4	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	24.10	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	11.26	mg/dL	7 - 18	Urease
SERUM URIC ACID	4.90	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.90	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	9.30	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	139.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.02	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	103.9	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:42PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.27	ng/mL	0.79 - 1.58	CLIA
T4	8.36	µg/dl	4.9 - 11.00	CLIA
TSH	3.20	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:25PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	25	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.50		4.5 - 7.0	
SPECIFIC GRAVITY	1.025		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	ABSENT		Nill	
Urine Protein	ABSENT		Nil	
Urine Ketones	ABSENT		Nil	
BLOOD	ABSENT		Absent	
Leukocyte esterase	ABSENT		Negative	
Bile pigments	ABSENT		Absent	
NITRITE	ABSENT		Negative	
UROBILINOGEN	ABSENT		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	1-2	/hpf	0 - 5	
EPITHELIAL CELLS	2-3	/hpf	0 - 5	
RBCs	ABSENT	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

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

Dr. Sarita Prasad
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Sr. Consultant (HMC.9669)

Patient NAME	: Mrs.JYOTI	Barcode NO	: 20010238
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 04:30PM
LabNo	: DPL21511	Sample Collected Date	: 09/Mar/2024 04:30PM
Referred BY	: SELF	Report Generated Date	: 12/Mar/2024 04:00PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CYTOPATHOLOGY

LIQUID BASED CYTOLOGY - PAP SMEAR

CASE NO:	LBC – 51/2024
SPECIMEN:	LBC fluid. Received 11.0 ml of fluid with brush. Single smear prepared from the cyto centrifuged sediment and stained with pap's stain.
MICROSCOPIC EXAMINATION:	Satisfactory for Evaluation Transformation zone: Absent Squamous cellularity: Adequate Inflammatory change: Moderate Negative for intraepithelial lesion or malignancy (NILM)- Atrophic smear
DIAGNOSIS:	**Negative for intraepithelial lesion or malignancy (NILM)– Atrophic smear**
ADVICE:	Follow up.

The PAP Smear is not a diagnostic procedure and should not be used as the sole means to evaluate cervical cancer. It is a screening procedure to aid in detection of cervical cancer and its precursors.
The foundation of Liquid Based Cytology (LBC) is that it produces uniform, thin layer slides and minimizes obscuring artefacts as, blood and mucus. On balance, LBC provides consistent improvement compared with conventional PAP testing in specimen adequacy and detection of LSIL and HSIL categories.
Cervico - vaginal cytology is screened & reported as per the Bethesda 2014.

References :

1. Johnson J and Patnick J. 2000. Achievable standards, benchmarks for reporting, and criteria for evaluating cervical cytopathology. Revised 2nd Edition. NHSCSP Publications NHS Cancer Screening Programmes.
2. Bankhead C, Austoker J, Davey C. 2003. Cervical Screening Results Explained a guide for primary care. NHS Cancer Screening Programme.
3. Gibb RK, Martens MG. The Impact of Liquid Based Cytology in decreasing the incidence of cervical cancer. Rev Obstet Gynecol 2011; 4(Suppl 1):S2-S11
4. The Bathesda system for reporting cervical cytology, 2014, 3rd Edition.

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

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MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: Mrs.JYOTI	Barcode NO	: 20010238
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 04:30PM
LabNo	: DPL21511	Sample Collected Date	: 09/Mar/2024 04:30PM
Referred BY	: SELF	Report Generated Date	: 12/Mar/2024 04:00PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF CYTOPATHOLOGY

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4. The Bathesda system for reporting cervical cytology, 2014, 3rd Edition.

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

Dr. Sarita Prasad
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Sr. Consultant (HMC.9669)

Final Bill

Name	: Mrs. Jyoti Vatsa	**Bill No**	: FSOH-OCR-931
Age/Gender	: 58 Y F	**Bill/Reg Date**	: 09.03.2024 14:44
Contact No	: +919911350753	**Referal Doctor**	: SELF
Address	: House number 3171 2nd floor	**Center**	: Sohna Road
UHID	: FSOH.0000003477	**Emp No/Auth Code**	: 386796

Corporate Name : ARCOFEMI HEALTHCARE LIMITED
Plan : ARCOFEMI MEDIWHEEL FEMALE AHC CREDIT PAN INDIA OP AGREEMENT

#	Department	Description Of Service	SAC Code	Qty	Rate	Amount	Discount	Net Value
1	Lab Tests	BLOOD GROUP AND RH TYPE		1	0.00	0.00	0.00	0.00
2	Lab Tests	GLYCOSYLATED HEMOGLOBIN (HBA1C)		1	0.00	0.00	0.00	0.00
3	Lab Tests	THYROID PROFILE - I(T3,T4 AND TSH)		1	0.00	0.00	0.00	0.00
4	Lab Tests	LIPID PROFILE TEST (PACKAGE)		1	0.00	0.00	0.00	0.00
5	Lab Tests	KFT - RENAL PROFILE-SERUM		1	0.00	0.00	0.00	0.00
6	Lab Tests	LIVER FUNCTION TEST (PACKAGE)		1	399.92	399.92	0.00	399.92
7	Lab Tests	GGTP: GAMMA GLUTAMYL TRANSPEPTIDASE		1	99.98	99.98	0.00	99.98
8	Service	ECG		1	149.97	149.97	0.00	149.97
9	Radiology Tests	ULTRASOUND WHOLE ABDOMEN		1	749.86	749.86	0.00	749.86
10	Lab Tests	PAP SMEAR FOR LBC		1	0.00	0.00	0.00	0.00
11	FITNESS BY GENERAL PHYSICIAN	doctor		1	0.00	0.00	0.00	0.00
12	DENTAL Consultation	doctor		1	0.00	0.00	0.00	0.00
13	ENT Consultation	doctor		1	0.00	0.00	0.00	0.00
14	Opthal Consultation	doctor		1	0.00	0.00	0.00	0.00
15	Diet Consultation	doctor		1	0.00	0.00	0.00	0.00
16	GYNAEC CONSULTATION	doctor		1	0.00	0.00	0.00	0.00
17	Lab Tests	GLUCOSE - (FASTING)		1	0.00	0.00	0.00	0.00
18	Lab Tests	GLUCOSE - (POST PRANDIAL)		1	0.00	0.00	0.00	0.00
19	Lab Tests	URINE GLUCOSE(FASTING)		1	0.00	0.00	0.00	0.00
20	Lab Tests	URINE GLUCOSE(POST PRANDIAL)		1	0.00	0.00	0.00	0.00
21	Service	2D ECHO		1	999.81	999.81	0.00	999.81
22	Radiology Tests	X-RAY CHEST PA		1	199.96	199.96	0.00	199.96
23	Radiology Tests	SONO MAMOGRAPHY		1	0.00	0.00	0.00	0.00
24	Service	Height Weight BP BMI		1	0.50	0.50	0.00	0.50
25	Lab Tests	URINE ROUTINE EXAMINATION		1	0.00	0.00	0.00	0.00
26	Lab Tests	COMPLETE HAEMOGRAM		1	0.00	0.00	0.00	0.00
27	Lab Tests	PERIPHERAL SMEAR		1	0.00	0.00	0.00	0.00
28	Package Charges	ARCOFEMI - MEDIWHEEL - FULL BODY ANNUAL PLUS CHECK ADVANCED - FEMALE - 2D ECHO - PAN INDIA - FY2324		1	0.00	0.00	0.00	0.00

Bill Amount:	2,600.00
Total Discount:	0.00
Net Payment:	0.00
Corporate Due:	2,600.00
Pri. Sponsor Amount	2,600.00

Pri. Sponsor Pay	0.00
Pri. Sponsor Due	**2,600.00**
Deductions (Patient Amount)	0.00
Less Deposits Set Off	0.00
Less Reward Points Amt.	0.00
Less Patient Payments	0.00

Authorized Signature :(Pankaj Kushwaha)

बैंक ऑफ़ बड़ौदा
Bank of Baroda

To,

The Coordinator,
Mediwheel (Arcofemi Healthcare Limited)
Helpline number: 011- 41195959

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following spouse of our employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS OF HEALTH CHECK UP BENEFICIARY	
NAME	JYOTI VATSA
DATE OF BIRTH	18-11-1965
PROPOSED DATE OF HEALTH CHECKUP FOR EMPLOYEE SPOUSE	09-03-2024
BOOKING REFERENCE NO.	23M153804100098294S
SPOUSE DETAILS	
EMPLOYEE NAME	MR. VATSA PRAMOD
EMPLOYEE EC NO.	153804
EMPLOYEE DESIGNATION	BRANCH HEAD
EMPLOYEE PLACE OF WORK	NEW DELHI,HARI NAGAR
EMPLOYEE BIRTHDATE	11-12-1965

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from **07-03-2024** till **31-03-2024**.The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a **cashless facility** as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee's spouse and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

Chief General Manager
HRM Department
Bank of Baroda

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact Mediwheel (Arcofemi Healthcare Limited))

बैंक ऑफ़ बड़ौदा
Bank of Baroda

ELECTION COMMISSION OF INDIA
IDENTITY CARD
भारत निर्वाचन आयोग
पहचान पत्र

HR/07/61/405748

Elector's Name	: JYOTI
निर्वाचक का नाम	: ज्योती
Father/Mother/Husband's Name	: PRAMOD
पिता/माता/पति का नाम	: प्रमोद
Sex / लिंग	: Female / स्त्री
Age as on 1.1.1994	: 26 Years
1.1.1994 को आयु	: 26 वर्ष

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DATE-

NAME - Jyoti | PHONE - 9911350753

AGE/GENDER - 58 Y/F | ADDRESS -

EMAIL - | CORPORATE NAME -

1. **Past medical history & medications**:-

-

2. **Any existing disease: -**

-

3. **Current medications :-**

-

4. **VITALS** - (To be filled by medical personnel)

- BLOOD PRESSURE - ...../.....
- PULSE RATE - .....
- TEMPERATURE – .....
- SPO2 – .....
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – .....
- WEIGHT – .....
- BMI – .....

Vision - Both Eye - 6/6.
Colour vision - Normal.

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5. **FINDINGS: -**

LAB INVESTIGATION: - Hb - 13.6
Deranged Lipid profile.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal.

RADIOLOGY INVESTIGATIONS: - CXR - Normal

6. **DOCTOR REMARKS:** – Abnormal Lipid Profile

[redacted]

Name – –
Patient ID **Jyoti**

09.03.2024 11:27:12
Standard 12-Lead

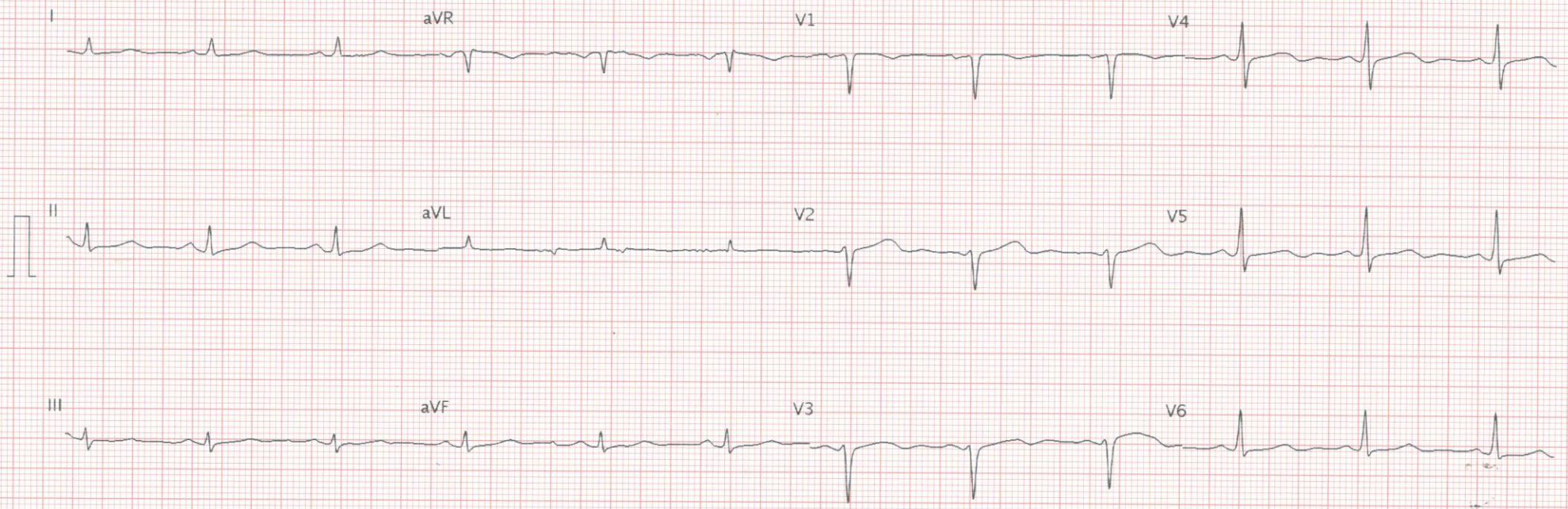
Date of birth	--	**Visit ID**			
Gender	Undefined	**Room**			
Height		**Medication**			
Weight		**Order ID**			
Ethnicity	Undefined	**Ord. prov.**			
Pacemaker	Unknown	**Ord. prot.**			

Indication
Remark

HR	**69 bpm**	**RR**	864 ms	Sinus rhythm
		P	104 ms	Normal electrical axis
		PR	146 ms	Low limb lead voltage
P axis	60 °	**QRS**	82 ms	Nonspecific T abnormality
QRS axis	33 °	**QT**	415 ms	Borderline ECG
T axis	56 °	**QTcB**	446 ms	

Unconfirmed report

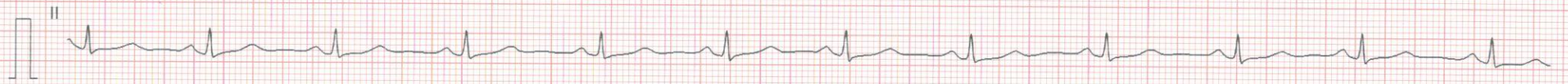
Borderline



25 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

AT-102 G2 1.2.0 (1080.009830)

Printed on 09.03.2024 11:27:24

[redacted] SCHILLER

Part No.2.157048M CE 0123 O.BD

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Patient's Name:-	MS. JYOTI	Date	:- 09/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 58Y/F

Radiograph of Chest (PA View)

Prominent broncho vascular marking are seen in bilateral lung fields.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

Dr Arushi Gupta
MBBS, DNB (Radio – Diagnosis)
Radiologist

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Jyoti Vats AGE/SEX: 58 / F DATE: 9 March 24

Through health checkup

O/E Dental carries 8/

Decayed 6/

Chr. gen. gingivitis

Advice → scaling & polishing

→ Ext^n of 8/

→ Ext^n & placement of implant /

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:50PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	**13.00**	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	**4.6**	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	**41.5**	%	42-52	Calculated
MCV	90.30	fL	78-100	Electrical Impedence
MCH	28.2	pg	27-31	Calculated
MCHC	**31.2**	gm/dL	32-36	Calculated
RDW-SD	**13.6**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	4160	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	56	%	40-80	VCSn Technology
LYMPHOCYTE	37	%	20-40	VCSn Technology
MONOCYTE	06	%	2-10	VCSn Technology
EOSINOPHIL	01	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	153	10^3/ul	150 - 450	Electrical Impedence
MPV	**13.9**	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	16.3	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	2.33	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	**1.54**	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.25	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.04**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	**22**	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. 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.

BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	AB			Gel Columns agglutination
Rh Typing	**POSITIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:46PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.80	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.25	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.55	mg/dL	0.1 - 1.0	Calculated
SGPT	20.10	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	26.50	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	1.32	Ratio	0.7 - 1.4	
GGT	36	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	**152.00**	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.70	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.40	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.3	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.33	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

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MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

Prasad

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	**233.00**	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	**189.10**	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	51.40	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	143.78	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	**181.6**	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	37.82	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	4.53	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	2.8	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.36	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

Prasad

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MBBS, DNB Pathology
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Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
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Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:58PM
Refer Lab/Hosp	: APOLLO CLINIC		

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APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.1	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	99.67	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	96.8	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	93.4	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	24.10	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	11.26	mg/dL	7 - 18	Urease
SERUM URIC ACID	4.90	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.90	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	9.30	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	139.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.02	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	103.9	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

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Patient NAME	: MRS.JYOTI	Barcode NO	: 20010213
Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:42PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.27	ng/mL	0.79 - 1.58	CLIA
T4	8.36	µg/dl	4.9 - 11.00	CLIA
TSH	3.20	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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Age/Gender	: 58 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:16PM
LabNo	: DPL21486	Sample Collected Date	: 09/Mar/2024 03:16PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:25PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 16

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	25	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.50		4.5 - 7.0	
SPECIFIC GRAVITY	1.025		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	ABSENT		Nill	
Urine Protein	ABSENT		Nil	
Urine Ketones	ABSENT		Nil	
BLOOD	ABSENT		Absent	
Leukocyte esterase	ABSENT		Negative	
Bile pigments	ABSENT		Absent	
NITRITE	ABSENT		Negative	
UROBILINOGEN	ABSENT		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	1-2	/hpf	0 - 5	
EPITHELIAL CELLS	2-3	/hpf	0 - 5	
RBCs	ABSENT	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

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

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