DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : PRATIBA VEDAVYAS **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138378 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0278XD000421** PATIENT ID : FH.12722596 CLIENT PATIENT ID: 164197 ABHA NO :	AGE/SEX :34 Years Female DRAWN :04/04/2024 09:17:55 RECEIVED :04/04/2024 09:20:09 REPORTED :04/04/2024 15:32:21

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 50 FEMALE	RESULT PENDING		
XRAY-CHEST	RESULT PENDING		
ECG	RESULT PENDING		
MEDICAL HISTORY	RESULT PENDING		
ANTHROPOMETRIC DATA & BMI	RESULT PENDING		
GENERAL EXAMINATION	RESULT PENDING		
CARDIOVASCULAR SYSTEM	RESULT PENDING		
BASIC EYE EXAMINATION	RESULT PENDING		
SUMMARY	RESULT PENDING		
FITNESS STATUS	RESULT PENDING		

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Agilus Diagnostics Ltd.
Building No 744/52,Chintal Plaza,33rd Cross,10th Main, 4th Block, Jayanagar,
Bangalore, 560011
Karnataka, India
Tel : 08041211945

Patient Ref. No. 775000007068935

DIAGNOSTIC REPORT

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Test Report Status **Preliminary**	Results	Units

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

TMT OR ECHO RESULT PENDING

****End Of Report****

Please visit www.agilusdiagnostics.com for related Test Information for this accession

CONDITIONS OF LABORATORY TESTING & REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
   i. Specimen received is insufficient or inappropriate
   ii. Specimen quality is unsatisfactory
   iii. Incorrect specimen type
   iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

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Test Report Status **Preliminary**

HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

Test	Results	Biological Reference Interval	Units
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN (HB)	12.7	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	4.62	3.8 - 4.8	mil/µL
WHITE BLOOD CELL (WBC) COUNT	7.82	4.0 - 10.0	thou/µL
PLATELET COUNT	268	150 - 410	thou/µL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	41.2	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	89.2	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.5	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	**30.8 Low**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	13.9	11.6 - 14.0	%
MENTZER INDEX	19.3		
MEAN PLATELET VOLUME (MPV)	10.3	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	51	40 - 80	%
LYMPHOCYTES	39	20 - 40	%
MONOCYTES	5	2 - 10	%
EOSINOPHILS	5	1 - 6	%
BASOPHILS	0	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	3.99	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	**3.05 High**	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT	0.42	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.42	0.02 - 0.50	thou/µL

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CIN - U74899PB1995PLC045956

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Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

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 CHECKUP BELOW 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD			
E.S.R	**37 High**	0 - 20	mm at 1 hr
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C	5.3	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)	105.4	< 116.0	mg/dL

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA 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, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, 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: Polycythermia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine,

salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for

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the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 45F FEMALE	RESULT PENDING
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD	RESULT PENDING

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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

GLUCOSE FASTING,FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	79	Normal 75 - 99 Pre-diabetics: 100 – 125 Diabetic: > or = 126	mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	84	70 - 139	mg/dL

LIPID PROFILE WITH CALCULATED LDL, SERUM

CHOLESTEROL, TOTAL	99	Desirable : < 200 Borderline : 200 - 239 High : > / = 240	mg/dL
TRIGLYCERIDES	48	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >/= 500	mg/dL
HDL CHOLESTEROL	51	At Risk: < 40 Desirable: > or = 60	mg/dL
CHOLESTEROL LDL	38	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL	48	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	9.6	< OR = 30.0	mg/dL

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CHOL/HDL RATIO	**1.9 Low**	Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO	0.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.42	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.29	< 0.30	mg/dL
BILIRUBIN, INDIRECT	0.13	0.1 - 1.0	mg/dL
TOTAL PROTEIN	7.4	6.0 - 8.0	g/dL
ALBUMIN	4.1	3.97 - 4.94	g/dL
GLOBULIN	3.3	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	20	< OR = 35	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	17	< OR = 35	U/L
ALKALINE PHOSPHATASE	74	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	12	0 - 40	U/L
LACTATE DEHYDROGENASE	156	125 - 220	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN	9	6 - 20	mg/dL
CREATININE, SERUM			
CREATININE	0.70	0.5 - 0.9	mg/dL

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BUN/CREAT RATIO			
BUN/CREAT RATIO	12.86	8.0 - 15.0	
URIC ACID, SERUM			
URIC ACID	5.5	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	7.4	6.0 - 8.0	g/dL
ALBUMIN, SERUM			
ALBUMIN	4.1	3.97 - 4.94	g/dL
GLOBULIN			
GLOBULIN	3.3	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM	**135 Low**	136 - 145	mmol/L
POTASSIUM, SERUM	4.26	3.5 - 5.1	mmol/L
CHLORIDE, SERUM	103	98 - 107	mmol/L

Interpretation(s)

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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 sothat 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 sulfonylureas,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 Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
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** results 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, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons 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.
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,Waldenstroms 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 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, Muscuophy
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-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,Waldenstroms 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.

Dr. Prajwal A, MD
CONSULTANT BIOCHEMIST
(SECTION HEAD)

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CIN - U74899PB1995PLC045956

Patient Ref. No. 775000007068935

DIAGNOSTIC REPORT

agilus diagnostics

PATIENT NAME : PRATIBA VEDAVYAS **REF. DOCTOR :** SELF

CODE/NAME & ADDRESS : C000138378 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	ACCESSION NO : **0278XD000421** PATIENT ID : FH.12722596 CLIENT PATIENT ID: 164197 ABHA NO :	AGE/SEX :34 Years Female DRAWN :04/04/2024 09:17:55 RECEIVED :04/04/2024 09:20:09 REPORTED :04/04/2024 15:32:21

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW		
APPEARANCE	CLEAR		

CHEMICAL EXAMINATION, URINE

PH	6.0	4.6 - 8.0	
SPECIFIC GRAVITY	1.005	1.003 - 1.035	
PROTEIN	NOTDETECTED		
GLUCOSE	NOTDETECTED		
KETONES	NOTDETECTED		
BLOOD	NOTDETECTED		
BILIRUBIN	NOTDETECTED		
UROBILINOGEN	NOTDETECTED		
NITRITE	NOTDETECTED		
LEUKOCYTE ESTERASE	NOTDETECTED		

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOTDETECTED		/HPF
PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
CASTS	NOTDETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOTDETECTED		
YEAST	NOT DETECTED	NOT DETECTED	

Dr.Suneet Kaur Hora
LAB HEAD & Sr. CONSULTANT PATHOLOGIST

Dr.Sneha Nayak S
Consultant Pathologist

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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 45 FEMALE	RESULT PENDING
PAPANICOLAOU SMEAR	RESULT PENDING
LETTER	RESULT PENDING

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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 45 FEMALE	RESULT PENDING		
PHYSICAL EXAMINATION,STOOL	RESULT PENDING		
CHEMICAL EXAMINATION,STOOL	RESULT PENDING		
MICROSCOPIC EXAMINATION,STOOL	RESULT PENDING		

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3	104.0	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
T4	6.04	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)	1.400	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL

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