

DEPARTMENT OF LABORATORY MEDICINE

Patient Name : Mrs. S SRIDEVIC	Order No : 1000078892
UHID : UHJ A23020974	Registered On : 23/03/2024 08:43:47 AM
Age/Sex : 40/Years Female	Collected On : 23/03/2024 09:20:29 AM
Ward / Bed No :	Reported On : 23/03/2024 02:21:18 PM
Reference : Dr. Preventive Health Check Up	Bill No : OPBJ A230025964
Station : At Hospital	Mobile No : 9742296483
Payer Name : Mediwheel	Report Status : Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	86	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	100	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	4.2	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	73.84	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.95	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	7.93	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	3.61	μIU/mL	0.34 - 5.60 μIU/mL (Non Pregnant) 0.3 - 4.5 μIU/mL (I trimester) 0.5 - 5.2 μIU/mL (II & III trimester)
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	197	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	67	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	55.9	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	127.7	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	13.40	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.5		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.28		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	141.1	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	4.3	mg/dL	2.6-6.0
LIVER FUNCTION TEST Sample: Serum			
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.84	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.17	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.67	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.15	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.14	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.93		2:1
SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	27	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	64	U/L	46-122
GGT (Method:IFCC)	28	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	14.5	mg/dL	17-43
BUN/CREATININE RATIO			
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	7	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.79	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	18.35		12~20 : 1

Sample: Serum



Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	12.26	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.0	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5500	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	66.90	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	23.24	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	3.14	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.47	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.25	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.10	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	87.9	fL	78-100
MCH (Method: Calculated)	29.9	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	14.0	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.17	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	8.58	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.5	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-20
BLOOD GROUPING & RH TYPING			Sample: Whole blood (EDTA)
ABO Group (Method:Agglutination Gel Method)	O		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed



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<u>CLINICAL PATHOLOGY</u>			
URINE EXAMINATION, ROUTINE Sample: Urine			
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.5		5.0-8.0
SPECIFIC GRAVITY	1.010		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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EPITHELIAL CELLS	2-4	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NA		
URINE SUGAR, FASTING	Absent		
(Method:GOD-POD)			

Verified By
Parameshwar B

---End of Report---



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*NABL renewal under process.



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore

Patient name :	Mrs. S SRIDEVI C	Date :	23/03/24
Age :	40 years GENDER: FEMALE	Patient ID :	20974
Ref by :	DR. CMO	OP/IP :	HEALTH CHECK

2D- ECHOCARDIOGRAPHY**M - MODE AND DOPPLER MEASUREMENTS**

(c.m)	(c.m)	(cm/sec)	
AO : 2.9 (2.5-3.7)	LVIDD : 4.6 (3.5-5.5)	MV EV : 72.8	AV : 46.9 MR : NORMAL
LA : 3.1 (1.9-4.0)	LVIDS : 2.9 (2.4-4.2)	AV : 94.3	AR : NORMAL
RA : 2.2 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 100	PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.1 (0.9-1.2)	TV EV : -----	AV : ----- TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 1.1 (0.6-1.1)	Diastolic Function : NO LVDD	
	LVPWS : 1.2 (0.9-1.2)		
	EF : 60%		

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis:	NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

NORMAL CHAMBER DIMENSIONS
 NORMAL LV SYSTOLIC FUNCTION EF : 60%
 NORMAL LV DIASTOLIC FUNCTION
 NO PULMONARY HYPERTENSION
 NO REGIONAL WALL MOTION ABNORMALITIES
 NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR. RAHUL PATIL
 CONSULTANT CARDIOLOGIST

DEPARTMENT OF RADIODIAGNOSIS

Name	S Sridevi C	Date	23/03/24
Age	40 years	Hospital ID	UHJA23020974
Sex	Female	Ref.	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

No radiographic abnormality.

Dr. Elluru Santosh Kumar
Consultant Radiologist

Disclaimer for Radiology Scans and Procedures :

- 1) Radiology results should be correlated and interpreted by qualified medical professionals only. In case of any clarification, the referring doctors or patients can contact the reception/respective department/doctor.
- 2) Radiology results are affected by patient body habitus, food consumption, bowel contents, hydration status, foreign bodies and artifacts.
- 3) Small renal/ureteric stones, some of the pathologies of bowel, peritoneum and retroperitoneum may not be detected on ultrasound study.
- 4) Antenatal ultrasound: Maternal body variables, gestational age, fetal position at the time of the scan affects the scanning. Patient should come for review scan if and when recommended. Chromosomal anomalies cannot be diagnosed on ultrasound only. If ultrasound markers indicate high risk for chromosomal anomalies, further evaluation including karyotyping may be needed.
- 5) Duplicate reports can be provided only upto 30 days from the date of scan/procedure.
- 6) X-ray is a screening modality and not a diagnostic test. It should be correlated clinically and complemented by other requisite imaging modalities and lab tests. X-ray cannot detect soft tissue injuries (like tendon/ ligament injuries) and small renal/ ureteric stones.
- 7) All disputes relating to the reports are subject to jurisdiction of courts at Bengaluru city only.