

DATE- 22/3/23  
 NAME - FARVEEN KUMAR  
 AGE/GENDER - Male (32y)  
 EMAIL - PKTEKARIA8892@apollo.com  
 PHONE - 9671522292  
 ADDRESS - v/o 'neharpu'  
 - Dist - Gurgaon  
 CORPORATE NAME - Bob

1. Past medical history & medications:-

no

2. Any existing disease: -

no

3. Current medications :-

no

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

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

VISION without glasses - RE - 6/18  
 LE - 6/12  
 Colours vision - Normal.

5. FINDINGS: -

LAB INVESTIGATION: - TSH - 5.60 (Borderline High).  
Rest investigation - Normal.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal.  
2D Echo - Normal.

RADIOLOGY INVESTIGATIONS: - USG - Grade I II fatty liver.  
CXR - Normal.

6. DOCTOR REMARKS: - As mentioned above.



<b>PATIENT NAME</b>	<b>MR PARVEEN KUMAR</b>	<b>REPORT DATE</b>	<b>3/23/2024</b>
<b>REF BY</b>	<b>P.H.M.C</b>	<b>AGE/SEX</b>	<b>32 YRS / M</b>

**ULTRASOUND WHOLE ABDOMEN**

*Clinical Profile-HEALTH CHECKUP.*

*Findings*

*The liver shows diffuse increase in its parenchymal echogenicity consistent with grade I-II fatty infiltration. No focal lesion is seen. The portal vein is normal in calibre and course.*

The gall bladder shows normal contents. 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 lymph node enlargement is seen in the para-aortic region.

The urinary bladder is normal in outline.

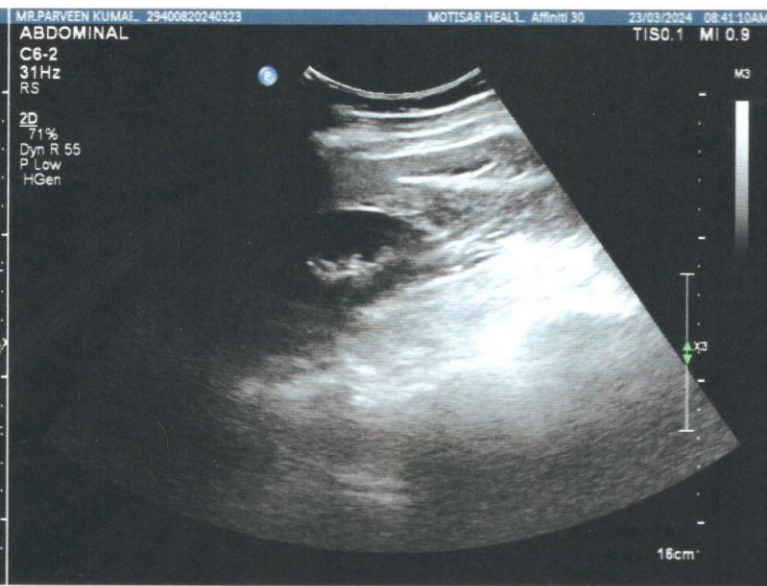
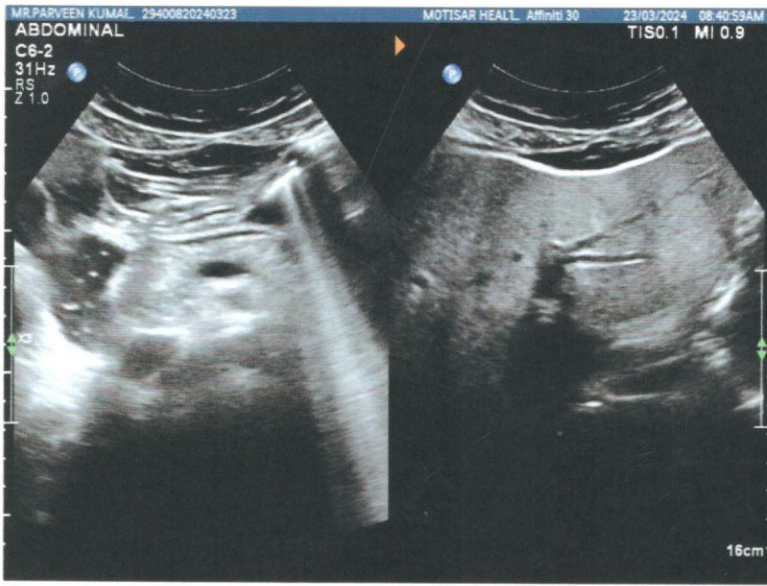
The prostate and seminal vesicles are unremarkable.

**IMPRESSION-  
GRADE I-II FATTY INFILTRATION OF LIVER.**

*Clinical correlation is necessary.*



**DR. RAJNISH JUNEJA,  
D.N.B (RADIO – DIAGNOSIS)**



Patient's Name:- MR. PARVEEN  
KUMAR

Date :- 23/03/2024

Referred By :- HEALTH CHEAKUP

Age/Sex :- 32Y/M

### Radiograph of Chest (PA View)

Visualized lungs fields appear normal.

Both hila appear normal

Both CP Angle are clear.

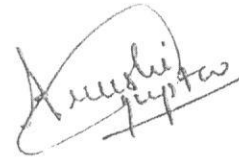
Domes are normally placed.

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

Name: Parveen Kumar  
 Patient ID: 12ba2c29-e31b-4cbf-837a-20e129bcb075

23.03.2024 09:21:47  
 Standard 12-Lead

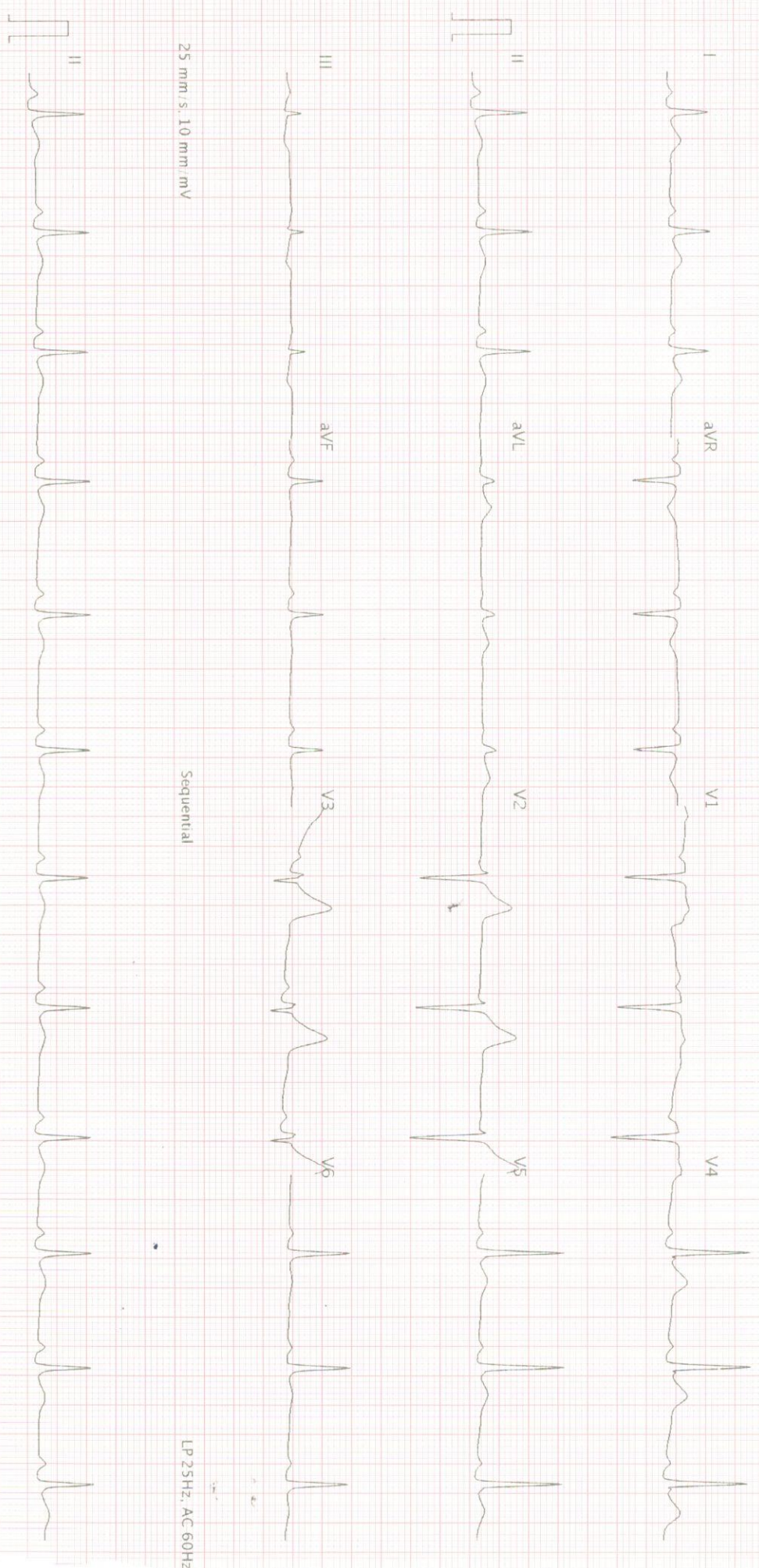
Date of birth: [Redacted]  
 Gender: Male  
 Height: [Redacted]  
 Weight: [Redacted]  
 Ethnicity: Undefined  
 Pacemaker: Unknown  
 Indication: [Redacted]  
 Remark: [Redacted]

Visit ID: [Redacted]  
 Room: [Redacted]  
 Medication: [Redacted]  
 Order ID: [Redacted]  
 Ord. prov.: [Redacted]  
 Ord. prot.: [Redacted]

HR 70 bpm  
 P axis 42°  
 QRS axis 44°  
 T axis 21°  
 RR 861 ms  
 P 93 ms  
 PR 143 ms  
 QRS 87 ms  
 QT 344 ms  
 QTcB 371 ms

Sinus rhythm  
 Normal electrical axis  
 Nonspecific ST abnormality (elevation)  
 Otherwise normal ECG  
 Unconfirmed report

Otherwise normal



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 23.03.2024 09:22:01

SCHILLER

Part No. 2.157048M

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Page

## ECHOCARDIOGRAPHY REPORT

<b>Patient's Name</b>	MR PARVEEN KUMAR	<b>Date</b>	23-03-2024
<b>Referred by</b>	HEALTH CHECK UP	<b>Age &amp; Sex</b>	32Yrs/M

### 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<sup>2</sup>  
 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 = **1.1 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 = **0.96** m/sec Aortic Annulus.....mm  
 Aortic Regurgitation **Absent** / Trivial/ Mild/Moderate/ Severe

<u>Measurements</u>	<u>Normal Values</u>	<u>Measurements</u>	<u>Normal Values</u>
Aorta- 2.2	(2.0-3.7 cm)	LAes- 2.5	(1.9-4.0 cm)
LVes- 2.4	(2.2-4.0 cm)	LVed- 3.7	(3.7-5.6 cm)
IVSed-0.7	(0.6-1.1 cm)	PW (LV) 0.7	(0.6-1.1 cm)
RV ed	(0.7-2.6 cm)	RV anterior wall	(up to 5 mm)
LVVd (ml)		LVVs (ml)	
EF <b>60-65 %</b>	(54%-76%)	IVS motion	<u>Normal</u> / Flat/ Paradoxical

**CHAMBERS:**

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

**COMMENTS AND SUMMARY**

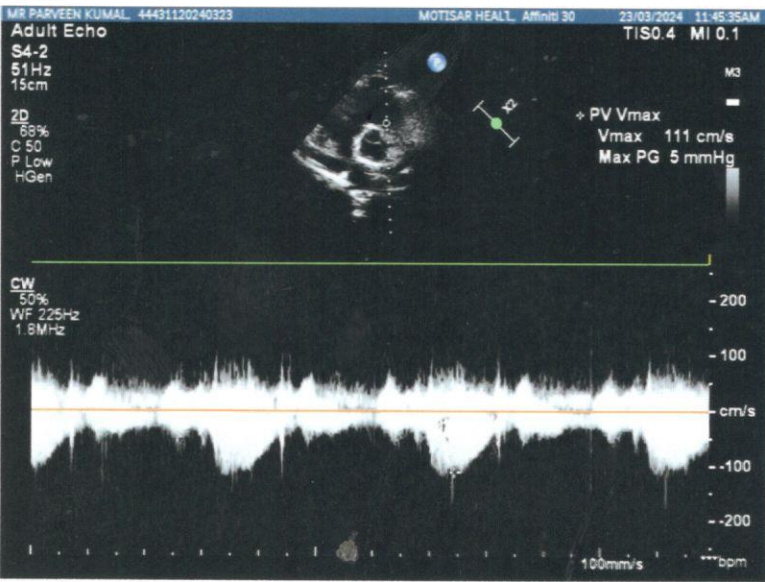
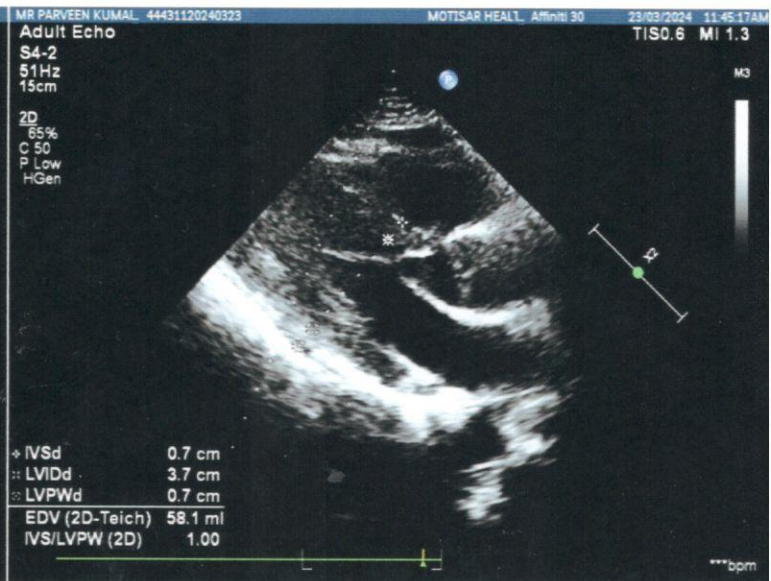
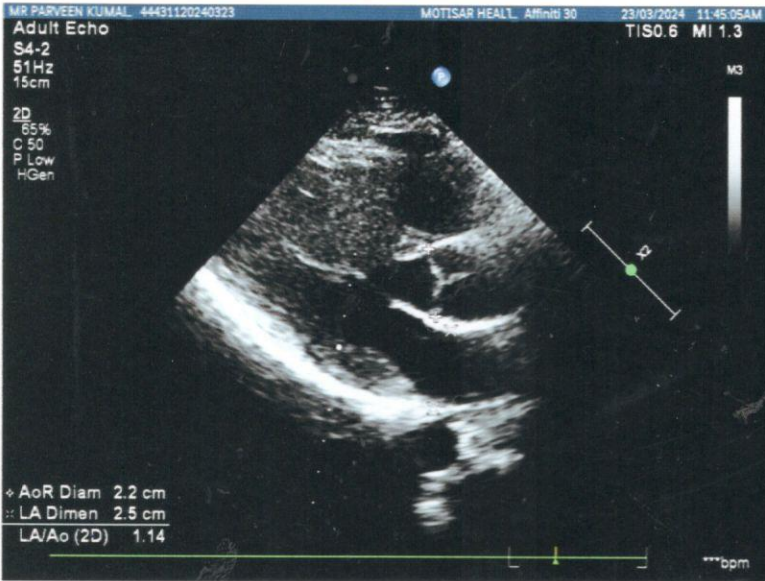
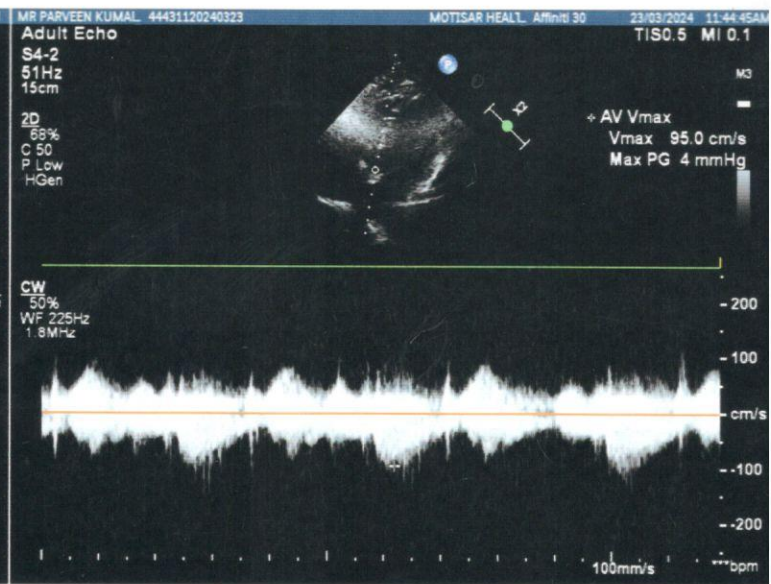
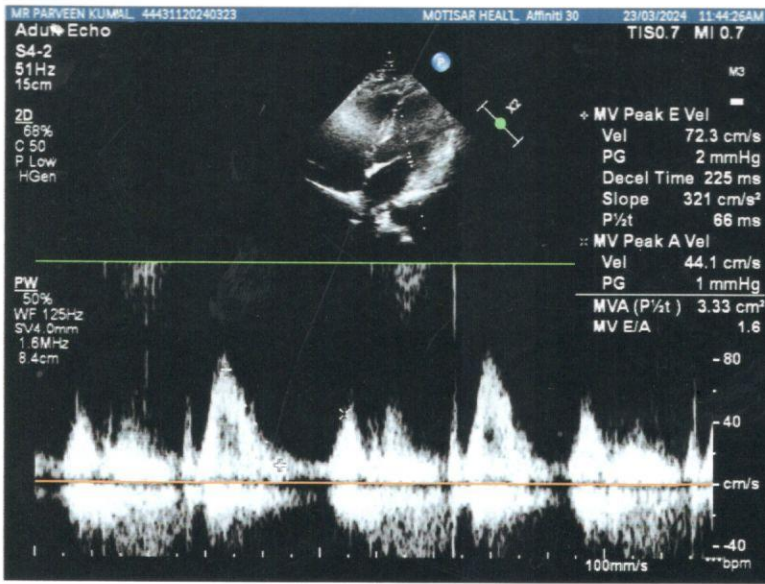
- ALL FOUR CHAMBERS NORMAL IS SIZE AND SHAPE
- ALL FOUR VALVES NORMAL IN MORPHOLOGY
- NO MR/AR/TR
- NO AORTIC STENOSIS
- NORMAL LV DIASTOLIC FUNCTION
- NO CLOT/MASS/PE SEEN
- NORMAL LV SYSTOLIC FUNCTION, LVEF= 60-65%

Kindly correlate clinically



**DR. ROHIT GOEL**  
 M.D, D.M (Cardiology)





Patient NAME : MR.PARVEEN KUMAR  
 Age/Gender : 32 Y O M O D /M  
 LabNo : DPL23808  
 Referred BY : SELF  
 Refer Lab/Hosp : APOLLO CLINIC

Barcode NO : 20011770  
 Registration Date : 23/Mar/2024 06:45PM  
 Sample Collected Date : 23/Mar/2024 06:45PM  
 Report Generated Date : 23/Mar/2024 07:31PM



DEPARTMENT OF HAEMATOLOGY  
 APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>COMPLETE BLOOD COUNT</b>				
<b>Sample Type : WHOLE BLOOD EDTA</b>				
HAEMOGLOBIN (HB)	15.30	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	5.7	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	49.6	%	42-52	Calculated
MCV	87.00	fL	78-100	Electrical Impedence
MCH	<b>26.9</b>	pg	27-31	Calculated
MCHC	<b>30.9</b>	gm/dL	32-36	Calculated
RDW-SD	<b>15</b>	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6420	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	59	%	40-80	VCSn Technology
LYMPHOCYTE	29	%	20-40	VCSn Technology
MONOCYTE	10	%	2-10	VCSn Technology
EOSINOPHIL	02	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	153	10 <sup>3</sup> /ul	150 - 450	Electrical Impedence
MPV	<b>12.7</b>	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	16.7	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	3.79	x10 <sup>3</sup> Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	<b>1.86</b>	x10 <sup>3</sup> Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.64	x10 <sup>3</sup> Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	<b>0.13</b>	x10 <sup>3</sup> 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.



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

83  
84

Patient NAME	: MR.PARVEEN KUMAR	Barcode NO	: 20011770
Age/Gender	: 32 Y O M O D /M	Registration Date	: 23/Mar/2024 06:45PM
LabNo	: DPL23808	Sample Collected Date	: 23/Mar/2024 06:45PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:31PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HAEMATOLOGY  
APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>ERYTHROCYTE SEDIMENTATION RATE</b>				
<b>Sample Type : WHOLE BLOOD EDTA</b>				
ERYTHROCYTE SEDIMENTATION RATE	20	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.



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Patient NAME	: MR.PARVEEN KUMAR	Barcode NO	: 20011770
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LabNo	: DPL23808	Sample Collected Date	: 23/Mar/2024 06:45PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:37PM
Refer Lab/Hosp	: <b>APOLLO CLINIC</b>		



**DEPARTMENT OF HAEMATOLOGY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>BLOOD GROUP ABO &amp; RH</b>				
<b>Sample Type : WHOLE BLOOD EDTA</b>				
ABO	"O"			Gel Columns agglutination
Rh Typing	<b>POSITIVE</b>			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	: MR.PARVEEN KUMAR	Barcode NO	: 20011770
Age/Gender	: 32 Y O M O D /M	Registration Date	: 23/Mar/2024 06:45PM
LabNo	: DPL23808	Sample Collected Date	: 23/Mar/2024 06:45PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 08:00PM
Refer Lab/Hosp	: <b>APOLLO CLINIC</b>		

**DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIVER FUNCTION TEST</b>				
<b>Sample Type : SERUM</b>				
TOTAL BILIRUBIN	0.80	mg/dL	0.1-1.2	Jendrasik Grof
CONJUGATED ( D. Bilirubin)	0.30	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED ( I.D. Bilirubin)	0.50	mg/dL	0.1 - 1.0	Calculated
SGPT	<b>54.10</b>	U/L	< 45	UV with P5P, IFCC 37 Degree
SGOT	33.40	U/L	< 50	UV with P5P, IFCC 37 degree
SGOT/SGPT	<b>0.62</b>	Ratio	0.7 - 1.4	
GGT	46	U/L	< 55	G-glutamyl-carboxy-nitroanilide
ALKALINE PHOSPHATASE	<b>121.00</b>	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.40	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.50	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	2.9	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.55	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 and 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 jaundice is 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, obstructive 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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Refer Lab/Hosp	: APOLLO CLINIC		

**DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
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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 is directly 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."



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 LabNo : DPL23808  
 Referred BY : SELF  
 Refer Lab/Hosp : APOLLO CLINIC

Barcode NO : 20011770  
 Registration Date : 23/Mar/2024 06:45PM  
 Sample Collected Date : 23/Mar/2024 06:45PM  
 Report Generated Date : 23/Mar/2024 07:59PM



**DEPARTMENT OF BIOCHEMISTRY**  
**APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIPID PROFILE</b>				
TOTAL CHOLESTEROL	163.00	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	117.40	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	53.20	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	86.32	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	109.8	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	23.48	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	<b>3.06</b>	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	1.62	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0	Calculated
HDL/LDL RATIO	0.62	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




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 LabNo : DPL23808  
 Referred BY : SELF  
 Refer Lab/Hosp : APOLLO CLINIC

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 Report Generated Date : 23/Mar/2024 07:59PM



DEPARTMENT OF BIOCHEMISTRY  
 APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
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Report Generated Date : 23/Mar/2024 08:29PM



DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>HBA1C</b>				
<b>Sample Type : WHOLE BLOOD EDTA</b>				
HBA1c	5.9	%	Non-Diabetic: <=6.0 Pre Diabetic: 6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood, HPLC
ESTIMATED AVG. GLUCOSE	122.34	mg/dL		

**Interpretations**

- HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
- 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.
- In known diabetic patients, following values can be considered as a tool for monitoring the glycemc 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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83  
84

Patient NAME	: MR.PARVEEN KUMAR	Barcode NO	: 20011770
Age/Gender	: 32 Y O M O D /M	Registration Date	: 23/Mar/2024 06:45PM
LabNo	: DPL23808	Sample Collected Date	: 23/Mar/2024 06:45PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 08:29PM
Refer Lab/Hosp	: <b>APOLLO CLINIC</b>		

DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>GLUCOSE - FASTING</b>				
<b>Sample Type : FLOURIDE PLASMA</b>				
Plasma Glucose Fasting	<b>107.5</b>	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 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>GLUCOSE - PP</b>				
<b>Sample Type : FLOURIDE PLASMA (PP)</b>				
Plasma Glucose PP	109.32	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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**83**  
**84**

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LabNo	: DPL23808	Sample Collected Date	: 23/Mar/2024 06:45PM
Referred BY	: SELF	Report Generated Date	: 23/Mar/2024 07:59PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>KIDNEY FUNCTION TEST</b>				
<b>Sample Type : SERUM</b>				
SERUM UREA	17.40	mg/dL	17-43	Urease GLDH
Blood Urea Nitrogen (BUN)	8.13	mg/dL	7-18	Urease
SERUM URIC ACID	6.00	mg/dL	3.5-7.2	Uricase/POD
SERUM CREATININE	0.90	mg/dL	0.67-1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	10.60	mg/dL	8.8-10.6	Arsenazo III
SERUM SODIUM	136.5	mmol/L	136-146	ISE
SERUM POTASSIUM	4.25	mmol/L	3.5-5.1	ISE
SERUM CHLORIDE	102.5	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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83  
84

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**DEPARTMENT OF BIOCHEMISTRY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
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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 normal anion-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 hyperfunction, 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 in overhydration, 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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Barcode NO : 20011770  
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 Report Generated Date : 23/Mar/2024 07:40PM



DEPARTMENT OF HORMONE ASSAYS  
 APOLLO PACKAGE 3

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>THYROID PROFILE (T3,T4,TSH)</b>				
<b>Sample Type : SERUM</b>				
T3	1.24	ng/mL	0.79 - 1.58	CLIA
T4	8.75	µg/dl	4.9 - 11.00	CLIA
TSH	<b>5.60</b>	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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**84**

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**DEPARTMENT OF CLINICAL PATHOLOGY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>URINE ROUTINE EXAMINATION</b>				
VOLUME	30	ml	-	
COLOUR	<b>PALE YELLOW</b>		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.50		4.5 - 7.0	
SPECIFIC GRAVITY	1.020		1.010 - 1.030	
<b>CHEMICAL EXAMINATION</b>				
URINE SUGAR.	Absent		Nil	
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	
<b>MICROSCOPIC EXAMINATION</b>				
PUS CELLS	1-2	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	Absent	/hpf	Absent	
CRYSTALS	Absent		Absent	
CASTS	Absent		Absent	
OTHER	Absent			

**URINE SUGAR - PP**

Sample Type : Urine

<b>Result</b>	Absent	Nil	Benedicts test
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**INTERPRETATION:**

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.




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**DEPARTMENT OF CLINICAL PATHOLOGY  
APOLLO PACKAGE 3**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>URINE FOR SUGAR - FASTING</b>				
<b>Sample Type : Urine</b>				
Result	Absent		Nil	Benedicts test

**INTERPRETATION:**

When the glucose level in blood exceeds the renal thresholds of glucose (160-180mg/dl) glucose starts to appear in urine. Glucose in urine gets excreted in diabetes mellitus. Elevated level of glucose in urine may also be a result of renal glucosuria. Other causes of glucose in urine are hyperthyroidism, high sugar diet, liver cirrhosis.

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



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