

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. CH RAVI SHANKAR RAJ U	Order No	: 1000079020
UHID	: UHJ A23021007	Registered On	: 23/03/2024 09:32:30 AM
Age/Sex	: 38/Years Male	Collected On	: 23/03/2024 10:23:30 AM
Ward / Bed No	:	Reported On	: 23/03/2024 03:31:52 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A230025998
Station	: At Hospital	Mobile No	: 7044942413
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	226	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	393	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	11.1	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	271.87	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	0.88	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	8.93	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	3.57	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	282	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	314	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	50.0	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	169.2	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	62.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.6		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.38		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	232	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.8	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	9	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.95	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	9.4		12~20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	1.28	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.22	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	1.07	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	6.9	g/dL	6.6-8.3

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ALBUMIN (Method:BCG)	4.65	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.25	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	2.06		2:1
SERUM SGOT (Method:IFCC without P5P)	24	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	31	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	90	U/L	50-116
GGT (Method:IFCC)	58	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.41	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	19.3	mg/dL	17-43
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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)	16.90	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	50.2	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	7090	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	53.90	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.25	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	4.98	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.56	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.31	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.34	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	94.1	fL	78-100
MCH (Method: Calculated)	31.6	pg	27-31
MCHC (Method: Calculated)	33.7	g/dL	31-37
RDW - CV (Method: Calculated)	13.5	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.43	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	9.57	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.1	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	15	mm/hour	1-15
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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CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE

Sample: Urine

PHYSICAL EXAMINATION

VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.025		1.005-1.030

CHEMICAL EXAMINATION

PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Present (1.5%)		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		

Verified By
Rashmita

---End of Report---



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*NABL renewal under process.

DEPARTMENT OF RADIODIAGNOSIS

Name	Ch Ravi Shankar Raju	Date	23/03/24
Age	38 years	Hospital ID	UHJA23021007
Sex	Male	Ref.	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is enlarged in size (15 cms) and shows moderately increased echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in size, course and caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (10.1 x 4.3 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (10.4 x 4.2 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi, mass or mural lesion.

Prostate is normal in echopattern and size, measures ~ 10 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **Mild hepatomegaly with moderate fatty infiltration (Grade II).**
- **No other definite sonological abnormality detected.**

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.

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Name	Ch Ravi Shankar Raju	Date	23/03/24
Age	38 years	Hospital ID	UHJA23021007
Sex	Male	Ref.	Healthcheck

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.**

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Consultant Radiologist

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