



BMI CHART

Date: 6/1/24

Name: Prachi Vamg Age: 38 yrs Sex: M/F

BP: 110/70 Height (cms): 154 cm Weight(kgs): 65.8 kg BMI: _____

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight				Healthy				Overweight				Obese				Extremely Obese							
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	35
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	24	25	25	26	27	28	28	29	30	31	31
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	24	25	25	26	27	28	28	29	30	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	28	29	30
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	28	29
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	28
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	27
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature



UHID	13064629	Date	01/04/2024		
Name	Mrs. Prachi Verma	Sex	Female	Age	38
OPD	Pap	Health Check Up			

Dr. Shefali

Drug allergy: → No Penicillin
 Sys illness:

38f Married 10 yrs Ectopic pregnancy 7-8 yrs

No fresh complaint

K/O Hypothyroidism 10 yrs on P. Thyronorm 62.5 mcg.

LMP → 1st week march
 Regular cycle / Normal flow 2-3 days / Every 28-30 days

O/H/O Laparoscopic done i/o ectopic → both tubes preserved → 7-8 yrs ago

Last Pap smear every done 1yr ago.

Father } DM + HTN
 Mother }

Adv
 - Pap smear done in 2023
 next Pap smear in 2026

- Pap smear every 3yrs
 - counselled about HPV vaccine
 (0, 2 months, 6 months)



UHID	13064629	Date	01/04/2024		
Name	Mrs. Prachi Verma	Sex	Female	Age	38
OPD	Ophthal 14	Health Check Up			

Clear No. Opt. Vn

H/O Thyroid (since 10 yrs)

Drug allergy: → No Penicillin?
 Sys illness: → No (grip??)
 Habit → No

Unit Vn → RG 6/36P
 → LG 6/9P (Ref)

Ref → RG - 1.25 / -0.75 x 90° 6/6
 → LG - 0.50 / -0.50 x 90° 6/6

MVA → RG N6
 → LG N6

FOP → RG → 13.8
 → LG → 15.3

(Signature)

C.V.D.
 20-20-rule
 20mi / 30mi
 ↓
 20psd 30ms
 (cont)

* Soft drops → 4 times / day
 4 weeks



UHID	13064629	Date	01/04/2024		
Name	Mrs. Prachi Verma	Sex	Female	Age	38
OPD	Dental 12	Health Check Up			

Drug allergy:
Sys illness:

MH → Thyroid . . 10 yrs.

O/E → Distally fractured $\frac{+}{7}$

Lx → Hx RUG $\frac{+}{7}$ & reevaluation

Prachi

Dr. Vaishali Lam
MDS (Perio)
A-39457

PATIENT NAME : MRS.PRACHI VERMA

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

ACCESSION NO : 0022XD000049

AGE/SEX : 38 Years Female

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL - VASHI,
MUMBAI 440001

PATIENT ID : FH.13064629

DRAWN : 01/04/2024 09:06:00

CLIENT PATIENT ID: UID:13064629

RECEIVED : 01/04/2024 09:07:08

ABHA NO :

REPORTED : 01/04/2024 13:19:16

CLINICAL INFORMATION :

UID:13064629 REQNO-1685870
CORP-OPD
BILLNO-150124OPCR018301
BILLNO-150124OPCR018301

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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	10.5 Low	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.36	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	6.20	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	294	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	34.3 Low	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	78.7 Low	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	24.1 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	30.6 Low	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	14.0	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	18.1		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	10.9	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT



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Consultant Pathologist

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NEUTROPHILS		61	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		29	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		3	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.78	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.80	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.43	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.19	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.1		
METHOD : CALCULATED				

MORPHOLOGY

RBC MILD HYPOCHROMASIA, MILD MICROCYTOSIS , MILD ANISOCYTOSIS
 METHOD : MICROSCOPIC EXAMINATION

WBC NORMAL MORPHOLOGY
 METHOD : MICROSCOPIC EXAMINATION

PLATELETS ADEQUATE
 METHOD : MICROSCOPIC EXAMINATION

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Test Report Status **Final**

Results

Biological Reference Interval Units

Interpretation(s)

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

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	26 High	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)			

ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

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, Vasculitides, 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: Polycythemia 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)



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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 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 patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/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 addition 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 platform (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

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE B

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.



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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.19 Low	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.07	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.12	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	6.8	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.6	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.2	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	14 Low	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	19	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	66	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE	21	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	102	81 - 234	U/L

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	93	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
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Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	4 Low	6 - 20	mg/dL
METHOD : UREASE - UV			

CREATININE EGFR- EPI

CREATININE	0.66	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			

AGE	38		years
-----	----	--	-------

GLOMERULAR FILTRATION RATE (FEMALE)	115.08	Refer Interpretation Below	mL/min/1.73m ²
METHOD : CALCULATED PARAMETER			

BUN/CREAT RATIO

BUN/CREAT RATIO	6.06	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			

URIC ACID, SERUM

URIC ACID	4.4	2.6 - 6.0	mg/dL
METHOD : URICASE UV			

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	6.8	6.4 - 8.2	g/dL
METHOD : BIURET			



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Patient Ref. No. 22000000912590

PATIENT NAME : MRS.PRACHI VERMA

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

ACCESSION NO : 0022XD000049

AGE/SEX : 38 Years Female

FORTIS VASHI-CHC -SPLZD

PATIENT ID : FH.13064629

DRAWN : 01/04/2024 09:06:00

FORTIS HOSPITAL - VASHI,

CLIENT PATIENT ID: UID:13064629

RECEIVED : 01/04/2024 09:07:08

MUMBAI 440001

ABHA NO :

REPORTED : 01/04/2024 13:19:16

CLINICAL INFORMATION :

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CORP-OPD

BILLNO-150124OPCR018301

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ALBUMIN, SERUM

ALBUMIN

3.6

3.4 - 5.0

g/dL

METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN

3.2

2.0 - 4.1

g/dL

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM

139

136 - 145

mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM

4.28

3.50 - 5.10

mmol/L

METHOD : ISE INDIRECT

CHLORIDE, SERUM

104

98 - 107

mmol/L

METHOD : ISE INDIRECT

Interpretation(s)

Interpretation(s)

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.



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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 Hypophosphatase, 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

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 so that 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; sulfonyleureas, 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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity 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 EGFR- EPI-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons. Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m2). This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).

Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.uw.edu/guideline/egfr>

Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325

Harrison's Principle of Internal Medicine, 21st ed, pg 62 and 334

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.



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REF. DOCTOR :

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ACCESSION NO : 0022XD000049

AGE/SEX : 38 Years Female

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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.



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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	168	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
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METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES	40	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
---------------	----	--	-------

METHOD : ENZYMATIC ASSAY

HDL CHOLESTEROL	50	< 40 Low >=60 High	mg/dL
-----------------	----	-----------------------	-------

METHOD : DIRECT MEASURE - PEG

LDL CHOLESTEROL, DIRECT	101	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
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METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT

NON HDL CHOLESTEROL	118	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
---------------------	-----	--	-------

METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN	8.0	<= 30.0	mg/dL
------------------------------	-----	---------	-------

METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO	3.4	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk
----------------	-----	--

METHOD : CALCULATED PARAMETER



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LDL/HDL RATIO	2.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk		
---------------	-----	--	--	--

METHOD : CALCULATED PARAMETER

Interpretation(s)

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
<small>METHOD : PHYSICAL</small>	
APPEARANCE	SLIGHTLY HAZY
<small>METHOD : VISUAL</small>	

CHEMICAL EXAMINATION, URINE

PH	5.5	4.7 - 7.5
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD</small>		
SPECIFIC GRAVITY	1.010	1.003 - 1.035
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)</small>		
PROTEIN	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE</small>		
GLUCOSE	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD</small>		
KETONES	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE</small>		
BLOOD	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN</small>		
BILIRUBIN	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT</small>		
UROBILINOGEN	NORMAL	NORMAL
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)</small>		
NITRITE	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE</small>		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED
<small>METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY</small>		

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MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		5-7	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	124.0	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
----	-------	---	-------

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

T4	8.52	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
----	------	---	-------

METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE

TSH (ULTRASENSITIVE)	3.960	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
----------------------	-------	---	--------

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

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CODE/NAME & ADDRESS : C000045507		ACCESSION NO : 0022XD000071	AGE/SEX : 38 Years Female
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BIOCHEMISTRY				
GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	95	70 - 140		mg/dL
METHOD : HEXOKINASE				

Interpretation(s)
 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 Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****
 Please visit www.agilusdiagnostics.com for related Test Information for this accession

Dr. Akshay Dhotre, MD
 (Reg.no. MMC 2019/09/6377)
 Consultant Pathologist



View Details



View Report

PERFORMED AT :
 Agilus Diagnostics Ltd.
 Hiranandani Hospital-Vashi, Mini Seashore Road, Sector 10,
 Navi Mumbai, 400703
 Maharashtra, India
 Tel : 022-39199222,022-49723322, Fax :
 CIN - U74099PB1995PLC045956
 Email : -



Patient Ref. No. 22000000912612

female

Htc

Sinus bradycardia

Normal ECG

Rate 69 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Baseline wander in lead(s) V4, V6

PR 150
 QRS 85
 QT 365
 QTc 391

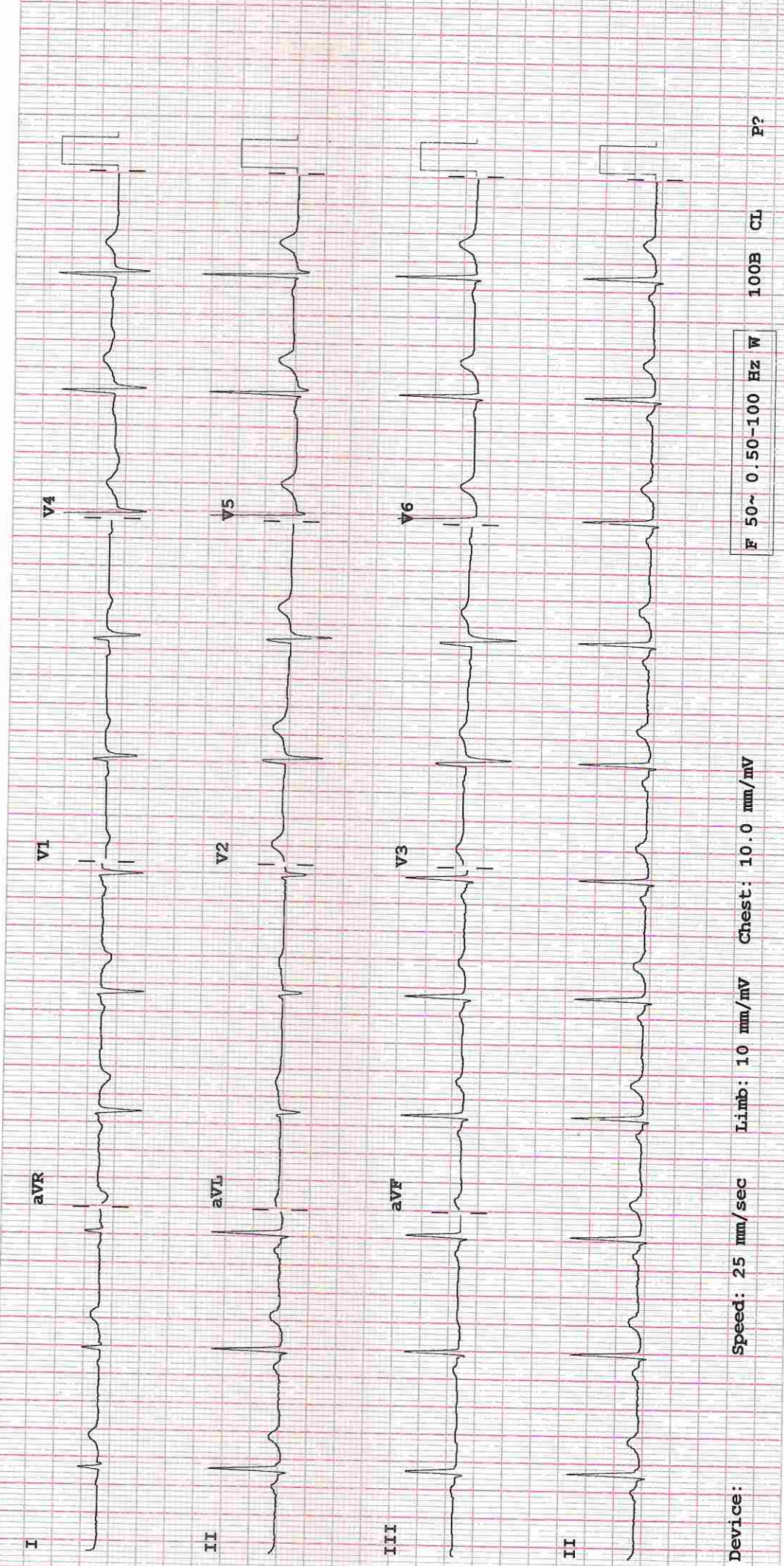
--AXIS--

P 70
 QRS 74
 T 32

- NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?

Hiranandani Healthcare Pvt. Ltd.

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For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D

(For Billing/Reports & Discharge Summary only)**DEPARTMENT OF NIC**

Date: 01/Apr/2024

Name: Mrs. Prachi Verma

UHID | Episode No : 13064629 | 18556/24/1501

Age | Sex: 38 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2404/38879 | 01-Apr-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 01-Apr-2024 11:54:01

Bed Name :

Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC**FINDINGS:**

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- Trivial mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 25 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 13 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	29	mm
AO Root	18	mm
AO CUSP SEP	14	mm
LVID (s)	28	mm
LVID (d)	43	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	32	mm
RA	33	mm
LVEF	60	%

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Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.

A WAVE VELOCITY:0.8 m/sec

E/A RATIO: 1.1

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Trivial
AORTIC VALVE	05			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- Trivial MR and TR. No PH.
- Normal LV and RV systolic function.

DR. PRASHANT PAWAR
DNB(MED), DNB (CARD)**DR. AMIT SINGH,**
MD(MED),DM(CARD)

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CIN: U85100MH2005PTC 154823

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PAN NO : AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

(For Billing/Reports & Discharge Summary only)

Date: 01/Apr/2024

Name: Mrs. Prachi Verma

Age | Sex: 38 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13064629 | 18556/24/1501

Order No | Order Date: 1501/PN/OP/2404/38879 | 01-Apr-2024

Admitted On | Reporting Date : 01-Apr-2024 15:11:44

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH

DMRD., DNB. (Radiologist)



(For Billing/Reports & Discharge Summary only)

Patient Name	: Prachi Verma	Patient ID	: 13064629
Sex / Age	: F / 38Y 8M 10D	Accession No.	: PHC.7834210
Modality	: US	Scan DateTime	: 01-04-2024 12:11:55
IPID No	: 18556/24/1501	ReportDatetime	: 01-04-2024 11:29:38

USG - BREAST

Findings:

Bilateral breast parenchyma appears normal.

No evidence of solid or cystic lesion.

No dilated ducts are noted.

The fibroglandular architecture is well maintained.

Retromammory soft tissues appear normal.

No evidence of axillary lymphadenopathy.

Impression:

- No significant abnormality detected.

Y. Shah

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)



(For Billing/Reports & Discharge Summary only)

Patient Name	:	Prachi Verma	Patient ID	:	13064629
Sex / Age	:	F / 38Y 8M 10D	Accession No.	:	PHC.7834210
Modality	:	US	Scan DateTime	:	01-04-2024 12:11:55
IPID No	:	18556/24/1501	ReportDatetime	:	01-04-2024 11:29:38

USG – WHOLE ABDOMEN

LIVER is normal in size and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 9.5 x 4.7 cm. Left kidney measures 10.2 x 4.5 cm.

PANCREAS: Head and body of pancreas is visualised and appears normal. Rest of the pancreas is obscured.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

UTERUS is normal in size, measuring 7.2 x 4.5 x 3.3 cm.

Endometrium measures 11.5 mm in thickness.

Both ovaries are normal.

Right ovary measures 2.8 x 1.6 cm. Left ovary measures 3.3 x 2.1 cm.

No evidence of ascites.

Impression:

- No significant abnormality is detected.



DR. KUNAL NIGAM
M.D. (Radiologist)