UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mrs. P GRACE LAVANYA	Order No	: 1000082581
UHID	: UHJA24000426	Registered On	: 13/04/2024 08:58:53 AM
Age/Sex	: 46/Years Female	Collected On	: 13/04/2024 09:08:06 AM
Ward / Bed No	:	Reported On	: 13/04/2024 12:42:10 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA240000561
Station	: At Hospital	Mobile No	: 9000306450
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	140	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	199	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	8.9	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	208.73	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.02	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	8.79	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	5.94	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	189	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	83	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.1	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	129.3	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.60	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.3		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.0		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	145.9	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.7	mg/dL	2.6-6.0
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.48	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.08	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.40	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.2	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.13	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	3.07	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.34		2:1
SERUM SGOT (Method:IFCC without P5P)	16	U/L	< 35

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SERUM SGPT (Method:IFCC without P5P)	12	U/L	< 35
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	73	U/L	46-122
GGT (Method:IFCC)	14	U/L	< 38
UREA (Method:Urease GLDH - Kinetic)	12.1	mg/dL	17-43
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	6	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	0.6	mg/dL	0.6-1.1
BUN/CRE-RATIO (Method: Calculated)	10.7		12¯20 : 1

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	11.46	g/dL	12-16
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	36.2	%	37-47
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4530	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	65.91	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	25.48	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	2.06	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.19	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.36	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.48	million/cum	4.0-5.2
MCV (Method:Derived from RBC Histogram)	80.9	fL	78-100
MCH (Method: Calculated)	25.6	pg	27-31
MCHC (Method: Calculated)	31.7	g/dL	31-37
RDW - CV (Method: Calculated)	15.6	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.24	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.68	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	18.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	16	mm/hour	1-20

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	O		
Rh Factor (Method:Agglutination Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

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Test Name	Result	Unit	Bio. Ref. Interval

CLINICAL PATHOLOGY

URINE EXAMINATION, ROUTINE — Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	5.0		5.0-8.0
SPECIFIC GRAVITY	1.005		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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Test Name	Result	Unit	Bio. Ref. Interval
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	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Present (1.5%)		

Verified By
Parameshwar B

---End of Report---

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*NABL renewal under process.

NABH NABL No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Patient name :	**Mrs. GRACE LAVANYA**	**Date :**	**13/04/24**
Age :	**46 years GENDER: FEMALE**	**Patient ID :**	**2400426**
Ref by :	**DR.CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.5 (2.5-3.7)	LVIDD : 4.5 (3.5-5.5)	MV EV : 56.1	AV : 43.1	MR : NORMAL
LA : 2.8 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 143		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 70.8		PR : NORMAL
RV : 2.2 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD : 0.9 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.1 (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

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DEPARTMENT OF RADIODIAGNOSIS

Name	P Grace Lavanya	**Date**	13/04/24
Age	46 years	**Hospital ID**	UHJA24000426
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

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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.