



BMI CHART

Date: 11/09/23

Name: Manoj Kumar Singh Age: 37 yrs Sex: M / F

BP: 110/80 mmHg Height (cms): 162 cm Weight(kgs): 69.8 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	36	
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	30	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	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31	
5'11" - 180.3	14	14	15	16	16	17	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30	30	
6'0" - 182.8	13	14	14	15	16	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30	
6'1" - 185.4	13	13	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	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	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	27	28	
6'4" - 193.0	12	12	13	14	14	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26	27	

Doctors Notes:

Signature



UHID	13084585	Date	11/04/2024		
Name	Mr. Manojkumar Bhagawati Singh	Sex	Male	Age	37
OPD	Dental 12	Health Check Up			

C/O - Pt complains of pain in lower left back tooth region of jaw.

Drug allergy:
 Sys illness:

PMH - NRH

O/E -

Initial caries \bar{c}
 (lingually tilted) $\frac{+}{8}$
 Stains +
 Calculus +

Advice -

Scaling
 Extraction \bar{c} $\frac{+}{8}$

Dr. Sushmita

DR. HARSH GHORPADE,
vashi, Navi Mumbai.

. Navi Mumbai - 400703
9199220
1255
1 Checkup: 022 - 39199300



Hiranandani
HOSPITAL

A Fortis Network Hospital

NAME
28 JAN 2021 10:56
): AABCH5894D

VD=12
<R> SPH CYL AX
+ 0.25 -0.50 26
+ 0.25 -0.25 28
+ 0.25 -0.25 25

+ 0.25 -0.25 28

<R> mm D AX
R1 7.57 44.50 23
R2 7.44 45.25 113
AVE 7.50 45.00
CYL -0.75 23

<L> SPH CYL AX
0.00 0.00
+ 0.50 -0.75 133
0.00 -0.50 169

0.00 0.00

<L> mm D AX
R1 7.60 44.50 50
R2 7.55 44.75 140
AVE 7.57 44.50
CYL -0.25 50

PD= 62

Grand Seiko Co., Ltd.
GR-3100K S/N:Y8AL2943

	Date	11/04/2024	
kumar Bhagawati Singh	Sex	Male	Age 37
Health Check Up			

Drug allergy: Nil
Sys illness: Nil

checkup
glasses.

6/6 N6

6/6 N6

of glasses

nx

softwise eye drop Both eyes x 1 month

| — | — |

PATIENT NAME : MR.MANOJKUMAR BHAGAWATI SINGH

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL - VASHI,
 MUMBAI 440001

ACCESSION NO : 0022XD001853
 PATIENT ID : FH.13084585
 CLIENT PATIENT ID: UID:13084585
 ABHA NO :

AGE/SEX : 37 Years Male
 DRAWN : 11/04/2024 08:39:00
 RECEIVED : 11/04/2024 08:41:27
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CLINICAL INFORMATION :

UID:13084585 REQNO-1690127
 CORP-OPD
 BILLNO-150124OPCR020050
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Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	15.0	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	5.03	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	5.82	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	229	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	44.8	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	89.1	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	29.8	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	33.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	11.8	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	17.7		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	9.5	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT



Page 1 Of 17

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 (Reg.no. MMC 2019/09/6377)
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NEUTROPHILS		57	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		31	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		11 High	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		1	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.32	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		0.64	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.06	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)		1.8		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE



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Page 2 Of 17



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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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Page 3 Of 17



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HAEMATOTOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	20 High	0 - 14	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.1	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)	%
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METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	99.7	< 116.0	mg/dL
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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, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine, salicylates)



Page 4 Of 17

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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:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- 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.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - 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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Page 5 Of 17



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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.



Page 6 Of 17

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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.85	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.16	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.69	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	8.5 High	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	4.6 High	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	0.9 Low	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	20	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	37	< 45.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	83	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	31	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE	161	85 - 227	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	95	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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METHOD : HEXOKINASE



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Page 7 Of 17



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REPORTED : 11/04/2024 15:06:18

CLINICAL INFORMATION :

UID:13084585 REQNO-1690127

CORP-OPD

BILLNO-150124OPCR020050

BILLNO-150124OPCR020050

Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN

11

6 - 20

mg/dL

METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE

0.96

0.90 - 1.30

mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

37

years

GLOMERULAR FILTRATION RATE (MALE)

104.40

Refer Interpretation Below

mL/min/1.73m2

METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO

11.46

5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID

6.7

3.5 - 7.2

mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN

8.5 High

6.4 - 8.2

g/dL

METHOD : BIURET



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Page 8 Of 17

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Email : -



Patient Ref. No. 2200000914394

PATIENT NAME : MR.MANOJKUMAR BHAGAWATI SINGH

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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

ACCESSION NO : 0022XD001853

PATIENT ID : FH.13084585

CLIENT PATIENT ID: UID:13084585

ABHA NO :

AGE/SEX : 37 Years Male

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ALBUMIN, SERUM

ALBUMIN	3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			

GLOBULIN

GLOBULIN	4.6 High	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	136	136 - 145	mmol/L
METHOD : ISE INDIRECT			

POTASSIUM, SERUM	4.31	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			

CHLORIDE, SERUM	102	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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Page 9 Of 17



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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 Hypophosphatasia, 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; sulfonylureas, 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 (KDIGO) 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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Page 10 Of 17



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Test Report Status **Final**

Results

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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.



Page 11 Of 17

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	211 High	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	338 High	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	34 Low	< 40 Low >= 60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	97	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL	177 High	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	67.6 High	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	6.2 High	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

2.9

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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Page 13 Of 17



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CLINICAL PATH - URINALYSIS

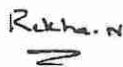
KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
METHOD : PHYSICAL	
APPEARANCE	CLEAR
METHOD : VISUAL	

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD		
SPECIFIC GRAVITY	1.015	1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)		
PROTEIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE		
GLUCOSE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		


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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

0-1

0-5

/HPF

METHOD : MICROSCOPIC EXAMINATION

CASTS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

CRYSTALS

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT 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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Page 15 Of 17



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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	121.6	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	6.94	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	1.810	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY			

Interpretation(s)



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Page 16 Of 17



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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	1.020	0.0 - 1.4	ng/mL
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METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.

- It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
- Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
- Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References-

1. Burtis CA, Ashwood ER, Bruns DE, Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

End Of Report

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

Page 17 Of 17



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 - U74899PB1995PLC045956
Email : -



Patient Ref. No. 2200000914394

PATIENT NAME : MR.MANOJKUMAR BHAGAWATI SINGH

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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

ACCESSION NO : 0022XD001912

PATIENT ID : FH.13084585

CLIENT PATIENT ID: UID:13084585

ABHA NO :

AGE/SEX : 37 Years Male

DRAWN : 11/04/2024 11:36:00

RECEIVED : 11/04/2024 11:37:36

REPORTED : 11/04/2024 13:09:02

CLINICAL INFORMATION :

UID:13084585 REQNO-1690127
CORP-OPD
BILLNO-150124OPCR020050
BILLNO-150124OPCR020050

Test Report Status	Final	Results	Biological Reference Interval	Units
--------------------	-------	---------	-------------------------------	-------

BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	105	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

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Email : -



Patient Ref. No. 2200000914453

4/11/2024 9:15:56 AM

manojkumar singh
Male

13084585
37 Years

Htc

Normal Q

Rate 79 Sinus rhythm.....normal P axis, V-rate 50- 99
 PR 148 Probable left atrial enlargement.....P >50ms, <-0.10mV V1
 QRS 89 RSR' in V1 or V2, probably normal variant.....small R' only
 QT 360
 QTc 413

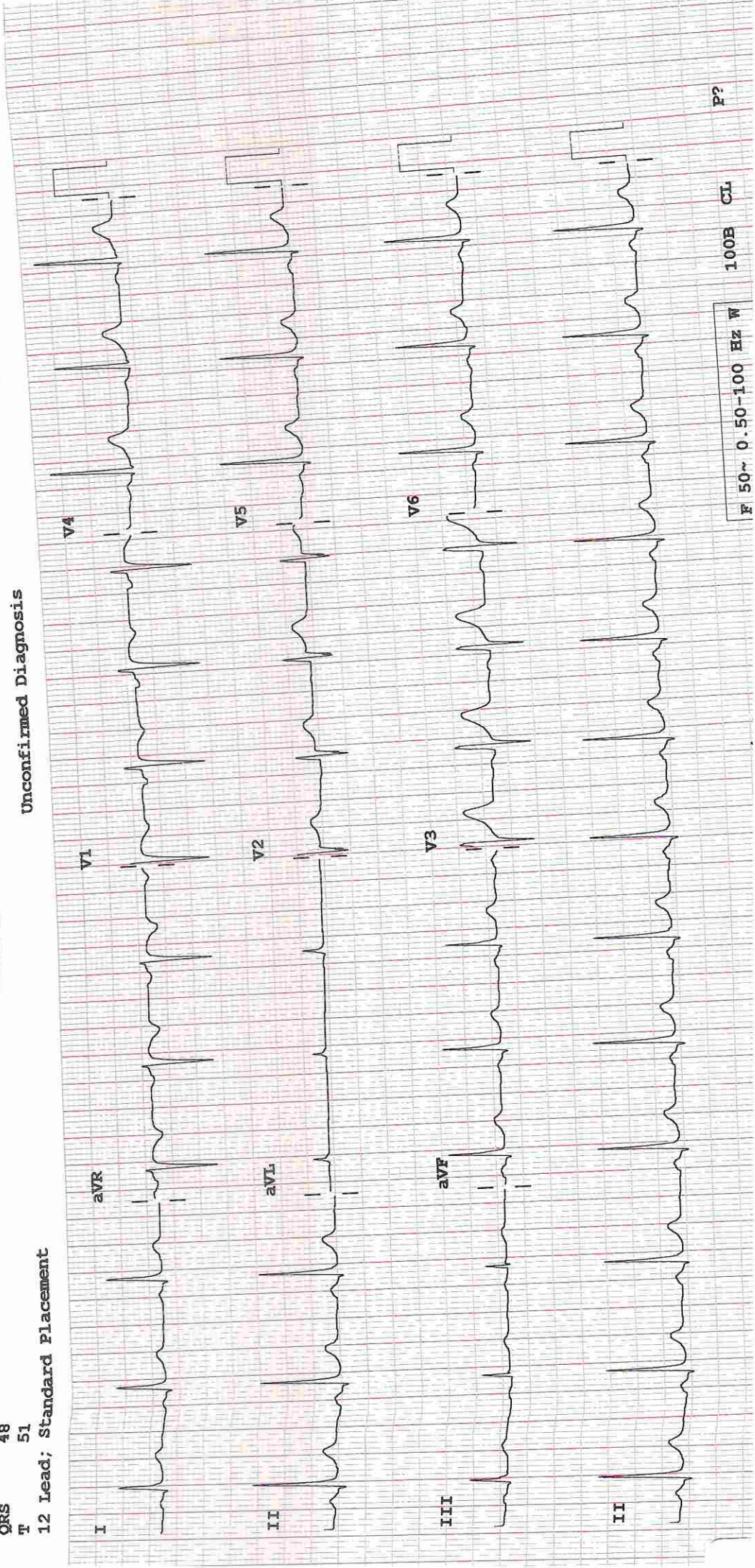
--AXIS--

P 57
 QRS 48
 T 51

12 Lead; Standard Placement

-- BORDERLINE ECG -

Unconfirmed Diagnosis



F 50~ 0.50-100 Hz W

100B CL

P?

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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Emergency: 022 - 39199100 | Ambulance: 1255

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

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



DEPARTMENT OF NIC

Date: 11/Apr/2024

Name: Mr. Manojkumar Bhagawati Singh

UHID | Episode No : 13084585 | 20392/24/1501

Age | Sex: 37 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2404/42581 | 11-Apr-2024

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Apr-2024 14:03:19

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 left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 14 mm with normal inspiratory collapse.

M-MODE MEASUREMENTS:

LA	30	mm
AO Root	17	mm
AO CUSP SEP	11	mm
LVID (s)	25	mm
LVID (d)	38	mm
IVS (d)		mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	28	mm
LVEF	60	%

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Age | Sex: 37 YEAR(S) | Male

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Order Station : FO-OPD

Admitted On | Reporting Date : 11-Apr-2024 14:03:19

Bed Name :

Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.


A WAVE VELOCITY: 0.5 m/sec

E/A RATIO: 1.4

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

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.


DR. PRASHANT PAWAR
DNB(MED), DNB (CARD)

DR. AMIT SINGH,
MD(MED), DM(CARD)

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 11/Apr/2024

Name: Mr. Manojkumar Bhagawati Singh

Age | Sex: 37 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 13084585 | 20392/24/1501

Order No | Order Date: 1501/PN/OP/2404/42581 | 11-Apr-2024

Admitted On | Reporting Date : 11-Apr-2024 14:34:47

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	:	Manojkumar Bhagawati Singh	Patient ID	:	13084585
Sex / Age	:	M / 37Y 7M 8D	Accession No.	:	PHC.7898475
Modality	:	US	Scan DateTime	:	11-04-2024 11:46:57
IPID No	:	20392/24/1501	ReportDatetime	:	11-04-2024 11:55:38

USG - WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised 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 10.2 x 3.8 cm.

Left kidney measures 10.9 x 5.4 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.

PROSTATE is normal in size & echogenicity. It measures ~ 10 cc in volume.

No evidence of ascites.

Impression:

- Grade I fatty infiltration of liver.

DR. KUNAL NIGAM
M.D. (Radiologist)