

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. ANIL KUMAR LALAM	Order No	: 1000081689
UHID	: UHJ A24000105	Registered On	: 02/04/2024 01:47:43 PM
Age/Sex	: 35/Years Male	Collected On	: 02/04/2024 01:49:49 PM
Ward / Bed No	:	Reported On	: 02/04/2024 03:01:10 PM
Reference	:	Bill No	: OOBJ A24000062
Station	: At Hospital	Mobile No	: 9652445665
Payer Name	:	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
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BIOCHEMISTRY

VITAMIN B12	83	pg/mL	75-807
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(Method:CLIA)

Interpretation Notes

Vitamin B12 or Cobalamin assay helps to diagnose the cause of anemia or neuropathy; to evaluate nutritional status in some patients; to monitor effectiveness of treatment for B12 deficiency. Vitamin B12 is necessary for normal RBC formation, tissue and cellular repair, and DNA synthesis. Vitamin B12 is also important for nerve health; a deficiency in either B12 or Folate can lead to macrocytic anemia. Interpretation of the result should be considered in relation to clinical circumstances. The concentration of Vitamin B12 obtained with different assay methods cannot be used interchangeably due to differences in assay methods and reagent specificity.

Verified By
PREETHI R

---End of Report---



Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.

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Age/Sex	: 35/Years Male	Collected On	: 02/04/2024 10:14:24 AM
Ward / Bed No	:	Reported On	: 02/04/2024 04:29:20 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJ A240000132
Station	: At Hospital	Mobile No	: 9652445665
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
<u>BIOCHEMISTRY</u>			
FASTING GLUCOSE (Method: Hexokinase)	120	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBA1C (Method: HPLC)	6.3	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	134.11	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method: CLIA)	1.18	ng/mL	0.87-1.78
TOTAL T4 (Method: CLIA)	10.93	ng/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method: CLIA: Ultra-sensitive)	2.69	μIU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method: CHOD-POD)	171	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method: Enzymatic GPO-POD)	51	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method: ENZYMATIC METHOD)	40.7	mg/dL	< 40 - Low ≥ 60 - High

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LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	120.1	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	10.19	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	4.20		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.95		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	130.3	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	7.3	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.92	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.83	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.67	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.0	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.58	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.41	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.89		2:1

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SERUM SGOT (Method:IFCC without P5P)	23	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	22	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	58	U/L	50-116
GGT (Method:IFCC)	26	U/L	< 55



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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.00	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.1	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	8380	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	57.94	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.16	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.84	%	0-6
MONOCYTES (Method:Optical/Impedance)	6.78	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.28	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	4.95	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	93.1	fL	78-100
MCH (Method: Calculated)	30.3	pg	27-31
MCHC (Method: Calculated)	32.5	g/dL	31-37
RDW - CV (Method: Calculated)	14.3	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	2.94	Lakhs/Cum	1.5-4.5

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MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.13	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	20.0	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	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	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		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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EPITHELIAL CELLS	0-2	/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)	Absent		

Verified By
NAGARATNA

---End of Report---



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NABH



NABL



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name : Mr.ANIL KUMAR LALAM

UHID : UHJA24000105

Age / Sex : 35 Years / Male

OP NO/Reg Dt : 02-04-2024 10:00 AM

Spouse / Father Name : MOUNIKA MITNASALA

Department :

Address : ., , Bengaluru Urban, Karnataka, INDIA,

Referred By :

Consultant : Dr.Preventive Health Check Up

KMC No. :

Complaints / Findings / Observations :

wt - 83.8
Ht - 168 cm
Bp - 115/84,
SpO2 - 97%
PR - 82b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor



NABH



NABL



No.1

**UNITED
HOSPITAL**Care Par Excellence
Jayanagar, Bangalore**DEPARTMENT OF RADIODIAGNOSIS**

Name	Anil Kumar Lalam	Date	02/04/24
Age	35 years	Hospital ID	UHJA24000105
Sex	Male	Ref.	Healthcheck

ULTRASOUND ABDOMEN AND PELVIS**FINDINGS:**

Liver is normal in size 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 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Left Kidney is normal in size (11.0 x 5.1 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.

Prostate is normal in echopattern and size, measures ~ 11.3 cc.

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

IMPRESSION:

- **Moderate fatty infiltration of liver (Grade II).**
- **No other definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist



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NABL



No.1



**UNITED
HOSPITAL**

Care Par Excellence
Jayanagar, Bangalore

DEPARTMENT OF RADIODIAGNOSIS

Name	Anil Kumar Lalam	Date	02/04/24
Age	35 years	Hospital ID	UHJA24000105
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.

Dr. Elluru Santosh Kumar
Consultant Radiologist



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No.1

**UNITED
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Jayanagar, Bangalore

Patient name :	Mr. ANIL KUMAR LALAM	Date :	02/04/24
Age :	35 years GENDER: MALE	Patient ID :	24000105
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 : 4.3 (3.5-5.5)	MV EV : 75.3	AV : 51.9	MR : NORMAL
LA : 2.9 (1.9-4.0)	LVIDS : 2.7 (2.4-4.2)	AV : 94.2		AR : NORMAL
RA : 2.4 (<4.4)	IVSD : 0.8 (0.6-1.1)	PV : 76.3		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.1 (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 : 1.2 (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

ID: 000105

Name: MR ANIL

Birth date: /

35 years

1100 Sinus rhythm
4038 Nonspecific ST elevation [ST elevation (V3, V4)]
9130 ** borderline ECG **

mmHg

medication:

symptoms:

history:

heart rate

R int

RS dur

P/QTc(E) int

VQRS/T axis

V5/SV1 amp

V5+SV1 amp

75 bpm

152 ms

86 ms

354/ 383 ms

45/ 29/ 22 °

1.44/ 0.62 mV

2.07 mV

Unconfirmed Report

Reviewed by:

10 mm/mV

Filter: H50 D 35 Hz

10 mm/mV 25 mm/s

