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DATE- 13/03/24

NAME - PRAMOD KATARA.

PHONE - 9811300753

AGE/GENDER - 58 / MALE

ADDRESS - HOUSE NO 3171 / 2nd floor

EMAIL -

CORPORATE NAME -

1. **Past medical history & medications**:-

   · DVT

2. **Any existing disease: -**

   HIGH BP

3. **Current medications :-**

4. **VITALS** - (To be filled by medical personnel)

- BLOOD PRESSURE - 115/82 mmHg
- PULSE RATE - 64 bpm
- TEMPERATURE – 97.5 F
- SPO2 – 98 %
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 179 cm.
- WEIGHT – 73.6 Kg.
- BMI – 24.3

VISION- RE - 6/20

LE - 6/22

Colour vision- Normal.

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5. **FINDINGS: -**

LAB INVESTIGATION: - All given investigations - Normal.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal
2D Echo - Normal

RADIOLOGY INVESTIGATIONS: - CXR - few small calcified Hilar Nodes.

6. **DOCTOR REMARKS: –**

None.

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

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ECHOCARDIOGRAPHY REPORT

Patient's Name	MR PRAMOD VATSA	Date	13-03-2024
Referred by	HEALTH CHECK UP	Age &Sex	58Yrs/M

MITRAL VALVE

Morphology **AML** - **Normal** / Thickening/Calcification/ Flutter/ Vegetation/ Prolapse/ SAM/ Doming
PML - **Normal**/ Thickening/ Calcification/ Mild Prolapse/ Paradoxical motion/ fixed.
Sub valvular deformity Present/ **Absent** Score: .....

Doppler **Normal**/Abnormal **E>A** A>E
Mitral Stenosis Present/**Absent** RR interval.....msec
EDG.....mmHg MDG.....mmHg MVA.....cm^2
Mitral Regurgitation **Absent** /Trivial/Mild/Moderate/Severe

TRICUSPID VALVE

Morphology **Normal**/ Atresia/Thickening/ Calcification/ Prolapse/ Vegetation/ Doming
Doppler **Normal**/ Abnormal
Tricuspid Stenosis Present/ **Absent** RR interval.....
EDG.....mmHg MDG.....mmHg
Tricuspid Regurgitation: **Absent**/ Trivial/ Mild/ Moderate/ Severe Fragmented signals
Velocity.....m/sec

PULMONARY VALVE

Morphology **Normal**/ Atresia/ Thickening/ Doming/ Vegetation
Doppler **Normal**/ Abnormal
Pulmonary Stenosis Present/**Absent** Level Valvular and Sub valvular
PV Max = **1.1 m/sec** PSG.....mmHg Pulmonary annulus.....mm
Pulmonary Regurgitation Present/ **Absent**
Early diastolic gradient.....mmHg. End Diastolic Gradient.....mmHg

AORTIC VALVE

Morphology **Normal**/ Thickening/ Tip Calcification/ Restricted Opening/ Flutter vegetation
No. of cusps 1/2/**3**/4

Doppler **Normal**/ Abnormal
Aortic Stenosis: Present/**Absent**
AV Max = **1.47** m/sec Aortic Annulus.....mm
Aortic Regurgitation **Absent**/ Trivial/ Mild/Moderate/ Severe

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Measurements	Normal Values	Measurements	Normal Values
Aorta- 2.7	(2.0-3.7 cm)	LAes- 3.5	(1.9-4.0 cm)
LVes- 2.6	(2.2-4.0 cm)	LVed- 4.1	(3.7-5.6 cm)
IVSed-1.0	(0.6-1.1 cm)	PW (LV) 0.7	(0.6-1.1 cm)
RV ed	(0.7-2.6 cm)	RV anterior wall	(up to 5 mm)
LVVd (ml)		LVVs (ml)	
EF **60-65 %**	(54%-76%)	IVS motion	**Normal**/ Flat/ Paradoxical

CHAMBERS:

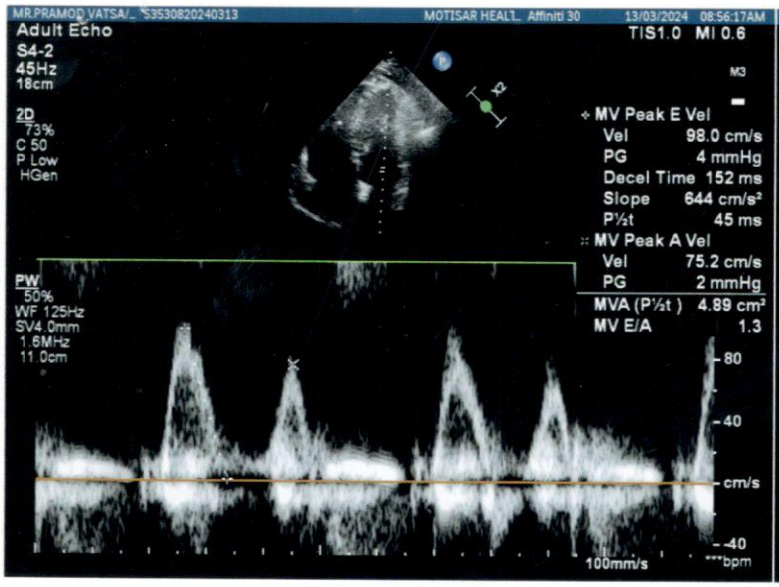
LV	**Normal** / Enlarged/ Clear/ Thrombus/hypertrophy Contraction **Normal** / Reduced
LA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RV	**Normal**/ Enlarged/ **Clear**/ Thrombus
Pericardium	**Normal**/ Thickening/ Calcification/ Effusion

COMMENTS AND SUMMARY

- **ALL FOUR CHAMBERS NORMAL IS SIZE AND SHAPE**
- **ALL FOUR VALVES NORMAL IN MORPHOLOGY**
- **NO MR/AR/TR**
- **NO AORTIC STENOSIS**
- **NORMAL LV DIASTOLIC FUNCTION**
- **NO CLOT/MASS/PE SEEN**
- **NORMAL LV SYSTOLIC FUNCTION, LVEF= 60-65%**

Kindly correlate clinically

DR. ROHIT GOEL
M.D, D.M (Cardiology)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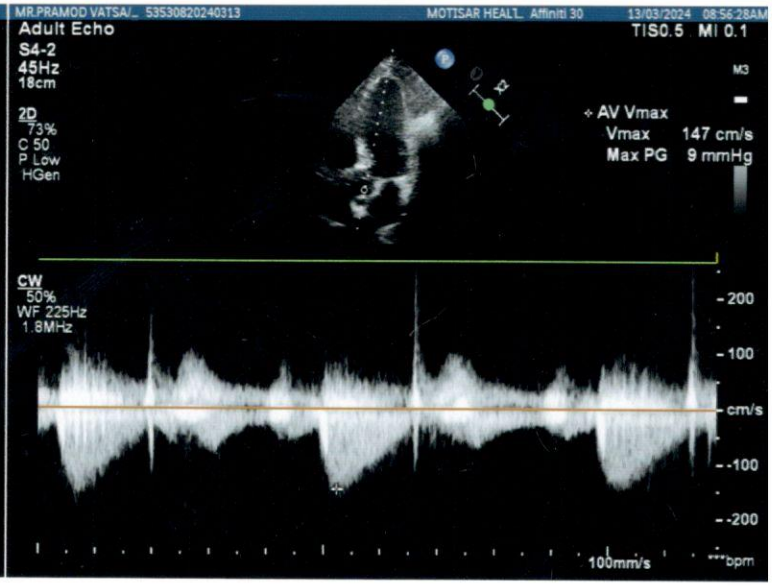
Adult Echo
TIS1.0 MI 0.6
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
MV Peak E Vel
Vel 98.0 cm/s
PG 4 mmHg
Decel Time 152 ms
Slope 644 cm/s²
P½t 45 ms
MV Peak A Vel
Vel 75.2 cm/s
PG 2 mmHg
MVA (P½t) 4.89 cm²
MV E/A 1.3
PW
50%
WF 125Hz
SV4.0mm
1.6MHz
11.0cm
80
40
cm/s
-40
100mm/s
***bpm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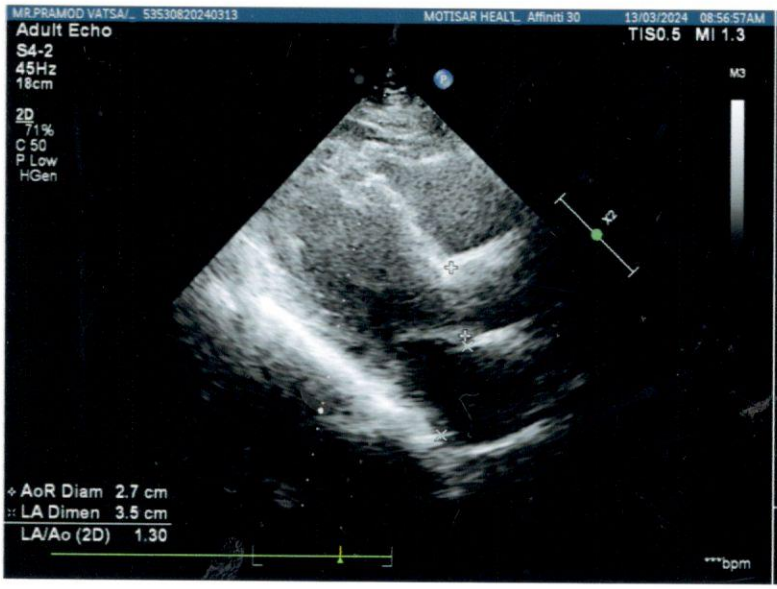
Adult Echo
TIS0.5 MI 0.1
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
AV Vmax
Vmax 147 cm/s
Max PG 9 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm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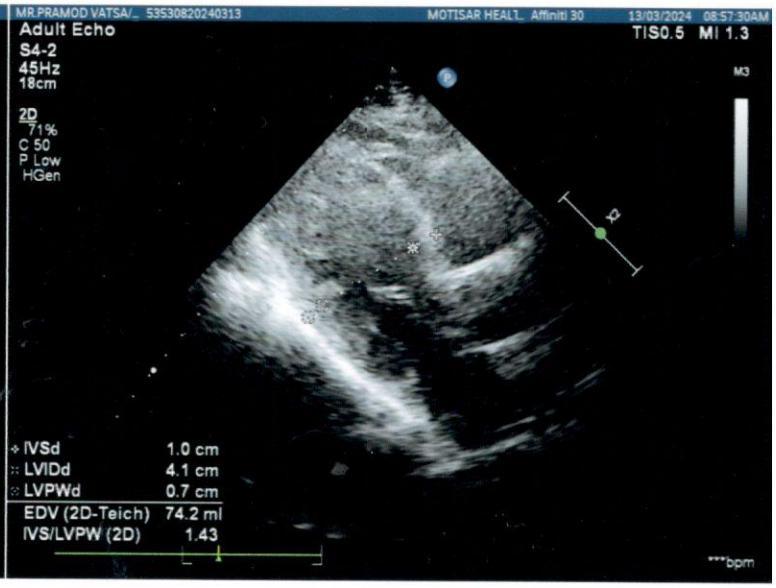
Adult Echo
TIS0.5 MI 1.3
S4-2
45Hz
18cm
2D
71%
C 50
P Low
HGen
AoR Diam 2.7 cm
LA Dimen 3.5 cm
LA/Ao (2D) 1.30
***bpm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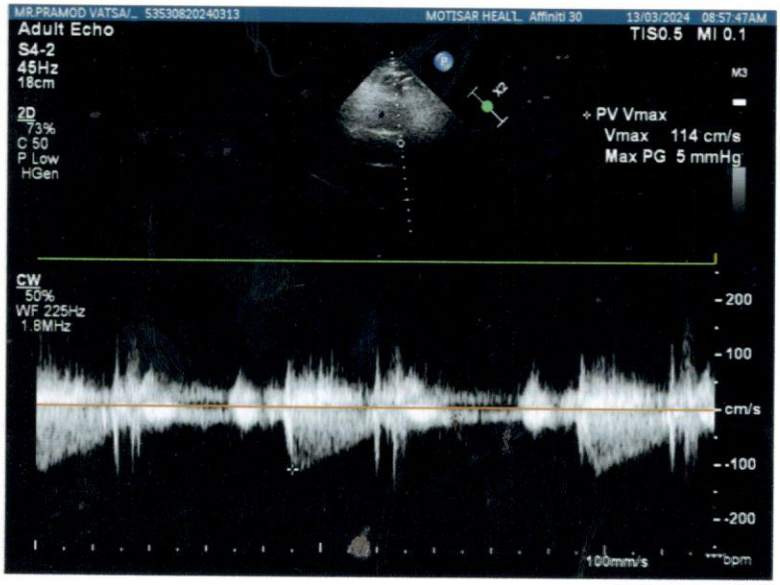
Adult Echo
TIS0.5 MI 1.3
S4-2
45Hz
18cm
2D
71%
C 50
P Low
HGen
IVSd 1.0 cm
LVIDd 4.1 cm
LVPWd 0.7 cm
EDV (2D-Teich) 74.2 ml
IVS/LVPW (2D) 1.43
***bpm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Adult Echo
TIS0.5 MI 0.1
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
PV Vmax
Vmax 114 cm/s
Max PG 5 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm

Name – –
Patient ID **Parmod vats**

13.03.2024 09:25:59
Standard 12-Lead

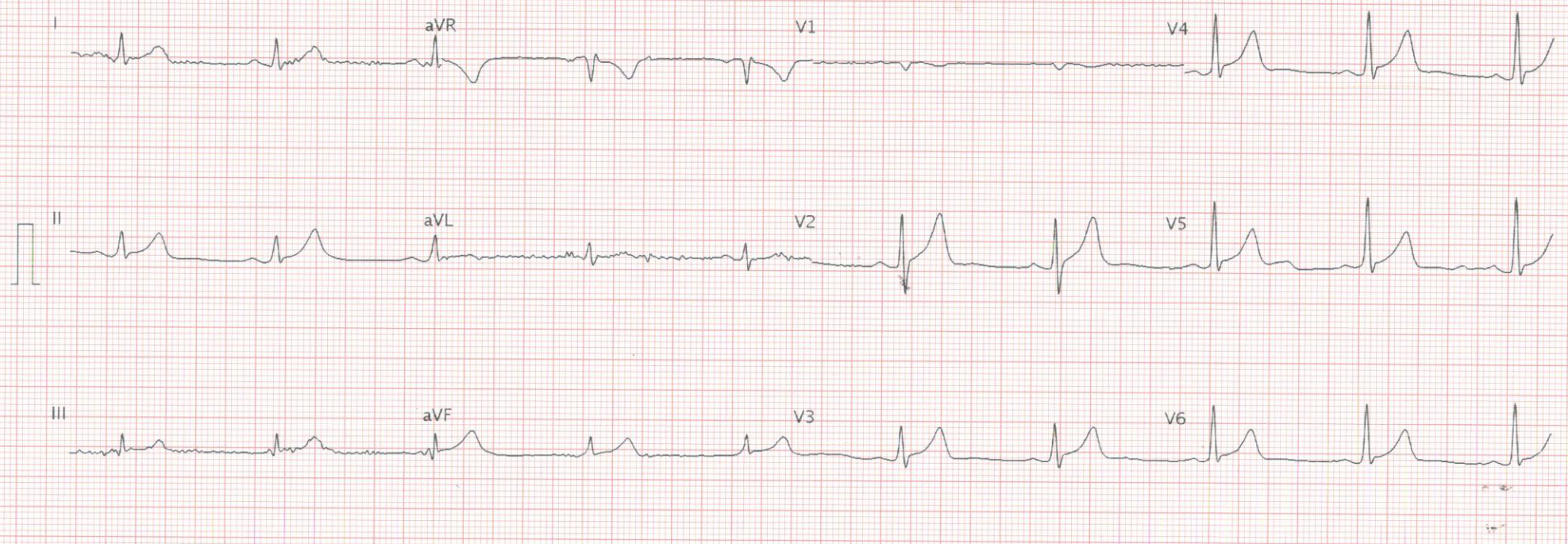
Date of birth	– –	**Visit ID**	**HR**	**57 bpm**	**RR** 1051 ms
Gender	Male	**Room**			**P** 98 ms
Height		**Medication**			**PR** 146 ms
Weight		**Order ID**	**P axis**	0 °	**QRS** 95 ms
Ethnicity	Undefined	**Ord. prov.**	**QRS axis**	47 °	**QT** 402 ms
Pacemaker	Unknown	**Ord. prot.**	**T axis**	48 °	**QTcB** 392 ms

Indication
Remark

Sinus rhythm
Normal electrical axis
Nonspecific ST abnormality (elevation)
Otherwise normal ECG

Unconfirmed report

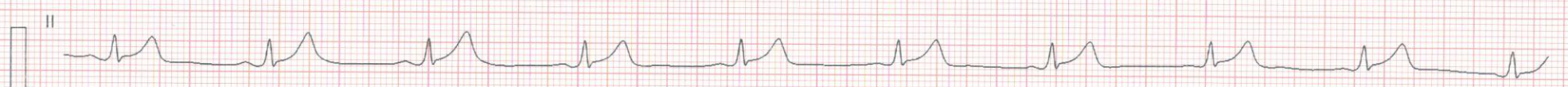
Otherwise normal



25 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

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Patient's Name:-	MR. PARMOD VATS	Date	:- 13/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 58Y/M

Radiograph of Chest (PA View)

Prominent broncho vascular marking are seen in bilateral lung fields.

Prominence bilateral hila are seen with few small calcified hilar lymph nodes.

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Mild degenerative changes are seen in visualised spine..

Please correlate clinically

Dr Arushi Gupta
MBBS, DNB (Radio – Diagnosis)
Radiologist

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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Mr. Pramod Vaisa on 13/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	✓
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____ recommended	
• Unfit	

Dr._____
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Pramod Vats AGE/SEX: 58/M DATE: March 13/24.

C/C → Through health checkup.

O/E → chr. gen. gingivitis. ⊼ localized periodontal cervical abrasion. in multiple teeth.

Advice:- → cervical filling's
→ scaling & polishing.

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

TO BOOK AN APPOINTMENT
08079 838383

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Patient's Name	MR PRAMOD VATSA	Date	17-03-2024
Referred By	P. M. H. C.	Age/Sex	58YRS/M

ULTRASOUND OF ABDOMEN & PELVIS

Clinical profile: - HEALTH CHECKUP

Liver: , is normal in size, outline and parenchymal echotexture . No focal lesion is seen. There is no evidence of intrahepatic biliary dilatation. The hepatic veins are normal. The portal vein shows normal flow and appears normal in calibre.

GALL BLADDER: is well distended. No calculus or mass is seen. Visualized portion of CBD is normal in calibre.

PANCREAS: Normal in size, shape and echo pattern. Main pancreatic diameter is normal.

SPLEEN: Normal in size shape and echopattern. No focal lesion is seen.

KIDNEYS- Both kidneys are normal in size, shape, position, axis and echopattern.

The corticomedullary differentiation is well maintained. *A 12mm simple cortical cyst is seen towards upper pole on right side*

No calculus or hydronephrosis is seen on either side..

URINARY BLADDER *shows mild irregularity of the outline.* No calculus/mass seen.

PROSTATE: **is enlarged. It measures 53x46x43mm and weighs 56gms.**

The prevoid urinary bladder is 173cc. the residual urine is 21cc

No free fluid is seen in abdominal cavity. No e/o any lymphadenopathy.

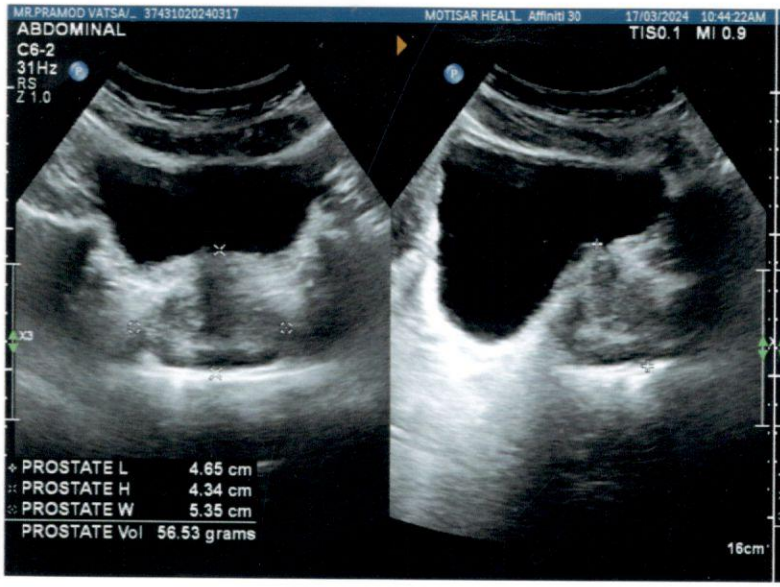
IMPRESSION:

FEATURES OF MILD CYSTITIS

PROSTATOMEGALY.

CLINICAL CORRELATION IS NECESSARY

DR. RAJNISH JUNEJA
MBBS, DNB RADIODIAGNOSIS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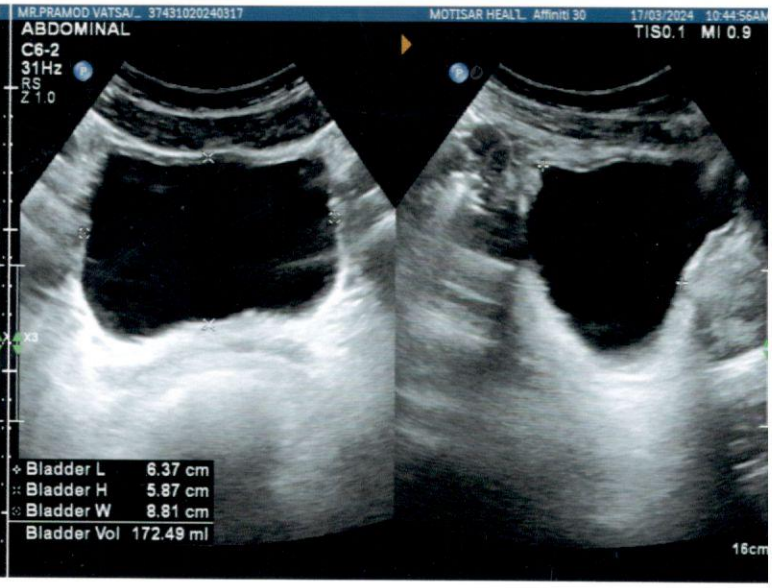
17/03/2024 10:44:22AM
ABDOMINAL
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 0.9
PROSTATE L 4.65 cm
PROSTATE H 4.34 cm
PROSTATE W 5.35 cm
PROSTATE Vol 56.53 grams
16cm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MOTISAR HEALT_ Affiniti 30
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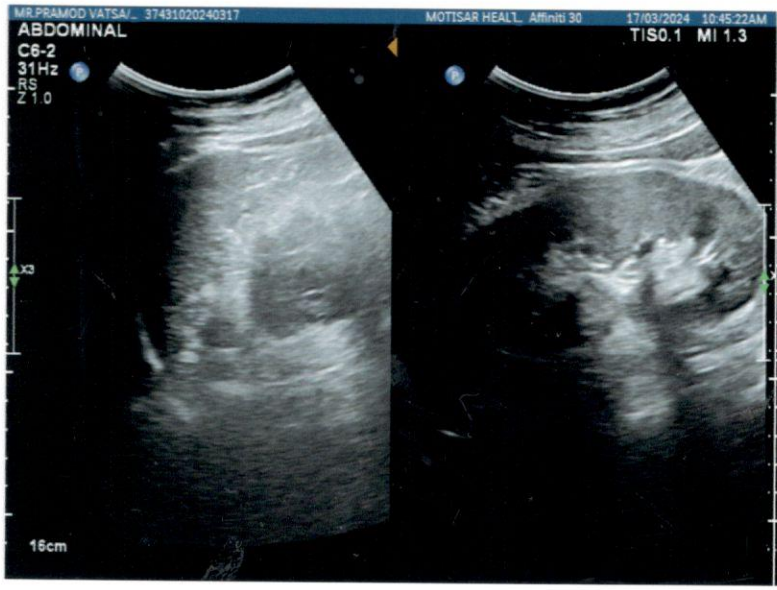
ABDOMINAL
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 0.9
Bladder L 6.37 cm
Bladder H 5.87 cm
Bladder W 8.81 cm
Bladder Vol 172.49 ml
16cm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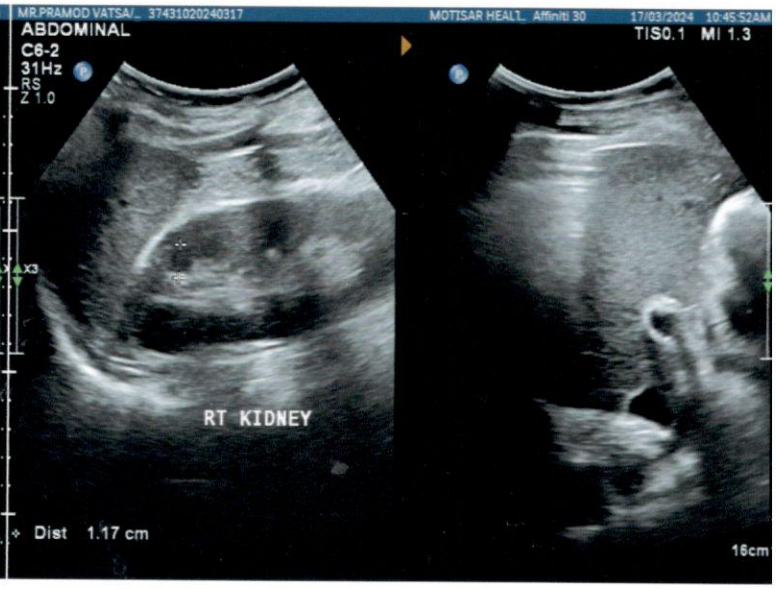
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 1.3
16cm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ABDOMINAL
C6-2
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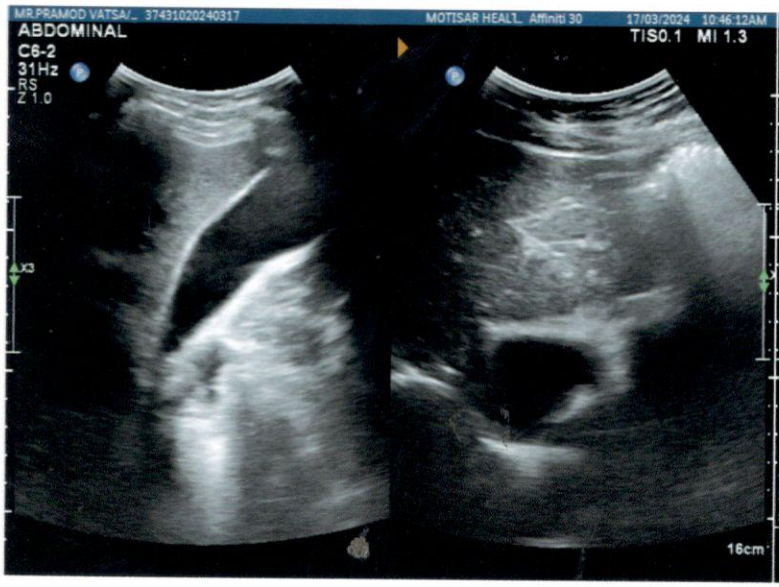
RS
Z 1.0
TIS0.1 MI 1.3
RT KIDNEY
Dist 1.17 cm
16cm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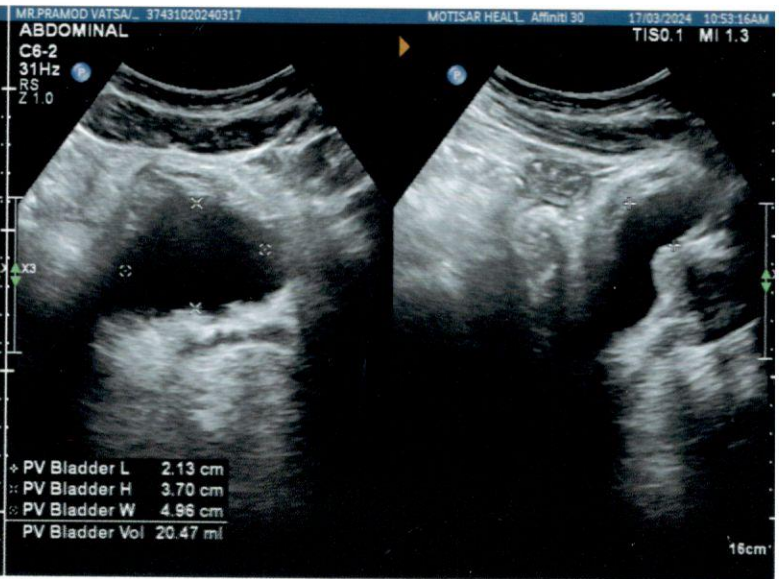
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 1.3
16cm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ABDOMINAL
C6-2
31Hz
RS
Z 1.0
TIS0.1 MI 1.3
PV Bladder L 2.13 cm
PV Bladder H 3.70 cm
PV Bladder W 4.96 cm
PV Bladder Vol 20.47 ml
16cm

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	14.40	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	**4.6**	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	42.7	%	42-52	Calculated
MCV	93.30	fL	78-100	Electrical Impedence
MCH	**31.5**	pg	27-31	Calculated
MCHC	33.7	gm/dL	32-36	Calculated
RDW-SD	**13.0**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	4780	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	50	%	40-80	VCSn Technology
LYMPHOCYTE	37	%	20-40	VCSn Technology
MONOCYTE	10	%	2-10	VCSn Technology
EOSINOPHIL	03	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	182	10^3/ul	150 - 450	Electrical Impedence
MPV	11.7	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	14.1	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	2.39	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	**1.77**	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.48	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.14**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	19	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 03:35PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	"B"			Gel Columns agglutination
Rh Typing	**POSITIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:06PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.69	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.20	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.49	mg/dL	0.1 - 1.0	Calculated
SGPT	21.50	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	20.80	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	0.97	Ratio	0.7 - 1.4	
GGT	22	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	89.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.20	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.10	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.1	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.32	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

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Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:06PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	147.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	106.50	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	59.30	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	66.40	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	87.7	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	21.3	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	**2.48**	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	1.12	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.89	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

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Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
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LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	6.4	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	136.98	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	**104.4**	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	87.3	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	19.20	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	8.97	mg/dL	7 - 18	Urease
SERUM URIC ACID	7.10	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.80	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	8.80	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	136.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.01	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	102.5	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

Prasad

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Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:19PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.38	ng/mL	0.79 - 1.58	CLIA
T4	8.62	µg/dl	4.9 - 11.00	CLIA
TSH	2.40	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:14PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL				
PROSTATE SPECIFIC ANTIGEN	1.4	ng/mL	0-4	CLIA

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.

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Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 03:35PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	30	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	7.00		4.5 - 7.0	
SPECIFIC GRAVITY	1.010		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	ABSENT		Nill	
Urine Protein	ABSENT		Nil	
Urine Ketones	ABSENT		Nil	
BLOOD	ABSENT		Absent	
Leukocyte esterase	TRACE		Negative	
Bile pigments	ABSENT		Absent	
NITRITE	ABSENT		Negative	
UROBILINOGEN	ABSENT		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	3-4	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	ABSENT	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

***** End Of Report *****

Dr. Sarita Prasad
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Sr. Consultant (HMC.9669)

Customer Pending Tests
Mr. Parmod Vats USG pending

Final Bill

Name	: Mr. Pramod Vatsa	**Bill No**	: FSOH-OCR-958
Age/Gender	: 58 Y M	**Bill/Reg Date**	: 13.03.2024 11:32
Contact No	: +919811350753	**Referal Doctor**	: SELF
Address	: 3171 2nd Floor Sector 46	**Center**	: Sohna Road
UHID	: FSOH.0000003516	**Emp No/Auth Code**	: 389729

Corporate Name : ARCOFEMI HEALTHCARE LIMITED
Plan : ARCOFEMI MEDIWHEEL MALE AHC CREDIT PAN INDIA OP AGREEMENT

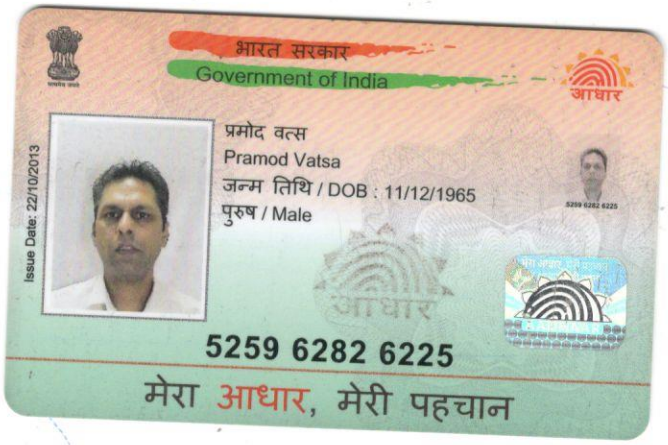
#	Department	Description Of Service	SAC Code	Qty	Rate	Amount	Discount	Net Value
1	Lab Tests	HAEMOGRAM		1	-0.01	-0.01	0.00	-0.01
2	Lab Tests	PERIPHERAL SMEAR		1	0.00	0.00	0.00	0.00
3	Lab Tests	BLOOD GROUP AND RH TYPE		1	0.00	0.00	0.00	0.00
4	Service	BODY MASS INDEX		1	0.37	0.37	0.00	0.37
5	Lab Tests	LDL CHOLESTEROL: LIPID PROFILE PACKAGE		1	0.00	0.00	0.00	0.00
6	Lab Tests	HDL CHOLESTEROL: LIPID PROFILE PACKAGE		1	0.00	0.00	0.00	0.00
7	Lab Tests	TRIGLYCERIDES: LIPID PROFILE PACKAGE		1	0.00	0.00	0.00	0.00
8	Lab Tests	VLDL CHOLESTEROL: LIPID PROFILE PACKAGE		1	0.00	0.00	0.00	0.00
9	Lab Tests	CHOLESTEROL: LIPID PROFILE PACKAGE		1	55.64	55.64	0.00	55.64
10	Lab Tests	UREA: KFT - RENAL FUNCTION TEST (BASIC)		1	0.00	0.00	0.00	0.00
11	Lab Tests	CREATININE: KFT - RENAL FUNCTION TEST (BASIC)		1	18.55	18.55	0.00	18.55
12	Lab Tests	URIC ACID: KFT - RENAL FUNCTION TEST (BASIC)		1	0.00	0.00	0.00	0.00
13	Lab Tests	BLOOD UREA NITROGEN(BUN): KFT - RENAL FUNCTION TEST (BASIC)		1	0.00	0.00	0.00	0.00
14	Lab Tests	LIVER FUNCTION TEST (PACKAGE)		1	296.73	296.73	0.00	296.73
15	Lab Tests	GGTP: GAMMA GLUTAMYL TRANSPEPTIDASE		1	74.18	74.18	0.00	74.18
16	Service	ECG		1	111.27	111.27	0.00	111.27
17	FITNESS BY GENERAL PHYSICIAN	doctor		1	0.00	0.00	0.00	0.00
18	Opthal Consultation	doctor		1	0.00	0.00	0.00	0.00
19	Lab Tests	URINE ROUTINE EXAMINATION		1	0.00	0.00	0.00	0.00
20	Radiology Tests	X-RAY CHEST PA		1	148.36	148.36	0.00	148.36
21	Radiology Tests	ULTRASOUND WHOLE ABDOMEN		1	556.36	556.36	0.00	556.36
22	DENTAL Consultation	doctor		1	0.00	0.00	0.00	0.00
23	ENT Consultation	doctor		1	0.00	0.00	0.00	0.00
24	Diet Consultation	doctor		1	0.00	0.00	0.00	0.00
25	Lab Tests	GLYCOSYLATED HEMOGLOBIN (HBA1C)		1	0.00	0.00	0.00	0.00
26	Lab Tests	THYROID PROFILE - I(T3,T4 AND TSH)		1	0.00	0.00	0.00	0.00
27	Lab Tests	GLUCOSE - (FASTING)		1	0.00	0.00	0.00	0.00
28	Lab Tests	GLUCOSE - (POST PRANDIAL)		1	0.00	0.00	0.00	0.00
29	Lab Tests	URINE GLUCOSE(FASTING)		1	0.00	0.00	0.00	0.00
30	Lab Tests	URINE GLUCOSE(POST PRANDIAL)		1	0.00	0.00	0.00	0.00
31	Service	2D ECHO		1	741.82	741.82	0.00	741.82

32	Lab Tests	PSA TOTAL	1	296.73	296.73	0.00	296.73
33	Package Charges	ARCOFEMI - MEDIWHEEL - FULL BODY ANNUAL PLUS ABOVE 50Y MALE - 2D ECHO - PAN INDIA - FY2324	1	0.00	0.00	0.00	0.00

Bill Amount:	2,300.00
Total Discount:	0.00
Net Payment:	0.00
Corporate Due:	2,300.00
Pri. Sponsor Amount	2,300.00
Pri. Sponsor Pay	0.00
Pri. Sponsor Due	**2,300.00**
Deductions (Patient Amount)	0.00
Less Deposits Set Off	0.00
Less Reward Points Amt.	0.00
Less Patient Payments	0.00

Authorized Signature :(Pankaj Kushwaha)

Patient First Name: MR.	Patient Last Name: VATSA PRAMOD	Patient Mobile Number: 9911350753
Patient E-mail ID: vatsapramod@yahoo.com	Date of Birth: 02-01-1966	Gender: male
Client: **ARCOFEMI HEALTHCARE LIMITED**	Agreement Name: (1) ARCOFEMI MEDIWHEEL MALE AHC CREDIT PAN INDIA OP AGREEMENT	
Package Name: (1) ARCOFEMI - MEDIWHEEL - FULL BODY ANNUAL PLUS ABOVE 50Y MALE - 2D ECHO - PAN INDIA - FY2324	Visit Type: in-clinic	
Visit Status: Show	Report Status: Order partially completed	City
Clinic: SOHNA ROAD	Order Date: 11-03-2024	Appointment Date: 13-03-2024
Slot Time: 09:00-09:15		
Net Amount: 2300	Appointment ID: 389729	Ref_Appointment ID: bobE14596
Visit ID		


भारत सरकार
Government of India
आधार
प्रमोद वत्स
Pramod Vatsa
जन्म तिथि / DOB : 11/12/1965
पुरुष / Male
Issue Date: 22/10/2013
5259 6282 6225
मेरा आधार, मेरी पहचान

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DATE- 13/03/24

NAME - PRAMOD VATSA.

PHONE - 9811300775 3

AGE/GENDER - 58 /MALE

ADDRESS - HOUSE NO 3171 /2nd floor

EMAIL -

CORPORATE NAME -

1. **Past medical history & medications**:-

   DVT

2. **Any existing disease: -**

   HIGH BP

3. **Current medications :-**

4. **VITALS** - (To be filled by medical personnel)

   - BLOOD PRESSURE - 115/82 mmHg
   - PULSE RATE - 64 b/m
   - TEMPERATURE – 97.5 F
   - SPO2 – 98 %
   - BLOOD SUGAR (RANDOM) – .....
   - HEIGHT – 174 cm.
   - WEIGHT – 73.6 K.g.
   - BMI – 24.3

VISION- RE - 6/20

LE - 6/22

Colour vision- Normal.

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5. **FINDINGS**: -

LAB INVESTIGATION: - All given investigations - Normal.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal
2D Echo - Normal

RADIOLOGY INVESTIGATIONS: - CxR - few small calcified Hilar Nodes.

6. **DOCTOR REMARKS:** –

None.

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

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ECHOCARDIOGRAPHY REPORT

Patient's Name	MR PRAMOD VATSA	Date	13-03-2024
Referred by	HEALTH CHECK UP	Age &Sex	58Yrs/M

MITRAL VALVE

Morphology **AML** - **Normal** / Thickening/Calcification/ Flutter/ Vegetation/ Prolapse/ SAM/ Doming
PML - **Normal**/ Thickening/ Calcification/ Mild Prolapse/ Paradoxical motion/ fixed.
Sub valvular deformity Present/ **Absent** Score: .....

Doppler **Normal**/Abnormal **E>A** A>E
Mitral Stenosis Present/**Absent** RR interval.....msec
EDG.....mmHg MDG.....mmHg MVA.....cm^2
Mitral Regurgitation **Absent** /Trivial/Mild/Moderate/Severe

TRICUSPID VALVE

Morphology **Normal**/ Atresia/Thickening/ Calcification/ Prolapse/ Vegetation/ Doming
Doppler **Normal**/ Abnormal
Tricuspid Stenosis Present/ **Absent** RR interval.....
EDG.....mmHg MDG.....mmHg
Tricuspid Regurgitation: **Absent**/ Trivial/ Mild/ Moderate/ Severe Fragmented signals
Velocity.....m/sec

PULMONARY VALVE

Morphology **Normal**/ Atresia/ Thickening/ Doming/ Vegetation
Doppler **Normal**/ Abnormal
Pulmonary Stenosis Present/**Absent** Level Valvular and Sub valvular
PV Max = **1.1 m/sec** PSG.....mmHg Pulmonary annulus.....mm
Pulmonary Regurgitation Present/ **Absent**
Early diastolic gradient.....mmHg. End Diastolic Gradient.....mmHg

AORTIC VALVE

Morphology **Normal**/ Thickening/ Tip Calcification/ Restricted Opening/ Flutter vegetation
No. of cusps 1/2/**3**/4

Doppler **Normal**/ Abnormal
Aortic Stenosis: Present/**Absent**
AV Max = **1.47** m/sec Aortic Annulus.....mm
Aortic Regurgitation **Absent**/ Trivial/ Mild/Moderate/ Severe

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Measurements	Normal Values	Measurements	Normal Values
Aorta- 2.7	(2.0-3.7 cm)	LAes- 3.5	(1.9-4.0 cm)
LVes- 2.6	(2.2-4.0 cm)	LVed- 4.1	(3.7-5.6 cm)
IVSed-1.0	(0.6-1.1 cm)	PW (LV) 0.7	(0.6-1.1 cm)
RV ed	(0.7-2.6 cm)	RV anterior wall	(up to 5 mm)
LVVd (ml)		LVVs (ml)	
EF **60-65 %**	(54%-76%)	IVS motion	**Normal**/ Flat/ Paradoxical

CHAMBERS:

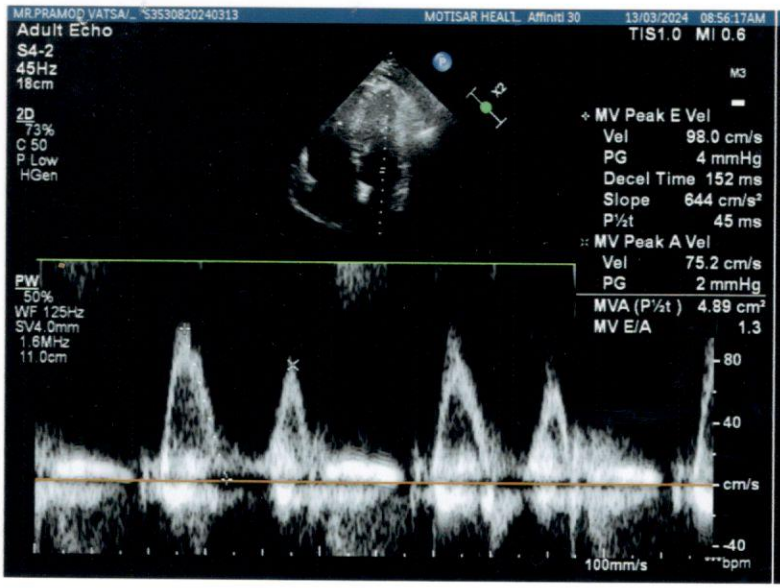
LV	**Normal** / Enlarged/ Clear/ Thrombus/hypertrophy Contraction **Normal** / Reduced
LA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RA	**Normal**/ Enlarged/ **Clear**/ Thrombus
RV	**Normal**/ Enlarged/ **Clear**/ Thrombus
Pericardium	**Normal**/ Thickening/ Calcification/ Effusion

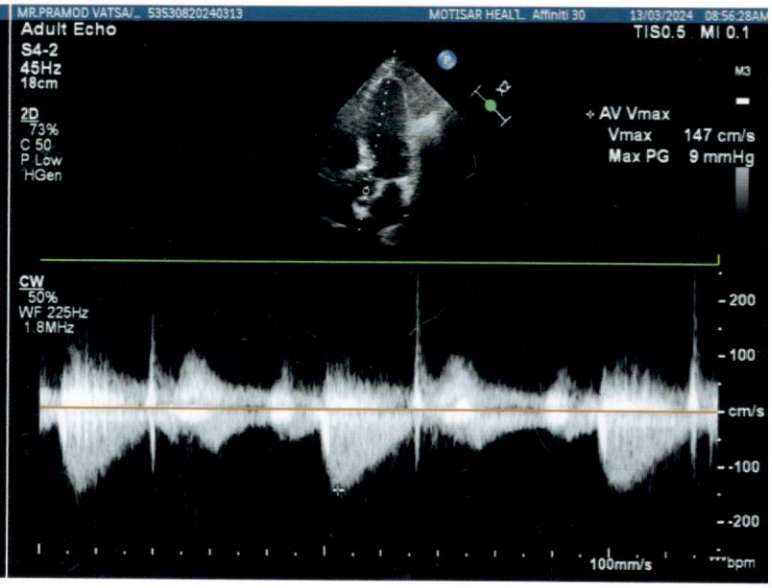
COMMENTS AND SUMMARY

- **ALL FOUR CHAMBERS NORMAL IS SIZE AND SHAPE**
- **ALL FOUR VALVES NORMAL IN MORPHOLOGY**
- **NO MR/AR/TR**
- **NO AORTIC STENOSIS**
- **NORMAL LV DIASTOLIC FUNCTION**
- **NO CLOT/MASS/PE SEEN**
- **NORMAL LV SYSTOLIC FUNCTION, LVEF= 60-65%**

Kindly correlate clinically

DR. ROHIT GOEL
M.D, D.M (Cardiology)


MR.PRAMOD VATSA/_ 53530820240313
MOTISAR HEALT_ Affiniti 30
13/03/2024 08:56:17AM
Adult Echo
TIS1.0 MI 0.6
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
MV Peak E Vel
Vel 98.0 cm/s
PG 4 mmHg
Decel Time 152 ms
Slope 644 cm/s²
P½t 45 ms
MV Peak A Vel
Vel 75.2 cm/s
PG 2 mmHg
MVA (P½t) 4.89 cm²
MV E/A 1.3
PW
50%
WF 125Hz
SV4.0mm
1.6MHz
11.0cm
80
40
cm/s
-40
100mm/s
***bpm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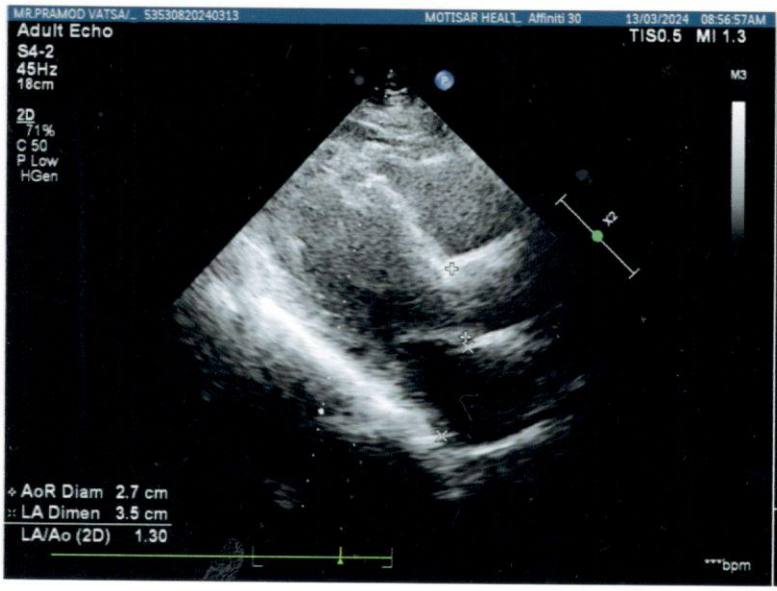
13/03/2024 08:56:28AM
Adult Echo
TIS0.5 MI 0.1
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
AV Vmax
Vmax 147 cm/s
Max PG 9 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm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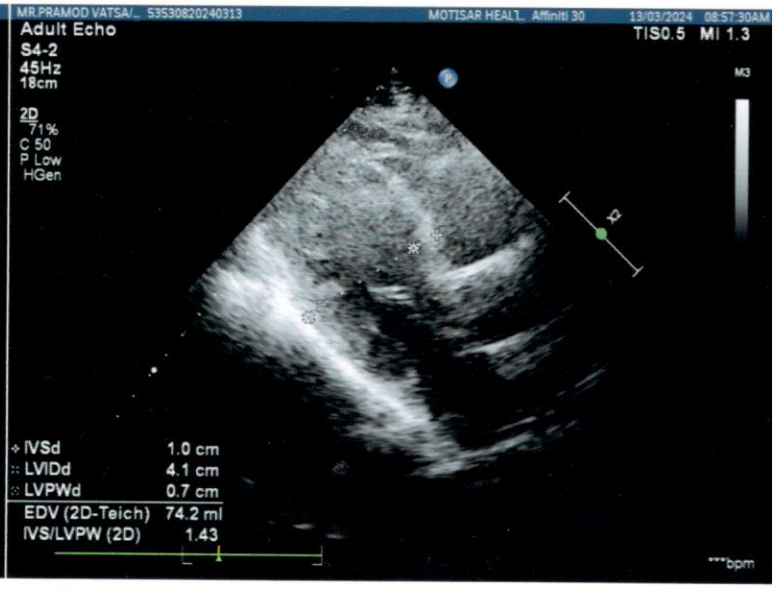
13/03/2024 08:56:57AM
Adult Echo
TIS0.5 MI 1.3
S4-2
45Hz
18cm
2D
71%
C 50
P Low
HGen
AoR Diam 2.7 cm
LA Dimen 3.5 cm
LA/Ao (2D) 1.30
***bpm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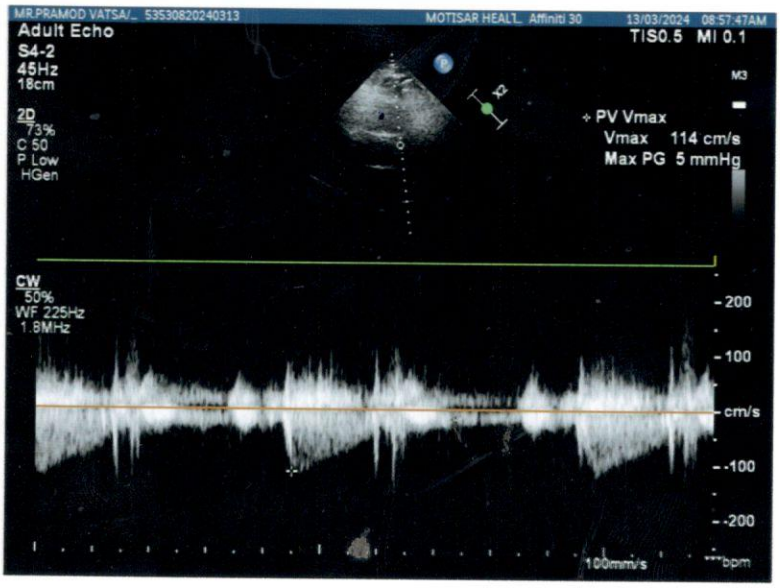
MOTISAR HEALT_ Affiniti 30
13/03/2024 08:57:30AM
Adult Echo
TIS0.5 MI 1.3
S4-2
45Hz
18cm
2D
71%
C 50
P Low
HGen
IVSd 1.0 cm
LVIDd 4.1 cm
LVPWd 0.7 cm
EDV (2D-Teich) 74.2 ml
IVS/LVPW (2D) 1.43
***bpm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MOTISAR HEALT_ Affiniti 30
13/03/2024 08:57:47AM
Adult Echo
TIS0.5 MI 0.1
S4-2
45Hz
18cm
2D
73%
C 50
P Low
HGen
PV Vmax
Vmax 114 cm/s
Max PG 5 mmHg
CW
50%
WF 225Hz
1.8MHz
200
100
cm/s
-100
-200
100mm/s
***bpm

Name – –
Patient ID **Parmod vats**

13.03.2024 09:25:59
Standard 12-Lead

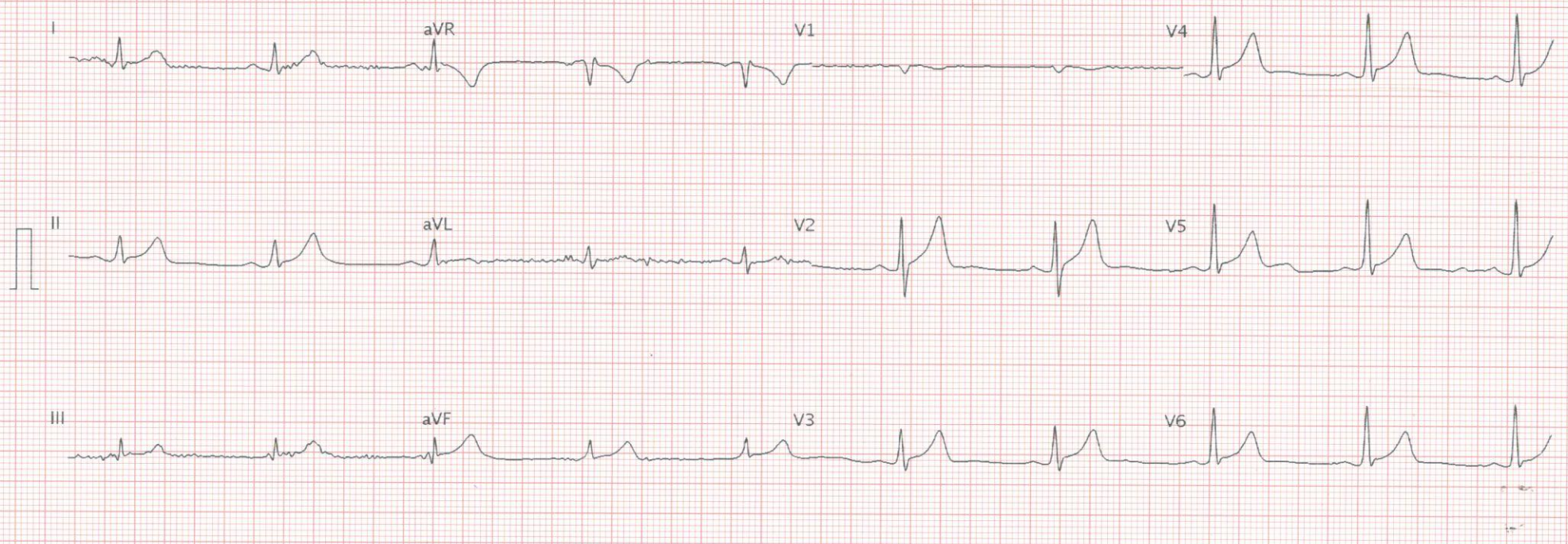
Date of birth	– –	**Visit ID**	**HR**	**57 bpm**	**RR**	1051 ms
Gender	Male	**Room**			**P**	98 ms
Height		**Medication**			**PR**	146 ms
Weight		**Order ID**	**P axis**	0 °	**QRS**	95 ms
Ethnicity	Undefined	**Ord. prov.**	**QRS axis**	47 °	**QT**	402 ms
Pacemaker	Unknown	**Ord. prot.**	**T axis**	48 °	**QTcB**	392 ms

Sinus rhythm
Normal electrical axis
Nonspecific ST abnormality (elevation)
Otherwise normal ECG

Unconfirmed report

Indication
Remark

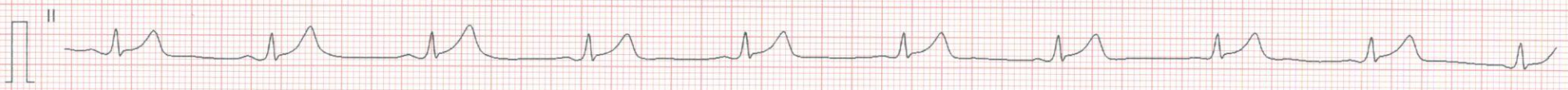
Otherwise normal



25 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

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Patient's Name:-	MR. PARMOD VATS	Date	:- 13/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 58Y/M

Radiograph of Chest (PA View)

Prominent broncho vascular marking are seen in bilateral lung fields.

Prominence bilateral hila are seen with few small calcified hilar lymph nodes.

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal.

Trachea and mediastinum are normal.

Mild degenerative changes are seen in visualised spine..

Please correlate clinically

Dr Arushi Gupta
MBBS, DNB (Radio – Diagnosis)
Radiologist

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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Mr. Pramod Vatsa on 13/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

	Tick
• Medically Fit	✓
• Fit with restrictions/recommendations Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____ recommended	
• Unfit	

Dr. _____
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

DR. BINDU BISHT
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Pramod Vats AGE/SEX: 58/M DATE: March 13/24.

C/C → Through health checkup.

O/E → dk. gen. gingivitis. ⊼ localized periodontal cervical abrasion. in multiple teeth.

Advice:- → cervical filling's
→ scaling & polishing.

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

TO BOOK AN APPOINTMENT
08079 838383

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
Age/Gender	: 58 Y 0 M 0 D /M	Registration Date	: 13/Mar/2024 12:59PM
LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:50PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	14.40	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	**4.6**	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	42.7	%	42-52	Calculated
MCV	93.30	fL	78-100	Electrical Impedence
MCH	**31.5**	pg	27-31	Calculated
MCHC	33.7	gm/dL	32-36	Calculated
RDW-SD	**13.0**	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	4780	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	50	%	40-80	VCSn Technology
LYMPHOCYTE	37	%	20-40	VCSn Technology
MONOCYTE	10	%	2-10	VCSn Technology
EOSINOPHIL	03	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	182	10^3/ul	150 - 450	Electrical Impedence
MPV	11.7	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	14.1	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	2.39	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	**1.77**	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.48	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	**0.14**	x10^3 Cells/uL	0.2-0.5	Automated Calculated

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

Patient NAME	: MR.PRAMOD VATSA	Barcode NO	: 20010614
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Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:50PM
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DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	19	mm/hr	<20	EDTA Whole blood, modified westerngren

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

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LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 03:35PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP ABO & RH				
Sample Type : WHOLE BLOOD EDTA				
ABO	"B"			Gel Columns agglutination
Rh Typing	**POSITIVE**			Gel agglutination

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

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LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
Referred BY	: SELF	Report Generated Date	: 13/Mar/2024 02:06PM
Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.69	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.20	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.49	mg/dL	0.1 - 1.0	Calculated
SGPT	21.50	U/L	<45	UV with P5P, IFCC 37 Degree
SGOT	20.80	U/L	<50	UV with P5P, IFCC 37 degree
SGOT/SGPT	0.97	Ratio	0.7 - 1.4	
GGT	22	U/L	<55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	89.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.20	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.10	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.1	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.32	Ratio	1.2 - 2.2	Calculated

Note:

Bilirubin Total

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

Bilirubin Direct

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

SGOT / AST

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

SGPT / ALT

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

Alkaline Phosphatase (ALP)

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

Total Protein

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

Albumin

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	147.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	106.50	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	59.30	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	66.40	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	87.7	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	21.3	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	**2.48**	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	1.12	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.89	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

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LabNo	: DPL22065	Sample Collected Date	: 13/Mar/2024 12:59PM
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Refer Lab/Hosp	: **APOLLO CLINIC**		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	6.4	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	136.98	mg/dL		

Interpretations

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	**104.4**	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (On more than one occasion)	Plasma, Hexokinase

Note:

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

Fasting is defined as no caloric intake for at least 8 hours

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - PP				
Sample Type : FLOURIDE PLASMA (PP)				
Plasma Glucose PP	87.3	mg/dl	80-140	Glucose Oxidase/Peroxidase

INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	19.20	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	8.97	mg/dL	7 - 18	Urease
SERUM URIC ACID	7.10	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.80	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	8.80	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	136.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.01	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	102.5	mmol/L	101 - 109	ISE

Note:

Blood Urea Nitrogen (BUN)

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

Creatinine

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

Calcium

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

Sodium

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

Potassium

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

Chloride

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

Prasad

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DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.38	ng/mL	0.79 - 1.58	CLIA
T4	8.62	µg/dl	4.9 - 11.00	CLIA
TSH	2.40	µIU/m	0.38 - 4.31	FIA

Interpretation

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

Condition	TSH	T4	T3
Primary Hypothyroidism	Increased	Low	Normal /Low
Subclinical Hypothyroidism	Increased	Normal	Normal
Primary Hyperthyroidism	Decreased	Increased	Increased
T3 Toxicosis	Decreased	Normal	Increased
Subclinical Hyperthyroidism	Decreased	Normal	Normal
Central Hyperthyroidism/ Thyroid Hormone Resistance	Increased /Normal	Increased	Increased
Central Hypothyroidism / Non Thyroidal Illness	Decreased /Normal	Decreased	Decreased

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DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL				
PROSTATE SPECIFIC ANTIGEN	1.4	ng/mL	0-4	CLIA

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.

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DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 2

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	30	ml	-	
COLOUR	**PALE YELLOW**		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	7.00		4.5 - 7.0	
SPECIFIC GRAVITY	1.010		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	ABSENT		Nill	
Urine Protein	ABSENT		Nil	
Urine Ketones	ABSENT		Nil	
BLOOD	ABSENT		Absent	
Leukocyte esterase	TRACE		Negative	
Bile pigments	ABSENT		Absent	
NITRITE	ABSENT		Negative	
UROBILINOGEN	ABSENT		Normal	
MICROSCOPIC EXAMINATION				
PUS CELLS	3-4	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	ABSENT	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

***** End Of Report *****

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