



DDRC SRL DIAGNOSTICS

GANDHI NAGAR, KTM KERALA, INDIA Tel: 93334 93334

Email: customercare.ddrc@srl.in

PATIENT NAME: ANITHA R PATIENT ID: ANITF1110764036

ACCESSION NO: 4036VJ002277 AGE: 46 Years SEX: Female

RECEIVED: 11/10/2022 12:22 11/10/2022 15:51 DRAWN: REPORTED:

REFERRING DOCTOR: DR. MEDIWHEEL CLIENT PATIENT ID:

Test Report Status Results **Biological Reference Interval Units**

MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT

TREADMILL TEST

TREADMILL TEST COMPLETED

DENTAL CHECK UP

DENTAL CHECK UP COMPLETED

OPTHAL

OPTHAL COMPLETED

PHYSICAL EXAMINATION

PHYSICAL EXAMINATION COMPLETED



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MEDIWHEEL HEALTH CHECKUP ABOVE 40(F)TMT

SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	7		6 - 20	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO	12.5		5 - 15	
CREATININE, SERUM				
CREATININE	0.56	Low	0.60 - 1.1	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	115		Diabetes Mellitus: > or = 200 mg/dL. Impaired Glucose tolerance/ Prediabetes: 140 to 199 mg/dL Hypoglycemia: < 55 mg/dL.	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SI	ERUM			
CHOLESTEROL	185		Desirable: <200 BorderlineHigh : 200-239 High : > or = 240	mg/dL
TRIGLYCERIDES	77		Normal: < 150 High: 150-199 Hypertriglyceridemia: 200-499 Very High: > 499	mg/dL
HDL CHOLESTEROL	55		40 - 60	mg/dL
DIRECT LDL CHOLESTEROL	129	High	Adult levels: Optimal < 100 Near optimal/above optimal: 10 129 Borderline high: 130-159 High: 160-189 Very high: = 190	mg/dL 00-
NON HDL CHOLESTEROL	130		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	3.4		3.30 - 4.40	
LDL/HDL RATIO	2.4		0.5 - 3.0	

15.4

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

VERY LOW DENSITY LIPOPROTEIN



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mg/dL

< or = 30.0





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GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.9	High	Normal: 4.0 - 5.6 %. Non-diabetic level: < 5.7%. More stringent goal: < 6.5 %. General goal: < 7%. Less stringent goal: < 8%. Glycemic targets in CKD:- If eGFR > 60: < 7%. If eGFR < 60: 7 - 8.5%.	%
MEAN PLASMA GLUCOSE	122.6	High	< 116.0	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.48		< 1.1	mg/dL
BILIRUBIN, DIRECT	0.20		0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT	0.28		0.00 - 1.00	mg/dL
TOTAL PROTEIN	7.0		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
ALBUMIN	4.3		3.5 - 5.2	g/dL
GLOBULIN	2.7		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.6		1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	13		< 33	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	16		< 34	U/L
ALKALINE PHOSPHATASE	56		35 - 105	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	27		< 40	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.0		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	5.1		2.4 - 5.7	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	TYPE B			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	12.2		12.0 - 15.0	g/dL
RED BLOOD CELL COUNT	4.37		3.8 - 4.8	mil/µL
WHITE BLOOD CELL COUNT	8.00		4.0 - 10.0	thou/µL
PLATELET COUNT	304		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	38.8		36 - 46	%



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				_
MEAN CORPUSCULAR VOL	89.0		83 - 101	fL
MEAN CORPUSCULAR HGB.	27.9		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	31.5		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	11.7		11.6 - 14.0	%
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	53		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	4.24		2.0 - 7.0	thou/µL
LYMPHOCYTES	41	High	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	3.28	High	1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.3			
EOSINOPHILS	06		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.48		0.02 - 0.50	thou/µL
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	33	High	0 - 20	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING	i		
SUGAR URINE - POST PRANDIAL				
SUGAR URINE - POST PRANDIAL	NOT DETECTED		NOT DETECTED	
THYROID PANEL, SERUM				
Т3	106.72		Male and Non-Pregnant Pregnant Trimester-wise 1st: 81-190 2nd: 100-260 3rd: 100-260	٥.
T4	9.60		3.2 - 12.6	μg/dl
TSH 3RD GENERATION	2.760		0.35 - 5.50	μIU/mL
SUGAR URINE - FASTING				
SUGAR URINE - FASTING	NOT DETECTED		NOT DETECTED	
URINE ANALYSIS				
COLOR	PALE YELLOW			
APPEARANCE	CLEAR			
PH	6.0		4.8 - 7.4	
SPECIFIC GRAVITY	1.015		1.015 - 1.030	
GLUCOSE	NOT DETECTED		NOT DETECTED	
PROTEIN	DETECTED (TRAC	E)	NOT DETECTED	
KETONES	NOT DETECTED		NOT DETECTED	



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Test Report Status Results Units **UROBILINOGEN** NORMAL NORMAL **BACTERIA DETECTED** (++) NOT DETECTED

CHEMICAL EXAMINATION, URINE

NOT DETECTED NOT DETECTED **BILIRUBIN**

MICROSCOPIC EXAMINATION, URINE

/HPF **WBC** 20-30 0-5 **EPITHELIAL CELLS** 0-5 /HPF 8-10 RED BLOOD CELLS NOT DETECTED /HPF NOT DETECTED

CASTS NOT DETECTED **CRYSTALS** NOT DETECTED

Comments

NOTE - Kindly correlate clinically.

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA 85 Diabetes Mellitus: > or = 126 mg/dL

mg/dL.

Impaired fasting Glucose/ Prediabetes: 101 to 125 mg/dL. Hypoglycemia: < 55 mg/dL.

Interpretation(s)

SERUM BLOOD ÙRÉA NITROGEN-

Causes of Increased levels

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
 Renal Failure

Post Renal

• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- Liver disease

• SIADH. CREATININE, SERUM-

Higher than normal level may be due to:

- Blockage in the urinary tract
 Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

GLUCOSE, POST-PRANDIAL, PLASMA-

ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water, over a period of 5 minutes. CORONARY RISK PROFILE (LIPID PROFILE), SERUM-

Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of



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plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High diabetes with elevels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL).

NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red

blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of

testing such as glycated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.'

References

- 1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006,
- 2. Forsham PH. Diabetes Mellitus: A rational plan for management. Postgrad Med 1982, 71,139-154.

 3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184. TOTAL PROTEIN, SERUM-

Serum 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

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. URIC ACID, SERUM-

Causes of Increased levels Dietary

- High Protein Intake.
- Prolonged Fasting.
- Rapid weight loss.

Gout

Lesch nyhan syndrome.

Type 2 DM.



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Metabolic syndrome.

Causes of decreased levels

- Low Zinc IntakeOCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluidsLimit animal proteins
- High Fibre foodsVit C Intake
- Antioxidant rich foods

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.

BLOOD COUNTS-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology. RBC AND PLATELET INDICES-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear

The cell morphology is well preserved for 2411s. However after 24-46 firs a progressive increase in MCV and nCT is observed leading to a decrease in MCR. A direct shear is recommended for an accurate differential count and for examination of RBC morphology.

WBC DIFFERENTIAL COUNT - NLRThe 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. ERYTHRO SEDIMENTATION RATE, BLOOD-

Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

- Nathan and Oski's Haematology of Infancy and Childhood, 5th edition
 Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin
 The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th Edition"

SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST

THYROID PANEL, SERUM-

Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the

(µg/dL) (µIU/mL) 0.1 - 2.5 0.2 - 3.0 81 - 190 100 - 260 6.6 - 12.4 6.6 - 15.5 First Trimester 2nd Trimester

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

T3

(ng/dL)

(ng/dL) New Born: 75 - 260 (μg/dL) 1-3 day: 8.2 - 19.9 1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.



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Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST
MUCROSCODIC EVANIMATION. LIDING

MICROSCOPIC EXAMINATION, URINE-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food

can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

GLUCOSE, FASTING, PLASMA-

ADA 2012 guidelines for adults as follows: Pre-diabetics: 100 - 125 mg/dL Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)



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ECG WITH REPORT

REPORT

COMPLETED

MAMMOGRAPHY-BOTH

REPORT

COMPLETED

USG ABDOMEN AND PELVIS

REPORT

COMPLETED

CHEST X-RAY WITH REPORT

REPORT

COMPLETED

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

PRASEEDA S NAIR LAB TECHNICIAN SREEDEVI V RAJU LAB TECHNICIAN

SMITHA BIJU LAB TECHNICIAN







OPHTHALMOLOGY REPORT

ACCESSION	NO:4036\	JJ002277
ACCESSION	INO. TOOO	00002211

This is to certify that I have examined

MR/MS ANITHA-R. Aged 46 F and

His / her visual standard is as follows.

Acuity of Vision

L 6/10

For Near

R.....∧8

r....V8

With Specs Rt > 6/6

With Specs N >

Colour Vision

..NORMAL...

DATE: 11/10/2022



OPTOMETRIST



Name: ANITHA.R Age/Sex: 46 yrs/F

Accession No: 4036VJ002277

Report Date: 11.10.2022 Ref.by: Mediwheel

USG ABDOMEN & PELVIS

OBSERVATIONS:

Liver:

Normal in size. Shows increased parenchymal echotexture. No focal

parenchymal lesion noted. The biliary radicals appear normal. Portal

vein is normal (9 mm).

Gall bladder:

Distended. No calculus seen. No e/o of any wall thickening / edema.

No e/o any pericholecystic collection. CBD: Not dilated (4 mm).

Spleen:

Normal in size (7.4 cm) and echotexture. No focal lesion.

Pancreas:

Head (2.2 cm), body (1.2 cm) and tail (1.4 cm) appear normal. No

focal lesion. No calcification or duct dilatation noted.

Kidneys:

Right suprarenal region shows a solid hypoechoic lesion measuring 2.2 x 1.6 cm. The lesion shows minimal colour flow on

applying Doppler.

Right kidney length measures 10 cm. Parenchymal thickness 1.5 cm

Normal in position & size. Cortical echogenicity is normal. There is good cortico-medullary differentiation. No calculus or mass lesion

seen. No hydronephrosis.

Left kidney length measures 10.4 cm. Parenchymal thickness 1.5 cm

Normal in position & size. Cortical echogenicity is normal. There is good cortico-medullary differentiation. No calculus or mass lesion

seen. No hydronephrosis. Ureters: Not dilated.

Urinary Bladder: Distended, No luminal or wall abnormality noted.

Uterus:

Is anteverted and enlarged in size measures 10 x 5.5 x 4.5 c

Myometrial echo is heterogeneous. A small intramural fibro measuring 1.6 x 1.1 cm is noted in the posterior wall. Endometrial ec

is normal. ET- 10 mm. Cavity is empty.

Ovaries:

Right ovary: 2.7 x 1.6 cm

Left ovary: 2.2 x 1.5 cm

Normal in size and morphology on both sides.

Adnexa:

No adnexal lesions.

Others:

lymphadenopathy. No evidence bowel

thickening/echogenic mesentery/dilated bowel loops. Normal peristal

seen. No free fluid in the peritoneal cavity. No pleural effusion noted.

IMPRESSION:

Grade I fatty changes in liver.

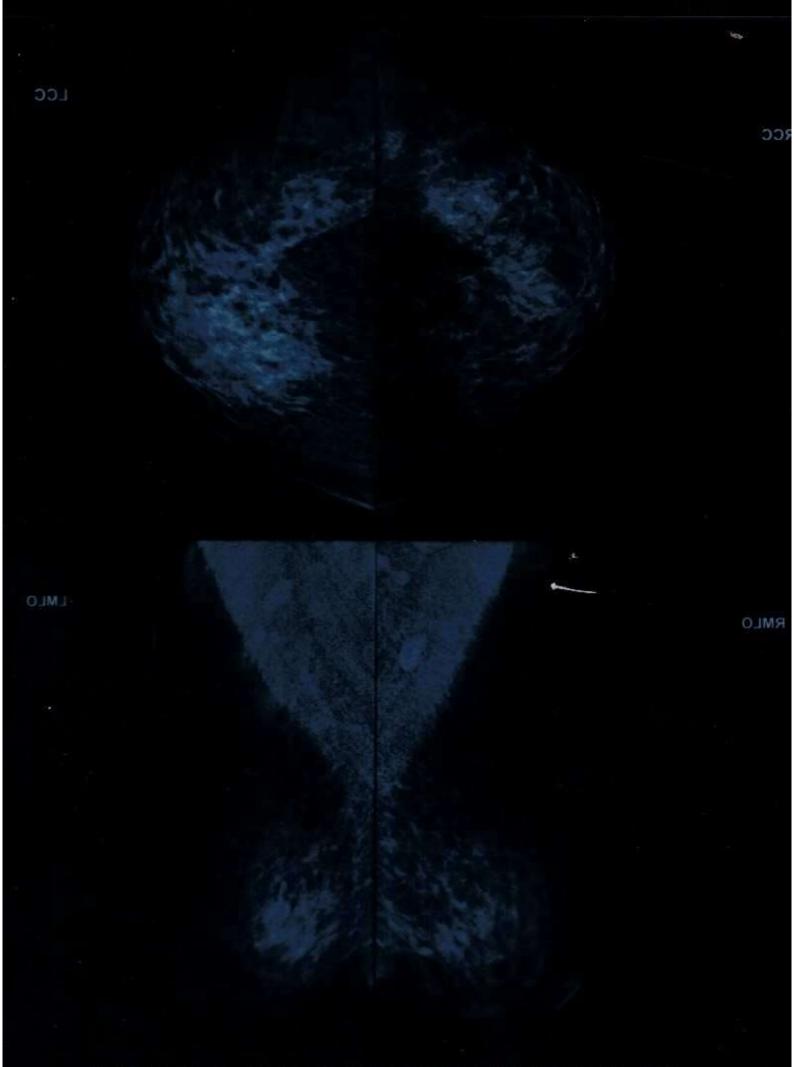
Right suprarenal hypoechoic solid lesion (suggest CECT abdomen with adrenal protoc

Dr. Deepak.V, MBBS, DMRD

Radiologist

Note: Please correlate clinically and investigate further as needed.

CIN: U85190MH2006PTC161480 (Refer to "CONDITIONS OF REPORTING" overleaf)



ANITHA SURESH 46 YRS 175768 MAMMOGRAM B/L DDRC 11-Oct-22 CMC Hospital, Kottayam

Patient		Exam	
ID Name Birth Date Gender	11-10-2022-0012 Other	Accession # Exam Date Description Sonographer	11
[2D] G32:118dBFA10:P90:HARFEII 1		[2D] G18/118d9/FA10/P90/HAR/F5I 1	
-10 -15	D1 1.07 cm	-10 -15	D1 2.2 D2 1.2 D3 1.4 Vol. 247
[ZD] GTB/T18d8FA10P90 HARFSI 1		(20) G18/118d8FA10P900HARFSI 1	
-15		-10 -15	D1 0.4 D2 0.9
2D) G27/18dB:FA16P90HARFSI 1		(2D) G22H18dBFA10P90HARFSI 1	
15	D1 2.27 cm	15	D1 10.07 D2 1.49

Patient Exam ID 11-10-2022-0012 Accession # Exam Date Birth Date Gender Other Sonographer









Name: ANITHA.R Age/Sex: 46 yrs/F

Accession No: 4036VJ002277

Report Date: 11.10.2022

Ref.by: Mediwheel

MAMMOGRAM REPORT (BOTH BREASTS)

Cranio-caudal and Medio-lateral oblique views of both breasts were taken.

Right breast

No evidence of any mass lesion / asymmetric density noted.

No clustered pleomorphic microcalcifications visualized.

No evidence of any architectural distortion seen.

There is no skin thickening or nipple retraction.

Few small benign lymph nodes are seen in the axillary regions.

High frequency Sonography: Reveals no focal / diffuse mass lesion or obviously dilated ducts.

Left breast

A small well circumscribed smooth hyperdense lesion is noted in the upper outer quadrant

No clustered pleomorphic microcalcifications visualized.

No evidence of any architectural distortion seen.

There is no skin thickening or nipple retraction.

Few small benign lymph nodes are seen in the axillary regions.

High frequency Sonography: A well defined hypoechoic lesion measuring 12 x 5 mm is noted at 2 o' clock position in mammary layer about 3.4 cm away from nipple.

IMPRESSION:

BIRADS 3 lesion in the left breast at 2 o' clock position, likely to be fibroadenoma.

Dr. Deepak.V, MBBS, DMRD Radiologist

Encl: Film

This is a professional opinion based on imaging findings and not a diagnosis by it self. Please correlate clinically and with other imaging / laboratory investigations.



ECG REPORT

ACCESSION NO : 4036VJ002277

NAME

: ANITHA R

AGE

: 46

SEX

: FEMALE

DATE

: 11.10.2022

COMPANY : MEDIWHEEL

RATE

: 89 mg

RHYTHM

: Noned shows

P. WAVE

Nound

P-R INTERVAL

201 mg

Q,R,S,T. WAVES

AXIS

ARRHYTHMIAS

QT INTERVAL

340m

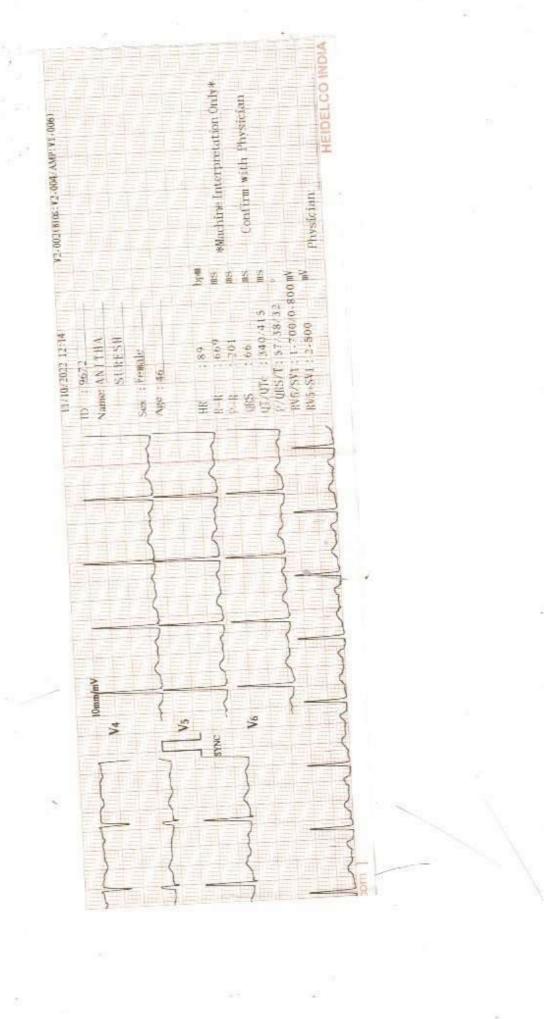
OTHERS

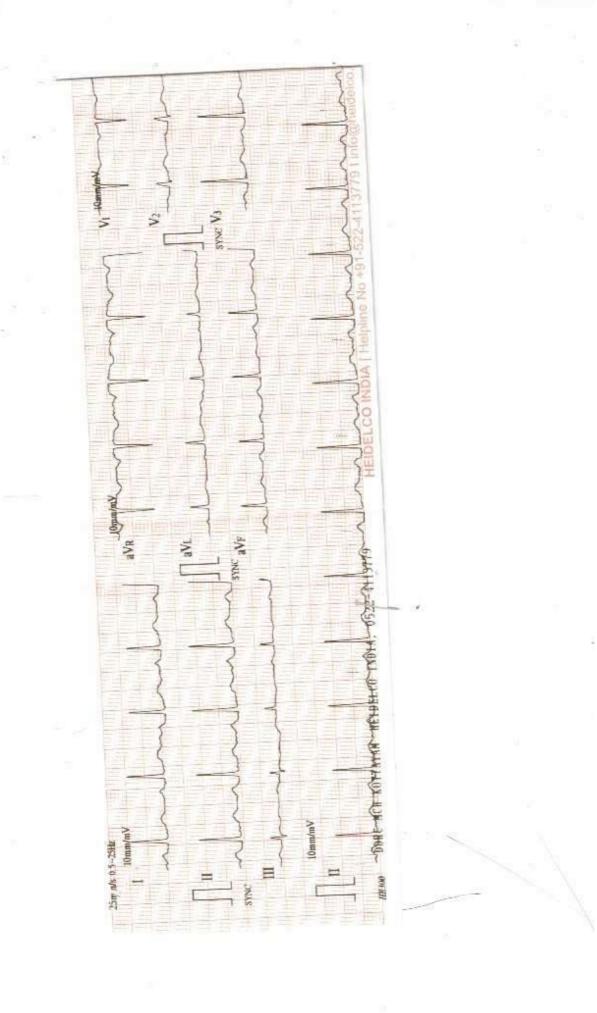
OPINION

ch











ANITHA SURESH 46Y 4154 CHEST-PA 11-10-2022

DDRC SRL DIAGNOSTICS, GANDHI NAGAR, KOTTAYAM



X - RAY CHEST - REPORT

ACCESSION NO : 4036VJ002277

NAME

: ANITHA R

AGE

: 46

SEX

: FEMALE

DATE

: 11.10.202

COMPANY

: MEDIWHEEL

EXPOSURE

POSITIONING

SOFT TISSUES

LUNG FIELDS

HEART SHADOW

CARDIOPHRENIC ANGLE

COSTOPHRENIC ANGLE

HILUM

OPINION



Dr. RAJENDRAN'S CARE & CURE DENTAL CLINIC

KH I - 2653/13
OTHALATHUMOOTTIL COMMERCIAL COMPLEX (FIRST FLOOR)
SAMKRANTHI, KOTTAYAM - 686 016, KERALA. Mob. 9446026310

OP NONAME	general dental cheelup.	*****
ND FOR		
X On	dental enamination of	
patient	named conitha 5 week	4
	was found to have	
general	ized stanie and calculus.	
Patient	Or. ANN NAMITHA JACOB, Buthe. Dental Surgeon Dental Surgeon KDC, Reg. No: 15586/A KDC, Reg. No. 15586/A	570

15 100 |- for cheeling





· Any disorders of Urinary System? · Any disorder of the Eyes, Ears Nose, Throat or Mouth & Skin FOR FEMALE CANDIDATES ONLY d. Do you have any history of miscarriage/ a. Is there any history of diseases of breast/genital organs? Y/N abortion or MTP b. Is there any history of abnormal PAP e. For Parous Women, were there any complication Smear/Mammogram/USG of Pelvis or any other during pregnancy such as gestational diabetes, hypertension etc tests? (If yes attach reports) c. Do you suspect any disease of Uterus, Cervix or f. Are you now pregnant? If yes, how many months?

CONFIDENTAIL COMMENTS FROM MEDICAL EXAMINER

> Was the examinee co-operative?

Ovaries?

Is there anything about the examine's health, lifestyle that might affect him/her in the near future with regard to his/her job?

Are there any points on which you suggest further information be obtained?

Based on your clinical impression, please provide your suggestions and recommendations below;

cect Abdornay (i renal protoco) advised of surgery consultation for BIRADS-3

Do you think he/she is MEDICALLY FIT or UNFIT for employment.

EIT

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner : Dr. AUSTIN VARCHEE

Australia

Seal of Medical Examiner : Dr. Austin Varghees
MBBS
TCMC Reg. No:77017

Name & Seal of DDRC SRL Branch ;

Date & Time :



Y/N

Y/N

Y/N

DDRC SR L Diagnostics Private Limited



Enlarged glands or any form of Cancer/Tumour?

Any Musculoskeletal disorder?

MEDICAL EXAMINATION REPORT (MER)

may be obliged to disclose the result of the

Name of the Mark of Ide Age/Date of Photo ID Co	ntification : (Mo	le/Scar/an	ANITH y other (specify 1976 tion Card/PAN (location)): Gender:	✓F/M ag Licence/Company ID)	
PHYSICAL DET	AILS:					
a. Height! d. Pulse Rate	197 A-C 18	ghtod Pressur	3.6 (Kgs) e:		th of Abdomen86 (cm lic /30 Diastolic 90	
			1" Reading			-
		2	2 nd Reading			
FAMILY HISTO	RY:			E 16		
Relation	Age if Living	Health	Health Status		If deceased, age at the time and cause	
Father	Nel	_130		- %		
Mother	Yes, 68	CHOOd				
Brother(s)	2, 48,49					
Sister(s)	1711			67.5		
HABITS & ADD	ICTIONS: Does the exami	nee consu	me any of the fo	llowing?		
	cco in any form		Sedative		Alcohol	
Tobas	cco in any form		Sedative			
from any mer	STORY ently in good health and ent attal or Physical impairment attach details.	or deform	ity. exami		LOSQT - 50 [E years have you been medical ed any advice or treatment or nospital?	ly
b. Have you und procedure?	dergone/been advised any st		(/N	you lost or	gained weight in past 12 mor	nths?
Have you ever su	ffered from any of the fol	lowing?	74477		N N SEE E	
 Psychologica the Nervous 	I Disorders or any kind of o System?	lisorders o	LIII UIICA	plained rec	Gastrointestinal System? urrent or persistent fever,	Y
 Any disorder 	s of Respiratory system?	,	1/1	and/or weight loss		
· Any Cardiac	or Circulatory Disorders?	,	Y/N_ • Have	Have you been tested for HIV/HBsAg / HCV		

DDRC SRL Diagnostics Private Limited

YIN

Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036 Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

before? If yes attach reports

Are you presently taking medication of any kind?

Y/