



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

Hiranandani Fortis Hospital
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Navi Mumbai - 400 703.
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Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 11/07/21

Name: Mr. Amil Sushash Salane Age: 31 yrs

Sex: M / F

BP: 130/70mmHg Height (cms): 175cm Weight(kgs): 83.2kg BMI: 26

WEIGHT lbs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight				Healthy				Overweight				Obese				Extremely Obese							
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39		
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38		
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37			
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36			
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35			
5'9" - 176.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
5'11" - 180.3	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34			
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33			
6'1" - 185.4	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33			
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			
6'4" - 193.0	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32			

Doctors Notes:

Signature



UHID	5619042	Date	11/02/2023		
Name	Mr Amit Subhash Sasane	Sex	Male	Age	35
OPD	Ophthal 14	Health Check Up			

Clr. No.

Drug allergy: → Not known.
 Sys illness: → No.

NG. No

U and V → R 6/6.
 → L 6/6.

Ref → R Pheri / -0.50 x 90° 6/6.
 → L Pheri 6/6.

UV → R NG
 → L NG

IOP → R → 12.2
 → L → 12.9.

[Handwritten Signature]



UHID	5619042	Date	11/02/2023		
Name	Mr Amit Subhash Sasane	Sex	Male	Age	35
OPD	Dental 12	Health Check Up			

Drug allergy:
 Sys illness:

Impacted $\frac{8}{8}$

caries $\frac{6}{67}$ Old cap $\frac{8}{8}$

stains & calculus 2

Treatment

Adv new cap $\frac{8}{8}$

Adv surgical removal $\frac{8}{8}$

Adv filling $\frac{6}{67}$

Adv op r.

Adv oral prophylaxis.

Dr Diksha Khehar



Cert. No. MC-2275

LABORATORY REPORT



PATIENT NAME : MR.AMIT SUBHASH SASANE

PATIENT ID : **FH.5619042**

CLIENT PATIENT ID : UID:5619042

ACCESSION NO : **0022WB002101** AGE : 35 Years SEX : Male

ABHA NO :

DRAWN : 11/02/2023 11:05:00

RECEIVED : 11/02/2023 11:05:55

REPORTED : 11/02/2023 13:10:59

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:5619042 REQNO-1370519
CORP-OPD
BILLNO-150123OPCR008379
BILLNO-150123OPCR008379

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

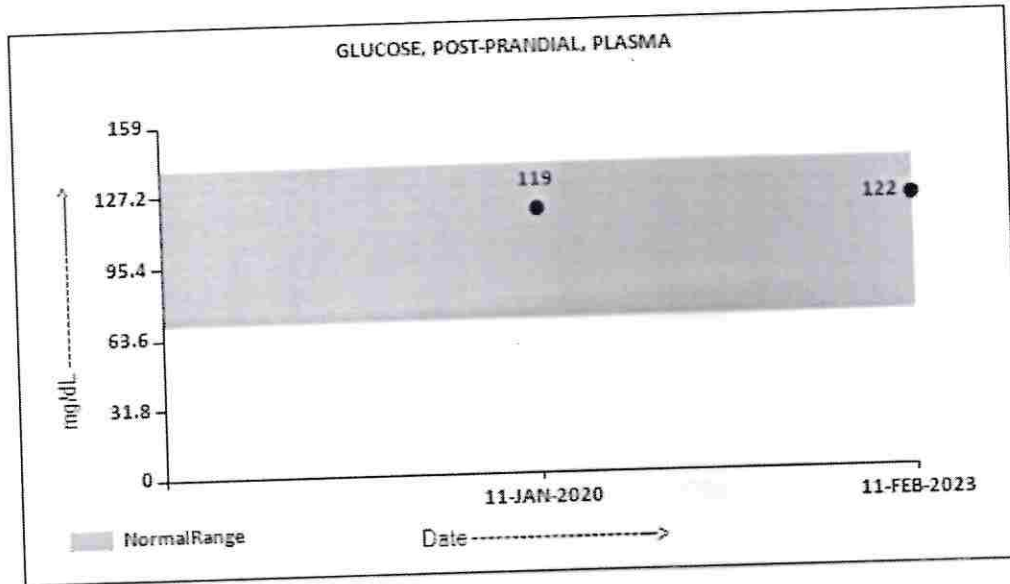
PPBS(POST PRANDIAL BLOOD SUGAR)

122

70 - 139

mg/dL

METHOD : HEXOKINASE



Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc. Additional test HbA1c

****End Of Report****

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Patient Ref. No. 2200000



Cert. No. MC-2275

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PATIENT ID : **FH.5619042**

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Final			

Dr.Akta Dubey
Counsltant Pathologist

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Patient Ref. No. 2200000



Cert. No. MC-2984



LABORATORY REPORT

PATIENT NAME : MR. AMIT SUBHASH SASANE

PATIENT ID : **FH.5619042**

CLIENT PATIENT ID : UID:5619042

ACCESSION NO : **0022WB002008**

AGE : 35 Years

SEX : Male

ABHA NO :

DRAWN : 11/02/2023 08:27:00

RECEIVED : 11/02/2023 08:27:44

REPORTED : 11/02/2023 14:20:51

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5619042 REQNO-1370519

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	65.82	Low 80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	4.75	Low 5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	3.540	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Comments

NOTE: PLEASE CORRELATE VALUES OF THYROID FUNCTION TEST WITH THE CLINICAL & TREATMENT HISTORY OF THE PATIENT.

Interpretation(s)

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Patient Ref. No. 2200000082



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SPECIALISED CHEMISTRY - TUMOR MARKER**PROSTATE SPECIFIC ANTIGEN, SERUM**

PROSTATE SPECIFIC ANTIGEN

0.474

< 1.4

ng/mL

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

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

- It is a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.

- Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.

- Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.

- Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.

- As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)

References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

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

786

Dr. Swapnil Sirmukaddam**Consultant Pathologist****SRL Ltd**

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NAVI MUMBAI, 410210

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**Patient Ref. No. 22000000827**



Cert. No. MC-2275



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PATIENT ID : FH.5619042

CLIENT PATIENT ID : UID:5619042

ACCESSION NO : 0022WB002008

AGE : 35 Years

SEX : Male

ABHA NO :

DRAWN : 11/02/2023 08:27:00

RECEIVED : 11/02/2023 08:27:44

REPORTED : 11/02/2023 13:50:31

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5619042 REQNO-1370519

CORP-OPD

BILLNO-150123OPCR008379

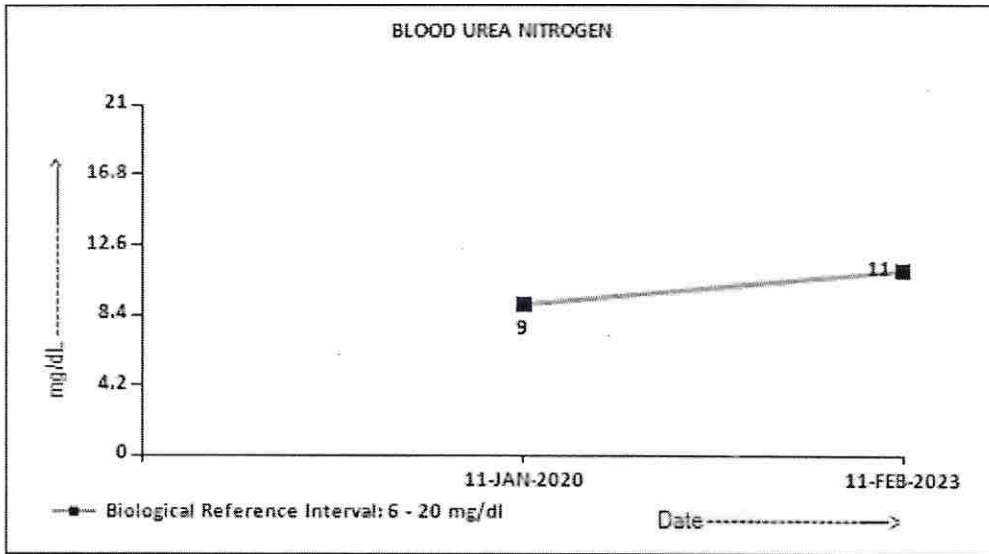
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	11	6 - 20	mg/dL
METHOD : UREASE - UV			



CREATININE EGFR- EPI

CREATININE	0.81	Low 0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	35		years
GLOMERULAR FILTRATION RATE (MALE)	117.92	Refer Interpretation Below	mL/min/1.73
METHOD : CALCULATED PARAMETER			

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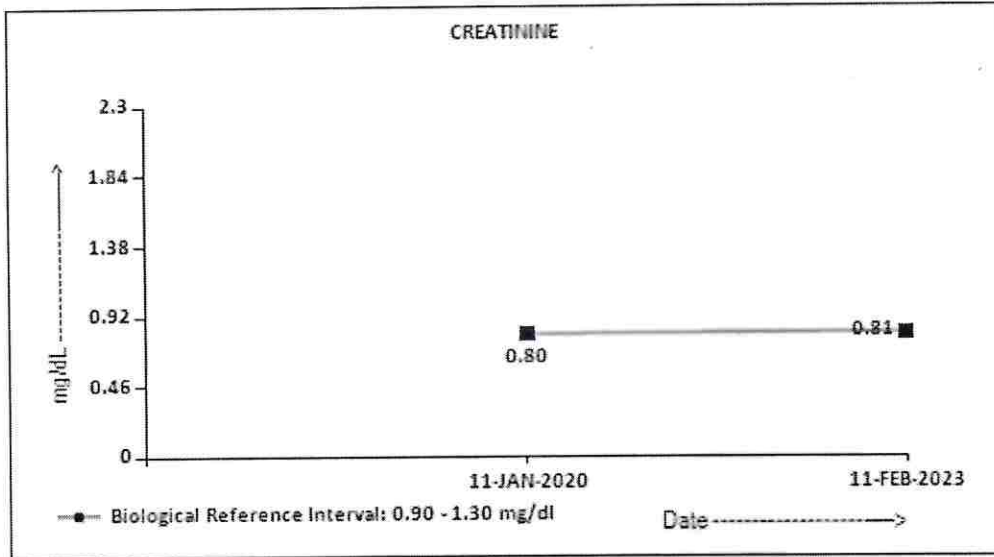
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BUN/CREAT RATIO

BUN/CREAT RATIO 13.58 5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 5.8 3.5 - 7.2 mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.5 6.4 - 8.2 g/dL

METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.4 3.4 - 5.0 g/dL

METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN 3.1 2.0 - 4.1 g/dL

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM 138 136 - 145 mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM 4.30 3.50 - 5.10 mmol/L

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METHOD : ISE INDIRECT CHLORIDE, SERUM METHOD : ISE INDIRECT		103	98 - 107	mmol/L
Interpretation(s)				

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
METHOD : PHYSICAL

APPEARANCE CLEAR
METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY 1.020 1.003 - 1.035
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD

KETONES NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN

BILIRUBIN NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT

UROBILINOGEN NORMAL NORMAL
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)

NITRITE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF
METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 0-1 0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION

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Test Report Status	Final	Results	Biological Reference Interval	Units
EPITHELIAL CELLS		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)

Interpretation(s)

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-GFR- Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

URIC ACID, SERUM-Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome

Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis

TOTAL PROTEIN, SERUM-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 made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, 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.

ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood se protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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HAEMATOLOGY - CBC**CBC-5, EDTA WHOLE BLOOD****MORPHOLOGY**

RBC

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

METHOD : MICROSCOPIC EXAMINATION

WBC

NORMAL MORPHOLOGY

METHOD : MICROSCOPIC EXAMINATION

PLATELETS

ADEQUATE

METHOD : MICROSCOPIC EXAMINATION

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)

13.2

13.0 - 17.0

g/dL

METHOD : SPECTROPHOTOMETRY

RED BLOOD CELL (RBC) COUNT

4.59

4.5 - 5.5

mil/ μ L

METHOD : ELECTRICAL IMPEDANCE

WHITE BLOOD CELL (WBC) COUNT

5.17

4.0 - 10.0

thou/ μ L

METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY

PLATELET COUNT

247

150 - 410

thou/ μ L

METHOD : ELECTRICAL IMPEDANCE

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)

38.9**Low** 40 - 50

%

METHOD : CALCULATED PARAMETER

MEAN CORPUSCULAR VOLUME (MCV)

84.7

83 - 101

fL

METHOD : CALCULATED PARAMETER

MEAN CORPUSCULAR HEMOGLOBIN (MCH)

28.9

27.0 - 32.0

pg

METHOD : CALCULATED PARAMETER

MEAN CORPUSCULAR HEMOGLOBIN

34.1

31.5 - 34.5

g/dL

CONCENTRATION(MCHC)

METHOD : CALCULATED PARAMETER

RED CELL DISTRIBUTION WIDTH (RDW)

14.0

11.6 - 14.0

%

METHOD : CALCULATED PARAMETER

MENTZER INDEX

18.5

MEAN PLATELET VOLUME (MPV)

9.6

6.8 - 10.9

fL

METHOD : CALCULATED PARAMETER

WBC DIFFERENTIAL COUNT

NEUTROPHILS

45

40 - 80

%

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**LABORATORY REPORT****PATIENT NAME : MR.AMIT SUBHASH SASANE**PATIENT ID : **FH.5619042**

CLIENT PATIENT ID : UID:5619042

ACCESSION NO : **0022WB002008** AGE : 35 Years SEX : Male

ABHA NO :

DRAWN : 11/02/2023 08:27:00

RECEIVED : 11/02/2023 08:27:44

REPORTED : 11/02/2023 13:50:31

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5619042 REQNO-1370519

CORP-OPD

BILLNO-150123OPCR008379

BILLNO-150123OPCR008379

Test Report Status	Final	Results	Biological Reference Interval
METHOD : FLOWCYTOMETRY			
LYMPHOCYTES		45	High 20 - 40 %
METHOD : FLOWCYTOMETRY			
MONOCYTES		07	2 - 10 %
METHOD : FLOWCYTOMETRY			
EOSINOPHILS		03	1 - 6 %
METHOD : FLOWCYTOMETRY			
BASOPHILS		00	0 - 2 %
METHOD : FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT		2.33	2.0 - 7.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT		2.33	1.0 - 3.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT		0.36	0.2 - 1.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT		0.16	0.02 - 0.50 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10 thou/ μ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1	
METHOD : CALCULATED PARAMETER			

Interpretation(s)

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 10650 This ratio element is a calculated parameter and out of NABL scope.)

HAEMATOLOGY**ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD**

E.S.R	06	0 - 14	mm at 1 hr
-------	----	--------	------------

METHOD : WESTERGREN METHOD

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LABORATORY REPORT

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PATIENT ID : **FH.5619042**

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UID:5619042 REQNO-1370519

CORP-OPD

BILLNO-150123OPCR008379

BILLNO-150123OPCR008379

Test Report Status	Final	Results	Biological Reference Interval
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Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE A
METHOD : TUBE AGGLUTINATION	
RH TYPE	POSITIVE
METHOD : TUBE AGGLUTINATION	

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.47	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.15	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.32	0.1 - 1.0	mg/dL

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CORP-OPD

BILLNO-150123OPCR008379

BILLNO-150123OPCR008379

Test Report Status	Final	Results	Biological Reference Interval
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN		7.5	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		4.4	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.1	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.4	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		13	Low 15 - 37 U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		23	< 45.0 U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE		66	30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		35	15 - 85 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE		143	100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)		108	High 74 - 99 mg/dL
METHOD : HEXOKINASE			

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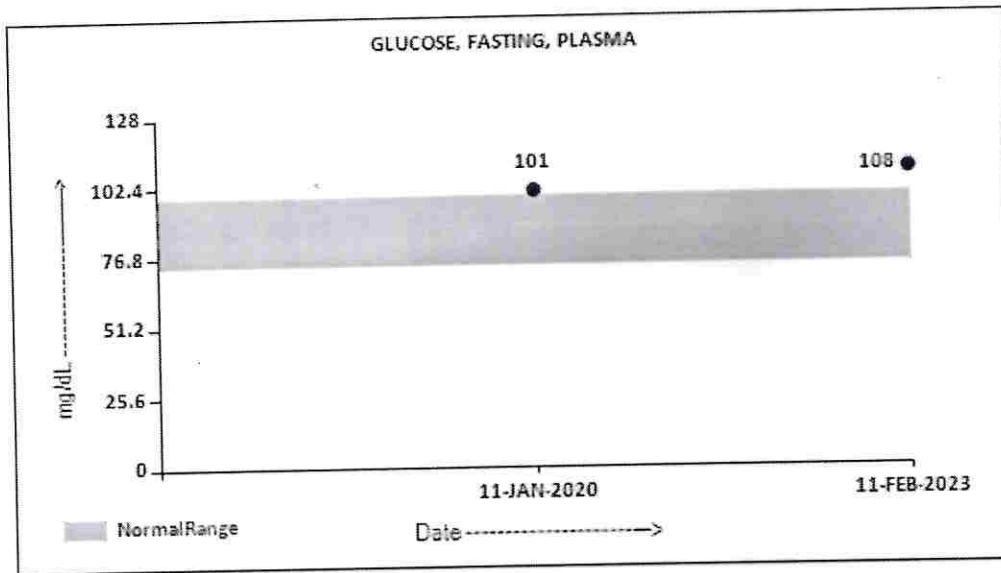
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C

5.8

High Non-diabetic: < 5.7
 Pre-diabetics: 5.7 - 6.4
 Diabetics: > or = 6.5
 Therapeutic goals: < 7.0
 Action suggested : > 8.0
 (ADA Guideline 2021)

METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)

119.8

High < 116.0 mg/dL

METHOD : CALCULATED PARAMETER

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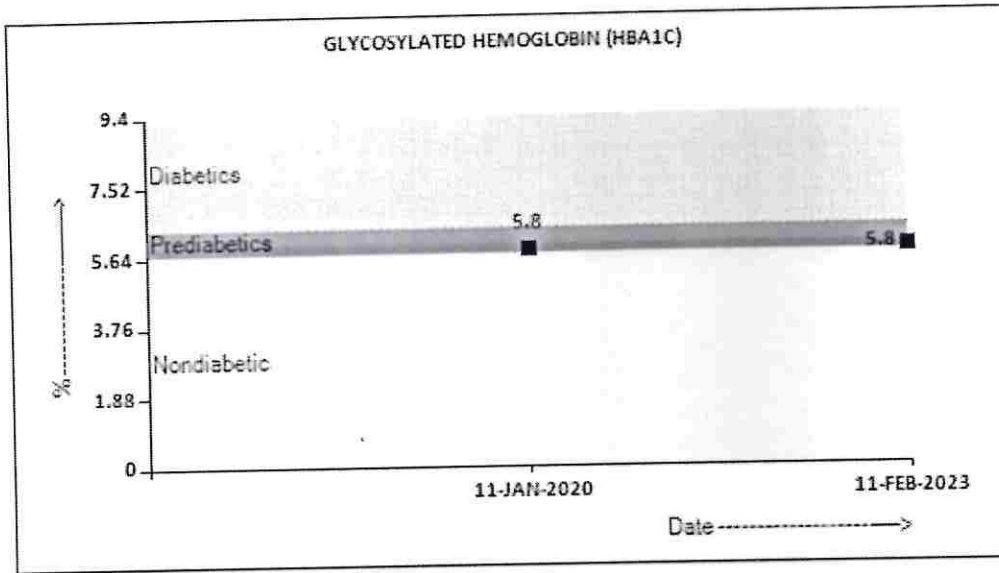
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CORP-OPD

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Test Report Status	Final	Results	Biological Reference Interval
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Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in viral hepatitis, drug reactions, alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in gallstones getting into the bile ducts, tumors & scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of hemolytic or pernicious anemia, transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in biliary obstruction, osteoblastic bone tumors, osteomalacia, hepatitis, hyperparathyroidism, leukemia, lymphoma, Paget's disease, rickets, sarcoidosis etc. Lower-than-normal ALP levels are seen in hypophosphatasia, malnutrition, protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. 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 globulin. 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. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in urine.

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PATIENT NAME : MR.AMIT SUBHASH SASANE

PATIENT ID : FH.5619042

CLIENT PATIENT ID : UID:5619042

ACCESSION NO : 0022WB002008 AGE : 35 Years SEX : Male ABHA NO :
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CLINICAL INFORMATION :

UID:5619042 REQNO-1370519
CORP-OPD
BILLNO-150123OPCR008379
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Table with 4 columns: Test Report Status, Final, Results, Biological Reference Interval

Increased in Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency, hypopituitarism,diffuse liver disease, malignancy (adrenocortical, stomach,fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases(e.g., galactosemia),Drugs- insulin, ethanol, propranolol; sulfonyleureas,tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals.Thus glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- 1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.Identifying patients at increased risk for diabetes (prediabetes).
The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiate: addition are reported to interfere with some assay methods,falsely increasing results.
IV.Interference of hemoglobinopathies in HbA1c estimation is seen in
a.Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b.Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c.HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

BIOCHEMISTRY - LIPID

Table with 4 columns: Test Name, Value, Reference Range, Unit. Rows include CHOLESTEROL, TOTAL (186), TRIGLYCERIDES (93), HDL CHOLESTEROL (39), LDL CHOLESTEROL, DIRECT (132)

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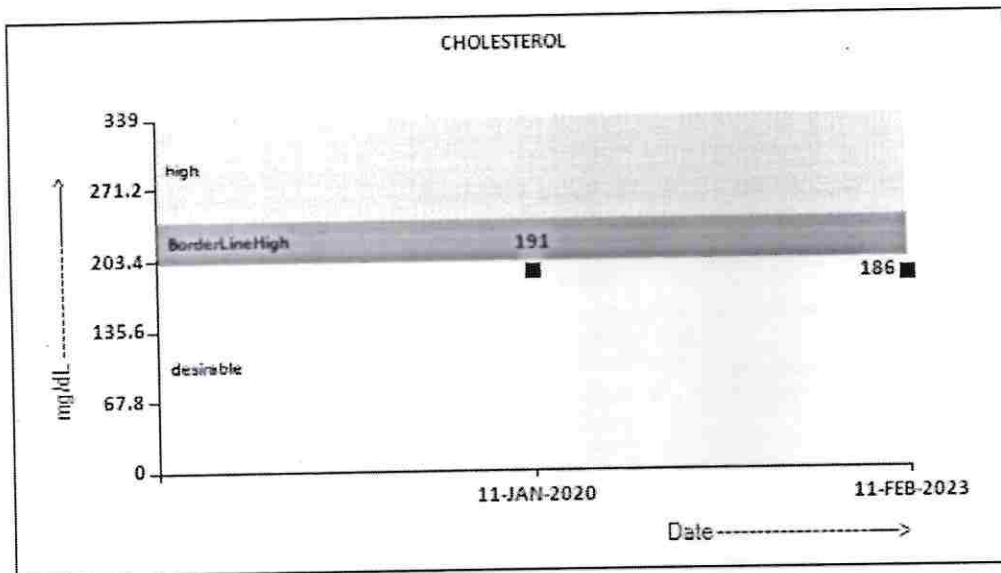
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CORP-OPD
BILLNO-150123OPCR008379
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Test Report Status	Final	Results	Biological Reference Interval
NON HDL CHOLESTEROL		147	High Desirable: Less than 130 mg/dL Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN		18.6	</= 30.0 mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO		4.8	High 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO		3.4	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
METHOD : CALCULATED PARAMETER			



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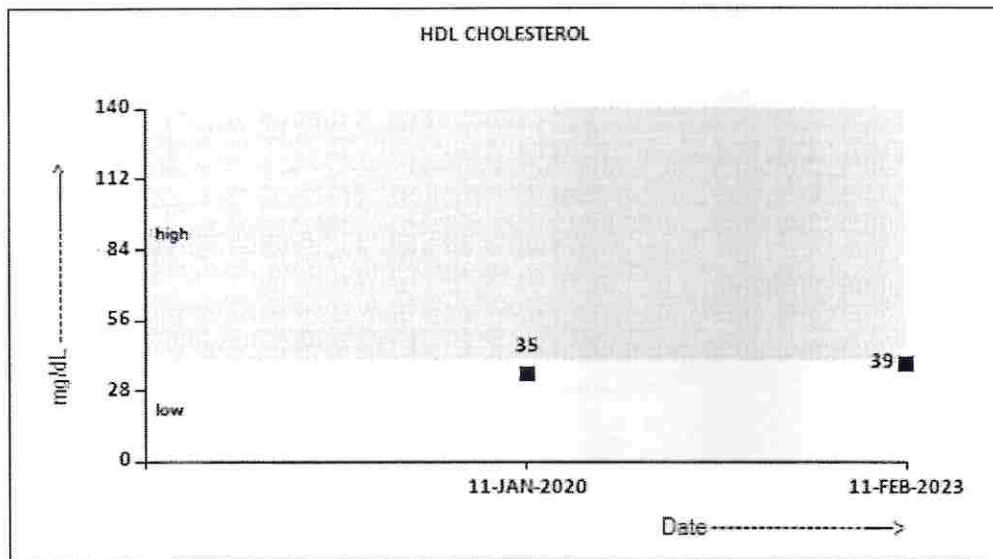
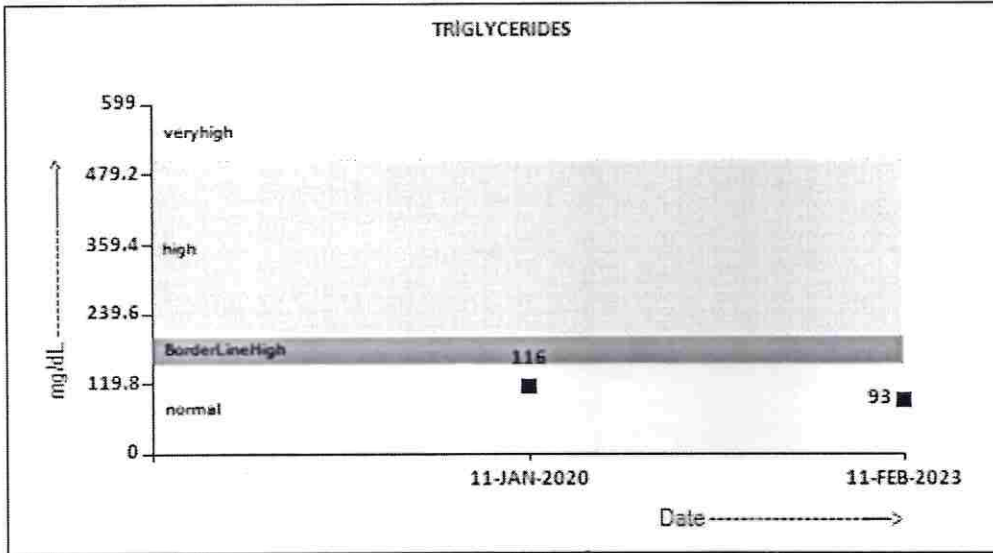
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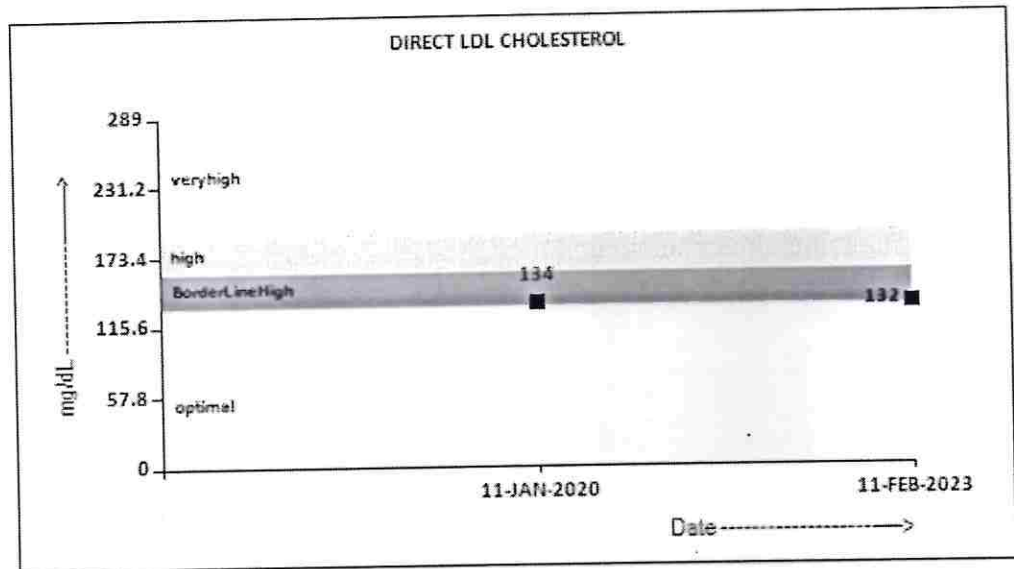
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BILLNO-150123OPCR008379

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Test Report Status	Final	Results	Biological Reference Interval
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Interpretation(s)

****End Of Report****

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

Dr.Akta Dubey
Counsltant Pathologist

Dr. Rekha Nair, MD
Microbiologist

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
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MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -



Scan to View Details



Scan to View Report



Patient Ref. No. 2200000082

5619042
35 Years

AMIT SASANE
Male

2/11/2023 9:44:03 AM

tk

Rate 62 . Sinus rhythm.....normal P axis, V-rate 50- 99
PR 137 . Baseline wander in lead(s) II, V1, V2, V6

QRSD 86
QT 373
QTc 379

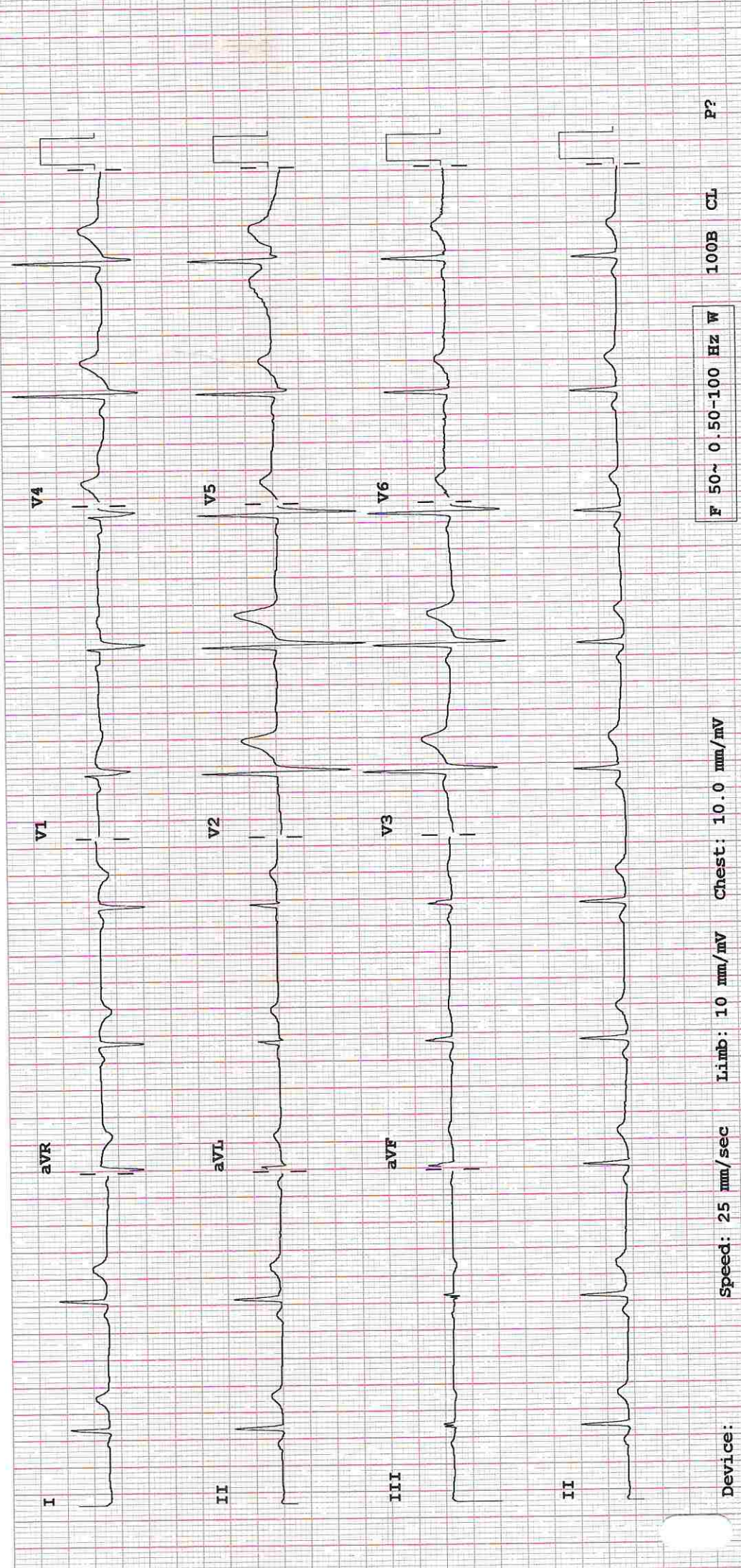
--AXIS--

P 42
QRS 36
T 26

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Sinus Rhythm
Normal
A



DEPARTMENT OF NIC

Date: 13/Feb/2023

Name: Mr. Amit Subhash Sasane
Age | Sex: 35 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5619042 | 8614/23/1501
Order No | Order Date: 1501/PN/OP/2302/17617 | 11-Feb-2023
Admitted On | Reporting Date : 13-Feb-2023 18:07:48
Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	35	mm
AO Root	22	mm
AO CUSP SEP	17	mm
LVID (s)	26	mm
LVID (d)	39	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	26	mm
RA	29	mm
LVEF	60	%



DEPARTMENT OF NIC

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Name: Mr. Amit Subhash Sasane

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Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.


A WAVE VELOCITY:0.5 m/sec

E/A RATIO:1.7

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

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.


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

Hiranandani Healthcare Pvt. Ltd.

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

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www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

DEPARTMENT OF RADIOLOGY

Date: 11/Feb/2023

Name: Mr. Amit Subhash Sasane

UHID | Episode No : 5619042 | 8614/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2302/17617 | 11-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Feb-2023 15:12:28

Bed Name :

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 11/Feb/2023

Name: Mr. Amit Subhash Sasane

UHID | Episode No : 5619042 | 8614/23/1501

Age | Sex: 35 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2302/17617 | 11-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Feb-2023 10:36:46

Bed Name :

Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

CBD appears normal in caliber.

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal.

No evidence of calculi/hydronephrosis.

Right kidney measures 10.9 x 5.0 cm.

Left kidney measures 10.0 x 5.6 cm.

PANCREAS is normal in size and morphology. No evidence of peripancreatic collection.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness.

No evidence of intravesical calculi.

PROSTATE is normal in size & echogenicity. It measures ~ 15 cc in volume.

No evidence of ascites.

IMPRESSION:

- Grade I fatty infiltration of liver.

Ys.
DR. YOGINI SHAH
DMRD., DNB. (Radiologist)