Patient Ref. No. 251000000143713

CLIENT CODE : C000138404

CLIENT'S NAME AND ADDRESS :

PROVISIONAL REPORT

SRL Ltd
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod, Tonk Road
JAIPUR, 302015
Rajasthan, INDIA

PATIENT NAME : SHARDA UMARWAL PATIENT ID : **SHARF090775251**

ACCESSION NO : **0251VG000730** AGE : 47 Years SEX : Female ABHA NO :

DRAWN : 09/07/2022 08:11 RECEIVED : 09/07/2022 12:51 REPORTED : 09/07/2022 15:26

REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012207090005

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	**11.8**	**Low**	12.0 - 15.0	g/dL
METHOD : CYANIDE FREE DETERMINATION				
RED BLOOD CELL COUNT	4.51		3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL COUNT	5.10		4.0 - 10.0	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	**142**	**Low**	150 - 410	thou/µL
METHOD : ELECTRONIC IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT	37.0		36 - 46	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOL	**82.0**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HGB.	**26.1**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	31.8		31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	18.2			
RED CELL DISTRIBUTION WIDTH	**16.4**	**High**	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MEAN PLATELET VOLUME	**11.1**	**High**	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	63		40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT	3.21		2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER				
LYMPHOCYTES	33		20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE LYMPHOCYTE COUNT	1.68		1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.9			
EOSINOPHILS	02		1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE EOSINOPHIL COUNT	0.10		0.02 - 0.50	thou/µL

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METHOD : CALCULATED PARAMETER				
MONOCYTES	02		2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE MONOCYTE COUNT	**0.10**	**Low**	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER				
BASOPHILS	00		0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR			
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	**22**	**High**	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	**6.1**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)				
MEAN PLASMA GLUCOSE	**128.4**	**High**	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**125**	**High**	74 - 99	mg/dL
METHOD : GLUCOSE OXIDASE				
GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	113		70 - 140	mg/dL
METHOD : GLUCOSE OXIDASE				
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.				
CHOLESTEROL	184		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE				
TRIGLYCERIDES	68		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : LIPASE/GPO-PAP NO CORRECTION				
HDL CHOLESTEROL	49		< 40 Low >/=60 High	mg/dL
METHOD : DIRECT CLEARANCE METHOD				

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DIRECT LDL CHOLESTEROL	99		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT CLEARANCE METHOD				
NON HDL CHOLESTEROL	**135**	**High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO	3.8		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	2.0		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN	13.6		</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.92		0 - 1	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID				
BILIRUBIN, DIRECT	**0.28**	**High**	0.00 - 0.25	mg/dL
METHOD : DIAZO WITH SULPHANILIC ACID				
BILIRUBIN, INDIRECT	0.64		0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	8.0		6.4 - 8.2	g/dL
METHOD : BIURET REACTION, END POINT				
ALBUMIN	**4.6**	**High**	3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN	3.4		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)	26		0 - 31	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	30		0 - 31	U/L
METHOD : TRIS BUFFER NO P5P IFCC / SFBC 37° C				
ALKALINE PHOSPHATASE	71		39 - 117	U/L

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METHOD : AMP OPTIMISED TO IFCC 37° C				
GAMMA GLUTAMYL TRANSFERASE (GGT)	17		7 - 32	U/L
METHOD : GAMMA GLUTAMYL-3 CARBOXY-4 NITROANILIDE (IFCC) 37° C				
LACTATE DEHYDROGENASE	406		230 - 460	U/L
METHOD : GERMAN METHODS 37° C				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	8		5.0 - 18.0	mg/dL
METHOD : UREASE KINETIC				
CREATININE, SERUM				
CREATININE	0.83		0.6 - 1.2	mg/dL
METHOD : ALKALINE PICRATE NO DEPROTEINIZATION				
BUN/CREAT RATIO				
BUN/CREAT RATIO	9.64			
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID	3.7		2.4 - 5.7	mg/dL
METHOD : URICASE PEROXIDASE WITH ASCORBATE OXIDASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	8.0		6.4 - 8.3	g/dL
METHOD : BIURET REACTION, END POINT				
ALBUMIN, SERUM				
ALBUMIN	**4.6**	**High**	3.8 - 4.4	g/dL
METHOD : BROMOCRESOL GREEN				
GLOBULIN				
GLOBULIN	3.4		2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM	142.3		137 - 145	mmol/L
METHOD : ION-SELECTIVE ELECTRODE				
POTASSIUM	**3.52**	**Low**	3.6 - 5.0	mmol/L
METHOD : ION-SELECTIVE ELECTRODE				
CHLORIDE	106.6		98 - 107	mmol/L
METHOD : ION-SELECTIVE ELECTRODE				
PHYSICAL EXAMINATION, URINE				
COLOR	PALE YELLOW			
METHOD : GROSS EXAMINATION				
APPEARANCE	CLEAR			
METHOD : GROSS EXAMINATION				

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SPECIFIC GRAVITY	1.020	1.003 - 1.035	
METHOD : IONIC CONCENTRATION METHOD			
CHEMICAL EXAMINATION, URINE			
PH	5.5	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : PROTEIN ERROR OF INDICATORS WITH REFLECTANCE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : GLUCOSE OXIDASE PEROXIDASE / BENEDICTS			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : SODIUM NITROPRUSSIDE REACTION			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : PEROCIDASE ANTI PEROXIDASE			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : EHRLICH REACTION REFLECTANCE			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : NITRATE TO NITRITE CONVERSION METHOD			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
PUS CELL (WBC'S)	1-2	0-5	/HPF
METHOD : DIPSTICK, MICROSCOPY			
EPITHELIAL CELLS	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/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	
THYROID PANEL, SERUM			
T3	98.5	60.0 - 181.0	ng/dL
METHOD : CHEMILUMINESCENCE			
T4	8.60	4.5 - 10.9	µg/dL

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METHOD : CHEMILUMINESCENCE			
TSH 3RD GENERATION	3.415	0.550 - 4.780	µIU/mL
METHOD : CHEMILUMINESCENCE			
PAPANICOLAOU SMEAR			
TEST METHOD	SAMPLE NOT RECEIVED		
STOOL: OVA & PARASITE			
COLOUR	SAMPLE NOT RECEIVED		
METHOD : GROSS EXAMINATION			
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE AB		
METHOD : TUBE AGGLUTINATION			
RH TYPE	NEGATIVE		
METHOD : TUBE AGGLUTINATION			

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-
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-
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 - NLR-
The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.
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.

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

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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, 879-884.
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.
GLUCOSE, FASTING, PLASMA-
ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL
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 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 triglyceride levels 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.

Recommendations:
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.
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 results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
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 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

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

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
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• 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
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's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
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 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 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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic 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.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
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

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CLIENT CODE : C000138404

CLIENT'S NAME AND ADDRESS :

PROVISIONAL REPORT

SRL Ltd
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod, Tonk Road
JAIPUR, 302015
Rajasthan, INDIA

PATIENT NAME : SHARDA UMARWAL PATIENT ID : **SHARF090775251**

ACCESSION NO : **0251VG000730** AGE : 47 Years SEX : Female ABHA NO :

DRAWN : 09/07/2022 08:11 RECEIVED : 09/07/2022 12:51 REPORTED : 09/07/2022 15:26

REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012207090005

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

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
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
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 circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

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

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	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.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
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
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc
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.

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Patient Ref. No. 251000000143713

CLIENT CODE : C000138404

CLIENT'S NAME AND ADDRESS :

PROVISIONAL REPORT

SRL Ltd
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod, Tonk Road
JAIPUR, 302015
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REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012207090005

Test Report Status **Final**	Results		Biological Reference Interval	Units
OUT OF RANGE REPORT				
MEDI WHEEL FULL BODY HEALTH CHECKUP ABOVE 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
PLATELET COUNT	142	Low	150 - 410	thou/µL
HEMOGLOBIN	11.8	Low	12.0 - 15.0	g/dL
LIVER FUNCTION PROFILE, SERUM				
ALBUMIN	4.6	High	3.8 - 4.4	g/dL
BILIRUBIN, DIRECT	0.28	High	0.00 - 0.25	mg/dL
ALBUMIN, SERUM				
ALBUMIN	4.6	High	3.8 - 4.4	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
POTASSIUM	3.52	Low	3.6 - 5.0	mmol/L
RBC AND PLATELET INDICES				
MEAN CORPUSCULAR HGB.	26.1	Low	27.0 - 32.0	pg
MEAN CORPUSCULAR VOL	82.0	Low	83 - 101	fL
MEAN PLATELET VOLUME	11.1	High	6.8 - 10.9	fL
RED CELL DISTRIBUTION WIDTH	16.4	High	11.6 - 14.0	%
WBC DIFFERENTIAL COUNT - NLR				
ABSOLUTE MONOCYTE COUNT	0.10	Low	0.2 - 1.0	thou/µL
ABSOLUTE BASOPHIL COUNT	0	Low	0.02 - 0.10	thou/µL
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	22	High	0 - 20	mm at 1 hr
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
MEAN PLASMA GLUCOSE	128.4	High	< 116.0	mg/dL
GLYCOSYLATED HEMOGLOBIN (HBA1C)	6.1	High	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	125	High	74 - 99	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.				
NON HDL CHOLESTEROL	135	High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

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

INVESTIGATOR :_____ MD
DATE:

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

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wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Ms. SHARDA UMARWAL**	Registration No:	36252
Age/Gender:	47 Y/Female	Registered	: 09/Jul/2022 08:11AM
Patient ID	: 012207090005	Analysed	: 10/Jul/2022 10:20AM
BarcodeNo	: 10053089	Reported	: 10/Jul/2022 10:20AM
Referred By :	Self	Panel	: BANK OF BARODA

DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.

Domes of diaphragm are normally placed.

Transverse diameter of heart appears with normal limits.

IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.

*** End Of Report ***

Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMCNO.005807/14853

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

PATIENT NAME:MRS SHARDA UMARWAL	AGE: 47 Yrs.
REF. by: MEDI WHEEL	DATE: 09/07/2022

Ultrasonography report: Breast and Axilla

Findings:

Right Breast:-

Skin, subcutaneous tissue and retroareolar region is normal.

Fibroglandular tissue shows normal architecture and echotexture.

Pre and retromammary regions are unremarkable.

No obvious cyst, mass or architectural distortion visualized.

Axillary lymphnodes are not significantly enlarged and their hilar shadows are preserved.

Left Breast:-

Skin, subcutaneous tissue and retroareolar region is normal.

Fibroglandular tissue shows normal architecture and echotexture.

Pre and retromammary regions are unremarkable.

No obvious cyst, mass or architectural distortion visualized.

Axillary lymphnodes are not significantly enlarged and their hilar shadows are preserved.

IMPRESSION: No abnormality detected.

DR NEERA MEHTA
MBBS, DMRD
RMCNO.005807/14853

*****

wellness partner

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Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name : **Ms. SHARDA UMARWAL**
Age/Gender: 47 Y/Female
Patient ID : 012207090005
BarcodeNo : 10053089
Referred By : Self

Registration No: 36252
Registered : 09/Jul/2022 08:11AM
Analysed : 09/Jul/2022 03:13PM
Reported : 09/Jul/2022 03:13PM
Panel : BANK OF BARODA

ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

2D/M-MOD

IVSD mm	8.1	IVSS mm	12.9	AORTA mm	21.3
LVID mm	40.6	LVIS mm	25.4	LA mm	28.8
LVPWD mm	8.8	LVPWS mm	12.2	EF%	60%

CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	1.23/1.04	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANITMETERY)		MVA cm2 (PHT)	
MR			

AORTIC

PEAK VELOCITY m/s	1.86	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

TRICUSPID

PEAK VELOCITY m/s	0.60	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR		PASP mmHg	

PULMONARY

PEAK VELOCITY m/s	1.61	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

IMPRESSION

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CIN NO.: U85195RJ2004PTC019563

Name	: Ms. SHARDA UMARWAL	Registration No:	36252
Age/Gender:	47 Y/Female	Registered	: 09/Jul/2022 08:11AM
Patient ID	: 012207090005	Analysed	: 09/Jul/2022 03:13PM
BarcodeNo	: 10053089	Reported	: 09/Jul/2022 03:13PM
Referred By :	Self	Panel	: BANK OF BARODA

- NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION
- NO RWMA LVEF 60%
- NORMAL RV FUNCTION
- TRACE TR
- NORMAL CHAMBER DIMENSIONS
- NORMAL VALVULAR ECHO
- INTACT IAS / IVS
- NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.
- IVC NORMAL

CONCLUSION : FAIR LV FUNCTION.

Cardiologist

*** End Of Report ***

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Name	: **Ms. SHARDA UMARWAL**	Registration No:	36252
Age/Gender:	47 Y/Female	Registered :	09/Jul/2022 08:11AM
Patient ID	: 012207090005	Analysed :	09/Jul/2022 11:19AM
BarcodeNo	: 10053089	Reported :	09/Jul/2022 11:19AM
Referred By	: Self	Panel :	BANK OF BARODA

USG: WHOLE ABDOMEN (Female)

LIVER : Is normal in size, shape and echogenecity.
The IHBR and hepatic radicals are not dilated.
No evidence of focal echopoor/echorich lesion seen.
Portal vein diameter and Common bile duct normal in size

GALL BLADDER : Is not visualized.H/o Cholecystectomy

PANCREAS: Is normal in size,shape and echotexture. Pancreatic duct is not dilated.

SPLEEN : Is normal in size,shape and echogenecity.Spleenic hilum is not dilated.

KIDNEYS : Right Kidney:-Size: 97x44 mm, Left Kidney:-Size: 101x39 mm.
Bilateral Kidneys are normal in size, shape and echotexture,
corticomedullary differentiation is fair and ratio appears normal.
Pelvi calyceal system is normal.No evidence of hydronephrosis/ nephrolithiasis.

URINARY BLADDER : Bladder walls are smooth,regular and normal thickness.
: No evidence of mass or stone in bladder lumen.

UTERUS : Uterus is anteverted with normal in size shape & echotexture.
Uterine muscular shadows normal echopattern.
Endometrium is normal and centrally placed with size: 3 mm.
No evidence of mass lesion is seen. Size of uterus: 64x38x24 mm.

ADNEXA : Both the ovaries are normal in size shape and echotexture.
No mass lesion/ polycystic ovarian cyst is seen.

SPECIFIC : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.
: NO evidence of lymphadenopathy or mass lesion in retroperitoneum.
: Visualized bowel loop appear normal.Great vessels appear normal.

IMPRESSION: Ultra Sonography findings are suggestive of: **NORMAL STUDY.**

*** End Of Report ***

Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMC NO.005807/14853

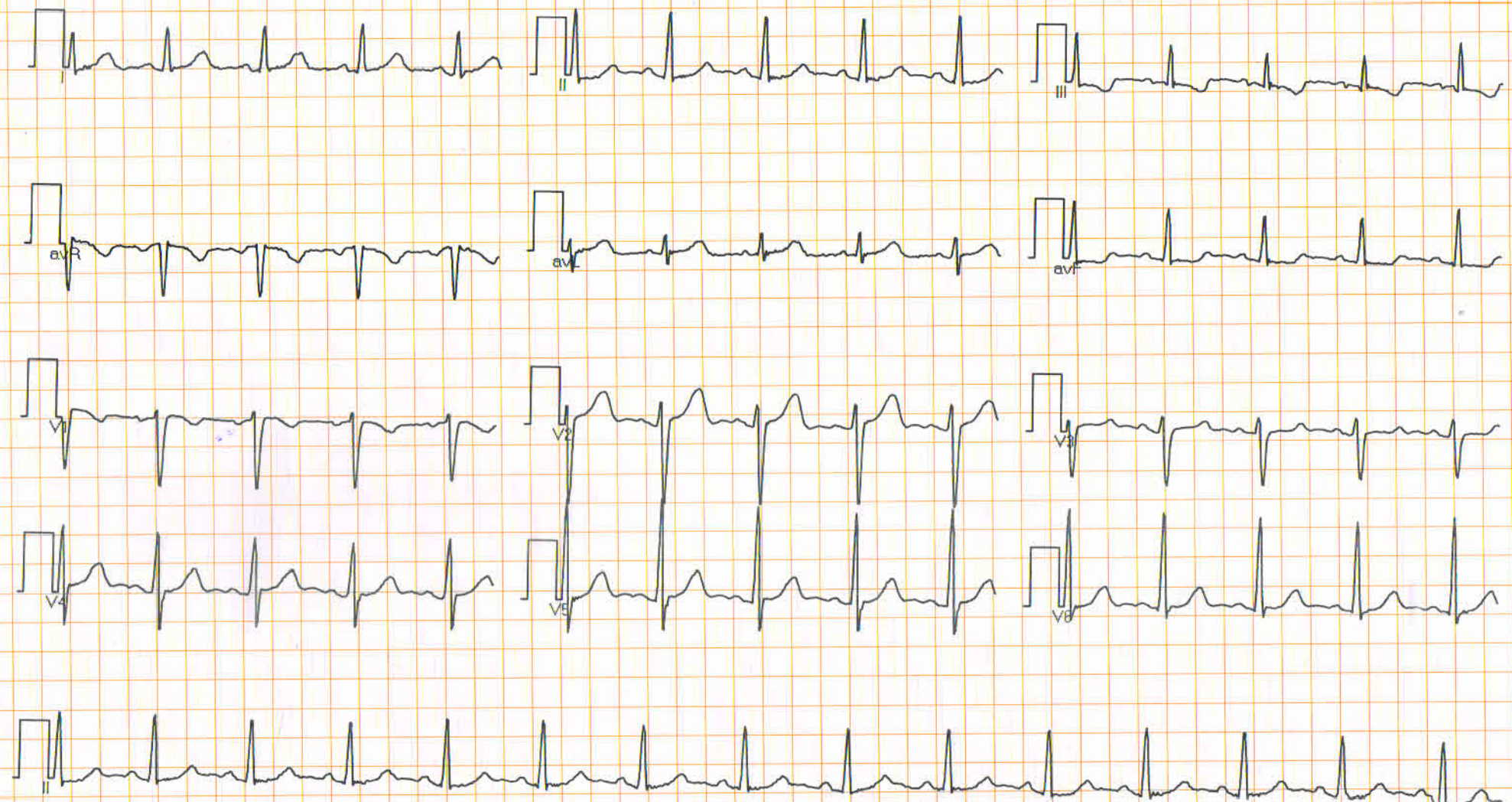
AAKRITI LAB PVT. LTD.

10925 / MRS. SHARDA UMARWAL / 47 Yrs / F/ Non Smoker

Heart Rate : 87 bpm / Tested On : 09-Jul-22 08:36:57 / HF 0.05 Hz - LF 100 Hz / Notch 50 Hz / Sn 1.00 Cm/mV / Sw 25 mm/s / Refd By.: MEDIWHEEL

ECG

AGHPL



Vent Rate : 87 bpm
PR Interval : 146 ms
QRS Duration: 88 ms
QT/QTc Int : 376/423 ms
P-QRS-T axis: 51.00• 59.00• 16.00•

Allengers ECG (Pisces)(PIS215191030)

ST-T changes III, aVF
correlate clinically

Reported By:DR. NITIZ GOYAL

Dr. NITIZ GOYAL
M.B.B.S., M.D
RMC - 023319