PLEASE SCAN QR CODE

Name	**: Mrs . PRASHANTHI NARASINGU 22E33169**	TID	: UMR1969801
Age/Gender	: 37 Years/Female	Registered On	: 16-Sep-2024 08:13 AM
Ref By	: Self	Reported On	: 16-Sep-2024 10:51 AM
Reg.No	: BIL4717417	Reference	: Arcofemi Health Care Ltd - Medi Whe

DEPARTMENT OF CARDIOLOGY
2D Echo/Doppler Study

MITRAL VALVE : Normal.

AORTIC VALVE : Normal.

TRICUSPID VALVE : Normal.

PULMONARY VALVE : Normal.

RIGHT ATRIUM : Normal.

RIGHT VENTRICLE : Normal.

LEFT ATRIUM : 3.2 cms.

LEFT VENTRICLE : EDD : 5.0 cm IVS (d) : 1.0 cm LVEF : 68%
ESD : 3.2 cm PW (d) : 1.0 cm FS : 38%
NO RWMA

IAS : Intact.

IVS : Intact.

AORTA : 3.0 cms.

PULMONARY ARTERY : Normal

PERICARDIUM : Normal.

IVC / SVC / CS : Normal.

PULMONARY VEINS : Normal.

INTRA - CARDIAC MASSES : No.

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Reg.No	: BIL4717417	Reference	: Arcofemi Health Care Ltd - Medi Whe

DOPPLER STUDY

MITRAL FLOW : E > A

AORTIC FLOW : 1.2 m/s

PULMONARY FLOW : 1.0 m/s

TRICUSPID FLOW : Normal

COLOUR FLOW MAPPING

MR : NIL
AR : TRIVIAL
TR : TRIVIAL
PR : NIL

IMPRESSION:

*** NO LV RWMA**

*** GOOD LV / RV FUNCTION**

*** NORMAL SIZED CARDIAC CHAMBERS**

*** TRIVIAL TR / AR; NO PAH**

*** NO PE / CLOT / VEGETATION**

- To correlate clinically

*** End Of Report ***

Dr.C Santosh kumar
M.D.D.M
Consultant Cardiologist

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Age/Gender	: 37 Years/Female	Registered On	: 16-Sep-2024 08:13 AM
Ref By	: Self	Reported On	: 16-Sep-2024 12:02 PM
Reg.No	: BIL4717417	Reference	: Arcofemi Health Care Ltd - Medi Whe

DEPARTMENT OF X-RAY
X-Ray Chest PA View

Lung fields appear normal.

Cardiac size is within normal limits.

Aorta and pulmonary vasculature is normal.

Bilateral domes of diaphragm and costophrenic angles are normal.

Visualised bones and soft tissues appear normal.

IMPRESSION:

*** Normal study.**

Suggested clinical correlation and follow up.

*** End Of Report ***

Dr. S SUCHARITHA
Consultant Radiologist

MRS, PRASHANTHI
ID: 4717417

7 Years

Female

16.09.2024 8:34:46
TENET DIAGNOSTIC CENTER
KOTHAPET
HYDERABAD

Location
Room
Order Number
Indication
Medication 1
Medication 2
Medication 3

66 bpm
-- / -- mmHg

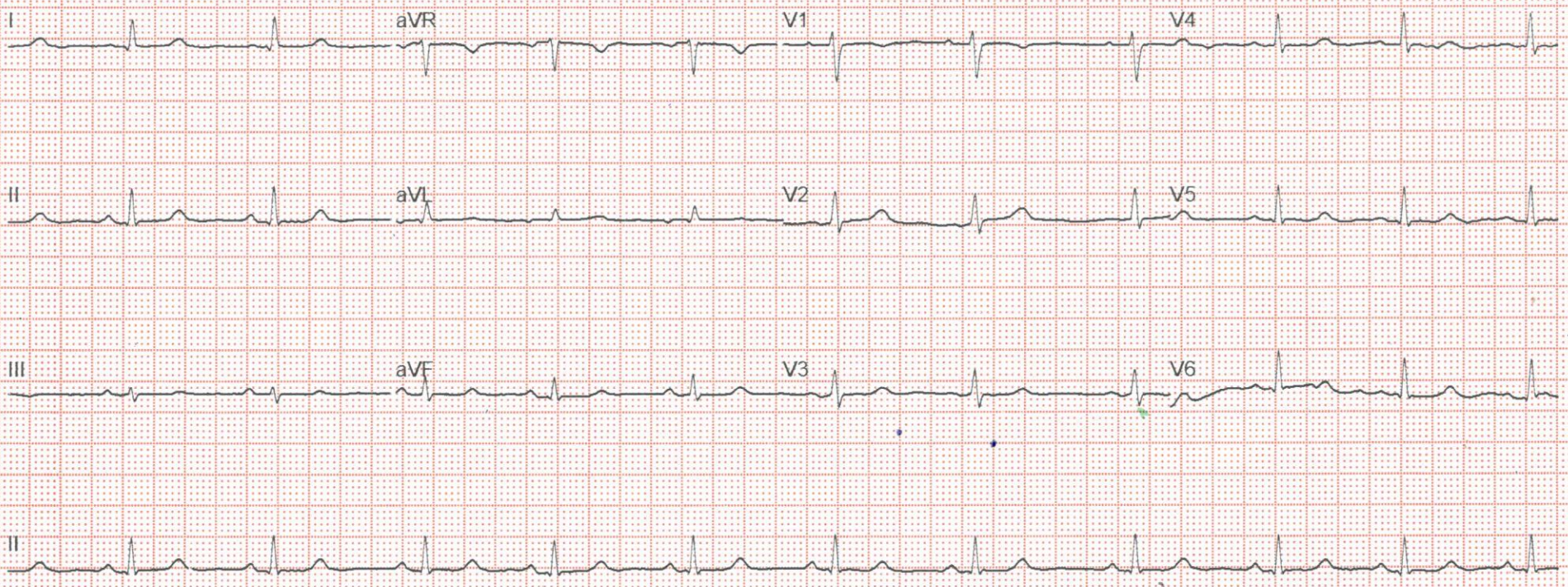
QRS	82 ms
QT / QTcBaz	430 / 450 ms
PR	158 ms
P	106 ms
RR / PP	902 / 909 ms
P / QRS / T	81 / 40 / 40 degrees

Normal sinus rhythm with sinus arrhythmia
Low voltage QRS
Borderline ECG

Technician
Ordering Ph
Referring Ph
Attending Ph

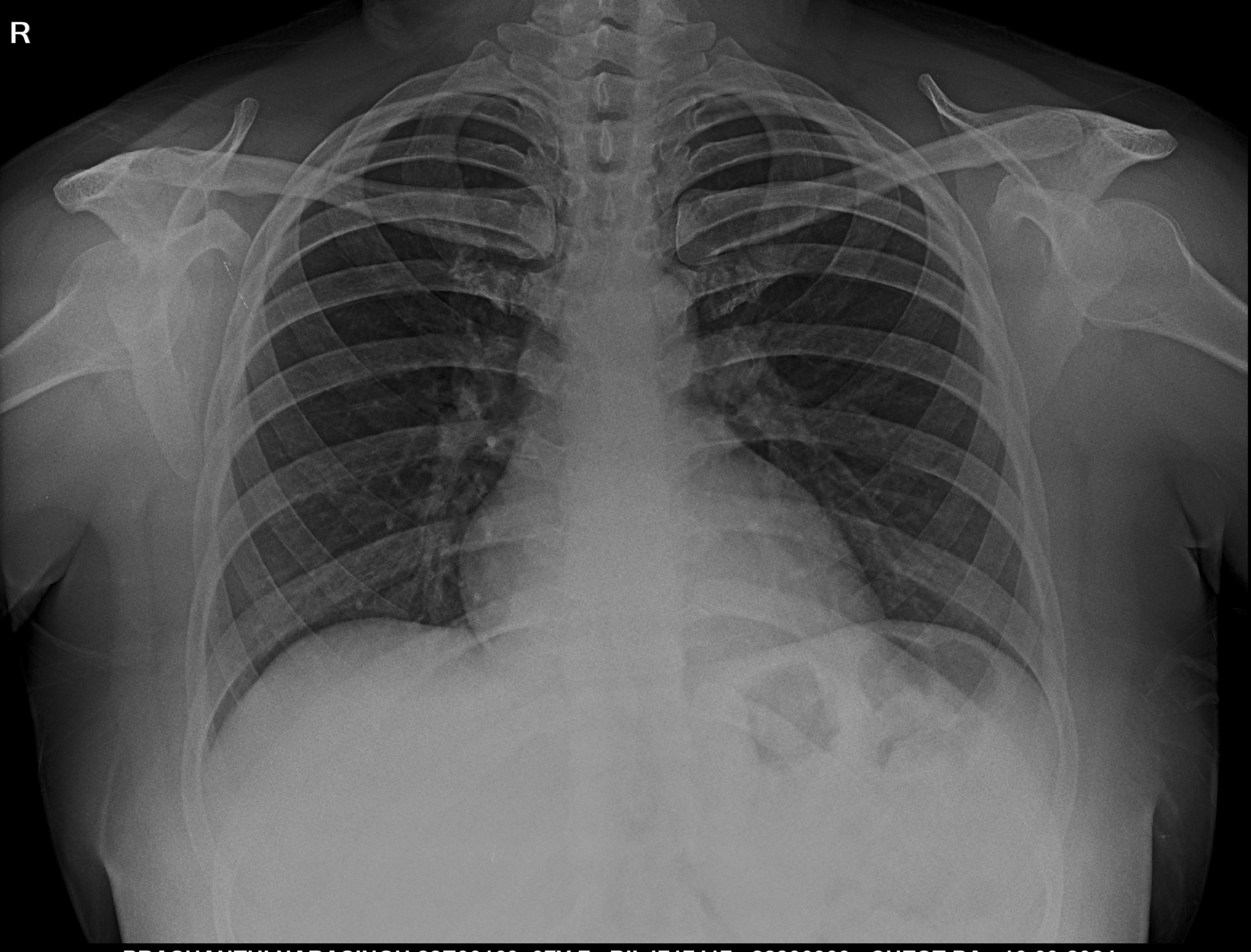
WNL

Dr. C. SANTOSH KUMAR
MD;DM
Consultant Cardiologist
Regd. No. 49661



Unconfirmed

GE MAC2000 1.1 12SL™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz 4x2.5x3_25_R1 1/1



PRASHANTHI NARASINGU 22E33169 37Y F BIL4717417 22830939 CHEST PA 16-09-2024

TENET DIAGNOSTICS KOTHAPET.

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MC-2977

PLEASE SCAN QR CODE
TO VERIFY THE REPORT ONLINE

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256003
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 14:15 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF HEMATOPATHOLOGY

Blood Grouping ABO And Rh Typing, EDTA Whole Blood

Parameter	Results
Blood Grouping (ABO)	B
Rh Typing (D)	Positive
Method:Hemagglutination Tube Method by Forward & Reverse Grouping	

Method: Hemagglutination Tube Method by Forward & Reverse Grouping

Reference: Tulip kit literature

Interpretation: The ABO grouping and Rh typing test determines blood type grouping (A,B, AB, O) and the Rh factor (positive or negative). A person's blood type is based on the presence or absence of certain antigens on the surface of their red blood cells and certain antibodies in the plasma. ABO antigens are poorly expresses at birth, increase gradually in strength and become fully expressed around 1 year of age.
In case of Rh(D) - Du(weak positive) or Weak D positive, the individual must be considered as Rh positive as donor and Rh negative as recipient.

Note: Records of previous blood grouping/Rh typing not available. Please verify before transfusion.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr Reenaz Shaik
Consultant Pathologist

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256003
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:11 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF HEMATOPATHOLOGY

Erythrocyte Sedimentation Rate (ESR), Whole Blood

Investigation	Observed Value	Biological Reference Intervals
ESR 1st Hour Method:Westergren/Vesmatic	**22**	<=12 mm/hour

Complete Blood Count (CBC), EDTA Whole Blood

Investigation	Observed Value	Biological Reference Intervals
Hemoglobin Method:Cyanide Free Lyse Hemoglobin	**11.3**	12.0-15.0 g/dL
PCV/HCT Method:Calculated	**32.8**	36.0-46.0 vol%
Total RBC Count Method:Electrical Impedance	4.38	3.80-4.80 mill /cu.mm
MCV Method:Calculated	**75.0**	83.0-101.0 fL
MCH Method:Calculated	**25.9**	27.0-32.0 pg
MCHC Method:Calculated	34.5	31.5-34.5 g/dL
RDW (CV) Method:Calculated	**16.8**	11.6-14.0 %
MPV Method:Calculated	7.6	7.0-10.0 fL
Total WBC Count Method:Electrical Impedance	6990	4000-10000 cells/cumm
Platelet Count Method:Electrical Impedance	3.28	1.50-4.10 lakhs/cumm
Differential count		
Neutrophils Method:Microscopy	47.5	40.0-80.0 %
Lymphocytes Method:Microscopy	**44.8**	20.0-40.0 %
Eosinophils	2.3	1.0-6.0 %
Monocytes	5.1	2.0-10.0 %
Basophils Method:Microscopy	0.3	< 1.0-2.0 %

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TEST REPORT

Absolute Neutrophil Count Method:Calculated	3320	2000-7000 cells/cumm
Absolute Lymphocyte Count (ALC)	**3132**	1000-3000 cells/cumm
Absolute Eosinophil Count (AEC)	161	20-500 cells/cumm
Absolute Monocyte Count Method:Calculated	356	200-1000 cells/cumm
Absolute Basophil Count Method:Calculated	21	20-100 cells/cumm
Neutrophil - Lymphocyte Ratio(NLR) Method:Calculated	1.06	0.78-3.53

Method: Automated Hematology Cell Counter, Microscopy

Reference: Dacie and Lewis Practical Hematology,12th Edition.
Wallach's interpretation of diagnostic tests, Soth Asian Edition.

Interpretation: A Complete Blood Picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

Note: These results are generated by a fully automated hematology analyzer and the differential count is computed from a total of several thousands of cells. Therefore the differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr Shruti Reddy
Consultant Pathologist
Reg No.TSMC/FMR/22656

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256005F
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:47 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF CLINICAL CHEMISTRY I

Blood Urea Nitrogen (BUN), Serum

Investigation	Observed Value	Biological Reference Interval
Blood Urea Nitrogen. Method:Calculated	7	6-20 mg/dL
Urea. Method:Urease/UV	14.9	12.8-42.8 mg/dL

Interpretation: Urea is a waste product formed in the liver when protein is metabolized. Urea is released by the liver into the blood and is carried to the kidneys, where it is filtered out of the blood and released into the urine. Since this is a continuous process, there is usually a small but stable amount of urea nitrogen in the blood. However, when the kidneys cannot filter wastes out of the blood due to disease or damage, then the level of urea in the blood will rise. The blood urea nitrogen (BUN) evaluates kidney function in a wide range of circumstances, to diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status as well.

Reference: Tietz Fundamentals of Clinical Chemistry and Molecular Diagnostics

Creatinine, Serum

Investigation	Observed Value	Biological Reference Interval
Creatinine. Method:Alkaline Picrate	0.71	0.50-0.90 mg/dL

Interpretation:

Creatinine is a nitrogenous waste product produced by muscles from creatine. Creatinine is majorly filtered from the blood by the kidneys and released into the urine, so serum creatinine levels are usually a good indicator of kidney function. Serum creatinine is more specific and more sensitive indicator of renal function as compared to BUN because it is produced from muscle at a constant rate and its level in blood is not affected by protein catabolism or other exogenous products. It is also not reabsorbed and very little is secreted by tubules making it a reliable marker. Serum creatinine levels are increased in pre renal, renal and post renal azotemia, active acromegaly and gigantism. Decreased serum creatinine levels are seen in pregnancy and increasing age.

Glucose Fasting (FBS), Sodium Fluoride Plasma

Investigation	Observed Value	Biological Reference Interval
Glucose Fasting Method:Hexokinase	87	Normal: <100 mg/dL Impaired FG: 100-125 mg/dL Diabetes mellitus: >/=126 mg/dL

Interpretation: It measures the Glucose levels in the blood with a prior fasting of 9-12 hours. The test helps screen a symptomatic/ asymptomatic person who is at risk for Diabetes. It is also used for regular monitoring of glucose levels in people with Diabetes.

Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022

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Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:47 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

Glucose Post Prandial (PPBS), Sodium Fluoride Plasma

Investigation	Observed Value	Biological Reference Interval
Glucose Post Prandial Method:Hexokinase	91	Normal : <140 mg/dL Impaired PG: 140-199 mg/dL Diabetes mellitus: >/=200 mg/dL

Interpretation: This test measures the blood sugar levels 2 hours after a normal meal. Abnormally high blood sugars 2 hours after a meal reflect that the body is not producing sufficient insulin which is indicative of Diabetes.

Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022

Glycosylated Hemoglobin (HbA1C), EDTA Whole Blood

Investigation	Observed Value	Biological Reference Interval
Glycosylated Hemoglobin (HbA1c) Method:High-Performance Liquid Chromatography	5.5	Non-diabetic: <= 5.6 % Pre-diabetic: 5.7 - 6.4 % Diabetic: >= 6.5 %
Estimated Average Glucose (eAG) Method:Calculated	111	mg/dL

Interpretation:

It is an index of long-term blood glucose concentrations and a measure of the risk for developing microvascular complications in patients with diabetes. Absolute risks of retinopathy and nephropathy are directly proportional to the mean HbA1c concentration. In persons without diabetes, HbA1c is directly related to risk of cardiovascular disease.

1) Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.

2) Interference of Hemoglobinopathies in HbA1c estimatiion:
A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
C. Heterozygous state detected (D10 is corrected for HbS and HbC trait).
3) In known diabetic patients, HbA1c can be considered as a tool for monitoring the glycemic control.
Excellent Control - 6 to 7 %,
Fair to Good Control - 7 to 8 %,
Unsatisfactory Control - 8 to 10 %
and Poor Control - More than 10 %.
Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022.

Bun/Creatinine Ratio, Serum

Investigation	Observed Value	
BUN/Creatinine Ratio Method:Calculated	10	10-20

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Interpretation:
The BUN/Creatinine ratio blood test is used to diagnose acute or chronic renal disease. BUN (blood urea nitrogen) and creatinine are both filtered in the kidneys and excreted in urine. The two together are used to measure overall kidney function

1. Increased ratio (>20) with normal creatinine occurs in the following conditions:
a) Increased BUN (prerenal azotemia), heart failure, salt depletion, dehydration
b) Catabolic states with tissue breakdown
c) GI hemorrhage
d) Impaired renal function plus excess protein intake, production, or tissue breakdown
2. Increased ratio (>20) with elevated creatinine occurs in the following conditions:
a) Obstruction of urinary tract
b) Prerenal azotemia with renal disease

3. Decreased ratio (<10) with decreased BUN occurs in the following conditions:
a) Acute tubular necrosis
b) Decreased urea synthesis as in severe liver disease or starvation
c) Repeated dialysis
d) SIADH
e) Pregnancy

4. Decreased ratio (<10) with increased creatinine occurs in the following conditions:
a) Phenacemide therapy (accelerates conversion of creatine to creatinine)
b) Rhabdomyolysis (releases muscle creatinine)
c) Muscular patients who develop renal failure

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
Consultant Biochemist
Reg.No - APMC/FMR/78102

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	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF CLINICAL CHEMISTRY I

Lipid Profile, Serum

Investigation	Observed Value	Biological Reference Interval
Total Cholesterol Method:Cholesterol Oxidase	162	Desirable: <200 mg/dL Borderline: 200-239 mg/dL High: >/=240 mg/dL
HDL Cholesterol Method:Direct Measurement	50	Low: <40 mg/dL High: >/=60 mg/dL
VLDL Cholesterol Method:Calculated	16.20	6.0-38.0 mg/dL
LDL Cholesterol Method:Calculated	95.8	Optimum: <100 mg/dL Near/above optimum: 100-129 mg/dL Borderline: 130-159 mg/dL High: 160-189 mg/dL Very high: >/=190 mg/dL
Triglycerides Method:Glycerol LPL/GK	81	Normal:<150 mg/dL Borderline: 150-199 mg/dL High: 200-499 mg/dL Very high: >/=500 mg/dL
Chol/HDL Ratio Method:Calculated	**3.24**	Low Risk: 3.3-4.4 Average Risk: 4.5-7.1 Moderate Risk: 7.2-11.0
LDL Cholesterol/HDL Ratio Method:Calculated	1.92	Desirable: 0.5-3.0 Borderline Risk: 3.0-6.0 High Risk: >6.0

Interpretation: Lipids are fats and fat-like substances which are important constituents of cells and are rich sources of energy. A lipid profile typically includes total cholesterol, high density lipoproteins (HDL), low density lipoprotein (LDL), chylomicrons, triglycerides, very low density lipoproteins (VLDL), Cholesterol/HDL ratio .The lipid profile is used to assess the risk of developing a heart disease and to monitor its treatment. The results of the lipid profile are evaluated along with other known risk factors associated with heart disease to plan and monitor treatment. Treatment options require clinical correlation.

Reference: Third Report of the National Cholesterol Education program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), JAMA 2001.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
Consultant Biochemist
Reg.No - APMC/FMR/78102

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DEPARTMENT OF CLINICAL CHEMISTRY I

Liver Function Test (LFT), Serum

Investigation	Observed Value	Biological Reference Interval
Total Bilirubin. Method:Diazo method	0.28	<1.2 mg/dL
Direct Bilirubin. Method:Diazo method	0.16	<0.30 mg/dL
Indirect Bilirubin. Method:Calculated	0.12	<0.9 mg/dL
Alanine Aminotransferase ,(ALT/SGPT) Method:UV wtihout P5P	10	<34 U/L
Aspartate Aminotransferase,(AST/SGOT) Method:UV wtihout P5P	15	<31 U/L
ALP (Alkaline Phosphatase). Method:PNPP-AMP Buffer	46	35-104 U/L
Gamma GT. Method:Gamma-Glutamyl - 3 - Carbossi - 4 - Nitroanilide (GCNA)	7	6-42 U/L
Total Protein. Method:Biuret	6.8	6.6-8.7 g/dL
Albumin. Method:Bromocresol Green (BCG)	4.1	3.5-5.2 g/dL
Globulin. Method:Calculated	2.70	1.8-3.8 g/dL
A/GRatio. Method:Calculated	1.52	0.8-2.0

Interpretation: Liver functions tests help to identify liver disease, its severity, and its type. Generally these tests are performed in combination, are abnormal in liver disease, and the pattern of abnormality is indicative of the nature of liver disease. An isolated abnormality of a single liver function test usually means a non-hepatic cause. If several liver function tests are simultaneously abnormal, then hepatic etiology is likely.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
Consultant Biochemist
Reg.No - APMC/FMR/78102

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DEPARTMENT OF CLINICAL CHEMISTRY I

Thyroid Profile (T3,T4,TSH), Serum

Investigation	Observed Value	Biological Reference Interval
Triiodothyronine Total (T3) Method:ECLIA	1.01	0.80-2.00 ng/mL Pregnancy: 1st Trimester: 0.81 - 1.90 ng/mL 2nd & 3rd Trimester: 1.00 - 2.60 ng/mL
Thyroxine Total (T4) Method:ECLIA	9.1	5.1-14.1 µg/dL
Thyroid Stimulating Hormone (TSH) Method:ECLIA	2.21	0.27-4.20 µIU/mL Pregnancy: 1st Trimester: 0.1 - 2.5 µIU/mL 2nd Trimester: 0.2 - 3.0 µIU/mL 3rd Trimester: 0.3 - 3.0 µIU/mL

Interpretation:

A thyroid profile is used to evaluate thyroid function and/or help diagnose hypothyroidism and hyperthyroidism due to various thyroid disorders. T4 and T3 are hormones produced by the thyroid gland. They help control the rate at which the body uses energy, and are regulated by a feedback system. TSH from the pituitary gland stimulates the production and release of T4 (primarily) and T3 by the thyroid. Most of the T4 and T3 circulate in the blood bound to protein. A small percentage is free (not bound) and is the biologically active form of the hormones.
Reference: Tietz textbook of Clinial Chemistry and Molecular Diagnostics, Nader Rifia, Andrea Ritas Horvath, Carl T. Wittwer.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
Consultant Biochemist
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DEPARTMENT OF CLINICAL CHEMISTRY I

Uric Acid, Serum

Investigation	Observed Value	Biological Reference Interval
Uric Acid. Method:Uricase	4.0	2.4-5.7 mg/dL

Interpretation

It is the major product of purine catabolism. Hyperuricemia can result due to increased formation or decreased excretion of uric acid which can be due to several causes like metabolic disorders, psoriasis, tissue hypoxia, pre-eclampsia, alcohol, lead poisoning, acute or chronic kidney disease, etc. Hypouricemia may be seen in severe hepato cellular disease and defective renal tubular reabsorption of uric acid.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
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It's Good to Know

MC-2977

PLEASE SCAN QR CODE
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Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256003
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 14:15 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF HEMATOPATHOLOGY

Blood Grouping ABO And Rh Typing, EDTA Whole Blood

Parameter	Results
Blood Grouping (ABO)	B
Rh Typing (D)	Positive
Method:Hemagglutination Tube Method by Forward & Reverse Grouping	

Method: Hemagglutination Tube Method by Forward & Reverse Grouping

Reference: Tulip kit literature

Interpretation: The ABO grouping and Rh typing test determines blood type grouping (A,B, AB, O) and the Rh factor (positive or negative). A person's blood type is based on the presence or absence of certain antigens on the surface of their red blood cells and certain antibodies in the plasma. ABO antigens are poorly expresses at birth, increase gradually in strength and become fully expressed around 1 year of age.
In case of Rh(D) - Du(weak positive) or Weak D positive, the individual must be considered as Rh positive as donor and Rh negative as recipient.

Note: Records of previous blood grouping/Rh typing not available. Please verify before transfusion.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr Reenaz Shaik
Consultant Pathologist

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256003
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
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	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF HEMATOPATHOLOGY

Erythrocyte Sedimentation Rate (ESR), Whole Blood

Investigation	Observed Value	Biological Reference Intervals
ESR 1st Hour Method:Westergren/Vesmatic	**22**	<=12 mm/hour

Complete Blood Count (CBC), EDTA Whole Blood

Investigation	Observed Value	Biological Reference Intervals
Hemoglobin Method:Cyanide Free Lyse Hemoglobin	**11.3**	12.0-15.0 g/dL
PCV/HCT Method:Calculated	**32.8**	36.0-46.0 vol%
Total RBC Count Method:Electrical Impedance	4.38	3.80-4.80 mill /cu.mm
MCV Method:Calculated	**75.0**	83.0-101.0 fL
MCH Method:Calculated	**25.9**	27.0-32.0 pg
MCHC Method:Calculated	34.5	31.5-34.5 g/dL
RDW (CV) Method:Calculated	**16.8**	11.6-14.0 %
MPV Method:Calculated	7.6	7.0-10.0 fL
Total WBC Count Method:Electrical Impedance	6990	4000-10000 cells/cumm
Platelet Count Method:Electrical Impedance	3.28	1.50-4.10 lakhs/cumm
Differential count		
Neutrophils Method:Microscopy	47.5	40.0-80.0 %
Lymphocytes Method:Microscopy	**44.8**	20.0-40.0 %
Eosinophils	2.3	1.0-6.0 %
Monocytes	5.1	2.0-10.0 %
Basophils Method:Microscopy	0.3	< 1.0-2.0 %

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It's Good to Know

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Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256003
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:11 PM
		Reference	: Arcofemi Health Care Ltd -

TEST REPORT

Absolute Neutrophil Count Method:Calculated	3320	2000-7000 cells/cumm
Absolute Lymphocyte Count (ALC)	**3132**	1000-3000 cells/cumm
Absolute Eosinophil Count (AEC)	161	20-500 cells/cumm
Absolute Monocyte Count Method:Calculated	356	200-1000 cells/cumm
Absolute Basophil Count Method:Calculated	21	20-100 cells/cumm
Neutrophil - Lymphocyte Ratio(NLR) Method:Calculated	1.06	0.78-3.53

Method: Automated Hematology Cell Counter, Microscopy

Reference: Dacie and Lewis Practical Hematology,12th Edition.
Wallach's interpretation of diagnostic tests, Soth Asian Edition.

Interpretation: A Complete Blood Picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

Note: These results are generated by a fully automated hematology analyzer and the differential count is computed from a total of several thousands of cells. Therefore the differential count appears in decimalised numbers and may not add upto exactly 100. It may fall between 99 and 101.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr Shruti Reddy
Consultant Pathologist
Reg No.TSMC/FMR/22656

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256005F
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
Ref.By	: SELF	Collected on	: 16-Sep-2024 / 08:17 AM
Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:47 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF CLINICAL CHEMISTRY I

Blood Urea Nitrogen (BUN), Serum

Investigation	Observed Value	Biological Reference Interval
Blood Urea Nitrogen. Method:Calculated	7	6-20 mg/dL
Urea. Method:Urease/UV	14.9	12.8-42.8 mg/dL

Interpretation: Urea is a waste product formed in the liver when protein is metabolized. Urea is released by the liver into the blood and is carried to the kidneys, where it is filtered out of the blood and released into the urine. Since this is a continuous process, there is usually a small but stable amount of urea nitrogen in the blood. However, when the kidneys cannot filter wastes out of the blood due to disease or damage, then the level of urea in the blood will rise. The blood urea nitrogen (BUN) evaluates kidney function in a wide range of circumstances, to diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status as well.

Reference: Tietz Fundamentals of Clinical Chemistry and Molecular Diagnostics

Creatinine, Serum

Investigation	Observed Value	Biological Reference Interval
Creatinine. Method:Alkaline Picrate	0.71	0.50-0.90 mg/dL

Interpretation:

Creatinine is a nitrogenous waste product produced by muscles from creatine. Creatinine is majorly filtered from the blood by the kidneys and released into the urine, so serum creatinine levels are usually a good indicator of kidney function. Serum creatinine is more specific and more sensitive indicator of renal function as compared to BUN because it is produced from muscle at a constant rate and its level in blood is not affected by protein catabolism or other exogenous products. It is also not reabsorbed and very little is secreted by tubules making it a reliable marker. Serum creatinine levels are increased in pre renal, renal and post renal azotemia, active acromegaly and gigantism. Decreased serum creatinine levels are seen in pregnancy and increasing age.

Glucose Fasting (FBS), Sodium Fluoride Plasma

Investigation	Observed Value	Biological Reference Interval
Glucose Fasting Method:Hexokinase	87	Normal: <100 mg/dL Impaired FG: 100-125 mg/dL Diabetes mellitus: >/=126 mg/dL

Interpretation: It measures the Glucose levels in the blood with a prior fasting of 9-12 hours. The test helps screen a symptomatic/ asymptomatic person who is at risk for Diabetes. It is also used for regular monitoring of glucose levels in people with Diabetes.

Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022

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	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

Glucose Post Prandial (PPBS), Sodium Fluoride Plasma

Investigation	Observed Value	Biological Reference Interval
Glucose Post Prandial Method:Hexokinase	91	Normal : <140 mg/dL Impaired PG: 140-199 mg/dL Diabetes mellitus: >/=200 mg/dL

Interpretation: This test measures the blood sugar levels 2 hours after a normal meal. Abnormally high blood sugars 2 hours after a meal reflect that the body is not producing sufficient insulin which is indicative of Diabetes.

Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022

Glycosylated Hemoglobin (HbA1C), EDTA Whole Blood

Investigation	Observed Value	Biological Reference Interval
Glycosylated Hemoglobin (HbA1c) Method:High-Performance Liquid Chromatography	5.5	Non-diabetic: <= 5.6 % Pre-diabetic: 5.7 - 6.4 % Diabetic: >= 6.5 %
Estimated Average Glucose (eAG) Method:Calculated	111	mg/dL

Interpretation:

It is an index of long-term blood glucose concentrations and a measure of the risk for developing microvascular complications in patients with diabetes. Absolute risks of retinopathy and nephropathy are directly proportional to the mean HbA1c concentration. In persons without diabetes, HbA1c is directly related to risk of cardiovascular disease.

1) Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.

2) Interference of Hemoglobinopathies in HbA1c estimatiion:
A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
C. Heterozygous state detected (D10 is corrected for HbS and HbC trait).
3) In known diabetic patients, HbA1c can be considered as a tool for monitoring the glycemic control.
Excellent Control - 6 to 7 %,
Fair to Good Control - 7 to 8 %,
Unsatisfactory Control - 8 to 10 %
and Poor Control - More than 10 %.
Reference: American Diabetes Association. Standards of Medical Care in Diabetes-2022.

Bun/Creatinine Ratio, Serum

Investigation	Observed Value	
BUN/Creatinine Ratio Method:Calculated	10	10-20

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256004
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	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

Interpretation:
The BUN/Creatinine ratio blood test is used to diagnose acute or chronic renal disease. BUN (blood urea nitrogen) and creatinine are both filtered in the kidneys and excreted in urine. The two together are used to measure overall kidney function

1. Increased ratio (>20) with normal creatinine occurs in the following conditions:
a) Increased BUN (prerenal azotemia), heart failure, salt depletion, dehydration
b) Catabolic states with tissue breakdown
c) GI hemorrhage
d) Impaired renal function plus excess protein intake, production, or tissue breakdown
2. Increased ratio (>20) with elevated creatinine occurs in the following conditions:
a) Obstruction of urinary tract
b) Prerenal azotemia with renal disease

3. Decreased ratio (<10) with decreased BUN occurs in the following conditions:
a) Acute tubular necrosis
b) Decreased urea synthesis as in severe liver disease or starvation
c) Repeated dialysis
d) SIADH
e) Pregnancy

4. Decreased ratio (<10) with increased creatinine occurs in the following conditions:
a) Phenacemide therapy (accelerates conversion of creatine to creatinine)
b) Rhabdomyolysis (releases muscle creatinine)
c) Muscular patients who develop renal failure

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

--- End Of Report ---

Dr.Abdur Rehman Asif
Consultant Biochemist
Reg.No - APMC/FMR/78102

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Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256004
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
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Req.No	: BIL4717417	Reported on	: 16-Sep-2024 / 12:47 PM
	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF CLINICAL CHEMISTRY I

Lipid Profile, Serum

Investigation	Observed Value	Biological Reference Interval
Total Cholesterol Method:Cholesterol Oxidase	162	Desirable: <200 mg/dL Borderline: 200-239 mg/dL High: >/=240 mg/dL
HDL Cholesterol Method:Direct Measurement	50	Low: <40 mg/dL High: >/=60 mg/dL
VLDL Cholesterol Method:Calculated	16.20	6.0-38.0 mg/dL
LDL Cholesterol Method:Calculated	95.8	Optimum: <100 mg/dL Near/above optimum: 100-129 mg/dL Borderline: 130-159 mg/dL High: 160-189 mg/dL Very high: >/=190 mg/dL
Triglycerides Method:Glycerol LPL/GK	81	Normal:<150 mg/dL Borderline: 150-199 mg/dL High: 200-499 mg/dL Very high: >/=500 mg/dL
Chol/HDL Ratio Method:Calculated	**3.24**	Low Risk: 3.3-4.4 Average Risk: 4.5-7.1 Moderate Risk: 7.2-11.0
LDL Cholesterol/HDL Ratio Method:Calculated	1.92	Desirable: 0.5-3.0 Borderline Risk: 3.0-6.0 High Risk: >6.0

Interpretation: Lipids are fats and fat-like substances which are important constituents of cells and are rich sources of energy. A lipid profile typically includes total cholesterol, high density lipoproteins (HDL), low density lipoprotein (LDL), chylomicrons, triglycerides, very low density lipoproteins (VLDL), Cholesterol/HDL ratio .The lipid profile is used to assess the risk of developing a heart disease and to monitor its treatment. The results of the lipid profile are evaluated along with other known risk factors associated with heart disease to plan and monitor treatment. Treatment options require clinical correlation.

Reference: Third Report of the National Cholesterol Education program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III), JAMA 2001.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

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Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256004
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DEPARTMENT OF CLINICAL CHEMISTRY I

Liver Function Test (LFT), Serum

Investigation	Observed Value	Biological Reference Interval
Total Bilirubin. Method:Diazo method	0.28	<1.2 mg/dL
Direct Bilirubin. Method:Diazo method	0.16	<0.30 mg/dL
Indirect Bilirubin. Method:Calculated	0.12	<0.9 mg/dL
Alanine Aminotransferase ,(ALT/SGPT) Method:UV wtihout P5P	10	<34 U/L
Aspartate Aminotransferase,(AST/SGOT) Method:UV wtihout P5P	15	<31 U/L
ALP (Alkaline Phosphatase). Method:PNPP-AMP Buffer	46	35-104 U/L
Gamma GT. Method:Gamma-Glutamyl - 3 - Carbossi - 4 - Nitroanilide (GCNA)	7	6-42 U/L
Total Protein. Method:Biuret	6.8	6.6-8.7 g/dL
Albumin. Method:Bromocresol Green (BCG)	4.1	3.5-5.2 g/dL
Globulin. Method:Calculated	2.70	1.8-3.8 g/dL
A/GRatio. Method:Calculated	1.52	0.8-2.0

Interpretation: Liver functions tests help to identify liver disease, its severity, and its type. Generally these tests are performed in combination, are abnormal in liver disease, and the pattern of abnormality is indicative of the nature of liver disease. An isolated abnormality of a single liver function test usually means a non-hepatic cause. If several liver function tests are simultaneously abnormal, then hepatic etiology is likely.

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--- End Of Report ---

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Reg.No - APMC/FMR/78102

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256004
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	TEST REPORT	Reference	: Arcofemi Health Care Ltd -

DEPARTMENT OF CLINICAL CHEMISTRY I

Thyroid Profile (T3,T4,TSH), Serum

Investigation	Observed Value	Biological Reference Interval
Triiodothyronine Total (T3) Method:ECLIA	1.01	0.80-2.00 ng/mL Pregnancy: 1st Trimester: 0.81 - 1.90 ng/mL 2nd & 3rd Trimester: 1.00 - 2.60 ng/mL
Thyroxine Total (T4) Method:ECLIA	9.1	5.1-14.1 µg/dL
Thyroid Stimulating Hormone (TSH) Method:ECLIA	2.21	0.27-4.20 µIU/mL Pregnancy: 1st Trimester: 0.1 - 2.5 µIU/mL 2nd Trimester: 0.2 - 3.0 µIU/mL 3rd Trimester: 0.3 - 3.0 µIU/mL

Interpretation:

A thyroid profile is used to evaluate thyroid function and/or help diagnose hypothyroidism and hyperthyroidism due to various thyroid disorders. T4 and T3 are hormones produced by the thyroid gland. They help control the rate at which the body uses energy, and are regulated by a feedback system. TSH from the pituitary gland stimulates the production and release of T4 (primarily) and T3 by the thyroid. Most of the T4 and T3 circulate in the blood bound to protein. A small percentage is free (not bound) and is the biologically active form of the hormones.
Reference: Tietz textbook of Clinial Chemistry and Molecular Diagnostics, Nader Rifia, Andrea Ritas Horvath, Carl T. Wittwer.

* Sample processed at National Reference Laboratory,
Tenet Diagnostics,Hyderabad

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Dr.Abdur Rehman Asif
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Reg.No - APMC/FMR/78102

Name	: **MRS.PRASHANTHI NARASINGU 22E33169**	TID/SID	: UMR1969801/ 28256004
Age / Gender	: 37 Years / Female	Registered on	: 16-Sep-2024 / 08:13 AM
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DEPARTMENT OF CLINICAL CHEMISTRY I

Uric Acid, Serum

Investigation	Observed Value	Biological Reference Interval
Uric Acid. Method:Uricase	4.0	2.4-5.7 mg/dL

Interpretation

It is the major product of purine catabolism. Hyperuricemia can result due to increased formation or decreased excretion of uric acid which can be due to several causes like metabolic disorders, psoriasis, tissue hypoxia, pre-eclampsia, alcohol, lead poisoning, acute or chronic kidney disease, etc. Hypouricemia may be seen in severe hepato cellular disease and defective renal tubular reabsorption of uric acid.

* Sample processed at National Reference Laboratory,
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Dr.Abdur Rehman Asif
Consultant Biochemist
Reg.No - APMC/FMR/78102

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MEDICAL FITNESS REPORT

I hereby certified that I have physically examined

Mr./~~Ms.~~/Mrs./~~Dr.~~ Prashanthi Narasimha F/37y

On Date 16.09.24 is medically ~~Fit~~/~~Unfit~~ to carry on the work.

The Annexed medical reports, Physical & Systemic examination of the Employee was taken into consideration for his/her current status of Health.

Doctor's Notes (Overview of the Medical Report's)

The client is medically fit

Doctor's Signature & Seal Stamp

Dr. SAMSON VARA PRASAD
M.B.B.S.
Reg. No: 35719

PLEASE SCAN QR CODE

Name	: Mrs . PRASHANTHI NARASINGU 22E33169	TID	: UMR1969801
Age/Gender	: 37 Years/Female	Registered On	: 16-Sep-2024 08:13 AM
Ref By	: Self	Reported On	: 16-Sep-2024 09:50 AM
Reg.No	: BIL4717417	Reference	: Arcofemi Health Care Ltd - Medi Whe

DEPARTMENT OF ULTRASOUND
Ultrasound Whole Abdomen

LIVER is normal shape, size (15.4 cms) and has uniform echopattern.
No evidence of focal lesion. No intrahepatic biliary ductal dilatation.
Hepatic and portal vein radicals are normal.

GALL BLADDER shows normal shape and has clear contents.
Gall bladder wall is of normal thickness.
CBD is of normal calibre.

PANCREAS has normal shape, size and uniform echopattern.
No evidence of ductal dilatation or calcification.

SPLEEN shows normal shape, size (9.7 cms) and echopattern.

KIDNEYS move well with respiration and have normal shape, size and echopattern. Cortico- medullary differentiations are well madeout.
No evidence of calculus or hydronephrosis.
A 27 x 26 mm cyst with incomplete internal septation noted in mid pole of right kidney.
Right kidney measures - 8.5 x 4.5 cms, Left kidney measures - 9.1 x 4.3 cms.

URINARY BLADDER shows normal shape and wall thickness.
It has clear contents. No evidence of diverticula.

UTERUS is anteverted has normal shape and size.
It has uniform myometrial echopattern.
Two well defined hypoechoic lesions meausring 36 x 35 mm & 26 x 20 mm noted arising from anterior and posterior uterine walls respectively - S/o Subserosal fibroids.
Endometrial echo is of normal thickness 8.5 mm.
Uterus measures 8.1 x 5.6 x 4.8 cms.

OVARIES are normal in size, shape and echotexture.
Right ovary: 2.3 x 1.8 cms, Left ovary: 3.2 x 1.7 cms.

No evidence of free fluid in the abdomen and pelvis.

PLEASE SCAN QR CODE

Name	**: Mrs . PRASHANTHI NARASINGU 22E33169**	TID	: UMR1969801
Age/Gender	: 37 Years/Female	Registered On	: 16-Sep-2024 08:13 AM
Ref By	: Self	Reported On	: 16-Sep-2024 09:50 AM
Reg.No	: BIL4717417	Reference	: Arcofemi Health Care Ltd - Medi Whe

IMPRESSION:

*** Right complex renal cortical cyst**

*** Subserosal uterine fibroids.**

Suggested clinical correlation and follow up

*** End Of Report ***

Dr. S SUCHARITHA
Consultant Radiologist