



BMI CHART

Date: 11/12/23

Name: MS Sarban Rana Age: 35 yrs Sex: M/F

BP: 120/70 Height (cms): 160 cm Weight(kgs): 56.2 kg BMI: 22
mm Hg

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	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

Signature



UHID	5652387	Date	11/02/2023		
Name	Ms.Sarbari raha	Sex	Female	Age	34
OPD	Dental 12	Health Check Up			

Drug allergy:
 Sys illness:

Caries $\frac{7}{876} \mid \frac{7}{878}$

Stains & calculus +

Treatment

Adv. filling $\frac{7}{86} \mid \frac{7}{67}$

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

Adv OPG.

Adv. oral prophylaxis

Dr. Pihole hehe



UHID	5652387	Date	11/02/2023		
Name	Ms.Sarbari raha	Sex	Female	Age	34
OPD	Ophthal 14	Health Check Up			

Clr. Ick dnu (bfr 6-7yr).

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

h.ia NO

U-V → R 6/6.
 → L 6/6

Ref → R Phus 6/6.
 → L Phus 6/6

NV → R NG
 → L NG

Foot → R → 15.2
 → L → 16.3

[Handwritten signature]



LABORATORY REPORT

PATIENT NAME : MS.SARBARI RAHA

PATIENT ID : FH.5652387

CLIENT PATIENT ID : UID:5652387

ACCESSION NO : 0022WB002162

AGE : 34 Years

SEX : Female

ABHA NO :

DRAWN : 11/02/2023 12:57:00

RECEIVED : 11/02/2023 12:56:40

REPORTED : 11/02/2023 14:50:05

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:5652387 REQNO-1370875

CORP-OPD

BILLNO-150123OPCR008469

BILLNO-150123OPCR008469

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

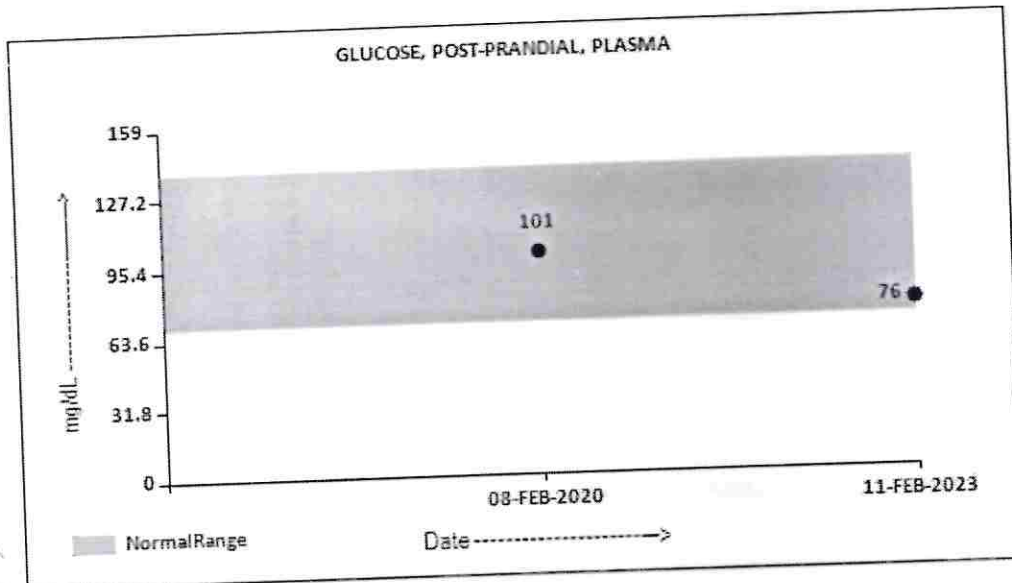
PPBS(POST PRANDIAL BLOOD SUGAR)

76

70 - 139

mg/dL

METHOD : HEXOKINASE



Comments

NOTE: POST PRANDIAL PLASMA GLUCOSE VALUES. TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

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. 220000008



Cert. No. MC-2275

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Final			

Dr.Akta Dubey
Counsellant Pathologist

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LABORATORY REPORT

PATIENT NAME : MS.SARBARI RAHA

PATIENT ID : **FH.5652387**

CLIENT PATIENT ID : UID:5652387

ACCESSION NO : **0022WB002083** AGE : 34 Years SEX : Female

ABHA NO :

DRAWN : 11/02/2023 10:26:00

RECEIVED : 11/02/2023 10:27:57

REPORTED : 11/02/2023 14:59:26

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

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5652387 REQNO-1370875
CORP-OPD
BILLNO-150123OPCR008469
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3 123.00 Non-Pregnant Women 80.0 - 200.0 ng/dL
Pregnant Women
1st Trimester:105.0 - 230.0
2nd Trimester:129.0 - 262.0
3rd Trimester:135.0 - 262.0

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

T4 7.88 Non-Pregnant Women 5.10 - 14.10 µg/dL
Pregnant Women
1st Trimester: 7.33 - 14.80
2nd Trimester: 7.93 - 16.10
3rd Trimester: 6.95 - 15.70

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

TSH (ULTRASENSITIVE) 3.920 0.270 - 4.200 µIU/mL

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

Interpretation(s)

****End Of Report****

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Dr. Swapnil Sirmukaddam
Consultant Pathologist

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Patient Ref. No. 22000000

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PATIENT ID : **FH.5652387** CLIENT PATIENT ID : UID:5652387
 ACCESSION NO : **0022WB002083** AGE : 34 Years SEX : Female ABHA NO :
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 CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

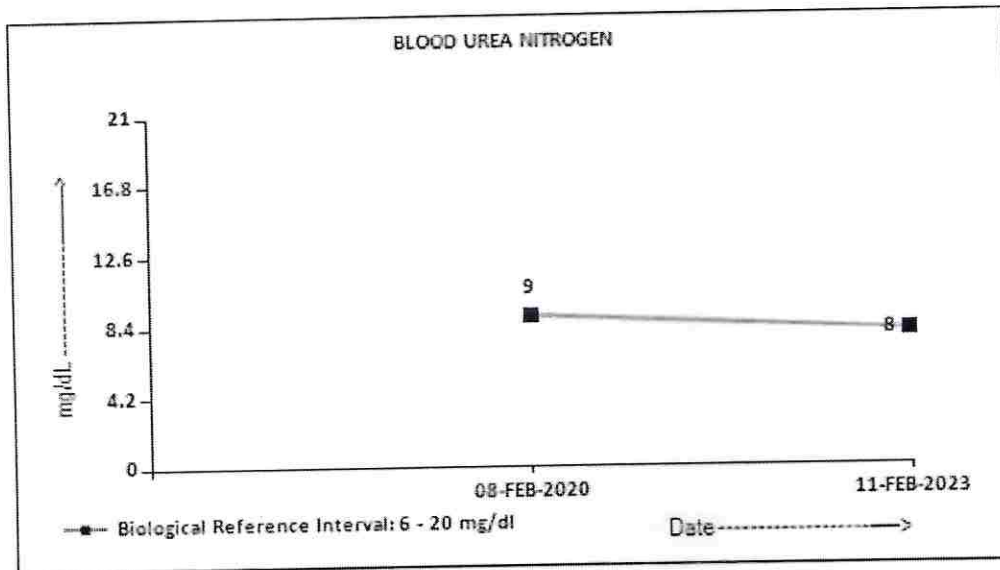
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 8 6 - 20 mg/dL
 METHOD : UREASE - UV



CREATININE EGFR- EPI

CREATININE 0.55 Low 0.60 - 1.10 mg/dL
 METHOD : ALKALINE PICRATE KINETIC JAFFES
AGE 34 years
GLOMERULAR FILTRATION RATE (FEMALE) 123.28 Refer Interpretation Below mL/min/
 METHOD : CALCULATED PARAMETER



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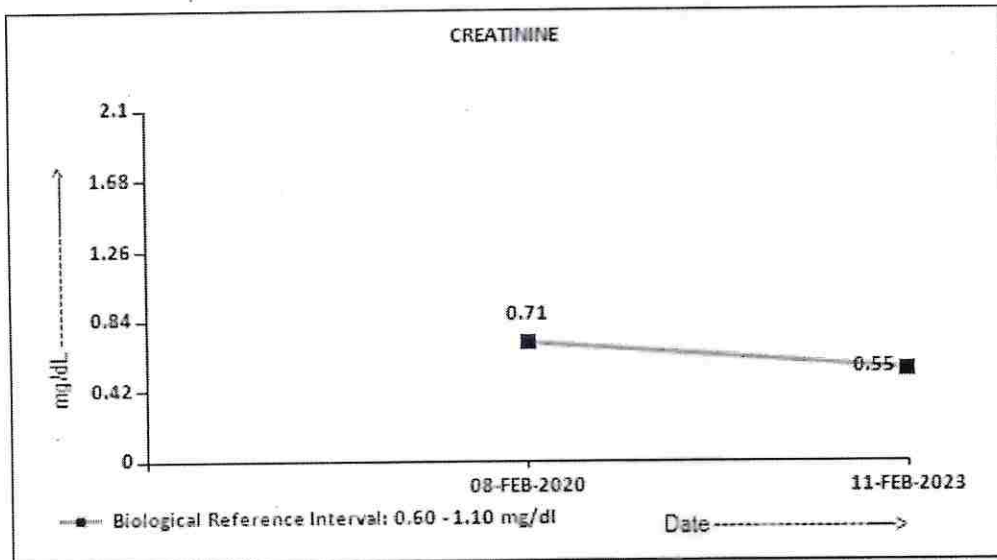
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BUN/CREAT RATIO

BUN/CREAT RATIO 14.55 5.00 - 15.00
 METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 3.0 2.6 - 6.0 mg/dL
 METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.6 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 3.9 3.4 - 5.0 g/dL
 METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN 3.7 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 4.49 3.50 - 5.10 mmol/L

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SEX : Female

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CORP-OPD
BILLNO-150123OPCR008469
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Table with 4 columns: Test Report Status, Results, Biological Reference Interval, Unit. Row 1: CHLORIDE, SERUM, 103, 98 - 107, mmol/L

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 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 protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burn hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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Patient Ref. No. 2200000



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PATIENT NAME : MS.SARBARI RAHA



PATIENT ID : FH.5652387

CLIENT PATIENT ID : UID:5652387

ACCESSION NO : 0022WB002083 AGE : 34 Years SEX : Female ABHA NO :
DRAWN : 11/02/2023 10:26:00 RECEIVED : 11/02/2023 10:27:57 REPORTED : 11/02/2023 13:07:10

CLIENT NAME : FORTIS VASHI-CHC -SPLZD REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5652387 REQNO-1370875
CORP-OPD
BILLNO-150123OPCR008469
BILLNO-150123OPCR008469

Test Report Status	Final	Results	Biological Reference Interval	Unit
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	42.4	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	85.2	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.8	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.7	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	21.8	High 11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	17.1		
MEAN PLATELET VOLUME (MPV)	11.0	High 6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	56	40 - 80	%
METHOD : FLOWCYTOMETRY			
LYMPHOCYTES	33	20 - 40	%
METHOD : FLOWCYTOMETRY			
MONOCYTES	08	2 - 10	%
METHOD : FLOWCYTOMETRY			
EOSINOPHILS	03	1 - 6	%
METHOD : FLOWCYTOMETRY			
BASOPHILS	00	0 - 2	%
METHOD : FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	2.58	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.52	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.37	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.14	0.02 - 0.50	thou/ μ L

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METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.7		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD ANISOCYTOSIS		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				
BLOOD COUNTS, EDTA WHOLE BLOOD				
HEMOGLOBIN (HB)		13.9	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL (RBC) COUNT		4.98	High 3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL (WBC) COUNT		4.60	4.0 - 10.0	thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY				
PLATELET COUNT		152	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE				

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(>: 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 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) 1
 This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R		26	High 0 - 20	mm at 1
METHOD : WESTERGREN METHOD				

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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) 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 referen the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE B
 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	0.43	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.15	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			

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Page 6 Of 15

Patient Ref. No. 2200000



Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MS.SARBARI RAHA



PATIENT ID : FH.5652387

CLIENT PATIENT ID : UID:5652387

ACCESSION NO : 0022WB002083 AGE : 34 Years SEX : Female ABHA NO :
DRAWN : 11/02/2023 10:26:00 RECEIVED : 11/02/2023 10:27:57 REPORTED : 11/02/2023 13:07:10

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:5652387 REQNO-1370875
CORP-OPD
BILLNO-150123OPCR008469
BILLNO-150123OPCR008469

Test Report Status	Final	Results	Biological Reference Interval
BILIRUBIN, INDIRECT		0.28	0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN		7.6	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		3.9	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.7	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.1	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		12	Low 15 - 37 U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		17	< 34.0 U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE		29	Low 30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		13	5 - 55 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE		132	100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)		83	74 - 99 mg/dL
METHOD : HEXOKINASE			

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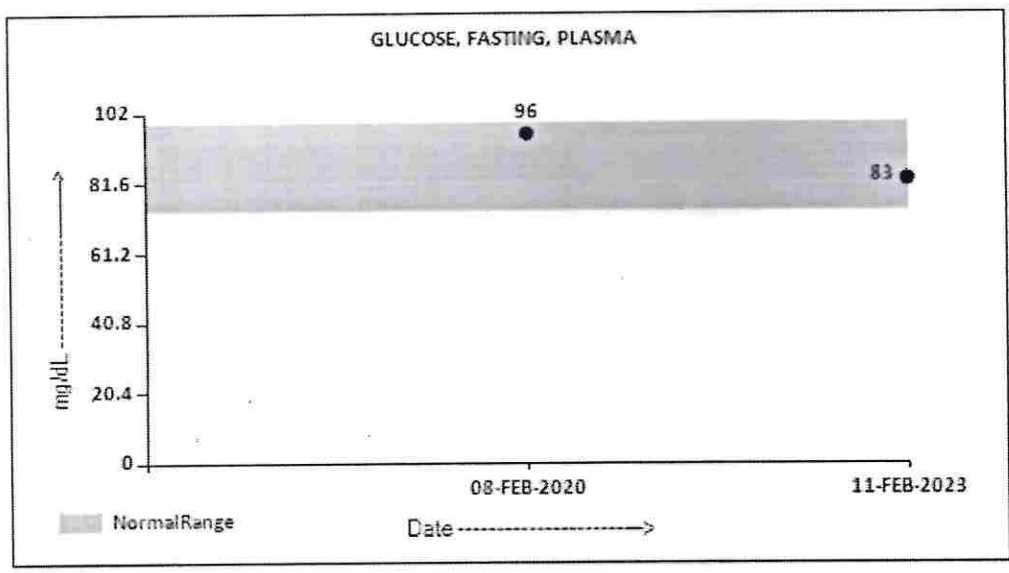
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LABORATORY REPORT
PATIENT NAME : MS.SARBARI RAHA

PATIENT ID : **FH.5652387** CLIENT PATIENT ID : UID:5652387
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Test Report Status	Final	Results	Biological Reference Interval
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.0	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)	96.8	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			



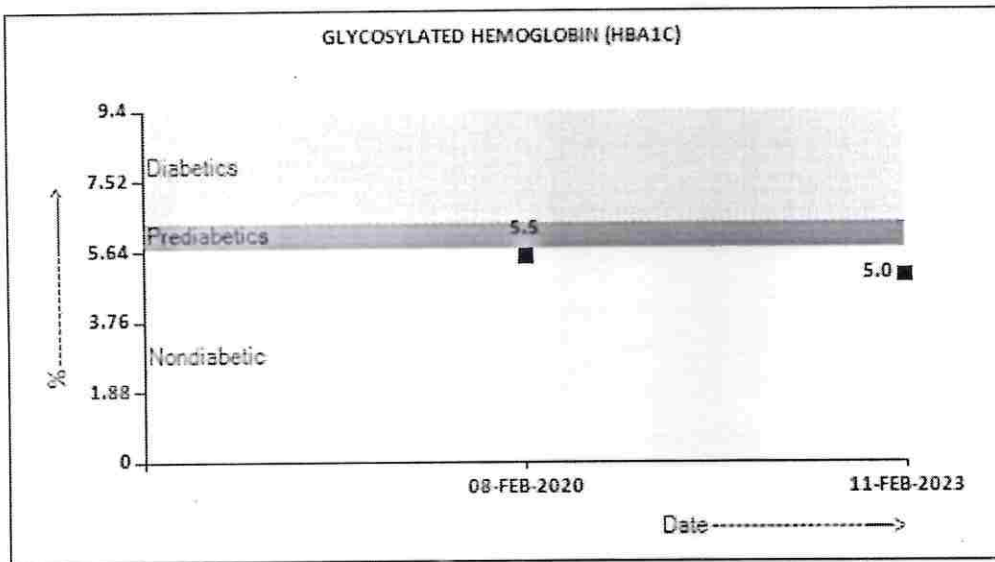
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PATIENT NAME : MS.SARBARI RAHA

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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 (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, which 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, gallbladder, 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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 CORP-OPD
 BILLNO-150123OPCR008469
 BILLNO-150123OPCR008469

Test Report Status	Final	Results	Biological Reference Interval
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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.T 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, Glycaer index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
 GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
- Diagnosing diabetes.
- 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.

- eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
- eAG gives an evaluation of blood glucose levels for the last couple of months.
- eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- 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.
- Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opi addition are reported to interfere with some assay methods,falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - HbF > 25% on alternate pallform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	149	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	47	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	49	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	95	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			

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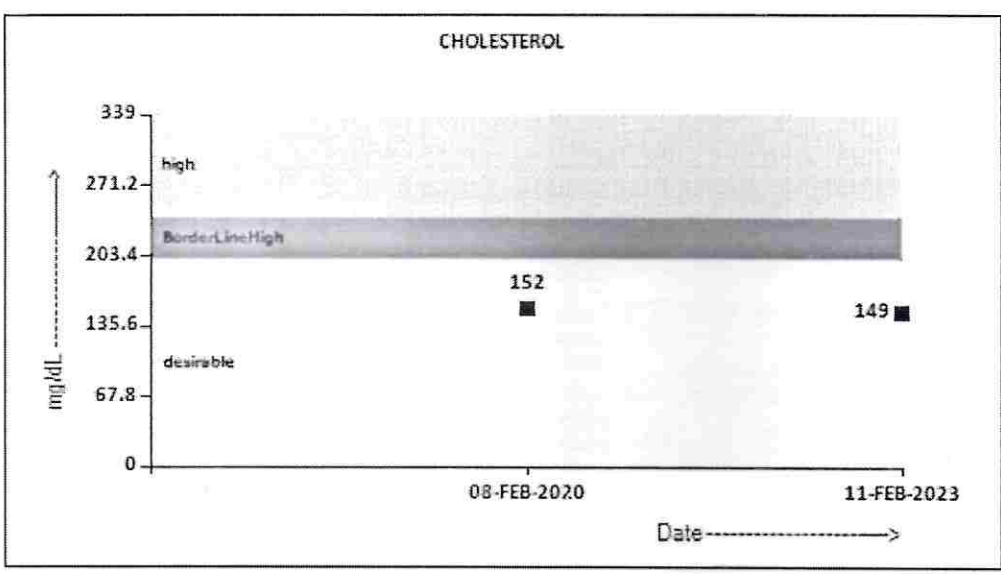


LABORATORY REPORT
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PATIENT ID : **FH.5652387** CLIENT PATIENT ID : UID:5652387
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CLINICAL INFORMATION :
 UID:5652387 REQNO-1370875
 CORP-OPD
 BILLNO-150123OPCR008469
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Test Report Status	Final	Results	Biological Reference Interval
NON HDL CHOLESTEROL		100	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		9.4	</= 30.0 mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO		3.0	Low 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		1.9	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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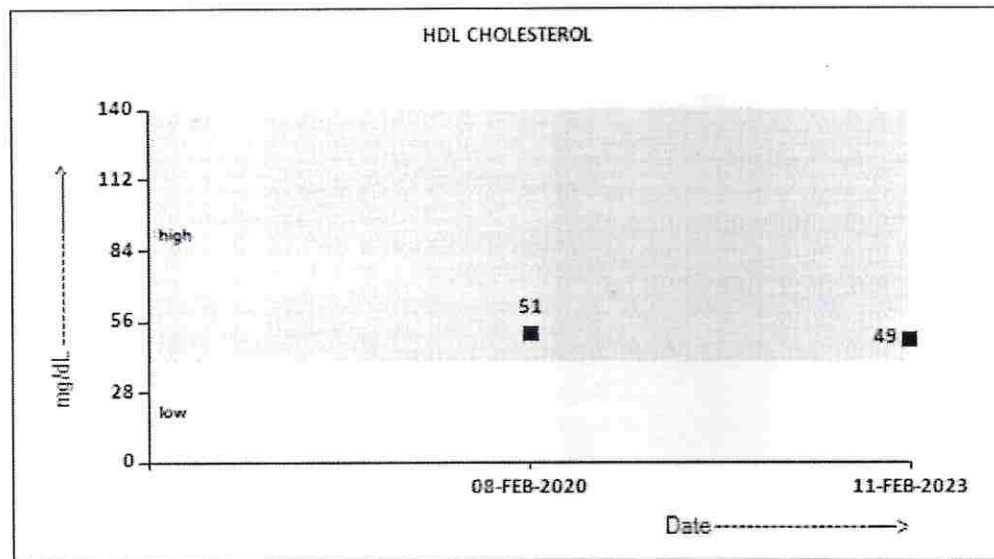
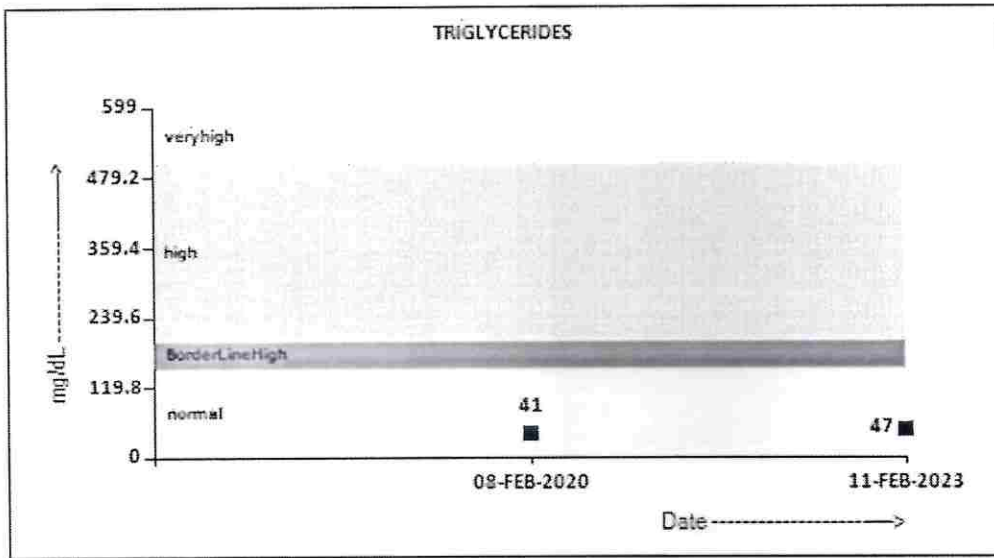
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CORP-OPD

BILLNO-1501230PCR008469

BILLNO-1501230PCR008469

Test Report Status	Results	Biological Reference Interval
Final		



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ACCESSION NO : **0022WB002083**

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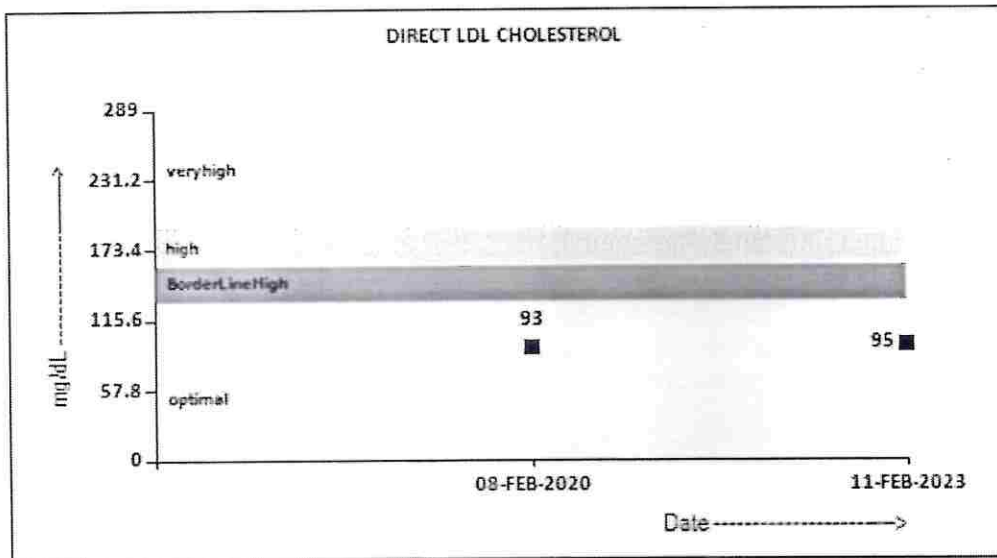
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CORP-OPD

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

CLINICAL PATH - URINALYSIS

URINALYSIS

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 >=1.030 1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN **DETECTED (+)** NOT DETECTED

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Test Report Status	Final	Results	Biological Reference Interval
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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)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	5-7	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CASTS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
CRYSTALS	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
BACTERIA	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)



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Cert. No. MC-2275



LABORATORY REPORT

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Test Report Status	Results	Biological Reference Interval
Final		

****End Of Report****

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

Dr. Rekha Nair, MD
Microbiologist

Dr. Akta Dubey
Counsultant Pathologist



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5652387
34 Years

SARBARI RAHA
Female

2/11/2023 11:25:05 AM

IHC

Sinus Rhythm
Normal
S

Rate 62 . Sinus rhythm.....normal P axis, V-rate 50- 99
: Short PR interval.....PR <110ms
: Baseline wander in lead(s) V1

PR 109
QRS 90
QT 387
QTc 393

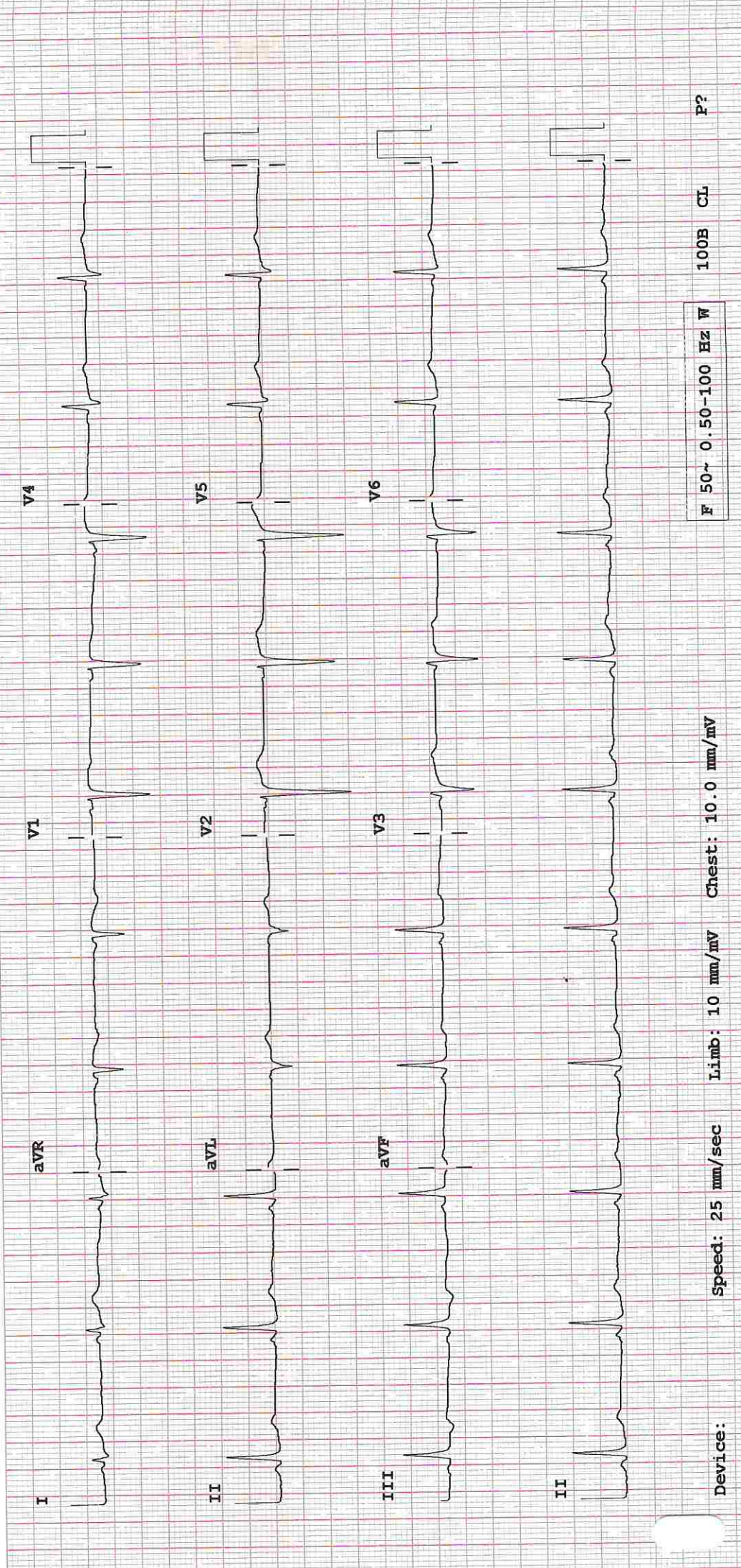
--AXIS--

P 62
QRS 83
T 22

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

**DEPARTMENT OF NIC**

Date: 14/Feb/2023

Name: Ms. Sarbari Raha
Age | Sex: 34 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 5652387 | 8683/23/1501
Order No | Order Date: 1501/PN/OP/2302/17809 | 11-Feb-2023
Admitted On | Reporting Date : 14-Feb-2023 12:59:10
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	29	mm
AO CUSP SEP	18	mm
LVID (s)	31	mm
LVID (d)	43	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	28	mm
LVEF	60	%



Date: 14/Feb/2023

DEPARTMENT OF NIC

Name: Ms. Sarbari Raha
Age | Sex: 34 YEAR(S) | Female
Order Station : FO-OPD
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Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 1.3 m/sec.

A WAVE VELOCITY: 0.7 m/sec

E/A RATIO: 1.9

	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.

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



DEPARTMENT OF RADIOLOGY

Date: 11/Feb/2023

Name: Ms. Sarbari Raha

Age | Sex: 34 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5652387 | 8683/23/1501

Order No | Order Date: 1501/PN/OP/2302/17809 | 11-Feb-2023

Admitted On | Reporting Date : 11-Feb-2023 15:19:52

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: Ms. Sarbari Raha

UHID | Episode No : 5652387 | 8683/23/1501

Age | Sex: 34 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2302/17809 | 11-Feb-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 11-Feb-2023 14:42:07

Bed Name :

Order Doctor Name : Dr.SELF.

USG-WHOLE ABDOMEN

LIVER is normal in size and 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 10.3 x 3.8 cm.

Left kidney measures 9.5 x 4.8 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.

UTERUS is normal in size, measuring 8.0 x 4.0 x 4.4 cm.

Endometrium measures 10 mm in thickness.

Both ovaries are normal.

Right ovary measures 2.4 x 1.2 cm.

Left ovary measures 3.2 x 2.4 cm and shows ruptured follicle within.

Minimal free fluid is seen in pouch of Douglas.

IMPRESSION:

- Minimal free fluid in pouch of Douglas.


DR. VIVEK MANE
MBBS., DMRE. (Radiologist)