

CLIENT CODE : C000138375
CLIENT'S NAME AND ADDRESS :
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
 NEW DELHI 110030
 DELHI INDIA
 8800465156

Agilus Diagnostics Ltd (Formerly SRL Ltd)
 M/S S.S. Wellness Centre, Ground Floor, C-22, Shastrri Nagar, Near Central
 Academy School
 Jodhpur, 342001
 Rajasthan, India
 Tel : 0291-2646000, 2644000, Fax :
 CIN - U74899PB1995PLC045956
 Email : srl.jodhpur@gmail.com

PATIENT NAME : SUNITA KANWAR 39482

PATIENT ID : SUNIF25039061

ACCESSION NO : **0061WC002369** AGE : 33 Years SEX : Female

DRAWN : RECEIVED : 25/03/2023 14:52 REPORTED : 01/04/2023 15:13

REFERRING DOCTOR : DR. BOB PACKAGE

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	12.2	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT	4.48	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT	6.77	4.0 - 10.0	thou/ μ L
PLATELET COUNT	325	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	36.8	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV)	82.1	Low 83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	27.2	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.2	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	15.1	High 11.6 - 14.0	%
MENTZER INDEX	18.3		
MEAN PLATELET VOLUME (MPV)	10.9	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS	74	40 - 80	%
LYMPHOCYTES	20	20 - 40	%
MONOCYTES	05	2 - 10	%
EOSINOPHILS	01	1 - 6	%

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	30	High 0 - 20	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	86	74 - 99	mg/dL
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METHOD : SPECTROPHOTOMETRY

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD

HBA1C	5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
ESTIMATED AVERAGE GLUCOSE (EAG)	105.4	< 116.0	mg/dL

LIPID PROFILE, SERUM



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CHOLESTEROL, TOTAL		211	High < 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : SPECTROPHOTOMETRY				
TRIGLYCERIDES		59	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : SPECTROPHOTOMETRY				
HDL CHOLESTEROL		55	< 40 Low >/=60 High	mg/dL
METHOD : SPECTROPHOTOMETRY				
CHOLESTEROL LDL		151	High < 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL		156	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN		11.8	</= 30.0	mg/dL
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	
LDL/HDL RATIO		2.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.4	0.2 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY				
BILIRUBIN, DIRECT		0.2	0.0 - 0.2	mg/dL
METHOD : SPECTROPHOTOMETRY				
BILIRUBIN, INDIRECT		0.2	0.1 - 1.0	mg/dL
METHOD : SPECTROPHOTOMETRY				
TOTAL PROTEIN		7.9	6.4 - 8.2	g/dL



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METHOD : SPECTROPHOTOMETRY				
ALBUMIN		4.1	3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY				
GLOBULIN		3.8	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)		23	15 - 37	U/L
METHOD : SPECTROPHOTOMETRY				
ALANINE AMINOTRANSFERASE (ALT/SGPT)		29	< 34.0	U/L
METHOD : SPECTROPHOTOMETRY				
ALKALINE PHOSPHATASE		131	High 30 - 120	U/L
METHOD : SPECTROPHOTOMETRY				
GAMMA GLUTAMYL TRANSFERASE (GGT)		38	5 - 55	U/L
METHOD : SPECTROPHOTOMETRY				
LACTATE DEHYDROGENASE		186	100 - 190	U/L
METHOD : SPECTROPHOTOMETRY				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		8	6 - 20	mg/dL
METHOD : SPECTROPHOTOMETRY				
CREATININE, SERUM				
CREATININE		0.79	0.60 - 1.10	mg/dL
METHOD : SPECTROPHOTOMETRY				
BUN/CREAT RATIO				
BUN/CREAT RATIO		10.13	5.00 - 15.00	
METHOD : SPECTROPHOTOMETRY				
URIC ACID, SERUM				
URIC ACID		6.0	2.6 - 6.0	mg/dL
METHOD : SPECTROPHOTOMETRY				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.9	6.4 - 8.2	g/dL
METHOD : SPECTROPHOTOMETRY				
ALBUMIN, SERUM				
ALBUMIN		4.1	3.4 - 5.0	g/dL
METHOD : SPECTROPHOTOMETRY				
GLOBULIN				
GLOBULIN		3.8	2.0 - 4.1	g/dL



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METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	140	136 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			
POTASSIUM, SERUM	4.6	3.50 - 5.10	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			
CHLORIDE, SERUM	106	98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY			

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR

CHEMICAL EXAMINATION, URINE

PH	5.5	4.7 - 7.5
SPECIFIC GRAVITY	1.010	1.003 - 1.035
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NOT DETECTED
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NORMAL	NORMAL
NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	DETECTED (OCCASIONAL)	NOT DETECTED	

METHOD : MICROSCOPIC EXAMINATION

YEAST	DETECTED (OCCASIONAL)	NOT DETECTED
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THYROID PANEL, SERUM



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T3		132.90	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester: 105.0 - 230.0 2nd Trimester: 129.0 - 262.0 3rd Trimester: 135.0 - 262.0	ng/dL
T4		8.03	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
TSH (ULTRASENSITIVE)		12.720	High Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL

PAPANICOLAOU SMEAR

TEST METHOD SAMPLE NOT RECEIVED

PHYSICAL EXAMINATION, STOOL

COLOUR SAMPLE NOT RECEIVED

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE A

METHOD : FORWARD/REVERSE

RH TYPE NEGATIVE

METHOD : FORWARD/REVERSE

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 - 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.

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

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

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



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TEST INTERPRETATION

Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
 Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
 In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.
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 the urine.
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 sulfonylureas, tolbutamide, and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.
 High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic 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 patient's metabolic control has remained continuously within the target range.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/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 & opiates 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 platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

LIVER FUNCTION PROFILE, SERUM-

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



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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, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons 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.

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, Waldenstroms 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 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

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, 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, Muscuophy

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- 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, Waldenstroms 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.

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.

****End Of Report****

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



Dr. Itisha Dhiman
Pathologist



CLIENT CODE : C000138375
CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

Agilus Diagnostics Ltd (Formerly SRL Ltd)
M/S S.S. Wellness Centre,Ground Floor,C-22,Shastri Nagar,Near Central
Academy School
Jodhpur, 342001
Rajasthan, India
Tel : 0291-2646000, 2644000, Fax :
CIN - U74899PB1995PLC045956
Email : srl.jodhpur@gmail.com

PATIENT NAME : SUNITA KANWAR 39482

PATIENT ID : SUNIF25039061

ACCESSION NO : 0061WC002369 AGE : 33 Years SEX : Female

DRAWN : RECEIVED : 25/03/2023 14:52 REPORTED : 01/04/2023 15:13

REFERRING DOCTOR : DR. BOB PACKAGE

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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CONDITIONS OF LABORATORY TESTING & REPORTING

- | | |
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| <ul style="list-style-type: none"> 1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form. 2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services. 3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event. 4. A requested test might not be performed if: <ul style="list-style-type: none"> i. Specimen received is insufficient or inappropriate ii. Specimen quality is unsatisfactory iii. Incorrect specimen type iv. Discrepancy between identification on specimen container label and test requisition form | <ul style="list-style-type: none"> 5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity. 6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis. 7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification. 8. Test results cannot be used for Medico legal purposes. 9. In case of queries please call customer care (91115 91115) within 48 hours of the report. |
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Agilus Diagnostics Ltd

Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

