

UPI Scan & Pay



OUTPATIENT BILL

GST No. : 03AAACF0987E1ZZ

Duplicate

Name : Mr. Santoshh Kumar Jha
UHID : 11826198
EpisodeNo : 7902/24/10021
Age/Sex : 47 YEAR(S)/Male
Primary Doctor : Dr SELF .
Contact No. : 9855074655
Payor Name : Arcofemi Healthcare Limited
Ref Doctor : Direct Walk in
Insurance : NA
Patient Address : 708 FIRST FLOOR OMEX CITY NEW CHANDIGARH
Mohali 140901 Punjab India

Bill No : 1002124OPCS009837
Bill Type : CASH
Bill Date : 25-May-2024 8:51 AM
Print Date : 28-May-2024 7:18 PM
Discount Scheme : NA
CIN No. : L85110PB1996PLC045933
Payor Site Name : 1002_Arcofemi Healthcare Limited
Employer Name : NA
TPA Name :

S.No	Particulars	Accession No	HSN Code	Qty	Service Amount	Contractual Discount	Net Gross Amount
1	MediWheel Full Body Health Checkup Male Above 40	PHC.8157311	999312	1.00	2650.00	0.00	2650.00
TOTAL AMOUNT					2650.00	0.00	2650.00
Less Contractual discount							0.00
TOTAL TAX AMOUNT						0.00	0.00
BILL AMOUNT							2650.00
PAYOR SHARE							0.00
PATIENT SHARE							2650.00
TOTAL DISCR. DISCOUNT						0.00	0.00
PAID BY PATIENT							2650.00
NET PATIENT PAYABLE							2650.00
BILL ROUND OFF AMOUNT							0.00

Rupees In Words : Rupees Two Thousand Six Hundred Fifty only

Payor Details

Name : Arcofemi Healthcare Limited
Address : 1002_Arcofemi Healthcare Limited
GSTIN : NA

Prepared By : Charanjeet Kaur

Cashier

Manager

Note :

Receipt Detail

S.No	Receipt No.	Receipt Date	Amount	Balance Amount	Payment Mode
1	10021/DP/2405/6287	25-May-2024 8:51 AM	2650.00	0.00	UPI Collection

PATIENT NAME : SANTOSHH KUMAR JHA

REF. DOCTOR : SELF

 CODE/NAME & ADDRESS : C000045483 - FORTIS
 FORTIS MOHALI-CHC -SPLZD
 FORTIS HOSPITAL - MOHALI,
 MOHALI 160062
 7087030817

 ACCESSION NO : **0006XE024833**
 PATIENT ID : FH.11826198
 CLIENT PATIENT ID: UID:11826198
 ABHA NO :

 AGE/SEX : 47 Years Male
 DRAWN : 25/05/2024 08:51:00
 RECEIVED : 25/05/2024 14:34:33
 REPORTED : 25/05/2024 16:35:30

CLINICAL INFORMATION :

 UID:11826198 REQNO-1707241
 CORP-OPD
 BILLNO-1002124OPCS009837
 BILLNO-1002124OPCS009837

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	13.2	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.10	4.5 - 5.5	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	5.57	4.0 - 10.0	thou/ μ L
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	242	150 - 410	thou/ μ L
METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY			

RBC AND PLATELET INDICES

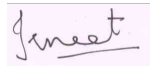
HEMATOCRIT (PCV)	44.7	40.0 - 50.0	%
METHOD : HYDRODYNAMIC FOCUSING			
MEAN CORPUSCULAR VOLUME (MCV)	87.6	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	25.9 Low	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	29.5 Low	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.3	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	17.2		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	11.2 High	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			



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 Senior Resident, 49300



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 Attending Consultant, 47150



 Dr. Irneet Mundi (MD,DNB
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 Associate Consultant, 34080

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ULR No.6000003391689-0006

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WBC DIFFERENTIAL COUNT

NEUTROPHILS	55	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
LYMPHOCYTES	30	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
MONOCYTES	11 High	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
EOSINOPHILS	4	1 - 6	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
BASOPHILS	00	0 - 2	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY			
ABSOLUTE NEUTROPHIL COUNT	3.06	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.67	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.61	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.22	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.8		
METHOD : CALCULATED PARAMETER			

Interpretation(s)

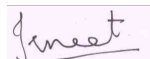
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
 WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
 This ratio element is a calculated parameter and out of NABL scope.



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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	20 High	0 - 14	mm at 1 hr
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METHOD : WESTERGREN METHOD

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	8.4 High	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	194.4 High	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

Interpretation(s)

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

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

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

TEST INTERPRETATION

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

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

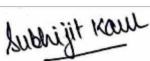
In pregnancy BRI in first trimester is 0-48 mm/hr (62 if anemic) and in second trimester (0-70 mm/hr (95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

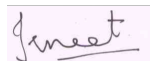
False Decreased : Poikilocytosis, (Sickle Cells, spherocytes), Microcytosis, Low fibrinogen, Very high WBC counts, Drugs (Quinine,



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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. GLYCOSYLATED HEMOGLOBIN(HbA1c), EDTA WHOLE BLOOD-Used For:

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

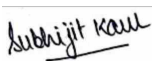
HbA1c Estimation can get affected due to :

1. 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.
2. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
3. 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.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.

b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)

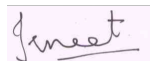
c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.98	UPTO 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.29	0.00 - 0.30	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.69 High	0.00 - 0.60	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.6	6.6 - 8.7	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN	4.5	3.97 - 4.94	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.1	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.5	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	34	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	77 High	0 - 41	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	123	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	57	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE UV	210	135 - 225	U/L

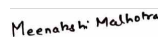
GLUCOSE FASTING, FLUORIDE PLASMA



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FBS (FASTING BLOOD SUGAR)

163 High

(Normal <100, Impaired fasting glucose: 100 to 125, Diabetes mellitus: >=126 (on more than 1 occasion) (ADA guidelines 2024))

METHOD : HEXOKINASE

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN

9

6 - 20

mg/dL

METHOD : UREASE - UV

URIC ACID, SERUM

URIC ACID

5.3

3.4 - 7.0

mg/dL

METHOD : URICASE, COLORIMETRIC

CREATININE EGFR

CREATININE

1.10

0.70 - 1.20

mg/dL

METHOD : ALKALINE PICRATE-KINETIC

AGE

47

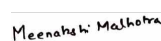
years



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GLOMERULAR FILTRATION RATE (MALE)	83	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)		mL/min/1.73mSq

Interpretation(s)

GLUCOSE POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	278 High	Non-Diabetes 70 - 140	mg/dL
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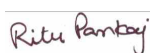
METHOD : HEXOKINASE

Interpretation(s)

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.

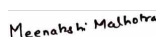
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of 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 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.



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ULR No. 6000003391689-0006



PATIENT NAME : SANTOSHH KUMAR JHA **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000045483 - FORTIS FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL - MOHALI, MOHALI 160062 7087030817	ACCESSION NO : 0006XE024833	AGE/SEX : 47 Years Male
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	CLIENT PATIENT ID: UID:11826198	RECEIVED : 25/05/2024 14:34:33
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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

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.

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.

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

GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

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Hardeep Kaur

**Ms. Hardeep Kaur, M.Sc.
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Meenakshi Malhotra

**Dr. Meenakshi Malhotra (MD,
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 FORTIS HOSPITAL - MOHALI,
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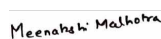
BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM


CHOLESTEROL, TOTAL	217 High	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	125	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	48	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	150 High	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	169 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	25.0	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	4.5 High	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	



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LDL/HDL RATIO		3.1 High	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
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METHOD : CALCULATED PARAMETER

Interpretation(s)

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR METHOD : MANUAL EXAMINATION	LT. YELLOW
APPEARANCE METHOD : MANUAL EXAMINATION	CLEAR

CHEMICAL EXAMINATION, URINE

PH METHOD : DOUBLE INDICATOR PRINCIPLE	7.5	4.7 - 7.5
SPECIFIC GRAVITY METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)	1.015	1.003 - 1.035
PROTEIN METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)	NOT DETECTED	NOT DETECTED
GLUCOSE METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)	NOT DETECTED	NOT DETECTED
KETONES METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)	NOT DETECTED	NOT DETECTED
BLOOD METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)	NOT DETECTED	NOT DETECTED
BILIRUBIN METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)	NOT DETECTED	NOT DETECTED
UROBILINOGEN METHOD : REFLECTANCE PHOTOMETRY (EHRlich'S REACTION)	NORMAL	NORMAL
NITRITE METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

 Dr. Shafira Garg (MD, Pathology) Attending Consultant,47150	 Dr. Irneet Mundi (MD,DNB Pathology) Associate Consultant, 34080	 Dr. Ritu Pankaj (MD,Pathology), PDCC Additional Director, 30897	Page 11 Of 16 View Details	 View Report
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RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)		NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS		NOT DETECTED	0-5	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY				
YEAST		NOT DETECTED	NOT DETECTED	

Interpretation(s)

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Dr. Irneet Mundi (MD,DNB Pathology)
Associate Consultant, 34080

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CLINICAL PATH - STOOL ANALYSIS

STOOL: OVA & PARASITE	RESULT PENDING
PHYSICAL EXAMINATION,STOOL	RESULT PENDING
CHEMICAL EXAMINATION,STOOL	RESULT PENDING
MICROSCOPIC EXAMINATION,STOOL	RESULT PENDING



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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	130.5	80.00 - 200.00	ng/dL
T4	7.09	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE)	4.140	0.270 - 4.200	µIU/mL

Meenakshi Malhotra

Ritu Pankaj

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.494	0.0 - 2.0	ng/mL
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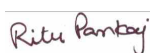
Interpretation(s)

- PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
- PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patients.
 - It is a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lines.
 - Measurement of total PSA alone may not clearly distinguish between benign prostatic hyperplasia (BPH) from cancer, this is especially true for the total PSA values between 4-10 ng/mL.
 - Total PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

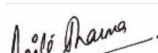
References-

1. Burtis CA, Ashwood ER, Bruns DE. Teitz textbook of clinical chemistry and Molecular Diagnostics. 4th edition.
2. Williamson MA, Snyder LM. Wallach's interpretation of diagnostic tests. 9th edition.

End Of Report

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|--|--|
| <ol 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: <ol 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 | <ol 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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