UPI Scan & Pay

OUTPATIENT BILL

GST No. : 03AAACF0987E1ZZ

Duplicate

Name	:	Mr. Santoshh Kumar Jha	**Bill No**	:	1002124OPCS009837
UHID	:	11826198	**Bill Type**	:	CASH
EpisodeNo	:	7902/24/10021	**Bill Date**	:	25-May-2024 8:51 AM
Age/Sex	:	47 YEAR(S)/Male	**Print Date**	:	28-May-2024 7:18 PM
Primary Doctor	:	Dr SELF .	**Discount Scheme**	:	NA
Contact No.	:	9855074655	**CIN No.**	:	L85110PB1996PLC045933
Payor Name	:	Arcofemi Healthcare Limited	**Payor Site Name**	:	1002_Arcofemi Healthcare Limited
Ref Doctor	:	Direct Walk in			
Insurance	:	NA	**Employer Name**	:	NA
Patient Address	:	708 FIRST FLOOR OMEX CITY NEW CHANDIGARH Mohali 140901 Punjab India	**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 :

Reciept 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

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

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

HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

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

RBC AND PLATELET INDICES

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

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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/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT	1.67	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT	0.61	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT	0.22	0.02 - 0.50	thou/µL
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

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)	%

METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	**194.4 High**	< 116.0	mg/dL

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, 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: Polycythermia 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,

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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 patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/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 addiction 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 paltform (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	0.98	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.29	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	**0.69 High**	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.6	6.6 - 8.7	g/dL
METHOD : BIURET			
ALBUMIN	4.5	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN	3.1	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.5	1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	34	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**77 High**	0 - 41	U/L
METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE			
ALKALINE PHOSPHATASE	123	40 - 129	U/L
METHOD : PNPP - AMP BUFFER			
GAMMA GLUTAMYL TRANSFERASE (GGT)	57	8 - 61	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	210	135 - 225	U/L
METHOD : LACTATE -PYRUVATE UV			

GLUCOSE FASTING,FLUORIDE PLASMA

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Additional Director, 30897

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FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	**163 High**	(Normal <100,Impaired fasting glucose:100 to 125,Diabetes mellitus:>=126(on more than 1 occasion)(ADA guidelines 2024)	mg/dL
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE - UV	9	6 - 20	mg/dL
URIC ACID, SERUM			
URIC ACID METHOD : URICASE, COLORIMETRIC	5.3	3.4 - 7.0	mg/dL
CREATININE EGFR			
CREATININE METHOD : ALKALINE PICRATE-KINETIC	1.10	0.70 - 1.20	mg/dL
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

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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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 sothat 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 Glyosuria,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

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

Ms. Hardeep Kaur, M.Sc. Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

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Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase Viii,
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Punjab, India
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ULR No.6000003391689-0006

DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

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

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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	

Ms. Hardeep Kaur, M.Sc.
Biochemistry

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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	

METHOD : CALCULATED PARAMETER

Interpretation(s)

Ms. Hardeep Kaur, M.Sc.
Biochemistry

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

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

CHEMICAL EXAMINATION, URINE

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

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

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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)

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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

Dr. Meenakshi Malhotra (MD, Pathology)
Senior Consultant,48159

Ritu Pankaj

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.494	0.0 - 2.0	ng/mL

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 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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Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

Dr. Anita Sharma (MD, Microbiology)
Director, Lab Medicine, 27672

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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:
   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
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 Limited
Fortis Hospital, Sector 62, Phase VIII,
Mohali 160062

Dr. Ritu Pankaj (MD,Pathology), PDCC
Additional Director, 30897

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