



BMI CHART

Date: 21/3/20

Name: Ms. Tanasi Pagi Age: 46 yrs Sex: (M) F

BP: 110/70 mmHg Height (cms): 168 cm Weight(kgs): 66 kg BMI: _____

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:



UHID	12365006	Date	21/03/2023		
Name	Mr. Tanaji Hari Patil	Sex	Male	Age	46
OPD	Opthal 14				

Drug allergy: → Not known
 Sys illness: → No

Chs. No

U/S No

U.V. → R 6/6
 → L 6/9

R → +0.50 on 6/6
 L → +0.75 on 6/6

Add → +1.75 → W.O.
 → W.O.

LOA → R → 10'6.
 → L → 12'4

(Same as P.H.P.)

Atul



UHID	12365006	Date	21/03/2023		
Name	Mr. Tanaji Hari Patil	Sex	Male	Age	46
OPD	Dental 12				

Drug allergy:
Sys illness:

missing $\leftarrow \frac{7}{6}$

secondary caries $\frac{4}{f}$
stains + Calculus +

Treatment

Adv. Implant $\frac{6}{f}$
Adv. Oral prophylaxis

Dr. Diksha Kaka



PATIENT NAME : MR.TANAJI HARI PATIL		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WC004180	AGE/SEX : 46 Years Male	
	PATIENT ID : FH.12365006	DRAWN : 21/03/2023 12:31:00	
	CLIENT PATIENT ID: UID:12365006	RECEIVED : 21/03/2023 12:32:34	
	ABHA NO :	REPORTED : 21/03/2023 13:38:46	

CLINICAL INFORMATION :

UID:12365006 REQNO-1398972
CORP-OPD
BILLNO-150123OPCR016507
BILLNO-150123OPCR016507

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	98	70 - 139	mg/dL
METHOD : HEXOKINASE			

Comments

NOTE: - RECHECKED FOR 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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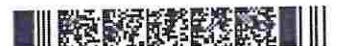
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CIN - U74899PB1995PLC045956
Email :-



Patient Ref. No. 22000000835713

PATIENT NAME : MR.TANAJI HARI PATIL		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001		ACCESSION NO : 0022WC004137 PATIENT ID : FH.12365006 CLIENT PATIENT ID: UID:12365006 ABHA NO :	AGE/SEX : 46 Years Male DRAWN : 21/03/2023 09:54:00 RECEIVED : 21/03/2023 09:54:31 REPORTED : 21/03/2023 17:12:56

CLINICAL INFORMATION :

UID:12365006 REQNO-1398972
 CORP-OPD
 BILLNO-150123OPCR016507
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM				
T3	113.80	80 - 200		ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
T4	7.09	5.1 - 14.1		µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				
TSH (ULTRASENSITIVE)	1.520	0.270 - 4.200		µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY				

Interpretation(s)



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 Consultant Pathologist



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 CIN - U74899PB1995PLC045956



PATIENT NAME : MR.TANAJI HARI PATIL		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS	ACCESSION NO : 0022WC004137	AGE/SEX : 46 Years Male	
FORTIS VASHI-CHC -SPLZD	PATIENT ID : FH.12365006	DRAWN : 21/03/2023 09:54:00	
FORTIS HOSPITAL # VASHI,	CLIENT PATIENT ID: UID:12365006	RECEIVED : 21/03/2023 09:54:31	
MUMBAI 440001	ABHA NO :	REPORTED : 21/03/2023 17:12:56	

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SPECIALISED CHEMISTRY - TUMOR MARKER


PROSTATE SPECIFIC ANTIGEN, SERUM				
PROSTATE SPECIFIC ANTIGEN	0.777	< 2.0		ng/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY				

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 patient.
 - 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-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)
 References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	15.2	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	4.70	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	4.20	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	272	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	43.7	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	92.9	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	32.4 High	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	34.8 High	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	15.1 High	11.6 - 14.0	%
MENTZER INDEX	19.8		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.1	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : FLOWCYTOMETRY	45	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	44 High	20 - 40	%

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REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
 FORTIS VASHI-CHC -SPLZD
 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : **0022WC004137**
 PATIENT ID : FH.12365006
 CLIENT PATIENT ID: UID:12365006
 ABHA NO :

AGE/SEX :46 Years Male
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MONOCYTES		9	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		2	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		1.89 Low	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.85	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.38	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.08	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.0		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

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.



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Patient Ref. No. 2200000835670

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REF. DOCTOR : SELF

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 FORTIS HOSPITAL # VASHI,
 MUMBAI 440001

ACCESSION NO : 0022WC004137
 PATIENT ID : FH.12365006
 CLIENT PATIENT ID: UID:12365006
 ABHA NO :

AGE/SEX : 46 Years Male
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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),WHOLE BLOOD

E.S.R	08	0 - 14	mm at 1 hr
METHOD : WESTERGREN METHOD			

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) 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, (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.



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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP METHOD : TUBE AGGLUTINATION	TYPE O
RH TYPE METHOD : TUBE AGGLUTINATION	POSITIVE

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.


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BIOCHEMISTRY				
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.73	0.2 - 1.0		mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, DIRECT	0.09	0.0 - 0.2		mg/dL
METHOD : JENDRASSIK AND GROFF				
BILIRUBIN, INDIRECT	0.64	0.1 - 1.0		mg/dL
METHOD : CALCULATED PARAMETER				
TOTAL PROTEIN	7.9	6.4 - 8.2		g/dL
METHOD : BIURET				
ALBUMIN	4.4	3.4 - 5.0		g/dL
METHOD : BCP DYE BINDING				
GLOBULIN	3.5	2.0 - 4.1		g/dL
METHOD : CALCULATED PARAMETER				
ALBUMIN/GLOBULIN RATIO	1.3	1.0 - 2.1		RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	20	15 - 37		U/L
METHOD : UV WITH PSP				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	22	< 45.0		U/L
METHOD : UV WITH PSP				
ALKALINE PHOSPHATASE	87	30 - 120		U/L
METHOD : PNPP-ANP				
GAMMA GLUTAMYL TRANSFERASE (GGT)	40	15 - 85		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)	96	74 - 99		mg/dL
METHOD : HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD				



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MAHARASHTRA, INDIA
Tel : 022-39199222, 022-49723322,
CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000835670

PATIENT NAME : MR.TANAJI HARI PATIL		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WC004137	AGE/SEX : 46 Years Male	DRAWN : 21/03/2023 09:54:00
	PATIENT ID : FH.12365006	RECEIVED : 21/03/2023 09:54:31	REPORTED : 21/03/2023 13:28:45
	CLIENT PATIENT ID : UID:12365006		
	ABHA NO :		

CLINICAL INFORMATION :

UID:12365006 REQNO-1398972
CORP-OPD
BILLNO-150123OPCR016507
BILLNO-150123OPCR016507

Test Report Status	Final	Results	Biological Reference Interval	Units
HBA1C		5.4	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)		108.3	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		15	6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE		1.11	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE		46		years
GLOMERULAR FILTRATION RATE (MALE)		82.94	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO		13.51	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		6.0	3.5 - 7.2	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.9	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN		4.4	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				

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Test Report Status	Final	Results	Biological Reference Interval	Units
GLOBULIN		3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		139	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		4.85	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM		102	98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

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 (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.

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 seen in Hypophosphatase, 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, biliary system 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 the



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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 glycaemic 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:

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 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 :

I.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.Fruktosamine is recommended in these patients which indicates diabetes control over 15 days.

II.Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).

III.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.

IV.Interference of hemoglobinopathies in HbA1c estimation is seen in

a.Homozygous hemoglobinopathy. Fruktosamine is recommended for testing of HbA1c.

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

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

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, less 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 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

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 Counsultant Pathologist



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Patient Ref. No. 22000000835670

PATIENT NAME : MR.TANAJI HARI PATIL		REF. DOCTOR : SELF	
CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001		ACCESSION NO : 0022WC004137 PATIENT ID : FH.12365006 CLIENT PATIENT ID: UID:12365006 ABHA NO :	AGE/SEX :46 Years Male DRAWN :21/03/2023 09:54:00 RECEIVED :21/03/2023 09:54:31 REPORTED :21/03/2023 13:28:45

CLINICAL INFORMATION :
 UID:12365006 REQNO-1398972
 CORP-OPD
 BILLNO-150123OPCR016507
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Test Report Status	Final	Results	Biological Reference Interval	Units
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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.



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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	222 High	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	104	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	68 High	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	134 High	< 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			
NON HDL CHOLESTEROL	154 High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN	20.8	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.3	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	2.0	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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Interpretation(s)



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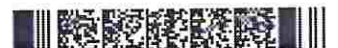
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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

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 <=1.005 1.003 - 1.035
 METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN NOT DETECTED NOT DETECTED
 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, KOTHERA'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)

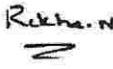
NITRITE NOT DETECTED NOT DETECTED
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

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


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 Dr. Rekha Nair, MD
 Microbiologist



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LABORATORY REPORT



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PUS CELL (WBC'S)		2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT 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)				

****End Of Report****

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Akta Dubey

Dr.Akta Dubey
Consultant Pathologist

Rekha N

Dr. Rekha Nair, MD
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12365006
46 Years

TANAJI PATIL
Male

3/21/2023 10:41:59 AM

HC

Rate 66 . Sinus rhythm.....normal P axis, V-rate 50- 99
. ST elev, probable normal early repol pattern.....ST elevation, age<55

PR 178
QRS 94
QT 421
QTc 442

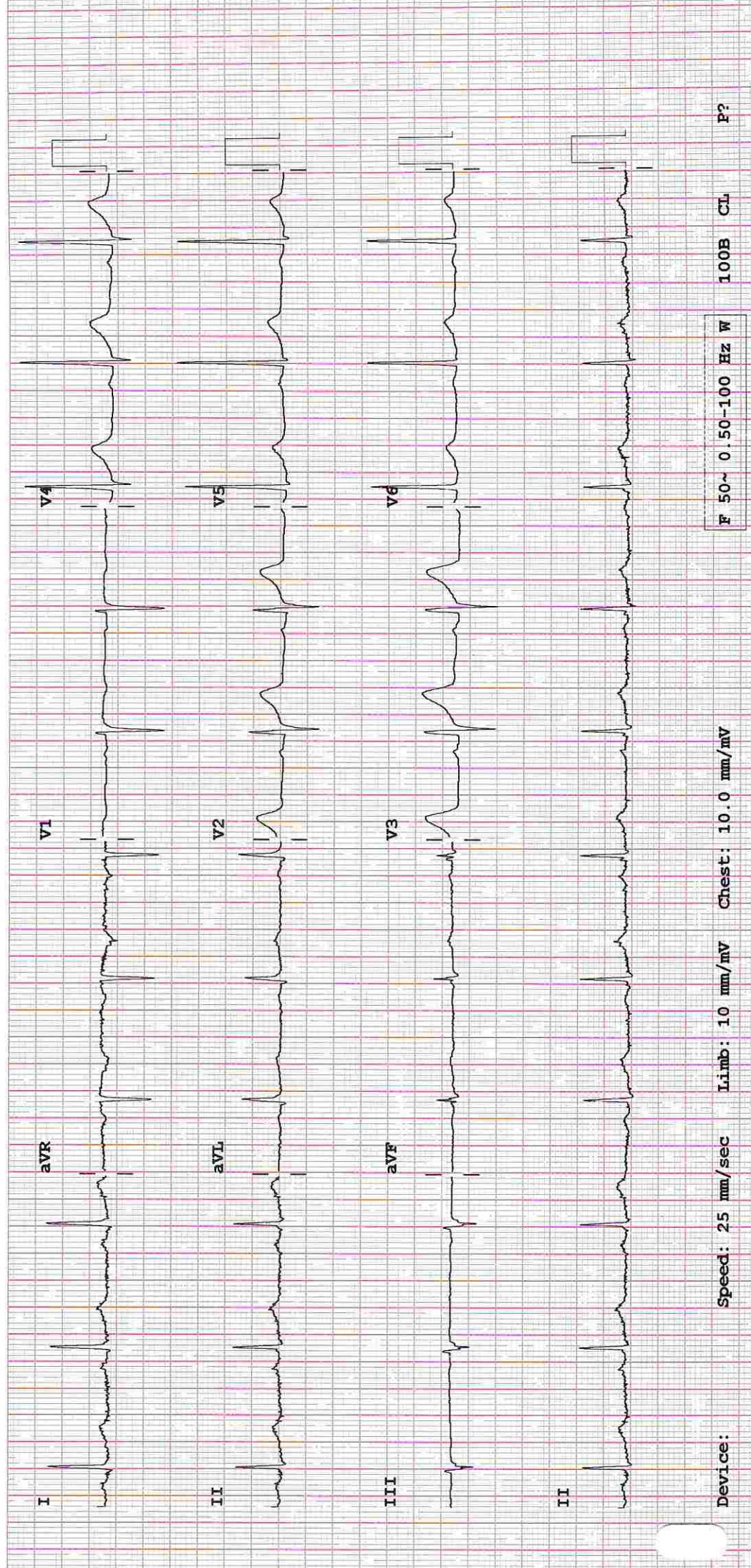
--AXIS--

P 3
QRS 9
T 27

12 Lead; Standard Placement

- NORMAL 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?

StuS Mystry
(Manga)
B



(For Billing/Reports & Discharge Summary only)

Date: 21/Mar/2023

DEPARTMENT OF NIC

Name: Mr. Tanaji Hari Patil
Age | Sex: 46 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 12365006 | 16699/23/1501
Order No | Order Date: 1501/PN/OP/2303/34779 | 21-Mar-2023
Admitted On | Reporting Date : 21-Mar-2023 13:57:15
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	30	mm
AO Root	21	mm
AO CUSP SEP	16	mm
LVID (s)	27	mm
LVID (d)	43	mm
IVS (d)	08	mm
LVPW (d)	07	mm
RVID (d)	24	mm
RA	30	mm
LVEF	60	%



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DOPPLER STUDY:

E WAVE VELOCITY: 0.7 m/sec.
A WAVE VELOCITY:0.6 m/sec
E/A RATIO:1.1

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	07			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	3.0			Nil

Final Impression :

- Normal 2 Dimensional and colour doppler echocardiography study.

DR. PRASHANT PAWAR
DNB(MED), DNB (CARDIOLOGY)



DEPARTMENT OF RADIOLOGY

Date: 21/Mar/2023

Name: Mr. Tanaji Hari Patil

UHID | Episode No : 12365006 | 16699/23/1501

Age | Sex: 46 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/34779 | 21-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 21-Mar-2023 13:21:43

Bed Name :

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 appear normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

DR. ADITYA NALAWADE

M.D. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 21/Mar/2023

Name: Mr. Tanaji Hari Patil

UHID | Episode No : 12365006 | 16699/23/1501

Age | Sex: 46 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2303/34779 | 21-Mar-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 21-Mar-2023 12:23:29

Bed Name :

Order Doctor Name : Dr.SELF.

US-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 and shows multiple calculi within the lumen, largest measuring 15 mm. Gall bladder reveals normal wall thickness. No evidence of pericholecystic collection.

CBD appears normal in caliber (3 mm).

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 9.4 x 3.9 cm.

Left kidney measures 9.8 x 4.4 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.

PROSTATE is normal in size & echogenicity. It measures ~ 12 cc in volume.

No evidence of ascites.

Impression:

- Cholelithiasis without changes of cholecystitis.

DR. ADITYA NALAWADE

M.D. (Radiologist)