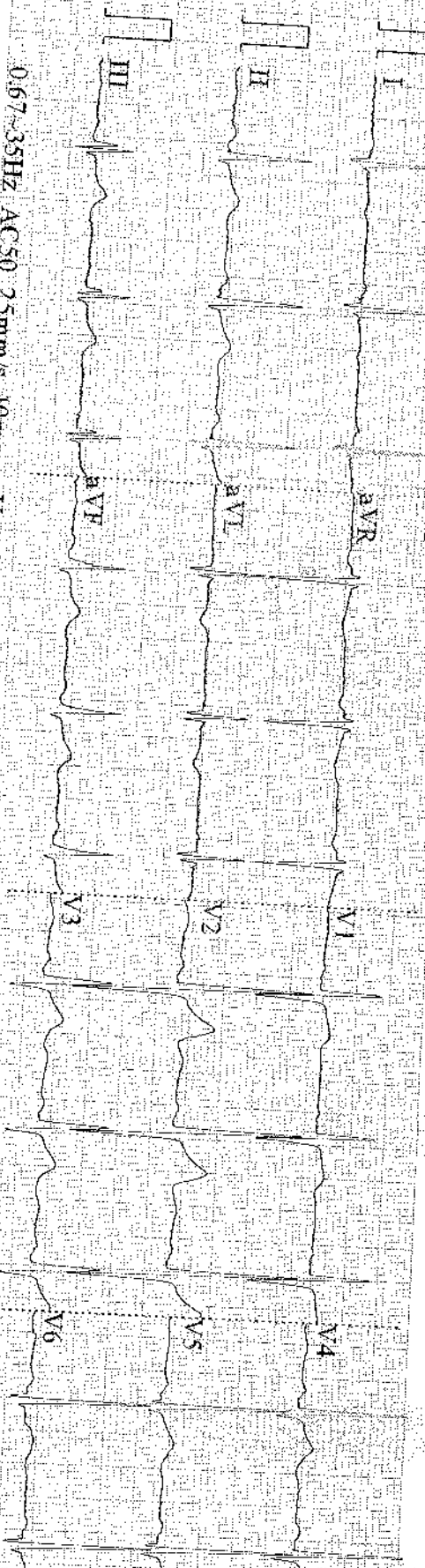


ID: 6374 28-01-2023 10:31:43 AM



0.67~35Hz AC50 25mm/s 10mm/mV ♣66 V1.0 SEMIP V1.7 DDRC SRL KADAPPAKKADA

ID: 6794

Male

48 Years

cm

mmHg

kg

Diagnosis Information

Men. Dose. n
48/ male

26 01 2023

CONSULTANT PANIC
Dr. [Signature]

HR	68	bpm
P	116	ms
PR	154	ms
QRS	91	ms
QT/QTc	410/439	ms
PQRST	5556/88	ms
RV5/SV1	1965/0930	mV

Report Confirmed by:

DIAGNOSTIC REPORTPatient Ref. No. **66600003186717**

CLIENT CODE : CA00010147 - MEDIWHEEL
ARCOFEMI HEALTHCARE LIMITED
CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : JOSE A **PATIENT ID :** JOSEM0305744071
ACCESSION NO : 4071WA006802 **AGE :** 48 Years **SEX :** Male **ABHA NO :**
DRAWN : **RECEIVED :** 28/01/2023 09:12 **REPORTED :** 28/01/2023 18:32
REFERRING DOCTOR : SELF **CLIENT PATIENT ID :** PKG10000236

Test Report Status	Results	Biological Reference Interval	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

TREADMILL TEST	
TREADMILL TEST	REPORTED
DENTAL CHECK UP	
DENTAL CHECK UP	REPORTED
OPHTHAL	
OPHTHAL	REPORTED
PHYSICAL EXAMINATION	
PHYSICAL EXAMINATION	REPORTED



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PATIENT NAME : JOSE A**PATIENT ID :** JOSEM0305744071ACCESSION NO : **4071WA006802** AGE : 48 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 28/01/2023 09:12

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Test Report Status	Preliminary	Results	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	13	Adult(<60 yrs) : 6 to 20	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	15.2		

Comments

*Kindly correlate clinically.
*Kindly inform lab within 24 hrs if clinically not correlating.

CREATININE, SERUM

CREATININE	0.85	18 - 60 yrs : 0.9 - 1.3	mg/dL
------------	------	-------------------------	-------

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	160	High Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
--------------------------------	------------	--	-------

Comments

*Kindly correlate clinically.
*Kindly inform lab within 24 hrs if clinically not correlating.

GLUCOSE FASTING, FLUORIDE PLASMA

GLUCOSE, FASTING, PLASMA	163	High Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
--------------------------	------------	--	-------

Comments

*Kindly correlate clinically.
*Kindly inform lab within 24 hours if clinically not correlating.

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

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GLYCOSYLATED HEMOGLOBIN (HBA1C)	7.5	High Normal : 4.0 - 5.6%. % Non-diabetic level : < 5.7%. Diabetic : >6.5% Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%. Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	
MEAN PLASMA GLUCOSE	168.6	High < 116.0	mg/dL
LIPID PROFILE, SERUM			
CHOLESTEROL	183	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	78	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	56	General range : 40-60	mg/dL
DIRECT LDL CHOLESTEROL	124	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	127	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	15.6	Desirable value : 10 - 35	mg/dL
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	
LDL/HDL RATIO	2.2	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	





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Test Report Status	Preliminary	Results	Units
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Interpretation(s)

- 1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.
- 2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.
- 3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL
- 4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.
- 5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)



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Extreme Risk Group Category A	<50 (Optional goal <OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL	0.51	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.18	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.33	0.00 - 0.60	mg/dL
TOTAL PROTEIN	7.6	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.3	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	3.3	General Range : 2 - 3.5 Premature Neonates : 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.3	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	43	Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	66	Adults : < 45	U/L
ALKALINE PHOSPHATASE	97	Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	135	High Adult (Male) : < 60	U/L

Comments

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TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.6	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
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URIC ACID, SERUM

URIC ACID	4.8	Adults : 3.4-7	mg/dL
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ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE O
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PATIENT NAME : JOSE A **PATIENT ID : JOSEM0305744071**

ACCESSION NO : **4071WA006802** AGE : 48 Years SEX : Male ABHA NO :
 DRAWN : RECEIVED : 28/01/2023 09:12 REPORTED : 28/01/2023 18:32

REFERRING DOCTOR : SELF CLIENT PATIENT ID : PKG10000236

Test Report Status	Preliminary	Results	Units
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RH TYPE	POSITIVE		
BLOOD COUNTS,EDTA WHOLE BLOOD			
HEMOGLOBIN	14.9	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	4.86	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL COUNT	5.12	4.0 - 10.0	thou/ μ L
PLATELET COUNT	168	150 - 410	thou/ μ L
RBC AND PLATELET INDICES			
HEMATOCRIT	44.1	40 - 50	%
MEAN CORPUSCULAR VOL	90.8	83 - 101	fL
MEAN CORPUSCULAR HGB.	30.7	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.9	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	12.7	11.6 - 14.0	%
MENTZER INDEX	18.7		
MEAN PLATELET VOLUME	10.2	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS	38	Low 40 - 80	%
LYMPHOCYTES	55	High 20 - 40	%
MONOCYTES	04	2 - 10	%
EOSINOPHILS	03	1 - 6	%
BASOPHILS	00	< 1 - 2	%
ABSOLUTE NEUTROPHIL COUNT	1.95	Low 2.0 - 7.0	thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT	2.82	1.0 - 3.0	thou/ μ L
ABSOLUTE MONOCYTE COUNT	0.20	0.2 - 1.0	thou/ μ L
ABSOLUTE EOSINOPHIL COUNT	0.15	0.02 - 0.50	thou/ μ L
ABSOLUTE BASOPHIL COUNT	00		thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	0.7		
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD			
SEDIMENTATION RATE (ESR)	07	0 - 14	mm at 1 hr
SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL	DETECTED (+)	NOT DETECTED	
PROSTATE SPECIFIC ANTIGEN, SERUM			



DIAGNOSTIC REPORTPatient Ref. No. **666000003186717**

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PATIENT NAME : JOSE A **PATIENT ID :** JOSEM0305744071
ACCESSION NO : 4071WA006802 **AGE :** 48 Years **SEX :** Male **ABHA NO :**
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Test Report Status	Preliminary	Results	Units
PROSTATE SPECIFIC ANTIGEN	0.537	Age Specific :- <49yrs : <2.5 50-59yrs : <3.5 60-69yrs : <4.5 >70yrs : <6.5	ng/mL
THYROID PANEL, SERUM			
T3	143.10	Adult : 80-200	ng/dL
T4	8.43	Adults : 4.5-12.1	µg/dl
TSH 3RD GENERATION	1.880	21-50 yrs : 0.4 - 4.2	µIU/mL



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Interpretation(s)

Triiodothyronine T3, Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

NOTE: It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4. TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

PH 6.0 4.8 - 7.4

SPECIFIC GRAVITY 1.020 1.015 - 1.030



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Test Report Status	Preliminary	Results	Units
PROTEIN		NOT DETECTED	NOT DETECTED
GLUCOSE		DETECTED (+)	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BLOOD		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
NITRITE		NOT DETECTED	NOT DETECTED
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED /HPF
WBC		1-2	0-5 /HPF
EPITHELIAL CELLS		0-1	0-5 /HPF
CASTS		NIL	
CRYSTALS		NIL	
BACTERIA		NOT DETECTED	NOT DETECTED



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Test Report Status	Preliminary	Results	Units
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Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

SUGAR URINE - FASTING RESULT PENDING
PHYSICAL EXAMINATION,STOOL RESULT PENDING
CHEMICAL EXAMINATION,STOOL RESULT PENDING
MICROSCOPIC EXAMINATION,STOOL RESULT PENDING





Patient Ref. No. 66600003186717

CLIENT CODE : CA00010147 - MEDIWHEEL
ARCOFEMI HEALTHCARE LIMITED
CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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Prathibha Junction, Kadappakada,
KOLLAM, 691008
KERALA, INDIA
Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : JOSE A**PATIENT ID :** JOSEM0305744071

ACCESSION NO : 4071WA006802 AGE : 48 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 28/01/2023 09:12

REPORTED : 28/01/2023 18:32

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : PKG10000236

Test Report Status	Preliminary	Results	Units
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Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of anti-diarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool maybe seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

- Stool Culture:** - This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin:** It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT):** This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay:** This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL:** In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.
- Rota Virus Immunoassay:** This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomiting & abdominal cramps. Adults are also affected. It is highly contagious in nature.



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 Email : customercare.ddrc@srl.in

PATIENT NAME : JOSE A **PATIENT ID :** JOSEM0305744071
ACCESSION NO : 4071WA006802 **AGE :** 48 Years **SEX :** Male **ABHA NO :**
DRAWN : **RECEIVED :** 28/01/2023 09:12 **REPORTED :** 28/01/2023 18:32
REFERRING DOCTOR : SELF **CLIENT PATIENT ID :** PKG10000236

Test Report Status	Preliminary	Results	Units
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Interpretation(s)

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
 Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM-Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

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
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; sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

NOTE:

While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD-Used For:

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 :

- 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. Fructosamine 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 addition are reported to interfere with some assay methods, falsely increasing results.
 - IV. 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
- LIPID PROFILE, SERUM-**Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease. This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.





Patient Ref. No. 66600003186712

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Tel : 93334 93334
Email : customercare.ddrc@srl.in

PATIENT NAME : JOSE A**PATIENT ID :** JOSEM0305744071

ACCESSION NO : 4071WA006802 AGE : 48 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 28/01/2023 09:12

REPORTED : 28/01/2023 18:32

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : PKG10000236

Test Report Status	Preliminary	Results	Units
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Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it does not need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

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
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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

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.

BLOOD COUNTS, EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait

(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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

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

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

TEST INTERPRETATION

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



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Patient Ref. No. 666000003186717

CLIENT CODE : CA00010147 - MEDIWHEEL
CLIENT'S NAME AND ADDRESS :
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 Email : customercare.ddrc@srl.in

PATIENT NAME : JOSE A**PATIENT ID :** JOSEM0305744071

ACCESSION NO : 4071WA006802 AGE : 48 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 28/01/2023 09:12

REPORTED : 28/01/2023 18:32

REFERRING DOCTOR : SELF

CLIENT PATIENT ID : PKG10000236

Test Report Status	Preliminary	Results	Units
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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 :

- 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.
- SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
 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 chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests



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DIAGNOSTIC REPORTPatient Ref. No. **66600003186717**

CLIENT CODE : CA00010147 - MEDIWHEEL
ARCOFEMI HEALTHCARE LIMITED
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PATIENT NAME : JOSE A PATIENT ID : **JOSEM0305744071**

ACCESSION NO : **4071WA006802** AGE : 48 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 28/01/2023 09:12 REPORTED : 28/01/2023 18:32

REFERRING DOCTOR : SELF CLIENT PATIENT ID : PKG10000236

Test Report Status	<u>Preliminary</u>	Results	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT**ECG WITH REPORT**

REPORT
REPORTED

****End Of Report****Please visit www.srlworld.com for related Test Information for this accession

DR. AMJAD A, M.D Pathology
(Reg No - TCMC 38949)
CONSULTANT PATHOLOGIST

JIBI J
LAB TECHNOLOGIST

RAJI R
LAB TECHNOLOGIST

DEVAYANI SATHEESAN
LAB TECHNOLOGIST



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Name : Mr. Jose Antony	Age : 48 yrs	Sex: M	RADIOLOGY DIVISION
Ref. from. Mediwheel Arcofemi			Date : 28.01.2023

USG OF ABDOMEN

LIVER: Is normal in size (14.8 cms). *Echotexture is increased uniformly through out of liver, suggestive of fatty changes.* No focal lesions are seen. No dilatation of intra-hepatic biliary radicles present. Portal vein is normal. Common bile duct is normal.

GALL BLADDER: Is minimally distended. Normal in wall thickness. No calculus or mass.

PANCREAS: Visualized head & body appear normal. *Rest obscured by bowel gas.*

SPLEEN: Is normal in size (9.5 cms) and echotexture.

RIGHT KIDNEY: Measures 10.2 x 3.9 cms. Normal in size and echotexture. Cortico medullary differentiation is well maintained. No calculus, hydronephrosis or mass.

LEFT KIDNEY: Measures 10.9 x 4.2 cms. Normal in size and echotexture. Cortico medullary differentiation is well maintained. No calculus, hydronephrosis or mass.

URINARY BLADDER: Is partially distended. Normal in wall thickness. No obvious calculus or mass noted.

PROSTATE: Is normal in size (Volume - 17.5 cc). Parenchymal echoes normal.


No ascites present. No retroperitoneal lymphadenopathy present.

No obvious bowel related mass / collection noted in the visualized segments during the scan time.

IMPRESSION: (Limited study due to bowel gas)

❖ *Grade I fatty infiltration of liver.*

- Suggested follow up & clinical correlation.
- Images overleaf.


Dr. AISALUTH THULASEEDHARAN
MBBS, DMRD

(Note: Diagnosis should not be made solely on one investigation. Advised further / repeat investigation and clinical correlation in suspected cases and in case of unexpected results, ultrasound is not 100% accurate and this report is not valid for medico legal purpose)

MSK Report

Patient ID : 28_01_2023_13_12_16

Sex : M

Age :

Patient Name : JOSE ANTONY

Study Date : 28/01/2023

Referring MD :

Performing MD :

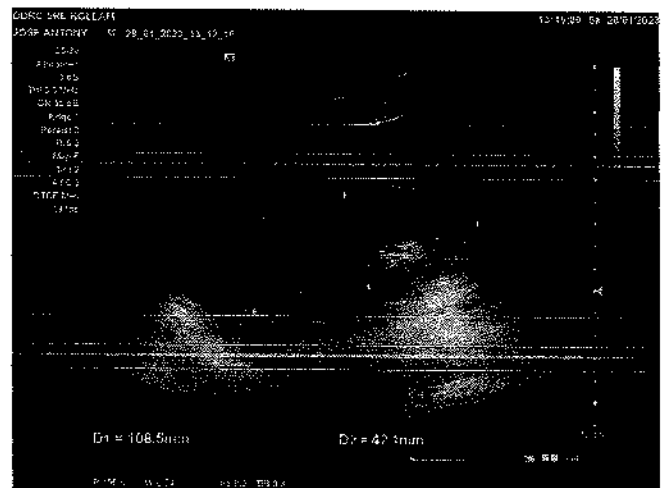
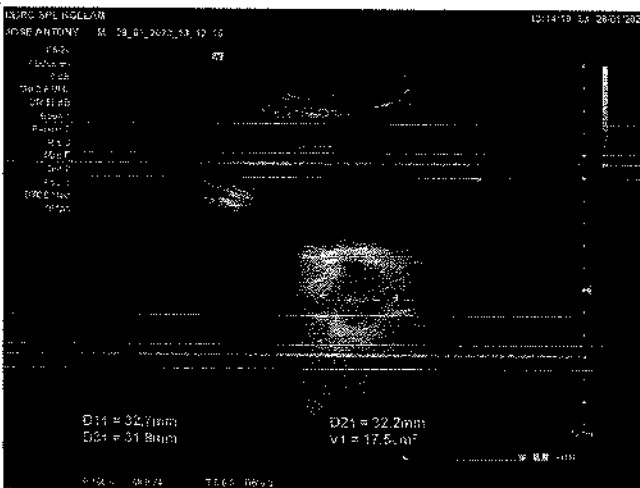
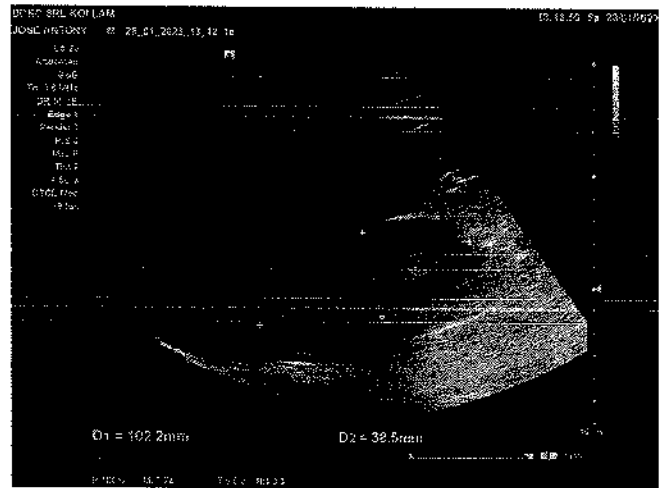
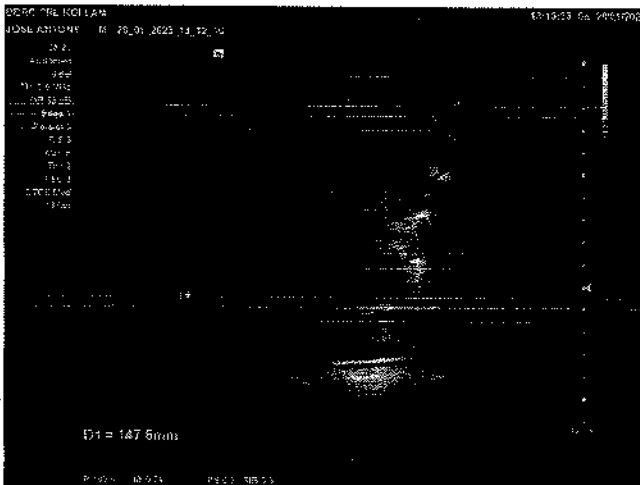
Sonographer :

Indication :

Exam Type : MSK

Height :

Weight :



Signature _____



NAME: JOSE A	AGE/ SEX : 48/M	28.01.2023
--------------	-----------------	------------

ELECTRO CARDIOGRAM REPORT

ELECTRO CARDIOGRAM

: NSR - ⁶⁸.../minute. No evidence of ischaemia or chamber hypertrophy

Impression

: ECG within normal limits.

Tinvelly 1aVL

DR AKHILA SEKHAR

MBBS,MD

CONSULTANT PATHOLOGIST

DDRC SRL DIAGNOSTICS

Dr. Akhila Sekhar MBBS,MD
Consultant Pathologist
Reg.No. 55174



NAME	AGE/ SEX	DATE
JOSE A	48/M	28.01.2023

CHEST X-RAY WITH REPORT**CHEST X-RAY : NORMAL****Impression : Within normal limits**

Dr. Akhila Sekhar MBBS MD
Consultant Pathologist
Reg.No. 55174

Dr. Akhila Sekhar MBBS MD
Consultant Pathologist
Reg.No. 55174

DR AKHILA SEKHAR**MBBS,MD****CONSULTANT PATHOLOGIST****DDRC SRL DIAGNOSTICS PVT LTD**



If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee : Mr./Mrs./Ms. JOSE A
 2. Mark of Identification : (Mole/Scar/any other (specify location)): *Stretch mark in the left hand*
 3. Age/Date of Birth : 48 3/5/74 Gender: F/M
 4. Photo ID Checked : (Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height1.72..... (cms) b. Weight85..... (Kgs) c. Girth of Abdomen ...11.0.... (cms)
 d. Pulse Rate70..... (/Min) e. Blood Pressure: Systolic Diastolic

1 st Reading	120	80
2 nd Reading		

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father	-	-	-
Mother	(75) Mary Anthony	Diabetes	-
Brother(s)	-	-	-
Sister(s)	54, 52, 47	-	-

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
NO	NO	NO

PERSONAL HISTORY

- a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. Y/N
- b. Have you undergone/been advised any surgical procedure? Y/N
- c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? Y/N
- d. Have you lost or gained weight in past 12 months? Y/N

Have you ever suffered from any of the following?

- Psychological Disorders or any kind of disorders of the Nervous System? Y/N
- Any disorders of Respiratory system? Y/N
- Any Cardiac or Circulatory Disorders? Y/N
- Enlarged glands or any form of Cancer/Tumour? Y/N
- Any Musculoskeletal disorder? Y/N
- Any disorder of Gastrointestinal System? Y/N
- Unexplained recurrent or persistent fever, and/or weight loss Y/N
- Have you been tested for HIV/HBsAg /HCV before? If yes attach reports Y/N
- Are you presently taking medication of any kind? Y/N

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 Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai - 400062.

• Any disorders of Urinary System?

Y/N

• Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin

Y/N

FOR FEMALE CANDIDATES ONLY

a. Is there any history of diseases of breast/genital organs?

Y/N

d. Do you have any history of miscarriage/abortion or MTP

Y/N

b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports)

Y/N

e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc

Y/N

c. Do you suspect any disease of Uterus, Cervix or Ovaries?

Y/N

f. Are you now pregnant? If yes, how many months?

Y/N

CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER

➤ Was the examinee co-operative?

Y/N

➤ Is there anything about the examinee's health, lifestyle that might affect him/her in the near future with regard to his/her job?

Y/N

➤ Are there any points on which you suggest further information be obtained?

Y/N

➤ Based on your clinical impression, please provide your suggestions and recommendations below;

.....
.....

➤ Do you think he/she is **MEDICALLY FIT** or **UNFIT** for employment.

Fit

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner :

[Handwritten Signature]

DR AKHILA A SEKHAR

Seal of Medical Examiner :

Dr. Akhila Sekhar MBBS MD
Consultant Pathologist
Reg No. 52474



Name & Seal of DDRC SRL Branch :

DDRC SRL PVT LTD


Date & Time :

28/1/23 3:00pm

DDRC SRL Diagnostics Private Limited

Corp. Office: DDRC SRL Tower, G-131, Panampilly Nagar, Ernakulam - 682 036
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Regd. Office: 4th Floor, Prime Square, Plot No. 1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai - 400062.

Dr Harikrishnan Cp MS Phaco Surgeon Cataract Services Email: info.cei@chaithanya.org Phone: 0484 2725500	Chaithanya Eye Hospital KOLLAM	
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MR No.	03-127133	Address :	AKKAL HOUSE,
Name	MR. JOSE ANTONY		
Age	48 Years		CHAVARA, Kollam.
Sex	Male		KERALA, INDIA - 691583.

Purpose of Visit Consultation--

Main Complaints

- Both eyes Blurring of vision 2 Year(s) Onset Gradual Progression Worsening

Past Ocular History

- Both eyes Nil

Past Medical History

Diabetes mellitus 5 Year(s) ON RX

Family History

Nil No

Allergy History

Not aware of

Visual Acuity Refraction GLASS PRESCRIPTION							
Eye	Sph	Distance Vision			Sph	BCVA	ADD
		Cyl	Axis	BCVA			Distance
RIGHT EYE	+0.00			6/6 (0.00)	+1.75	N6	
LEFT EYE	+0.00			6/6 (0.00)	+1.75	N6	
Right Eye							
Lids	Normal						
Conjunctiva	Normal						
Cornea	Normal						
Sclera	Normal						
Iris	Normal						
Lens Status	Clear,						
Left Eye							
Lids	Normal						
Conjunctiva	Normal						
Cornea	Normal						
Sclera	Normal						
Iris	Normal						
Lens Status	Clear,						
Right Eye							
Disc	Normal						
Left Eye							
Disc	Normal						

Glass Prescription Report: Glasses were Prescribed

Diagnosis

EYE DESCRIPTION

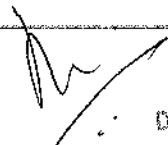
Both Eyes Presbyopia - H52.4

Follow Up/Action Plan

GLASSES FOR NEAR WORK R.W FOR DILATED FUNDUS EXAMINATION FOR DIABETIC RETINOPATHY SCREENING

For queries, get in touch with your doctor or to fix up an appointment please use following contact details :

Address Chaithanya Eye Hospital
KOLLAM



Dr. HARIKRISHNAN. CP MBBS, MS (Ophthalmology)
 Consultant Phaco Surgeon
 Reg. No. 47049
 Chaithanya Eye Hospital & Research Institute
 Prathiba Junction, Kollappakkada
 Kollam - 691003



From,

JOSE ANTONY.

AKKAL HOUSE.

CHAVARA BPO.


KOLLAM - 691583.

To,

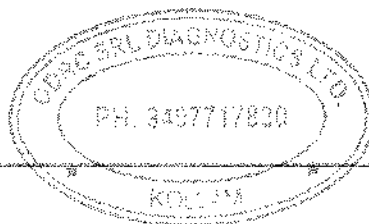
Mediwheel

Dear Sir,

Kindly take into notice that ~~we~~ ^I have not done ~~any~~ testing for urine and stool testing for fasting and also renal check up is also not done.

Yours faithfully


(JOSE ANTONY.)



DDRC Hospital

MR. JOSE A (48 M)

ID: 2113

Date: 28-Jan-23

Exec Time : 10 m 3 s Stage Time : 1 m 0 s

HR: 133 bpm

Protocol: Bruce

Stage: Recovery(1)

Speed: 0 mph

Grade: 0 %

(THR: 154 bpm)

B.P: 150 / 80

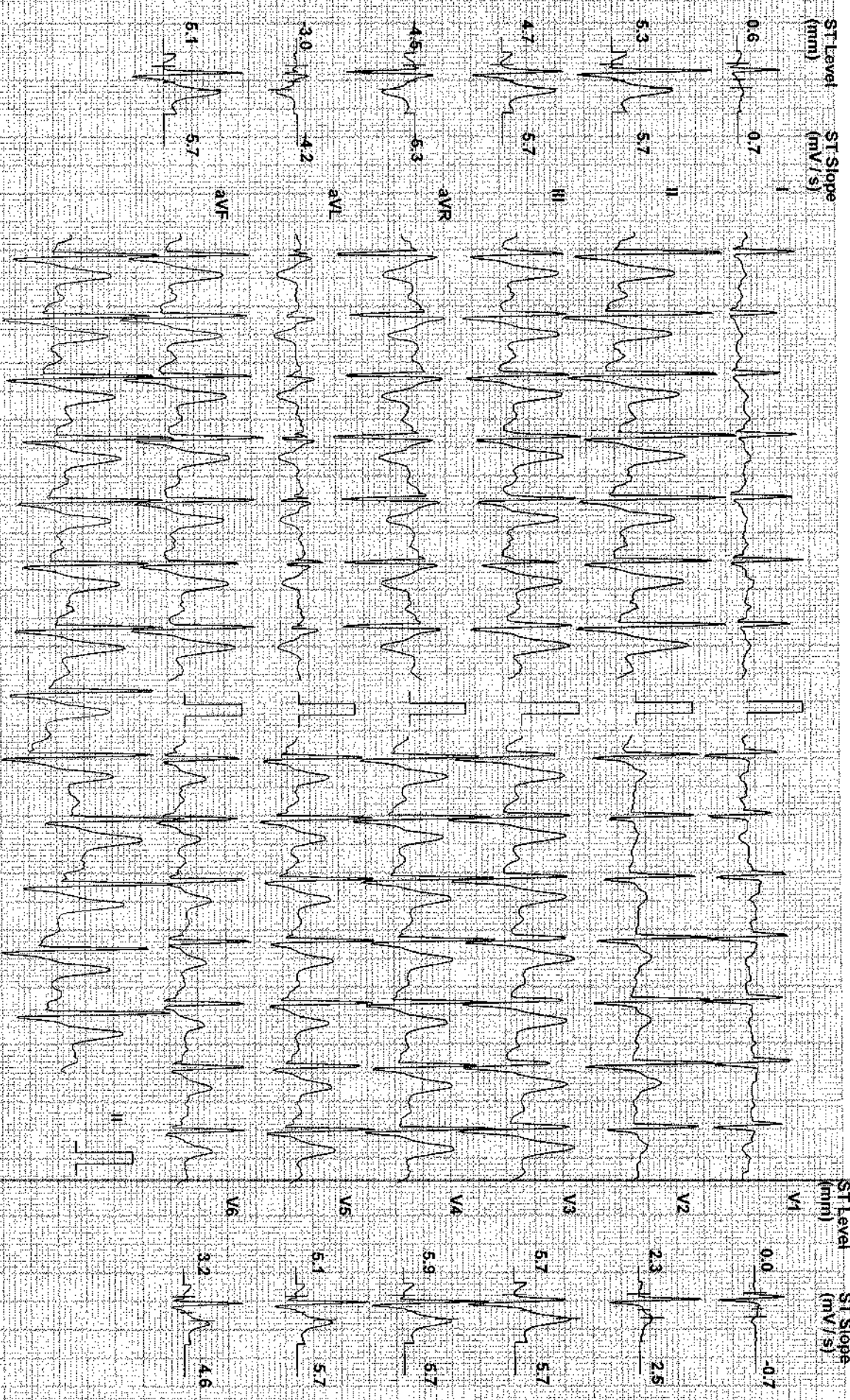


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

150 - R - 60 ms

J - R - 60 ms

Post J - 1 * 60 ms

Shimizu-Spedfan V447

DDR Hospital

MR. JOSE A (48 M)

ID: 2113

Date: 28-Jan-23

Exec Time : 10 m 3 s Stage Time : 1 m 0 s

HR: 112 bpm

Protocol: Bruce

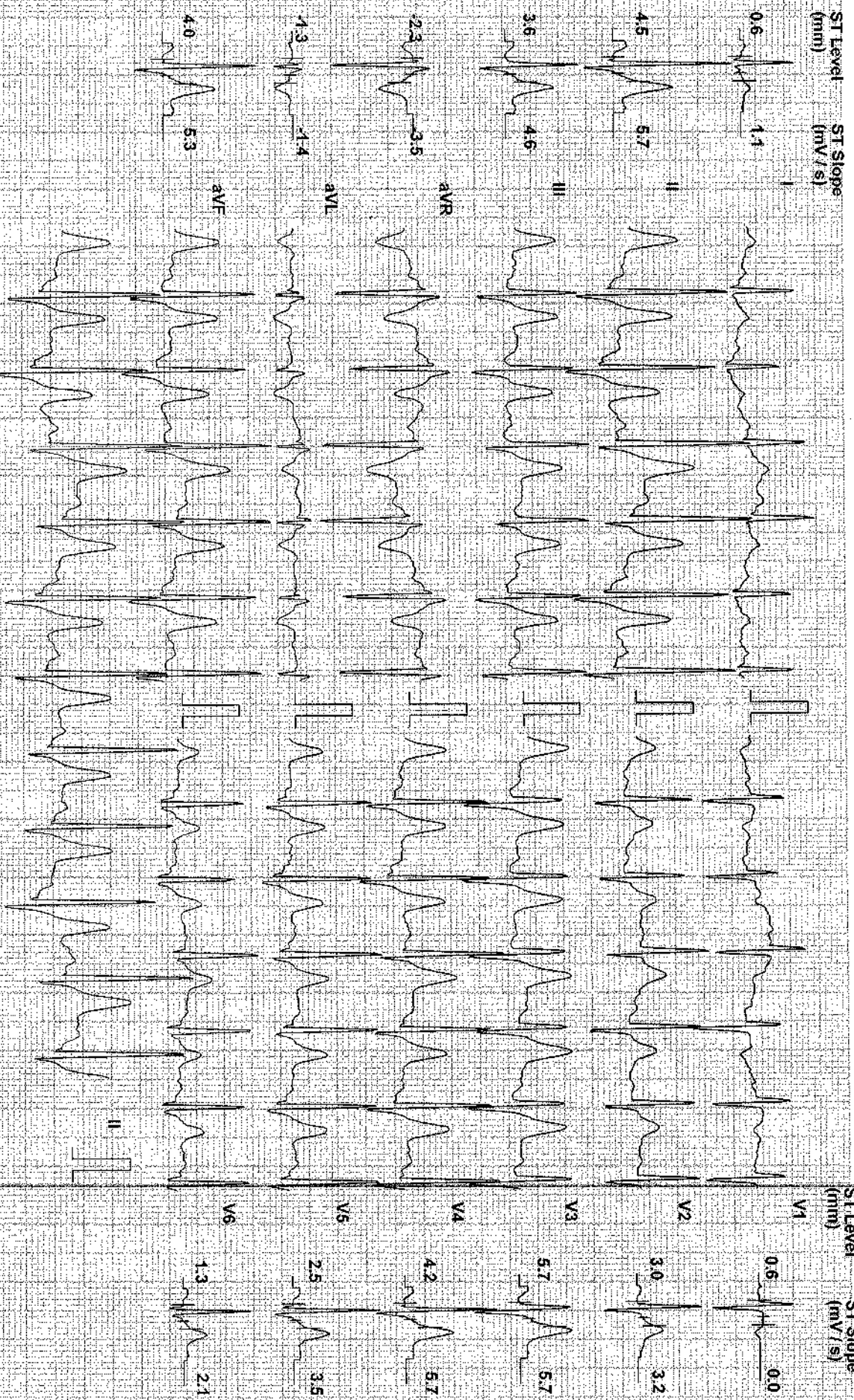
Stage: Recovery(2)

Speed: 0 mph

Grade: 0 %

(THR: 154 bpm)

B.P: 150 / 80



MR. JOSE A (48 M)

ID: 2113

Date: 28-Jan-23

Exec Time : 10 m 3 s Stage Time : 1 m 0 s

HR: 107 bpm

Protocol: Bruce

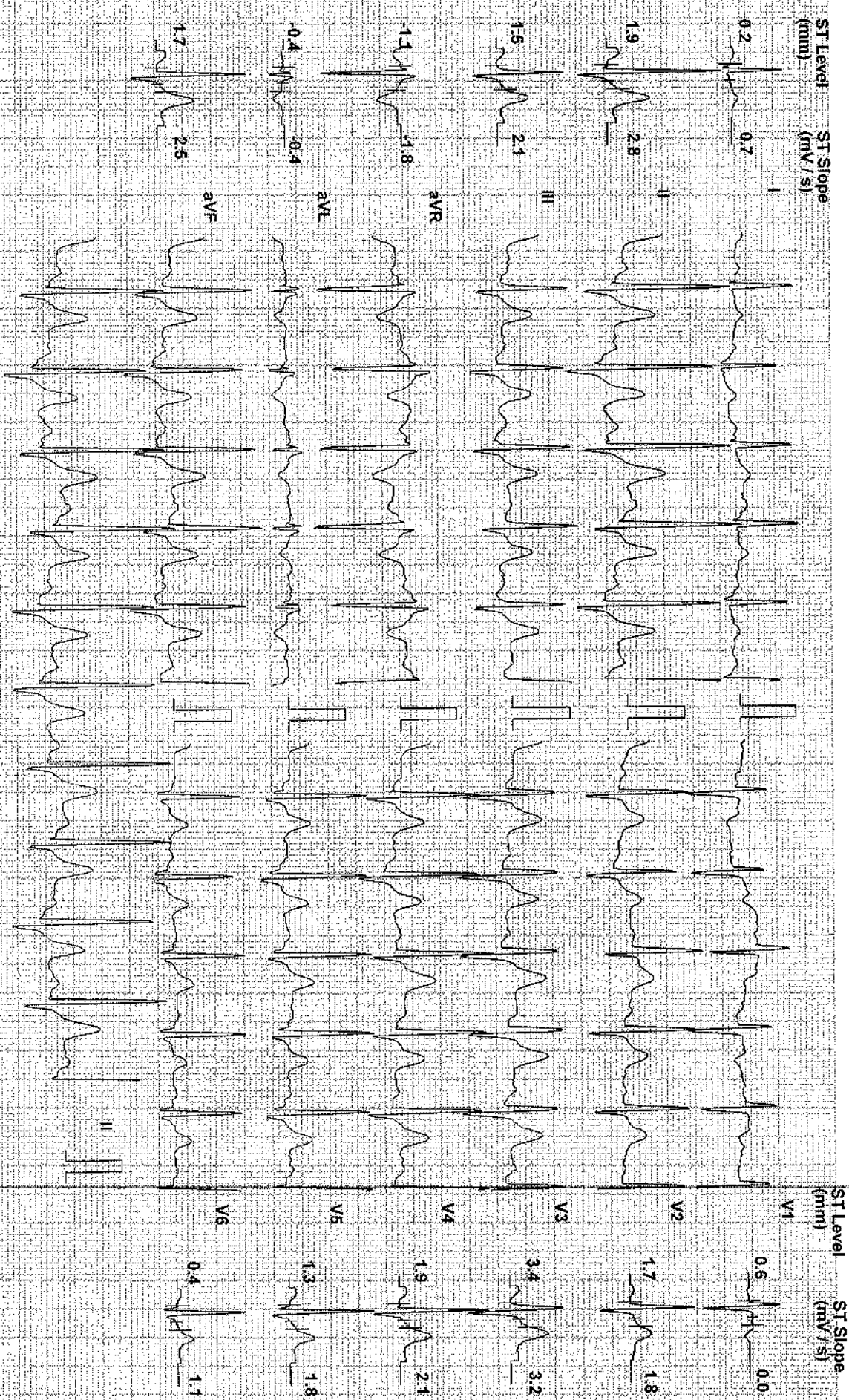
Stage: Recovery(3)

Speed: 0 mph

Grade: 0 %

(THR: 154 bpm)

B.P: 150 / 80



DDRC Hospital

MR JOSEA A (48 M)

ID: 2113

Date: 28-Jan-23

Exec Time : 10 m 3 s Stage Time : 1 m 0 s

HR: 101 bpm

Protocol: Bruce

Stage: Recovery(4)

Speed: 0 mph

Grade: 0 %

(THR: 154 bpm)

B.P: 150 / 80

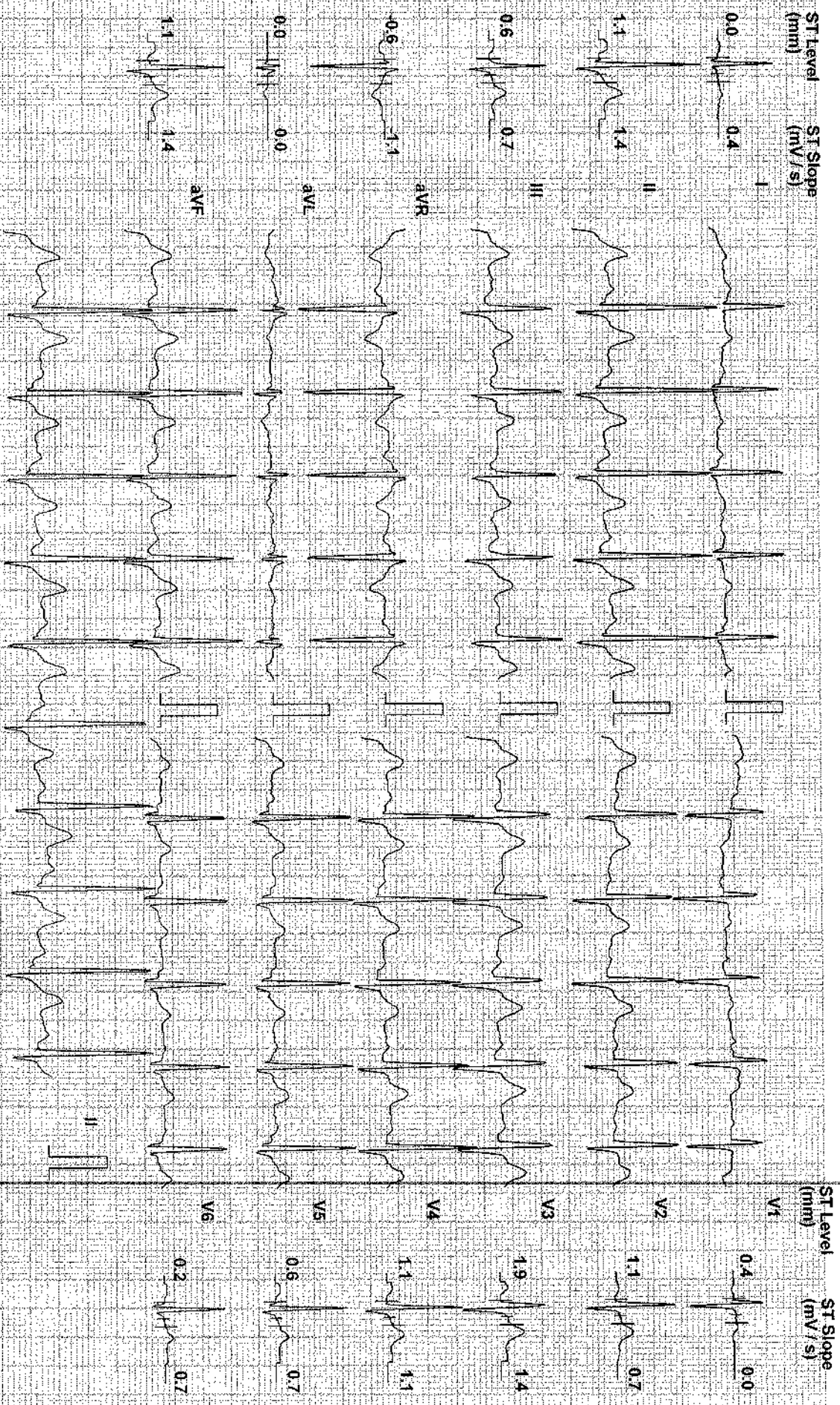


Chart Speed: 25 mm/sec
Schiller Standard V.4.7

Filter: 35 Hz

Mains Fil: ON

Amp: 10 mm

ISO - R: 60ms

J - R: 60ms

Positive: J + 60ms

DDRC Hospital

MR. JOSEA (48 M)

ID: 2113

Date: 28-Jan-23

Exec Time : 10 m 3 s Stage Time : 1 m 0 s

HR: 102 bpm

Protocol: Bruce

Stage: Recovery(5)

Speed: 0 mph

Grade: 0 %

(THR: 154 bpm)

B.P: 150 / 80

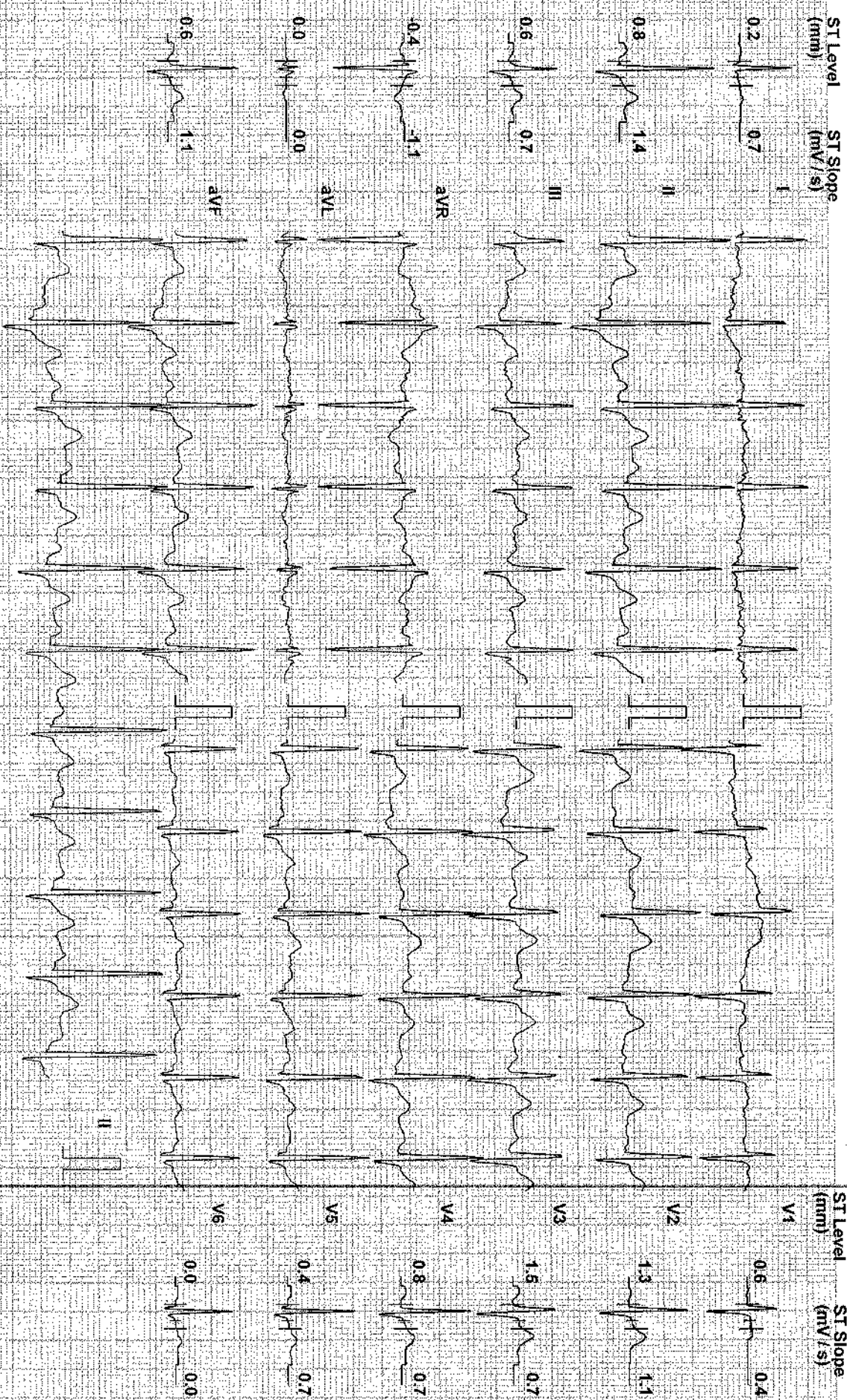


Chart Speed: 25 mm/sec
Schiller Spardar V 4.7

Filter: 35 Hz

Main's Filter: ON

Amp: 10 mm

ISO = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

DDRC Hospital

Patient Details

Date: 28-Jan-23

Time: 12:10:19 PM

Name: MR JOSE A ID: 2113

Age: 48 y

Sex: M

Height: 172 cms

Weight: 85 Kgs

Clinical History: ROUTINE CHECK UP

Medications: MEDICINE TAKEN FOR DIABETES

Test Details

Protocol: Bruce

Pr.MHR: 172 bpm

THR: 154 (90% of Pr.MHR) bpm

Total Exec. Time: 10 m 3 s

Max. HR: 173 (101% of Pr.MHR) bpm

Max. Mets: 13.50

Max. BP: 150/80 mmHg

Max. BP x HR: 25950 mmHg/min

Min. BP x HR: 5280 mmHg/min

Test Termination Criteria: TARGET HR ATTAINED

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 28	1.0	0	0	66	115/80	-0.42 aVR	1.77 II
Standing	0 12	1.0	0	0	69	115/80	-0.42 aVR	1.42 II
Hyperventilation	0 6	1.0	0	0	68	115/80	-0.42 aVR	1.06 II
1	3 0	4.6	1.7	10	132	115/80	-1.70 aVR	5.66 II
2	3 0	7.0	2.5	12	158	115/80	-1.49 aVR	5.66 II
3	3 0	10.2	3.4	14	169	115/80	-2.34 aVR	5.66 II
Peak EX	1 3	13.5	4.2	16	173	115/80	-2.34 aVR	5.66 II
Recovery(1)	1 0	1.8	1	0	133	150/80	-4.67 aVR	5.66 II
Recovery(2)	1 0	1.0	0	0	112	150/80	-4.46 aVR	5.66 II
Recovery(3)	1 0	1.0	0	0	107	150/80	-2.34 aVR	5.66 II
Recovery(4)	1 0	1.0	0	0	101	150/80	-1.06 aVR	3.18 V3
Recovery(5)	1 0	1.0	0	0	102	150/80	-0.64 aVR	1.77 II
Recovery(6)	0 45	1.0	0	0	103	150/80	-0.42 aVR	1.77 II

DDRC Hospital

Patient Details

Date: 28-Jan-23

Time: 12:10:19 PM

Name: MR JOSE A ID: 2113

Age: 48 y

Sex: M

Height: 172 cms

Weight: 85 Kgs

Interpretation

The Patient exercised according to the Bruce Protocol for 10 m 03 s achieving a work level of
Maximum Mets: 13.50 Resting heart rate initially 66 bpm. Rose to a maximum heart rate
173(101% of PR. MHR)/bpm Resting Blood pressure: 115/80 mmHg. Rose to maximum blood
pressure of 150/80 mmHg

No angina, arrhythmia, significant ST changes, signs of
LV dysfunction during exercise or at recovery.

ECG negative for provocative myocardial ischemia



Dr. Joseph A. ...
DDRC Hospital
1111 ...
...

Ref Doctor

Doctor SSN

ru0
CHEST-PA

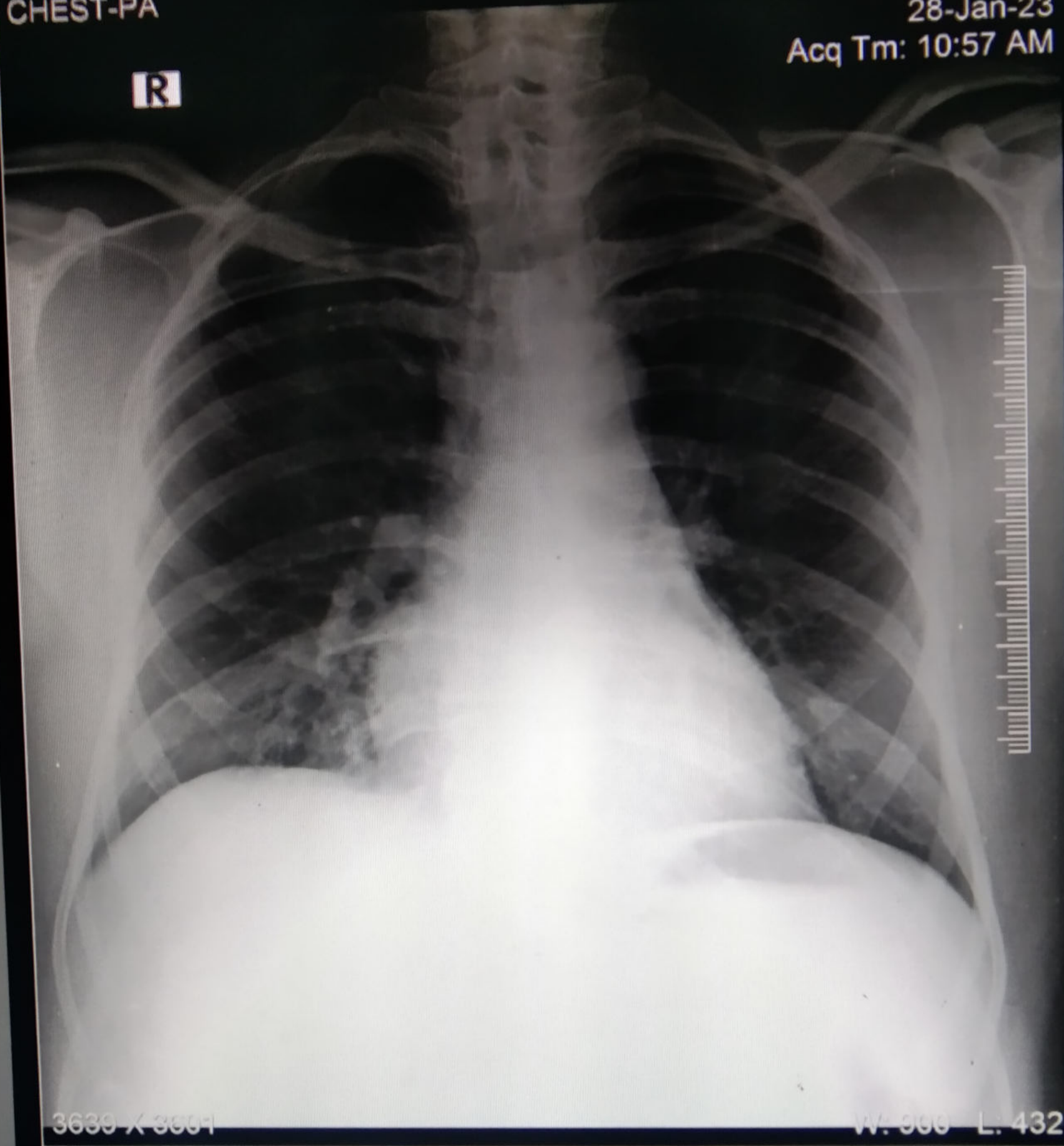
DDRC SRL DIAGNOSTIC (P) LTD, KADAPPAKADA, KOLLAM

JOSE A 48Y

28-Jan-23

Acq Tm: 10:57 AM

R



3639 X 3601

W: 900 L: 432

JOSE A 48Y M CHEST-PA 28-Jan-23 10:56 AM

DDRC SRL DIAGNOSTIC (P) LTD, KADAPPAKADA, KOLLAM