

PATIENT NAME : NAZARE MAHESH VIJAY**REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000138362

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

F-703, LADO SARAI, MEHRAULISOUTH WEST
DELHI

NEW DELHI 110030

8800465156

ACCESSION NO : **0030WC005596**

PATIENT ID : NAZAM11127330

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX :49 Years Male

DRAWN :

RECEIVED : 25/03/2023 08:32:20

REPORTED : 27/03/2023 15:43:05

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**XRAY-CHEST**

IMPRESSION

NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO

TMT IS POSITIVE

ECG

ECG

BRDYCARDIA AND REST WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY

NOT SIGNIFICANT

RELEVANT PAST HISTORY

H/O LIPOMA OPERATED LAST YEAR

RELEVANT PERSONAL HISTORY

NOT SIGNIFICANT

RELEVANT FAMILY HISTORY

HEART DISEASE.

OCCUPATIONAL HISTORY

NOT SIGNIFICANT

HISTORY OF MEDICATIONS

NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS

1.74

mts

WEIGHT IN KGS.

78

Kgs

BMI

26

BMI & Weight Status as follows/sqmts

Below 18.5: Underweight

18.5 - 24.9: Normal

25.0 - 29.9: Overweight

30.0 and Above: Obese

GENERAL EXAMINATION

MENTAL / EMOTIONAL STATE

NORMAL

PHYSICAL ATTITUDE

NORMAL

GENERAL APPEARANCE / NUTRITIONAL
STATUS

HEALTHY

BUILT / SKELETAL FRAMEWORK

AVERAGE

FACIAL APPEARANCE

NORMAL

SKIN

NORMAL

UPPER LIMB

NORMAL

LOWER LIMB

NORMAL

NECK

NORMAL

NECK LYMPHATICS / SALIVARY GLANDS

NOT ENLARGED OR TENDER


Dr. Swati Pravin Mulani
Lab Head

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Tel : 9111591115, Fax : 020 30251212

CIN - U74899PB1995PLC045956

Email : customercare.pune@srl.in



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THYROID GLAND	NOT ENLARGED			
CAROTID PULSATION	NORMAL			
TEMPERATURE	NORMAL			
PULSE	50/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT			
RESPIRATORY RATE	NORMAL			
CARDIOVASCULAR SYSTEM				
BP	100/70 MM HG (SITTING)			mm/Hg
PERICARDIUM	NORMAL			
APEX BEAT	NORMAL			
HEART SOUNDS	S1, S2 HEARD NORMALLY			
MURMURS	ABSENT			
RESPIRATORY SYSTEM				
SIZE AND SHAPE OF CHEST	NORMAL			
MOVEMENTS OF CHEST	SYMMETRICAL			
BREATH SOUNDS INTENSITY	NORMAL			
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)			
ADDED SOUNDS	ABSENT			
PER ABDOMEN				
APPEARANCE	NORMAL			
VENOUS PROMINENCE	ABSENT			
LIVER	NOT PALPABLE			
SPLEEN	NOT PALPABLE			
HERNIA	ABSENT			
CENTRAL NERVOUS SYSTEM				
HIGHER FUNCTIONS	NORMAL			
CRANIAL NERVES	NORMAL			
CEREBELLAR FUNCTIONS	NORMAL			
SENSORY SYSTEM	NORMAL			
MOTOR SYSTEM	NORMAL			
REFLEXES	NORMAL			
MUSCULOSKELETAL SYSTEM				



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SPINE

NORMAL

JOINTS

NORMAL

BASIC EYE EXAMINATION

CONJUNCTIVA

NORMAL

EYELIDS

NORMAL

EYE MOVEMENTS

NORMAL

CORNEA

NORMAL

DISTANT VISION RIGHT EYE WITH GLASSES

DISTANT VISION - 6/6 (NORMAL)

DISTANT VISION LEFT EYE WITH GLASSES

DISTANT VISION - 6/6 (NORMAL)

NEAR VISION RIGHT EYE WITH GLASSES

NEAR VISION - N 6 (NORMAL)

NEAR VISION LEFT EYE WITH GLASSES

NEAR VISION - N 6 (NORMAL)

COLOUR VISION

NORMAL

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL

NORMAL

TYMPANIC MEMBRANE

NORMAL

NOSE

NO ABNORMALITY DETECTED

SINUSES

NORMAL

THROAT

NO ABNORMALITY DETECTED

TONSILS

NOT ENLARGED

SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

HDL CHOLESTEROL LOW (35 mg/dL)

TSH RAISED - 5.040 µIU/mL

RELEVANT NON PATHOLOGY DIAGNOSTICS

NO ABNORMALITIES DETECTED

REMARKS / RECOMMENDATIONS

ADV. INCREASE UNSATURATED FATS IN DIET
 FOLLOW UP WITH FAMILY PHYSICIAN / SRL DR.
 FOLLOW UP WITH ENDOCRINOLOGIST
 MONITOR PULSE RATE WITH FAMILY PHYSICIAN
 FOLLOW UP WITH CARDIOLOGIST.

FITNESS STATUS

FITNESS STATUS

FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)



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Comments

OUR DOCTORS ON PANEL FOR NON-PATHOLOGICAL REPORTS:

1. DR. JIGNESH PARIKH: DNB (CARDIOLOGY), N.B.E (CONSULTANT CARDIOLOGIST)
2. DR.SANJAY JOSHI, D M R D, DNB - RADIOLOGIST
3. DR. SUCHARITA PARANJPE, MBBS, FCPS (OPHTHALMOLOGY)
4. DR. (MRS.) MANJUSHA PRABHUNE - GYNAECOLOGIST.
5. DR. (MRS.) NIMKAR - GYNAECOLOGIST.

This report bears the signature of the in-charge of the facility.
Panel doctors are responsible for the results/reports of their individual specialty.



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MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

Interpretation(s)

MEDICAL HISTORY: ***** THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS. *****

FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for. These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) - SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre-employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
- Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
- Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.2	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.06	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : ELECTRICAL IMPEDANCE	7.70	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	203	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED	44.0	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED	87.0	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED	30.1	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED	34.6 High	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED	12.4	11.6 - 14.0	%
MENTZER INDEX	17.2		
MEAN PLATELET VOLUME (MPV) METHOD : CELL COUNTER (CALCULATED)	8.7	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	57	40 - 80	%
LYMPHOCYTES METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	33	20 - 40	%
MONOCYTES	8	2 - 10	%
EOSINOPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	2	1 - 6	%
BASOPHILS METHOD : ELECTRICAL IMPEDANCE/MICROSCOPY	0	0 - 2	%



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ABSOLUTE NEUTROPHIL COUNT

4.39

2.0 - 7.0

thou/ μ L

METHOD : CALCULATED

ABSOLUTE LYMPHOCYTE COUNT

2.54

1.0 - 3.0

thou/ μ L

METHOD : CALCULATED

ABSOLUTE MONOCYTE COUNT

0.62

0.2 - 1.0

thou/ μ L

METHOD : CALCULATED

ABSOLUTE EOSINOPHIL COUNT

0.15

0.02 - 0.50

thou/ μ L

METHOD : CALCULATED

ABSOLUTE BASOPHIL COUNT

0.00 Low

0.02 - 0.10

thou/ μ L

METHOD : CALCULATED

NEUTROPHIL LYMPHOCYTE RATIO (NLR)

1.7

METHOD : CALCULATED

MORPHOLOGY**REMARKS**

RBCS: PREDOMINANTLY NORMOCYTIC NORMOCHROMIC.

WBCS: WBCS ARE NORMAL IN NUMBER & MORPHOLOGY.

PLATELETS: ADEQUATE ON PERIPHERAL SMEAR.

Interpretation(s)

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

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

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

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

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



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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R	5	0 - 14	mm at 1 hr
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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 Issue injury, Pregnancy, Estrogen medication, Aging.

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

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

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

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

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

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

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

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.0	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	96.8	< 116.0	mg/dL
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GLUCOSE FASTING,FLUORIDE PLASMA FBS (FASTING BLOOD SUGAR)

FBS (FASTING BLOOD SUGAR)	97	74 - 99	mg/dL
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METHOD : HEXOKINASE

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	116	Normal: < 140, Impaired Glucose Tolerance: 140-199 Diabetic > or = 200	mg/dL
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METHOD : HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	154	Desirable: <200 BorderlineHigh : 200-239 High : > or = 240	mg/dL
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TRIGLYCERIDES	113	Desirable: < 150 Borderline High: 150 - 199 High: 200 - 499 Very High : > or = 500	mg/dL
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METHOD : ENZYMATIC WITH GLYCEROL BLANK

HDL CHOLESTEROL	35 Low	< 40 Low > or = 60 High	mg/dL
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METHOD : DIRECT MEASURE - PEG

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 MAHARASHTRA, INDIA
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 CIN - U74899PB1995PLC045956
 Email : customercare.pune@srl.in



Patient Ref. No. 775000002710915

PATIENT NAME : NAZARE MAHESH VIJAY

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000138362
 ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULISOUTH WEST
 DELHI
 NEW DELHI 110030
 8800465156

ACCESSION NO : **0030WC005596**
 PATIENT ID : NAZAM11127330
 CLIENT PATIENT ID:
 ABHA NO :


AGE/SEX : 49 Years Male
 DRAWN :
 RECEIVED : 25/03/2023 08:32:20
 REPORTED : 27/03/2023 15:43:05

Test Report Status	Final	Results	Biological Reference Interval	Units
CHOLESTEROL LDL		96	Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL		119	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 CHOL/HDL RATIO		22.6 4.4		mg/dL
LDL/HDL RATIO		2.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.65	0.0 - 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.20	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.45	0.00 - 1.00	mg/dL
TOTAL PROTEIN METHOD : BIURET, REAGENT BLANK, END POINT	6.7	6.4 - 8.3	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN (BCG)	4.4	3.50 - 5.20	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.3	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.9	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	17	UPTO 40	U/L



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 Lab Head



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ALANINE AMINOTRANSFERASE (ALT/SGPT)	16	UP TO 45	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	56	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL-3-CARBOXY-4-NITROANALIDE (IFCC)	22	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	202	135 - 225	U/L
BLOOD UREA NITROGEN (BUN), SERUM			
BLOOD UREA NITROGEN METHOD : UREASE COLORIMETRIC	9	6 - 20	mg/dL
CREATININE, SERUM			
CREATININE METHOD : JAFFE'S ALKALINE PICRATE -IFCC IDMS STANDARDIZED	1.16	0.70 - 1.20	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	7.76	5.0 - 15.0	
URIC ACID, SERUM			
URIC ACID METHOD : URICASE, COLORIMETRIC	4.6	3.5 - 7.2	mg/dL
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET, REAGENT BLANK, END POINT	6.7	6.4 - 8.3	g/dL
ALBUMIN, SERUM			
ALBUMIN METHOD : BROMOCRESOL GREEN (BCG)	4.4	3.5 - 5.2	g/dL
GLOBULIN			
GLOBULIN METHOD : CALCULATED PARAMETER	2.3	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM, SERUM METHOD : ISE INDIRECT	142	137 - 145	mmol/L
POTASSIUM, SERUM METHOD : ISE INDIRECT	4.30	3.6 - 5.0	mmol/L
CHLORIDE, SERUM METHOD : ISE INDIRECT	107	98 - 107	mmol/L

Interpretation(s)



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Sodium	Potassium	Chloride
Decreased in: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, anti depressants (SSRI), antipsychotics.	Decreased in: Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.	Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.
Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.	Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.	Increased in: Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO ₃ -), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.
Interferences: Severe lipemia or hyperproteinemia, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.	Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.	Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)

Interpretation(s)

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

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

HbA1c Estimation can get affected due to :

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is

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recommended for detecting a hemoglobinopathy
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; sulfonureas, 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.

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

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. Issues 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 Hypophosphatasia, 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.

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

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
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic

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Dr. Swati Pravin Mulani
 Lab Head



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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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Test Report Status **Final**

Results

Biological Reference Interval Units

CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

PHYSICAL EXAMINATION, URINE

COLOR	PALE YELLOW
APPEARANCE	CLEAR

METHOD : DIPSTICK, MICROSCOPY

CHEMICAL EXAMINATION, URINE

PH	7.0	4.7 - 7.5
SPECIFIC GRAVITY	<= 1.005	1.003 - 1.035
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NOT DETECTED
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NOT DETECTED
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NORMAL	NORMAL
NITRITE	NOT DETECTED	NOT DETECTED

METHOD : DIPSTICK

MICROSCOPIC EXAMINATION, URINE

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

METHOD : MICROSCOPIC EXAMINATION

METHOD : MICROSCOPIC EXAMINATION

METHOD : MICROSCOPIC EXAMINATION

METHOD : MICROSCOPIC EXAMINATION

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METHOD : MICROSCOPIC EXAMINATION

BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

REMARKS

URINE ANALYSIS : MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

Interpretation(s)

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

THYROID PANEL, SERUM

T3 <small>METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA)</small>	84.41	58 - 159	ng/dL
T4 <small>METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA)</small>	7.43	4.87 - 11.71	µg/dL
TSH (ULTRASENSITIVE) <small>METHOD : CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY (CMIA)</small>	5.040 High	0.350 - 4.940	µIU/mL

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, Free T4 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



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CODE/NAME & ADDRESS : C000138362

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI

NEW DELHI 110030

8800465156

ACCESSION NO : 0030WC005596

PATIENT ID : NAZAM11127330

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX :49 Years Male

DRAWN :

RECEIVED : 25/03/2023 08:32:20

REPORTED : 27/03/2023 15:43:05

Test Report Status	Final	Results	Biological Reference Interval	Units
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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.Guidlines 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.

****End Of Report****Please visit www.srlworld.com for related Test Information for this accession**CONDITIONS OF LABORATORY TESTING & REPORTING**

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 SRL 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. SRL 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.

SRL LimitedFortis Hospital, Sector 62, Phase VIII,
Mohali 160062

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Dr.Swati Pravin Mulani
Lab Head



View Details



View Report

PERFORMED AT :

SRL Ltd
Ground floor 365/6, Aaj Ka Aanand building, Shivaji Nagar
PUNE, 411005
MAHARASHTRA, INDIA
Tel : 9111591115, Fax : 020 30251212
CIN - U74899PB1995PLC045956
Email : customercare.pune@srl.in



Patient Ref. No. 775000002710915