



**BMI CHART**

Date 10/06/23

Name: Mrs. Sarajit Day Age: 40 yrs Sex: M/F  
BP: 140/80 mm/Hg Height (cms): 178 cm Weight(kgs): 91.9 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	45.4	47.7	50.0	52.3	54.6	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	
	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'0" - 152.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40		
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40		
5'2" - 157.4	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40		
5'3" - 160.0	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	
5'4" - 162.5	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	
5'5" - 165.1	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
5'6" - 167.6	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
5'7" - 170.1	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
5'8" - 172.7	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
5'9" - 176.2	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
5'10" - 177.8	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
5'11" - 180.3	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
6'0" - 182.8	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
6'1" - 185.4	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37
6'2" - 187.9	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
6'3" - 190.5	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
6'4" - 193.0	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36

Doctors Notes:

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UHID	12521224	Date	10/06/2023		
Name	Mr. Surajit Dey	Sex	Male	Age	40
OPD	Opthal 14	Health Check Up			

Drug allergy: → Not known  
 Sys illness: → No  
Habit → No

Cls. Bln Vision.

Yrs. NO

U-M → R → 6/60  
 → L → 6/60 (Bln) (Same as P.U.P.)

R → R → -4.50 / -0.75 x 20° 6/6  
 → L → -5.25 / -1.00 x 180° 6/6.

F.O.P. → R → 15.2  
 → L → 15.1.

All up

C.V.S  
 20/20rh  
 +  
 20mi / 30mi.  
 ↓  
 20sc / 30sc  
 (miff)



UHID	12521224	Date	10/06/2023
Name	Mr. Surajit Dey	Sex	Male Age 40
OPD	Dental 12 - 7387696540	Health Check Up	

Drug allergy:  
Sys illness:

localised periodontitis  $\frac{6}{7}$

Anterior deep bite with attrition.

stains ++ calculus ++

Treatment

Adv. OP  $\frac{6}{7}$

Adv. Laser flap surgery  $\frac{6}{7}$

Adv. Oral prophylaxis

Adv. orthodontic treatment.

Rx

① Metrogyl (400mg)

1 — 0 — 1.

② Zerodal SR

1 — 0 — 1.

} 3 days.

~~Plated~~



# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

AGE : 40 Years SEX : Male

ABHA NO :

DRAWN : 10/06/2023 10:30:00

RECEIVED : 10/06/2023 10:29:58

REPORTED : 10/06/2023 17:08:47

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:12521224 REQNO-1533446  
CORP-OPD  
BILLNO-150123OPCR032643  
BILLNO-150123OPCR032643

Test Report Status	Results	Biological Reference Interval	Units
<b>Final</b>			

**HAEMATOLOGY - CBC**

**CBC-5, EDTA WHOLE BLOOD**

**MORPHOLOGY**

RBC

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE

**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN (HB)

METHOD : SPECTROPHOTOMETRY

15.5

13.0 - 17.0

g/dL

RED BLOOD CELL (RBC) COUNT

METHOD : ELECTRICAL IMPEDANCE

5.48

4.5 - 5.5

mil/ $\mu$ L

WHITE BLOOD CELL (WBC) COUNT

METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY

6.32

4.0 - 10.0

thou/ $\mu$ L

PLATELET COUNT

METHOD : ELECTRICAL IMPEDANCE

168

150 - 410

thou/ $\mu$ L

**RBC AND PLATELET INDICES**

HEMATOCRIT (PCV)

METHOD : CALCULATED PARAMETER

44.8

40 - 50

%

MEAN CORPUSCULAR VOLUME (MCV)

METHOD : CALCULATED PARAMETER

**81.8**

Low 83 - 101

fL

MEAN CORPUSCULAR HEMOGLOBIN (MCH)

METHOD : CALCULATED PARAMETER

28.2

27.0 - 32.0

pg

MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)

METHOD : CALCULATED PARAMETER

34.5

31.5 - 34.5

g/dL

RED CELL DISTRIBUTION WIDTH (RDW)

METHOD : CALCULATED PARAMETER

13.9

11.6 - 14.0

%

MENTZER INDEX

METHOD : CALCULATED PARAMETER

14.9

High 6.8 - 10.9

fL

MEAN PLATELET VOLUME (MPV)

METHOD : CALCULATED PARAMETER

**11.0**

40 - 80

%

**WBC DIFFERENTIAL COUNT**

NEUTROPHILS

53

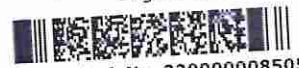
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# LABORATORY REPORT

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METHOD : FLOWCYTOMETRY			
LYMPHOCYTES		33	20 - 40 %
METHOD : FLOWCYTOMETRY			
MONOCYTES		8	2 - 10 %
METHOD : FLOWCYTOMETRY			
EOSINOPHILS		6	1 - 6 %
METHOD : FLOWCYTOMETRY			
BASOPHILS		0	0 - 2 %
METHOD : FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT		3.35	2.0 - 7.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT		2.09	1.0 - 3.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT		0.51	0.2 - 1.0 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT		0.38	0.02 - 0.50 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10 thou/ $\mu$ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6	
METHOD : CALCULATED PARAMETER			

**Interpretation(s)**

RBC AND PLATELET INDICES-Mentzer Index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia (>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

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

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504)

This ratio element is a calculated parameter and out of NABL scope.

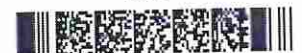
**Agilus Diagnostics Ltd (Formerly SRL Ltd)**  
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Maharashtra, India  
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Patient Ref. No. **22000000850557**

# LABORATORY REPORT



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PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

AGE : 40 Years

SEX : Male

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UID:12521224 REQNO-1533446

CORP-OPD

BILLNO-150123OPCR032643

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Test Report Status	Final	Results	Biological Reference Interval
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**HAEMATOLOGY**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

E.S.R 17 High 0 - 14 mm at 1 hr

METHOD : WESTERGRÉN 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(52 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. AACCC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

**IMMUNOHAEMATOLOGY**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP TYPE B

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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Patient Ref. No. 22000000850557



# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

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**BIOCHEMISTRY**

**KIDNEY PANEL - 1**

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	13	6 - 20	mg/dL
<small>METHOD : UREASE - UV</small>			

**CREATININE EGFR- EPI**

CREATININE	1.15	0.90 - 1.30	mg/dL
<small>METHOD : ALKALINE PICRATE KINETIC JAFFES</small>			

AGE	40		years
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GLOMERULAR FILTRATION RATE (MALE)	82.51	Refer Interpretation Below	mL/min/1.73m2
<small>METHOD : CALCULATED PARAMETER</small>			

**BUN/CREAT RATIO**

BUN/CREAT RATIO	11.30	5.00 - 15.00	
<small>METHOD : CALCULATED PARAMETER</small>			

**URIC ACID, SERUM**

URIC ACID	5.8	3.5 - 7.2	mg/dL
<small>METHOD : URICASE UV</small>			

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	7.6	6.4 - 8.2	g/dL
<small>METHOD : BIURET</small>			

**ALBUMIN, SERUM**

ALBUMIN	4.2	3.4 - 5.0	g/dL
<small>METHOD : BCP DYE BINDING</small>			

**GLOBULIN**

GLOBULIN	3.4	2.0 - 4.1	g/dL
<small>METHOD : CALCULATED PARAMETER</small>			

**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	<b>1.31</b>	High 0.2 - 1.0	mg/dL
<small>METHOD : JENDRASSIK AND GROFF</small>			

BILIRUBIN, DIRECT	<b>0.23</b>	High 0.0 - 0.2	mg/dL
<small>METHOD : JENDRASSIK AND GROFF</small>			

BILIRUBIN, INDIRECT	<b>1.08</b>	High 0.1 - 1.0	mg/dL
<small>METHOD : CALCULATED PARAMETER</small>			

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**Patient Ref. No. 22000000850552**

# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

AGE : 40 Years

SEX : Male

ABHA NO :

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

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**CLINICAL INFORMATION :**

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CORP-OPD

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Test Report Status	Final	Results	Biological Reference Interval
TOTAL PROTEIN		7.6	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		4.2	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.4	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.2	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)		29	15 - 37 U/L
METHOD : UV WITH PSP			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		<b>46</b>	High < 45.0 U/L
METHOD : UV WITH PSP			
ALKALINE PHOSPHATASE		87	30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		23	15 - 85 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE		158	100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
<b>KIDNEY PANEL - 1</b>			
<b>ELECTROLYTES (NA/K/CL), SERUM</b>			
SODIUM, SERUM		138	136 - 145 mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM		4.88	3.50 - 5.10 mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM		103	98 - 107 mmol/L
METHOD : ISE INDIRECT			
<b>Interpretation(s)</b>			
<b>GLUCOSE FASTING, FLUORIDE PLASMA</b>			
FBS (FASTING BLOOD SUGAR)		<b>105</b>	High Normal : < 100 mg/dL Pre-diabetes: 100-125 Diabetes: >=126
METHOD : HEXOKINASE			

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Patient Ref. No. 2200000850557





PATIENT NAME : MR.SURAJIT DEY

PATIENT ID : FH.12521224

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**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	6.1	High	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
ESTIMATED AVERAGE GLUCOSE(EAG)	128.4	High	< 116.0	mg/dL

METHOD : HB VARIANT (HPLC)

METHOD : CALCULATED PARAMETER

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 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-is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma,Waldenstroms disease.

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

ALBUMIN, 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.

LIVER FUNCTION PROFILE, SERUM-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.

ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.

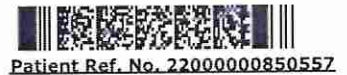
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Maharashtra, India  
Tel : 022-39199222,022-49723322,  
CIN - U74899PB1995PLC045956  
Email : -



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PATIENT NAME : MR.SURAJIT DEY

PATIENT ID : FH.12521224

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : 0022WF001798

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 10/06/2023 10:30:00

RECEIVED : 10/06/2023 10:29:58

REPORTED : 10/06/2023 17:08:47

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:12521224 REQNO-1533446

CORP-OPD

BILLNO-150123OPCR032643

BILLNO-150123OPCR032643

Test Report Status	Final	Results	Biological Reference Interval
--------------------	-------	---------	-------------------------------

**GGT** is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc.

**Total Protein** also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

**Albumin** is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in :** Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs: insulin, ethanol, propranolol, 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 Hypoglycemics & 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:

- 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 addition are reported to interfere with some assay methods, falsely increasing results.
- 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

**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	176	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
--------------------	-----	-------------------------------------------------------------	-------

METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE

TRIGLYCERIDES	88	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High	mg/dL
---------------	----	---------------------------------------------------------------------------------	-------

METHOD : ENZYMATIC ASSAY

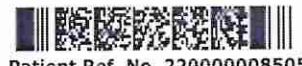
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CIN - U74899PB1995PLC045956  
Email : -



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Patient Ref. No. 2200000850557

# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224** CLIENT PATIENT ID : UID:12521224  
 ACCESSION NO : **0022WF001798** AGE : 40 Years SEX : Male ABHA NO :  
 DRAWN : 10/06/2023 10:30:00 RECEIVED : 10/06/2023 10:29:58 REPORTED : 10/06/2023 17:08:47  
 CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:12521224 REQNO-1533446  
 CORP-OPD  
 BILLNO-150123OPCR032643  
 BILLNO-150123OPCR032643

Test Report Status	Final	Results	Biological Reference Interval
HDL CHOLESTEROL		<b>37</b>	Low < 40 Low >/=60 High mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT		<b>120</b>	< 100 Optimal mg/dL 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT			
NON HDL CHOLESTEROL		<b>139</b>	High Desirable: Less than 130 mg/dL Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220
METHOD : CALCULATED PARAMETER			
VERY LOW DENSITY LIPOPROTEIN		<b>17.6</b>	</= 30.0 mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO		<b>4.8</b>	High 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		<b>3.2</b>	High 0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
METHOD : CALCULATED PARAMETER			

**Interpretation(s)**

**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

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Patient Ref. No. 2200000850557



# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798** AGE : 40 Years SEX : Male

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:12521224 REQNO-1533446

CORP-OPD

BILLNO-150123OPCR032643

BILLNO-150123OPCR032643

Test Report Status	Final	Results	Biological Reference Interval
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY		1.010	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, ROTHERA'S PRINCIPLE			
BLOOD		DETECTED (TRACE) IN URINE	
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			
<b>MICROSCOPIC EXAMINATION, URINE</b>			
RED BLOOD CELLS		<b>DETECTED (OCCASIONAL)</b>	NOT DETECTED /HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)		0-1	0-5 /HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS		0-1	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	

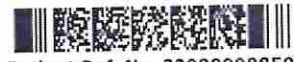
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Patient Ref. No. 22000000850557

**LABORATORY REPORT**



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 10/06/2023 10:30:00

RECEIVED : 10/06/2023 10:29:58

REPORTED : 10/06/2023 17:08:47

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:12521224 REQNO-1533446

CORP-OPD

BILLNO-150123OPCR032643

BILLNO-150123OPCR032643

Test Report Status	Final	Results	Biological Reference Interval
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**Interpretation(s)**

**SPECIALISED CHEMISTRY - HORMONE**

**THYROID PANEL, SERUM**

T3	134.2	80.0 - 200.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	10.81	5.10 - 14.10	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.550	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, SANDWICH IMMUNOASSAY			

**Interpretation(s)**

**SPECIALISED CHEMISTRY - TUMOR MARKER**

**PROSTATE SPECIFIC ANTIGEN, SERUM**

PROSTATE SPECIFIC ANTIGEN	0.177	0.0 - 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

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# LABORATORY REPORT



**PATIENT NAME : MR.SURAJIT DEY**

PATIENT ID : **FH.12521224**

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : **0022WF001798**

AGE : 40 Years

SEX : Male

ABHA NO :

DRAWN : 10/06/2023 10:30:00

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REPORTED : 10/06/2023 17:08:47

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

**CLINICAL INFORMATION :**

UID:12521224 REQNO-1533446

CORP-OPD

BILLNO-150123OPCR032643

BILLNO-150123OPCR032643

Test Report Status	Results	Biological Reference Interval
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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)  
PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations. Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

**\*\*End Of Report\*\***

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession  
**TEST MARKED WITH '\*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.**

Dr. Akta Dubey  
Consultant Pathologist

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Patient Ref. No. 22000000850557



# LABORATORY REPORT



PATIENT NAME : MR.SURAJIT DEY

PATIENT ID : FH.12521224

CLIENT PATIENT ID : UID:12521224

ACCESSION NO : 0022WF001871 AGE : 40 Years SEX : Male

ABHA NO :

DRAWN : 10/06/2023 13:31:00

RECEIVED : 10/06/2023 13:31:14

REPORTED : 10/06/2023 16:58:20

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR :

### CLINICAL INFORMATION :

UID:12521224 REQNO-1533446  
CORP-OPD  
BILLNO-150123OPCR032643  
BILLNO-150123OPCR032643

Test Report Status	Final	Results	Biological Reference Interval	Units
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### BIOCHEMISTRY

#### GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)

84

70 - 140

mg/dL

METHOD : HEXOKINASE

#### Comments

NOTE: - 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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Dr.Akta Dubey  
Counsultant Pathologist

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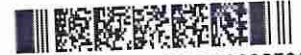


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Patient Ref. No. 22000000850630

Male

HC

Rate 70  
 PR 140  
 QRS 73  
 QT 368  
 QTc 398

*sinus rhy*

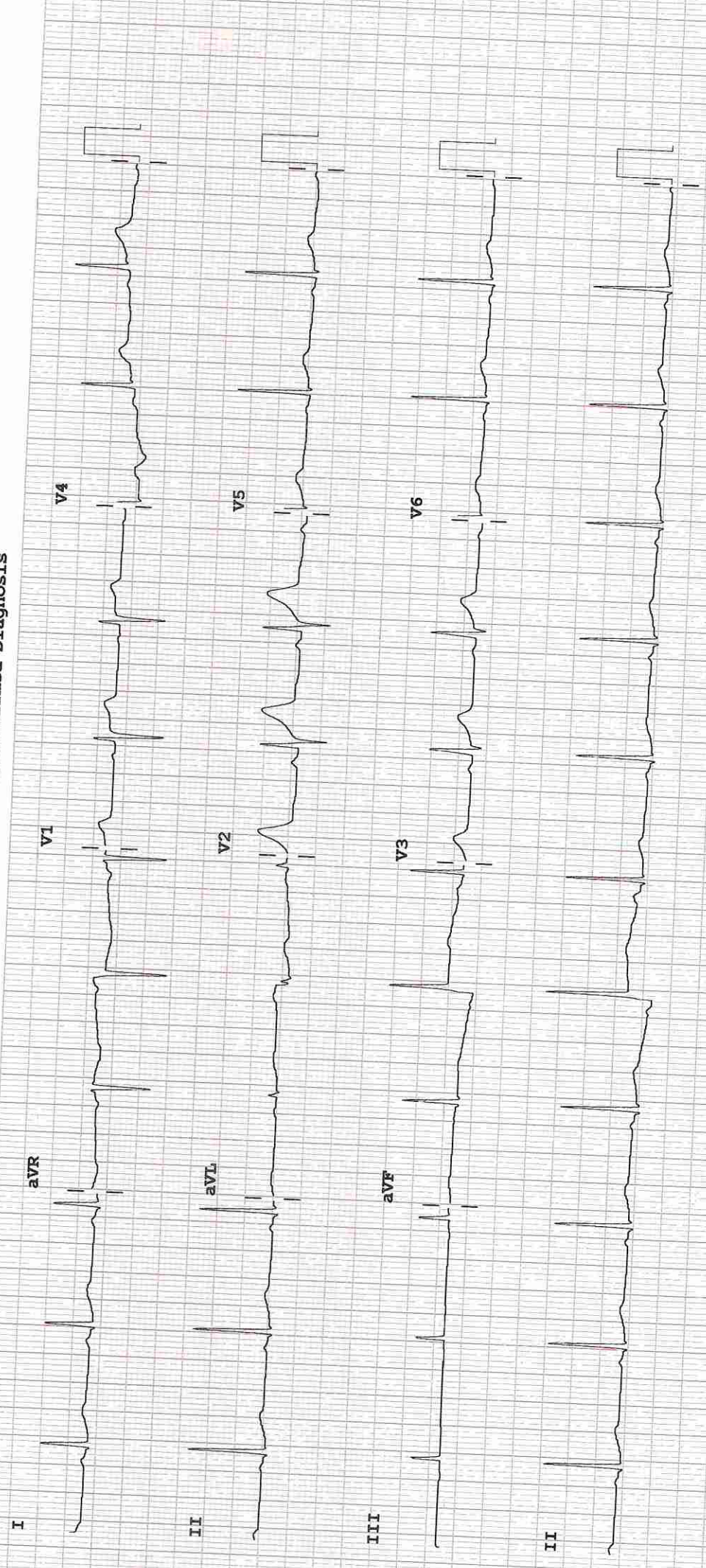
*[Signature]*

--AXIS--  
 P 13  
 QRS 49  
 T 22

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

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?





DEPARTMENT OF NIC

Date: 10/Jun/2023

Name: Mr. Surajit Dey

Age | Sex: 40 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12521224 | 33011/23/1501

Order No | Order Date: 1501/PN/OP/2306/68953 | 10-Jun-2023

Admitted On | Reporting Date : 10-Jun-2023 17:25:43

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	36	mm
AO Root	25	mm
AO CUSP SEP	16	mm
LVID (s)	29	mm
LVID (d)	42	mm
IVS (d)	10	mm
LVPW (d)	09	mm
RVID (d)	28	mm
RA	31	mm
LVEF	60	%





DEPARTMENT OF NIC

Date: 10/Jun/2023

Name: Mr. Surajit Dey

Age | Sex: 40 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12521224 | 33011/23/1501

Order No | Order Date: 1501/PN/OP/2306/68953 | 10-Jun-2023

Admitted On | Reporting Date : 10-Jun-2023 17:25:43

Order Doctor Name : Dr.SELF .

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.9 m/sec.

A WAVE VELOCITY: 0.6 m/sec

E/A RATIO: 1.5

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	06			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	2.0			Nil

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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

Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

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For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D

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DEPARTMENT OF RADIOLOGY

Date: 10/Jun/2023

Name: Mr. Surajit Dey

UHID | Episode No : 12521224 | 33011/23/1501

Age | Sex: 40 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2306/68953 | 10-Jun-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 10-Jun-2023 14:46:28

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 appears normal.

Both costophrenic angles are well maintained.

Bony thorax appears unremarkable.

**DR. SIDDHANT LOLGE**  
**MD (Radiologist)**



DEPARTMENT OF RADIOLOGY

Date: 10/Jun/2023

Name: Mr. Surajit Dey

UHID | Episode No : 12521224 | 33011/23/1501

Age | Sex: 40 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2306/68953 | 10-Jun-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 10-Jun-2023 11:51:25

Bed Name :

Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

**LIVER** is normal in size and shows mildly raised echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

**GALL BLADDER** is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

**CBD** appears normal in caliber.

**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 10.5 x 5.6 cm.

Left kidney measures 11.2 x 5.1 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

**URINARY BLADDER** is partially distended. Bladder wall is normal in thickness. No evidence of intravesical calculi.

**PROSTATE** is normal in size & echogenicity. It measures ~ 23.3 cc in volume.

No evidence of ascites.

**Impression:**

- Grade I fatty infiltration of liver.

**DR. CHETAN KHADKE**

**M.D. (Radiologist)**