DEPARTMENT OF HAEMATOLOGY

Patient Name	: Mr. A RAJESHWAR	**Age /Gender**	: 55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	**Referred By**	: Dr. RAVIKANTI NAGARAJU MBBS, DN
Received Dt	: 23-Mar-24 12:17 pm	**Report Date**	: 23-Mar-24 03:43 pm

Parameter	Specimen	Result Values	
BLOOD GROUPING AND RH			
BLOOD GROUP	Blood	" B "	
Rh (D) Typing		POSITIVE	
E S R		05mm/1hrs	Male : 0 - 10.0 mm/hr Female : 0 - 20.0 mm/hr
CBP(COMPLETE BLOOD PICTURE)			
Haemoglobin		14.9	11.0 - 16.5 gm%
RBC.		5.35	3.5 - 4.5 mill / cumm
WBC Count		8,800	4,000 - 11,000 cells/cum
DIFFERENTIAL COUNT			
Polymorphs	blood	65	40 - 75 %
Lymphocytes		25	20 - 40 %
Monocytes		07	2 - 10 %
Eosinophils		03	1 - 6 %
Basophils		00	0 - 2 %
Platelet count		2.11	1.5 - 4.0 Lakhs/Cumm
Haemotocrit(PCV)		45	35.0 - 50.0 Vol%
Mean Cell Volume (MCV)		84	80 - 97 fl
Mean Cell Haemoglobin (MCH)		28	27 - 32 pg
Mean Cell Haemoglobin Concentration (MCHC)		32	31.5 - 36.0 gms%

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

Dr. RACHAKONDA SUHELA, MD (PATHOLOGY)
CONSULTANT PATHOLOGIST

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MEDICOVER HOSPITALS

A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD

Department Of Laboratory

Patient Name	: Mr. A RAJESHWAR	Age /Gender	55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	Referred By	Dr. RAVIKANTI NAGARAJU MBBS, D
Received Dt	: 23-Mar-2024 12:17:16 PM	Report Date	23-Mar-2024 03:43 pm

Parameter	Specimen	Result Values	Biological Reference Interval	Method
Blood Urea Nitrogen(BUN)	Serum	17	5.0 - 21.0 mg/dl	Calculation from Urea
Post Prandial Blood Sugar	Serum	178	DIABETES : >= 200 md/dl NORMAL : 70 - 139 mg/dl PREDIABETES : 140 - 199 mg/dl	TRINDERS METHOD
PLBS(POST LUNCH URINE S		NIL	NIL - NIL	
LIPID PROFILE				
Total Cholesterol	Serum	113	Borderline high : 200 - 239 mg/dl High : > 240 mg/dl Desirable : < 200 mg/dl	TRINDERS METHOD
HDL Cholesterol		28	High : > 60 mg/dl Low : < 40 mg/dl	Phosphotungstate
LDL Cholesterol		68	Optimal : < 100 mg/dl Borderline high : 130 - 159 mg/dl High : 160 - 189 mg/dl above optimal : 100 - 129 mg/dl	Calculation
VLDL Cholesterol		17	6 - 35 mg/dl	Calculation
Triglycerides		85	Very high : > 500 mg/dl High : 200 - 499 mg/dl Borderline high : 150 - 199 mg/dl	GPO-TRINDERS METHOD
Fasting Blood Sugar	Serum	164.1	NORMAL : 70.0 - 109.0 mg/dl PREDIABETES : 110 - 125 mg/dl DIABETES : >= 126 md/dl	TRINDERS METHOD
Fasting Urine Sugar		Nil		
Creatinine	Serum	0.8	0.6 - 1.5 mg/dl	Jaffe's - End Point
Uric Acid	Serum	4.4	3.4 - 7.0 mg/dl	Enzymatic Uricase/End point

*** End Of Report ***

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A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD

DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mr. A RAJESHWAR		
Bill No/ UMR No	: KAB240323071/KAU100274	**Age /Gender**	55 Y(s)/Male
Received Dt	: 23-Mar-24 12:17 pm	**Referred By**	Dr.:RAVIKANTI NAGARAJU MBBS, DN
		Report Date	23-Mar-24 03:43 pm

LIVER FUNCTION TEST

Parameter	Specimen	Result Values	Biological Reference Interval	
Total Bilirubin	Blood	1.0	0.3 - 1.2 mg/dl	Jendrassik & Grof
Direct Bilirubin		0.4	0.0 - 0.3 mg/dl	DPD
Indirect Bilirubin		0.6		Calculation
Serum Alkaline Phosphatase		104	56 - 119 U/L	Paranitro Phenyl phosphate kinase
SGPT/ALT		24		UV Kinetic LDH-Alanine
SGOT/AST		22	0 - 35 U/L	UV Kinetic LDH
Total Proteins		7.0	6.6 - 8.3 gms/dl	Biuret
Serum Albumin		4.7	3.5 - 5.2 g/dL	Bromocresol green
Serum Globulin		2.3	1.80 - 3.60 gms/dl	

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

LAB INCHARGE

Dr. RACHAKONDA SUHELA, MD (PATHOLOG
CONSULTANT PATHOLOGIST

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HOSPITALS
A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD

DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mr. A RAJESHWAR	**Age /Gender**	: 55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	**Referred By**	: Dr. RAVIKANTI NAGARAJU MBBS, DN
Received Dt	: 23-Mar-24 12:17 pm	**Report Date**	: 23-Mar-24 03:43 pm

Parameter	Specimen	Result Values	Biological Reference Interval	Method
GLYCOSYLATED HAEMOGLOBIN (HBA1C)				
HbA1c	EDTA Blood	5.7 %	Non Diabetic : 4 - 6 % Good Control : 6 - 7 % Fair Control : 7 - 8 % Poor Control : 8 - 10 % Very Poor Control : > 10 %	Ion exchange resin
MBG				Calculation
THYROID PROFILE				
T3		1.06	0.67 - 1.81 ng/mL	ELFA
T4		6.30	4.66 - 9.32 µg/dL	ELFA
TSH		2.95	0.25 - 5.00 µIU/ml	ELFA

*** End Of Report ***

*Suggested Clinical Correlation * If neccessary, Please discuss*

Lab Incharge

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DEPARTMENT OF PATHOLOGY

A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD.

Patient Name	: Mr. A RAJESHWAR	**Age /Gender**	: 55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	**Referred By**	: Dr. RAVIKANTI NAGARAJU MBBS
Received Dt	: 23-Mar-24 12:17 pm	**Report Date**	: 23-Mar-2024 03:43 pm

COMPLETE URINE EXAMINATION

Parameter	Specimen	Result Values	Method
PHYSICAL EXAMINATION			
Colour	Urine	Pale yellow	
Appearance		Clear	
Reaction		Acidic	
Specific gravity		1.015	
CHEMICAL EXAMINATION			
Protein		Nil	
Sugar		Nil	
Blood		Negative	
MICROSCOPIC EXAMINATION			
Pus Cells		2-3/hpf	
Epithelial Cells		1-2/hpf	
R.B.C.		Nil	
Casts		Nil	
Crystals		Nil	

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

Lab Incharge

Test results related only to the item tested.

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PATIENT NAME: Rajeshwar.A
BILL:OP

AGE: 56/M
DATE: 23-03-2024

USG ABDOMEN & PELVIS

* LIVER : Normal in size and echotexture.
  No evidence of any focal solid or cystic lesions.
  No evidence of any intrahepatic biliary dilatation.

* GALL BLADDER : Well distended. Wall thickness is normal.
  Calculus measuring 4 mm noted.

* CBD &PV : Normal.

* PANCREAS : Visualized aspect appears normal.

* SPLEEN : Normal in size and echotexture.
  No evidence of focal lesions or calcification.

* RIGHT KIDNEY : Normal in size(10.0 x 5.5 cms,CT- 10 mm)
  and raised echotexture. CMD maintained.
  Mild pelvicalyceal dilatation noted.
  Few calculi noted largest measuring 7 mm in lower pole.

* LEFT KIDNEY : Normal in size(10.2 x 5.8 cms,CT- 10 mm)
  and raised echotexture. CMD maintained.
  No evidence of any pelvicalyceal dilatation.
  Few cortical cysts noted largest measuring 7 mm.

* URINARY BLADDER : Well distended. No calculi seen.

*PROSTATE: Enlarged in size (40 cc) with median lobe hypertrophy (7 mm)
  indenting into base of bladder.

No evidence of any free fluid in peritoneal cavity and pelvis .

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IMPRESSION:

Cholelithiasis. No features of acute cholecystitis.

Bilateral kidneys shows grade – I renal parenchymal disease changes – Kindly correlate with RFT.

Right non obstructive renal calculus.

Right mild hydroureteronephrosis noted – Suggested CT KUB to rule out ureteric calculus .

Grade – II prostatomegaly (40 cc) with median lobe hypertrophy (7 mm) indenting into base of bladder.

- For clinical correlation.

Dr ANVESH REDDY
MD RADIO-DIAGNOSIS

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MEDICOVER HOSPITALS

A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD

DEPARTMENT OF CARDIOLOGY

Patient Name	: Mr. A RAJESHWAR	Age /Gender	: 55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	Referred By	: Dr. RAVIKANTI NAGARAJU MBBS
Received Dt	: 23-Mar-24 12:13 pm	Report Date	: 23-Mar-2024 01:42 pm

2D ECHO WITH COLOUR DOPPLER

MITRAL VALVE	NORMAL
TRICUSPID VALVE	NORMAL
AORTIC VALVE	SCLEROTIC
PULMONARY VALVE	NORMAL
RIGHT VENTRICLE	NORMAL
RIGHT ATRIUM	NORMAL
LEFT ATRIUM	3.4 cm
LEFT VENTRICLE	LVEDD= 4.8cm X LVESD= 2.7cm; EF= 60% IVSD=0.8 cm LVPWD=0.8 cm
IAS	INTACT
IVS	INTACT
AORTA	3.0 cm
PULMONARY ARTERY	NORMAL
PERICARDIUM	NORMAL
INTRACARDIAC MASS	NIL
DOPPLER STUDY	MITRAL INFLOW:A>E AORTIC FLOW VELOCITY: 1.7 m/s PULMONARY FLOW VELOCITY: 0.8 m/s
COLOUR DOPPLER	MITRAL REGURGITATION: 1+MR MITRAL STENOSIS: NO AORTIC REGURGITATION:1+AR AORTIC STENOSIS: NO TRICUSPID REGURGITATION: 1+TR (RVSP: 25 mmHg)
IMPRESSION	NORMAL SIZED CARDIAC CHAMBERS NO RWMA NORMAL LV / RV SYSTOLIC FUNCTION (EF:60%) GRADE- I DIASTOLIC DYSFUNCTION TRIVIAL MR / AR / TR WITH NO PAH IVC- NORMAL, COLLAPSING WELL NO PE / CLOTS / VEG.

*** End Of Report ***

Dr. CARDIOLOGIST CONSULTATION
CONSULTANT CARDIOLOGIST

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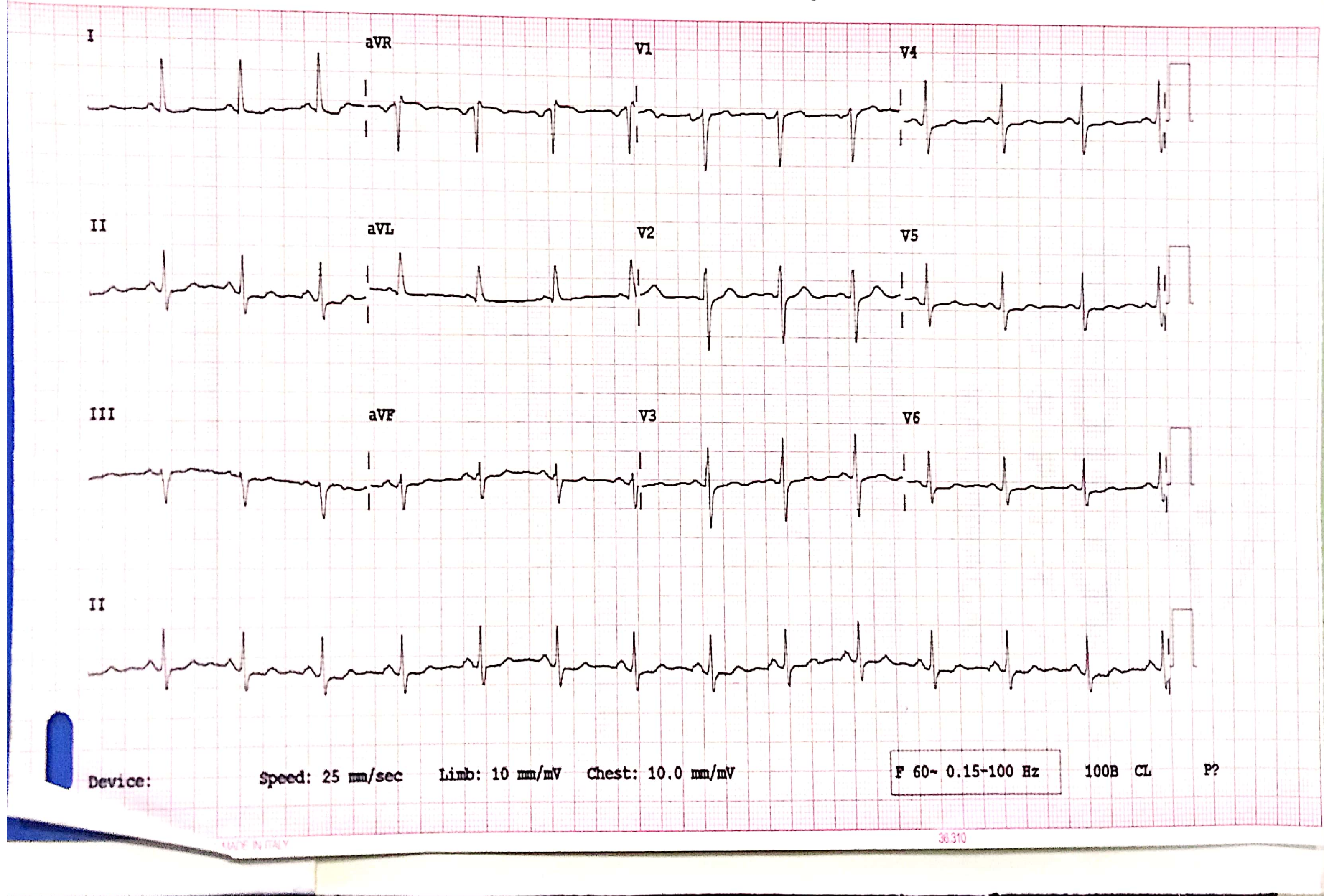
Rajeshwar 56/M



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A UNIT OF SAHRUDAYA HEALTHCARE PVT LTD

DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mr. A RAJESHWAR	**Age /Gender**	55 Y(s)/Male
Bill No/ UMR No	: KAB240323071/KAU100274	**Referred By**	Dr.:RAVIKANTI NAGARAJU MBBS, DN
Received Dt	: 23-Mar-24 12:17 pm	**Report Date**	25-Mar-24 09:54 am

Parameter	Specimen	Result Values	Biological Reference Interval	Method
PSA (Total)	Serum	0.26	0 - 4 ng/mL	CMIA

*** End Of Report ***

Suggested Clinical Correlation * If neccessary, Please discuss

Dr. RACHAKONDA SUHELA, MD (PATHOLOGY)
CONSULTANT PATHOLOGIST

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P33 PACKAGE RAJESHWAR A 56Y M [Male]

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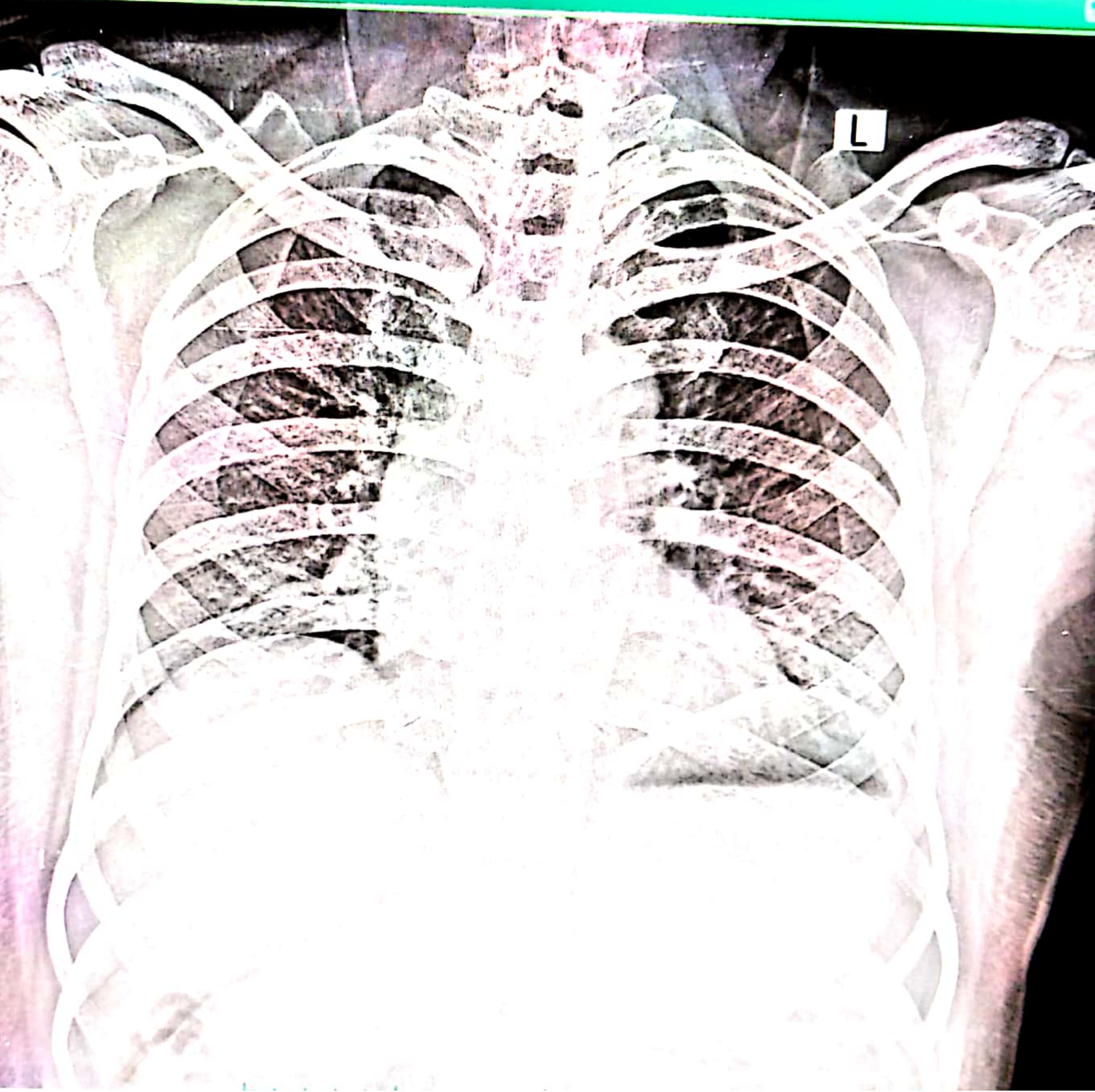

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