

 **बैंक ऑफ बड़ोदा**
Bank of Baroda

नाम **जाट लालचंद परमेश्वर**
Name **JAT LALCHAND PARMESHWAR**

EC No. 170158




अधिकारी प्राधिकारी
Issuing Authority


धारक के हस्ताक्षर
Signature of Holder

Lalchand

U.C.
Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291



General Physical Examination

Date of Examination: 09/07/2022

Name: JAT LALCHAND PARMESHWAR Age: 34yr DOB: 25.01.1988 Sex: M

Referred By: Bank of Baroda

Photo ID: Emb. ID #: 170158

Ht: 176 (cm) Wt: 95 (Kg)

Chest (Expiration): 107 (cm) Abdomen Circumference: 107 (cm)

Blood Pressure: 129/76 mm Hg PR: 72/min RR: 19/min Temp: afebrad.

BMI 30

Eye Examination: R/E - 6/6, N/6 NCB
L/E - 6/6, N/6 NCB

Other: N/A

On examination he/she appears physically and mentally fit: Yes / No

Signature Of Examinee: Jalchand

Name of Examinee: JAT LALCHAND PARMESHWAR

Signature Medical Examiner: Dr. U.C. Gupta

Name Medical Examiner: Dr. U.C. Gupta

Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291



MR. LAL CHAND PARMESHWAR	34 Y/Male
Registration Date: 09/07/2022	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (14.9 cm). **Echo-texture is increased.** No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is of normal size. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size (10.3 cm) and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. Collecting system does not show any calculus or dilatation.

Right kidney is measuring approx. 11.3 x 5.1 cm.

Left kidney is measuring approx. 11.9 x 5.6 cm.

Urinary bladder is partially distended and does not show any calculus or mass lesion.

Prostate is normal in size with normal echotexture and outline.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

No significant free fluid is seen in pelvis.

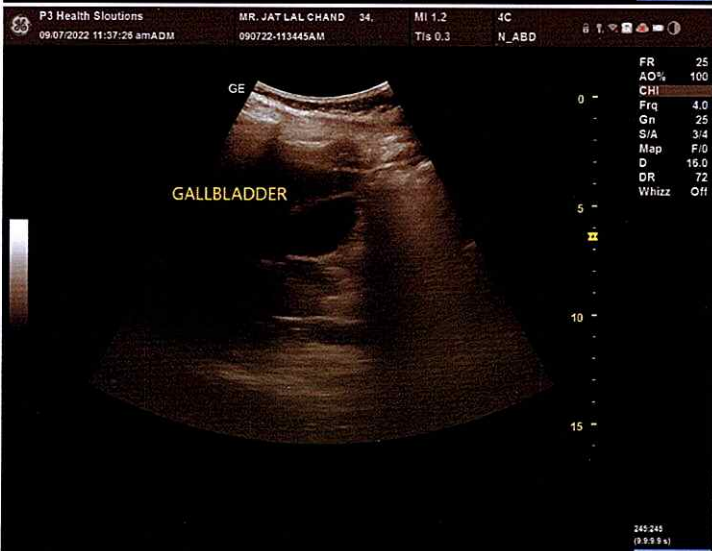
IMPRESSION:

- Grade 1 fatty liver.
- Rest no significant abnormality is detected.

DR. SHALINI GOEL

M.B.B.S, D.N.B (Radiodiagnosis)

RMC no.: 21954





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NAME:	MR. JAT LAL CHAND PARMESHWAR	AGE	34 YRS/M
REF.BY	BANK OF BARODA	DATE	09/07/2022

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

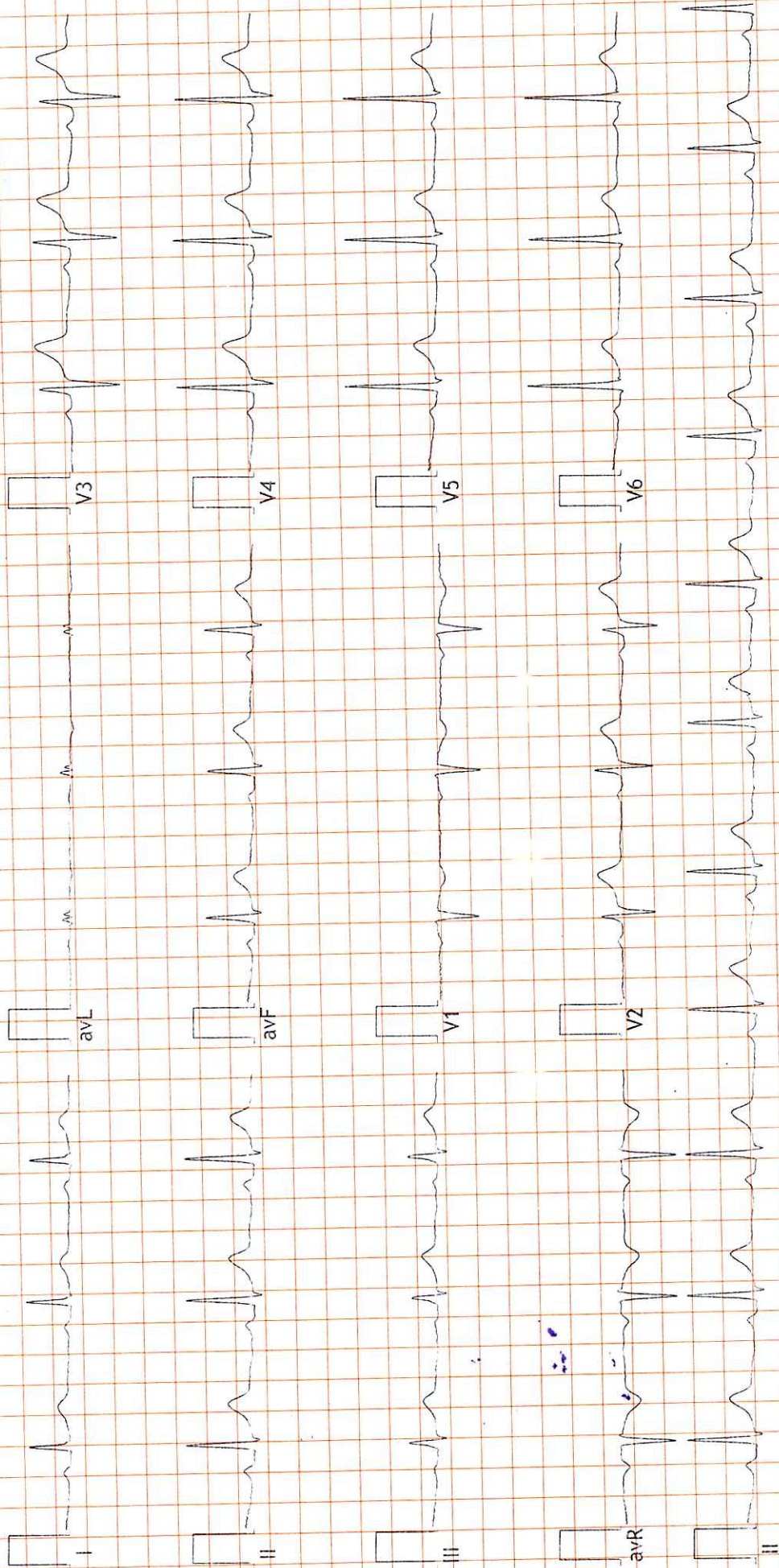
Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

Soft tissue shadows appear normal.

IMPRESSION: No significant abnormality is detected.

DR. SHALINI GOEL
M.B.B.S, D.N.B (Radiodiagnosis)
RMC No.: 21954



Sinus rhythm with 75%
Patterns in V1, V2

INDICATIONS: (Normal)

Vent Rate : 63 bpm; PR Interval : 192 ms; QRS Duration: 136 ms; QT/QTc Int : 384/395 ms

P-QRS-T axis: 45• 50• 59• (Deg)

Comments :

Dr. Naresh Kumar Mohanka
RMC No.: 35703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)



Stage	Stage Time (min:sec)	Phase Time (min:sec)	Speed (mph)	Grade (%)	MTs	H.R. (bpm)	B.P. (mmHg)	R.P.P. x100	PVC	Comments
Supine					1.0	63	125/85	78	-	
Standing					1.0	86	125/85	107	-	
HV					1.0	70	125/85	87	-	
ExStart					1.0	77	125/85	96	-	
Stage 1	1:01	3:02	1.7	10.0	4.7	110	135/85	148	-	
Stage 2	1:01	6:02	2.5	12.0	7.7	138	145/85	200	-	
PeakEx	2:11	8:12	3.4	14.0	9.4	166	155/90	257	-	
Recovery	1:00		0.0	0.0	1.7	130	155/90	201	-	V1
Recovery	2:00		0.0	0.0	1.0	108	155/90	167	-	
Recovery	3:00		0.0	0.0	1.0	96	145/85	139	-	
Recovery	4:00		0.0	0.0	1.0	95	135/85	128	-	

Findings :

Exercise Time : 08:11
 Max HR Attained : 166 bpm (85% of Max Predictable HR 186)
 Max BP : 155/90 (mmHg)
 Max Workload attained : 9.4 (Good Effort Tolerance)

Dr. Naresh Kumar Mohanka

Advice/Comments:

Dr. Naresh Kumar Mohanka
 RMC No.: 35703
 MBBS, DIP. CARDIO (ESCORTS)
 D.E.M. (RCGP-UK)

STMS is Negative



HR: 63 bpm

METS: 1.0

BP: 125/85

MPHR: 33% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

12 Lead + Median

Ex Time 00:33

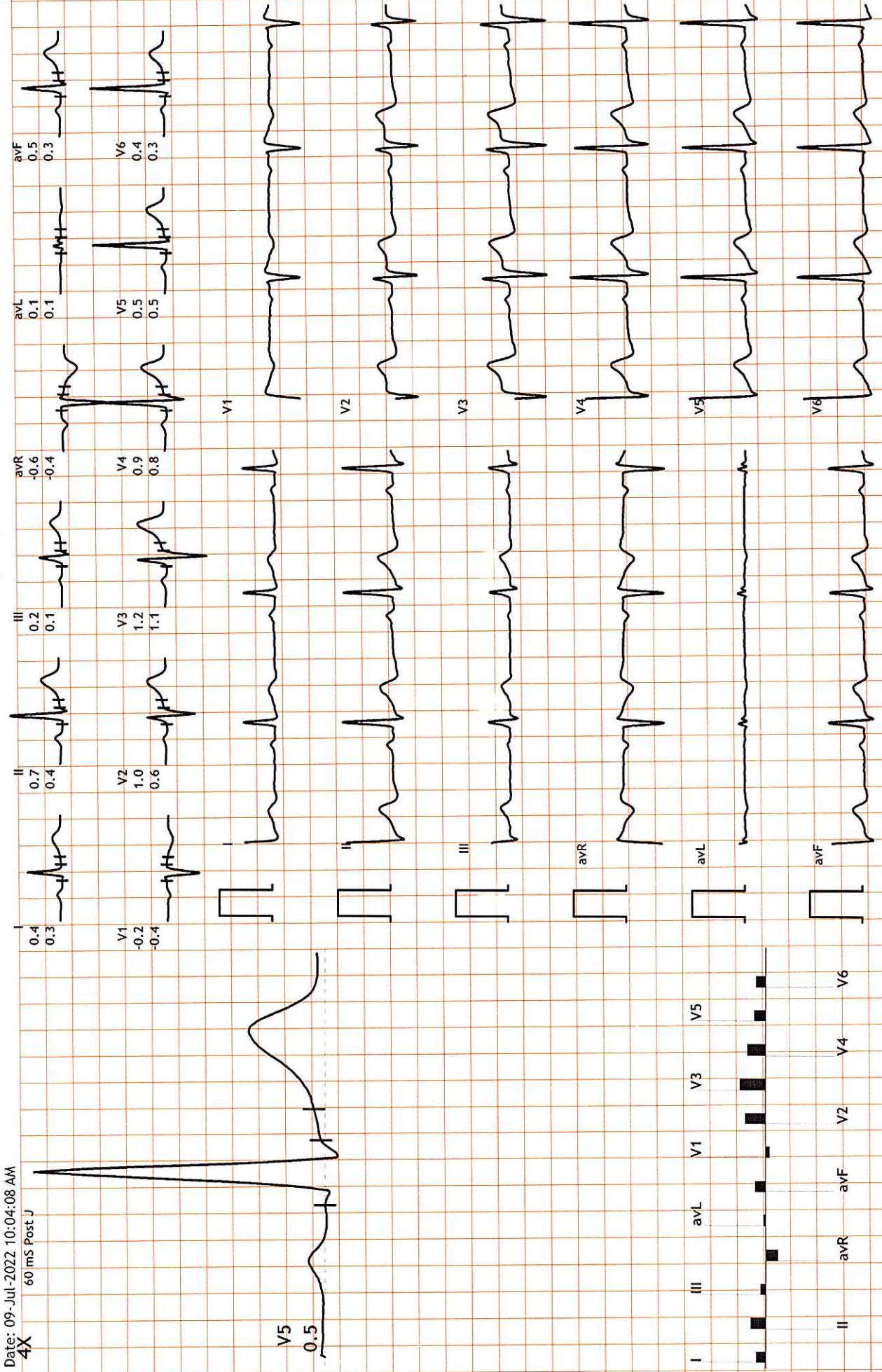
BLC :On

Notch :On

Supine

10.0 mm/mV

25 mm/Sec.



HR: 85 bpm

METS: 1.0

BP: 125/85

MPHR: 45% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

12 Lead + median

Ex Time 00:55

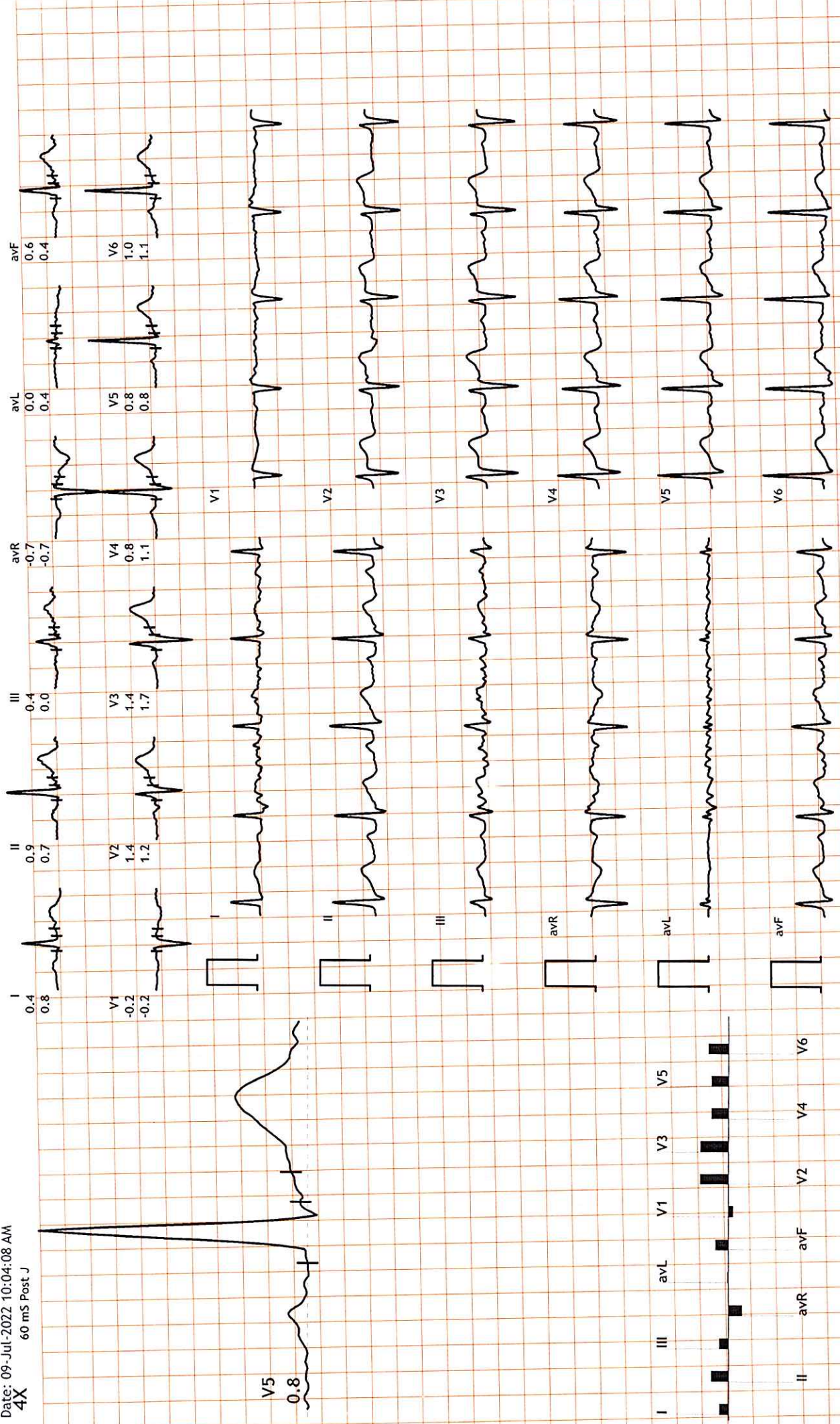
BLC :On

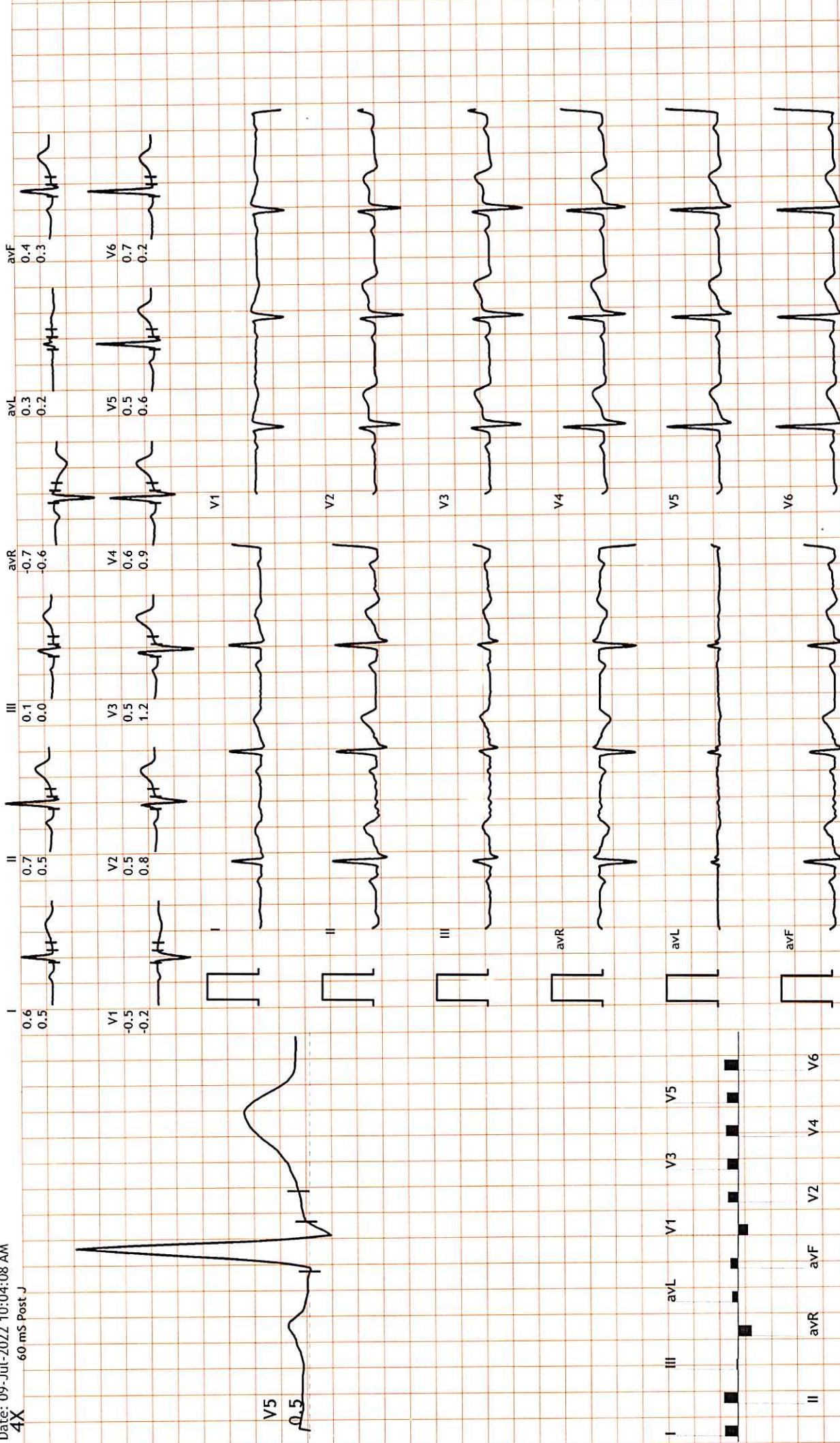
Notch :On

Standing

10.0 mm/mV

25 mm/Sec.





10010/MR. JAT LAL CHAND PARMESHWAR
34 Yrs/Male
0 Kg/0 Cms
Date: 09-Jul-2022 10:04:08 AM
4X 60 mS Post J

HR: 111 bpm
METS: 4.7
BP: 135/85

MPHR: 59% of 186
Speed: 1.7 mph
Grade: 10.0%

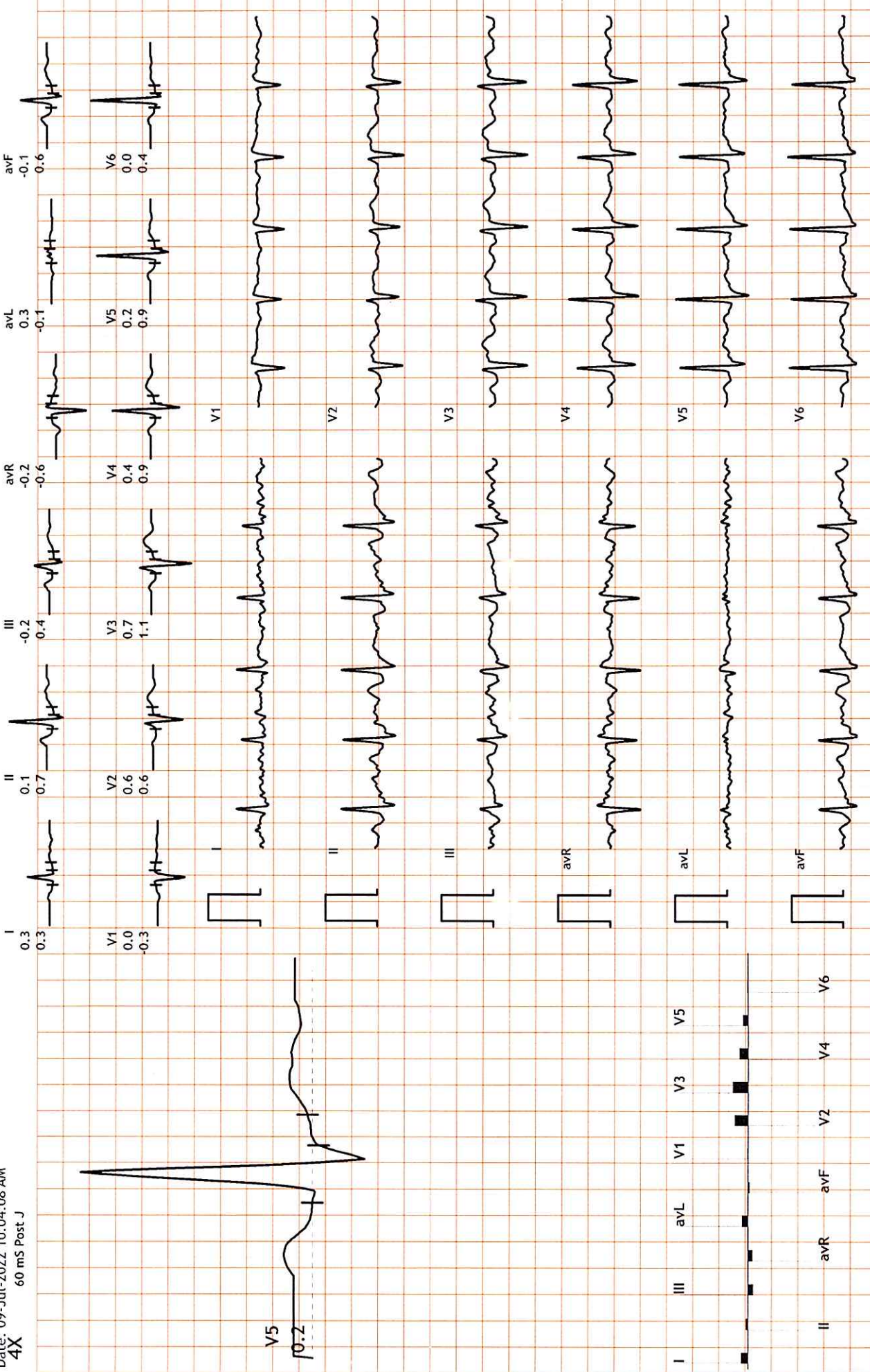
Raw ECG
BRUCE
(1.0-35)HZ

Ex Time 02:59
BLC :On
Notch :On

BRUCE: Stage 1 (3:00)
10.0 mm/mV
25 mm/Sec.



I, II Lead + Median



HR: 138 bpm

METS: 7.1

BP: 145/85

MPHR: 74% of 186

Speed: 2.5 mph

Grade: 12.0%

Raw ECG

BRUCE

(1.0-35)Hz

1/2 Lead + Median

Ex Time 05:59

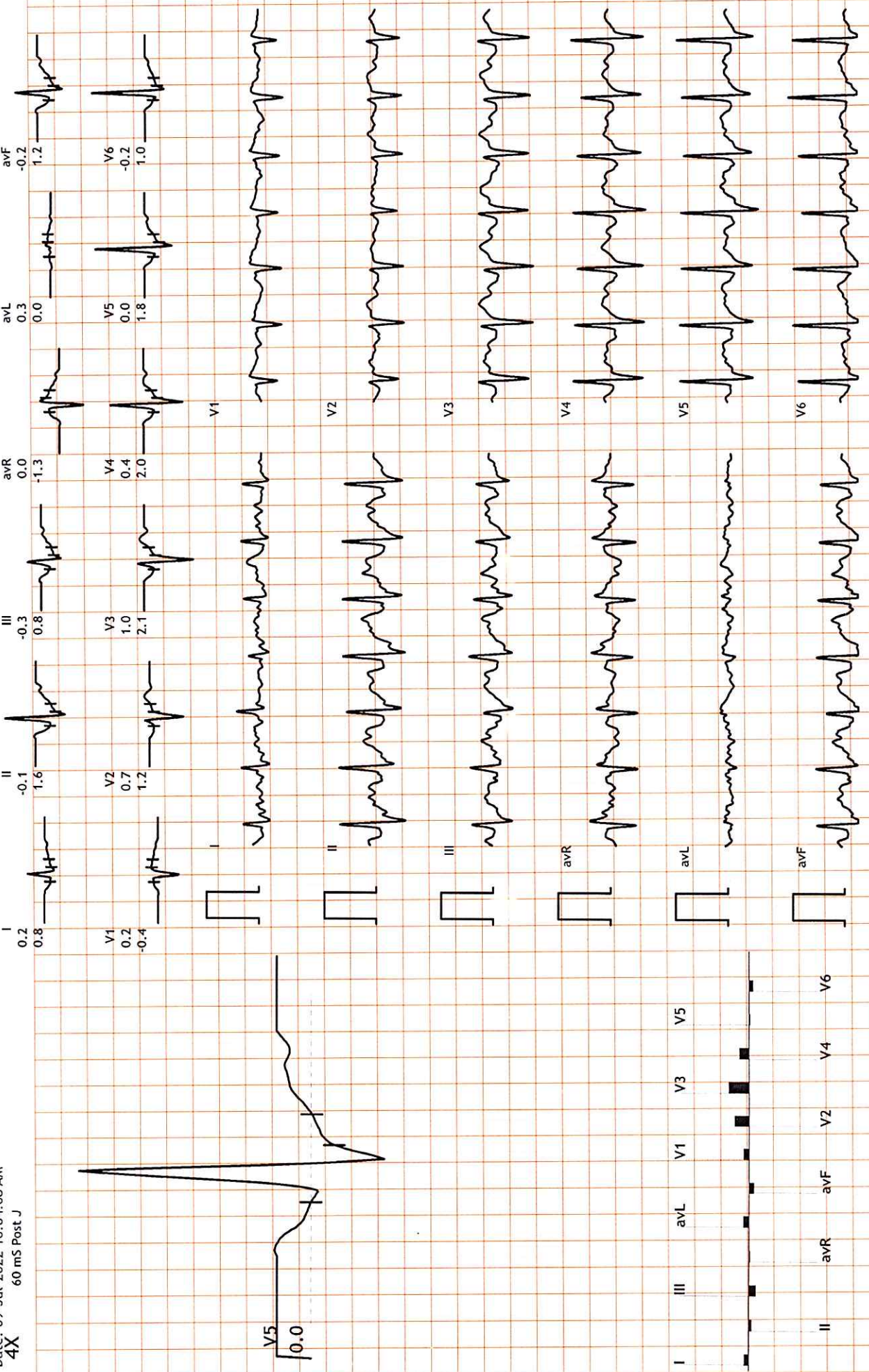
BLC : On

Notch : On

BRUCE: Stage 2(3:00)

10.0 mm/mV

25 mm/Sec.



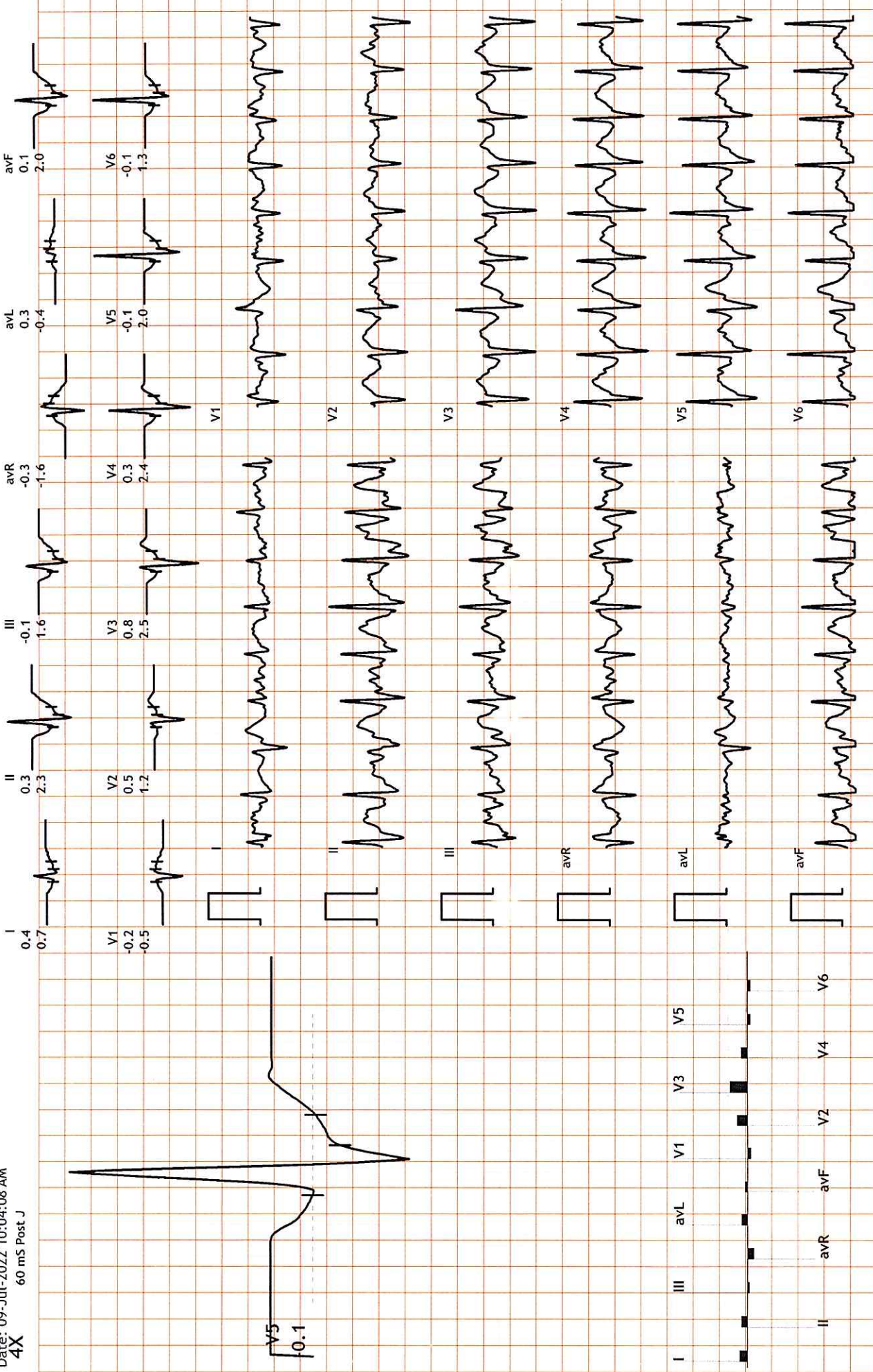
HR: 164 bpm
METS: 9.4
BP: 155/90

MPHR: 88% of 186
Speed: 3.4 mph
Grade: 14.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 08:09
BLC :On
Notch :On

BRUCE: PeakEx(2:09)
10.0 mm/mV
25 mm/Sec.





12 Lead + median

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10010/MR. JAT LAL CHAND PARMESHWAR

34 Yrs/Male
0 Kg/0 Cms

Date: 09-Jul-2022 10:04:08 AM
4X
60 ms Post J

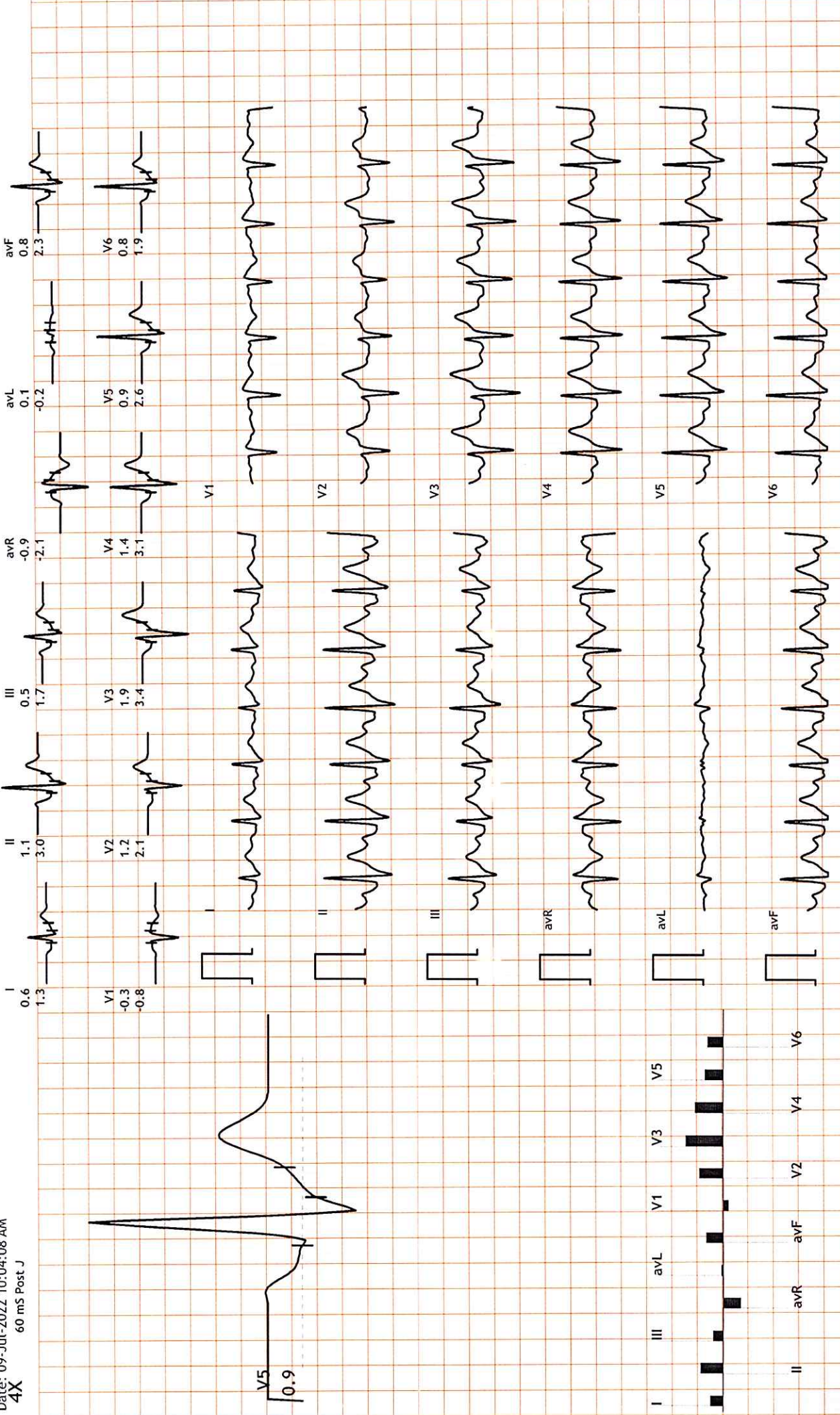
HR: 131 bpm
METs: 1.3
BP: 155/90

MPHR: 70% of 186
Speed: 0.0 mph
Grade: 0.0%

Raw ECG
BRUCE
(1.0-35)Hz

Ex Time 08:11
BLC :On
Notch :On

Recovery(1:00)
10.0 mm/mV
25 mm/Sec.



avF 0.8
2.3

avL 0.1
-0.2

avR -0.9
-2.1

III 0.5
1.7

II 1.1
3.0

I 0.6
1.3

V6 0.8
1.9

V5 0.9
2.6

V4 1.4
3.1

V3 1.9
3.4

V2 1.2
2.1

V1 -0.3
-0.8

V5 0.9

V5

V3

V1

avL

III

I

V6

V4

V2

avF

avR

II

HR: 107 bpm

METS: 1.0

BP: 155/90

MpHR: 57% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

1.2 Lead + Median

Ex Time 08:11

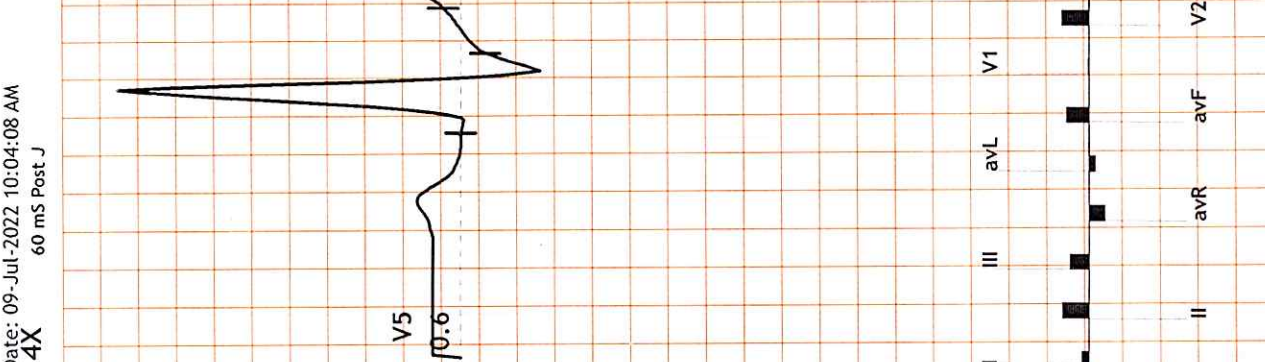
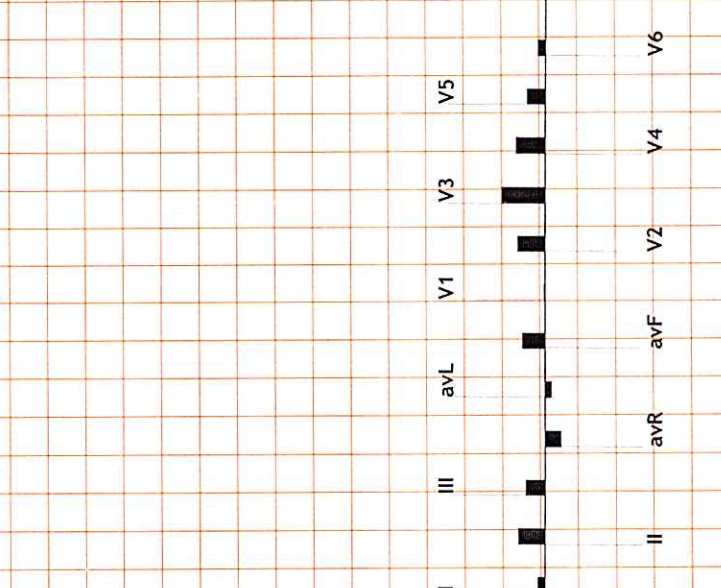
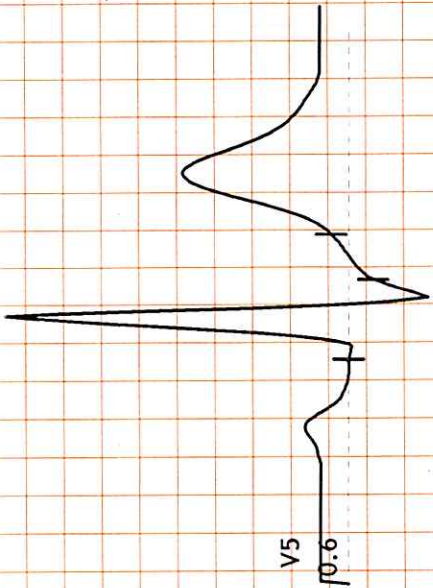
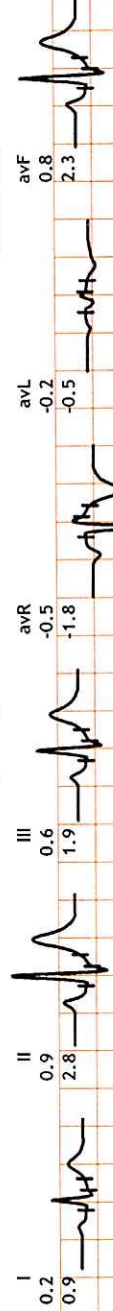
BLC : On

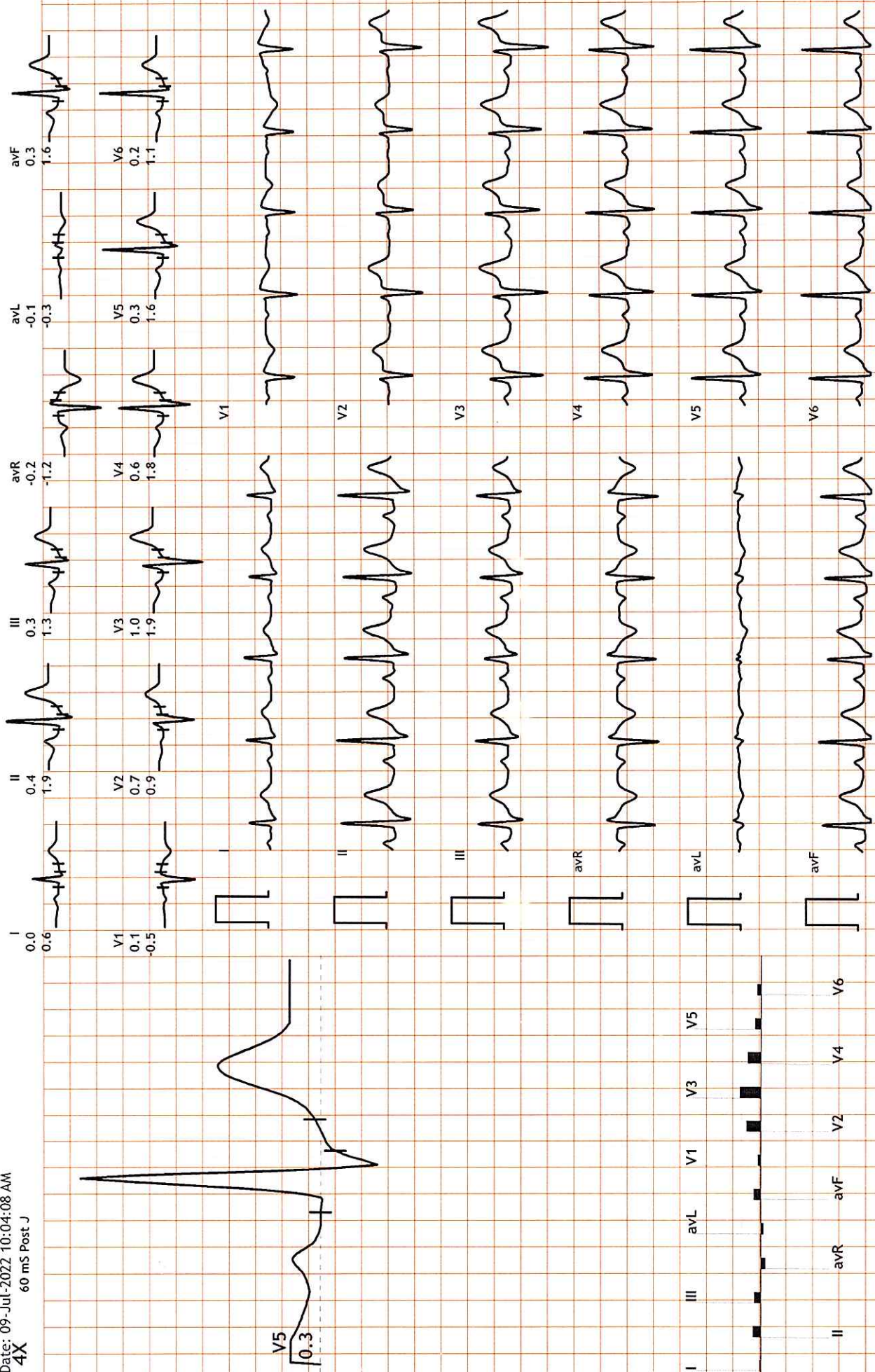
Notch : On

Recovery(2:00)

10.0 mm/mV

25 mm/Sec.





HR: 95 bpm

METS: 1.0

BP: 135/85

MpHR: 51% of 186

Speed: 0.0 mph

Grade: 0.0%

Raw ECG

BRUCE

(1.0-35)Hz

1.2 Lead + Median

Ex Time 08:11

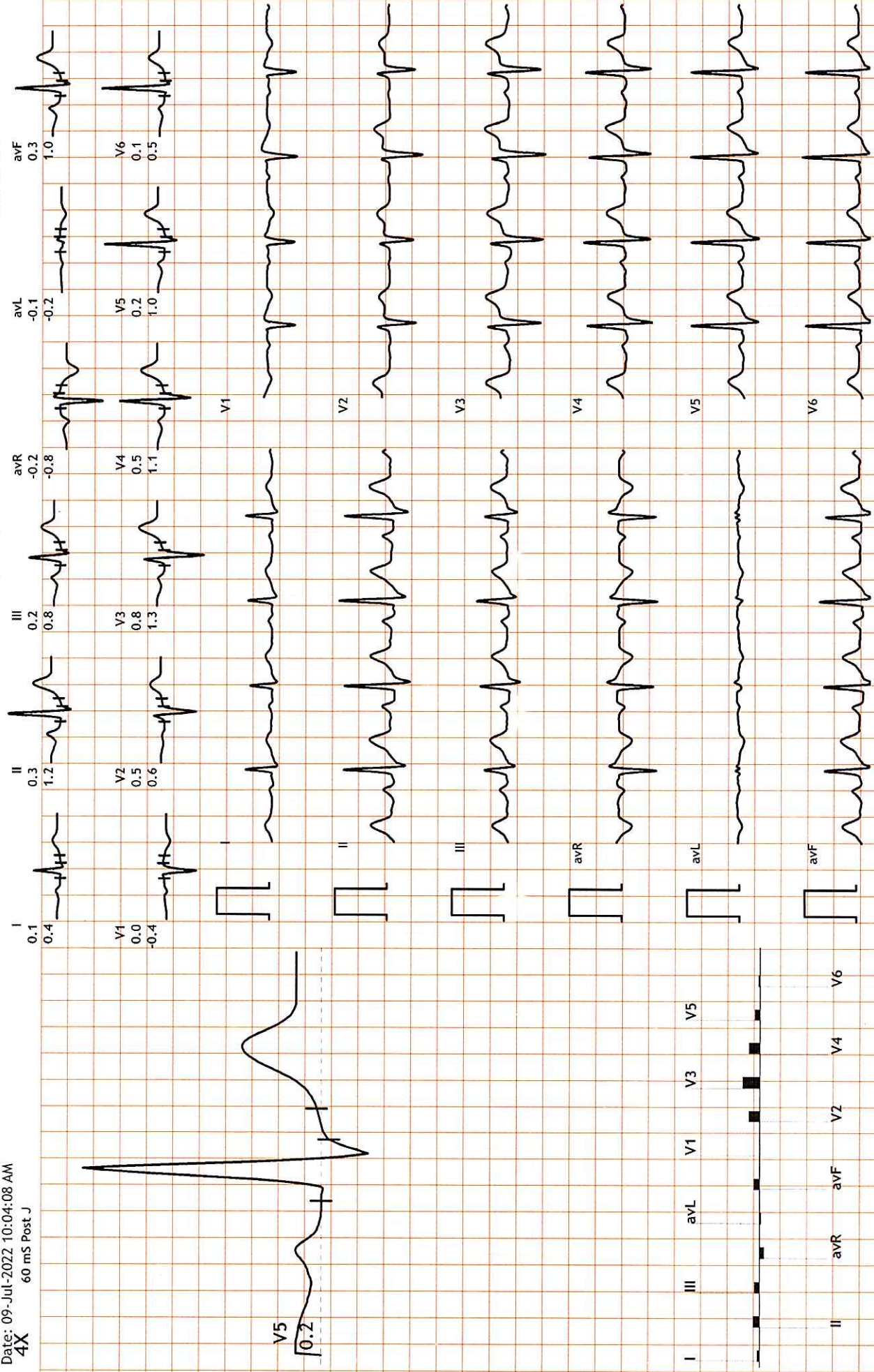
BLC :On

Notch :On

Recovery(4:00)

10.0 mm/mV

25 mm/Sec.

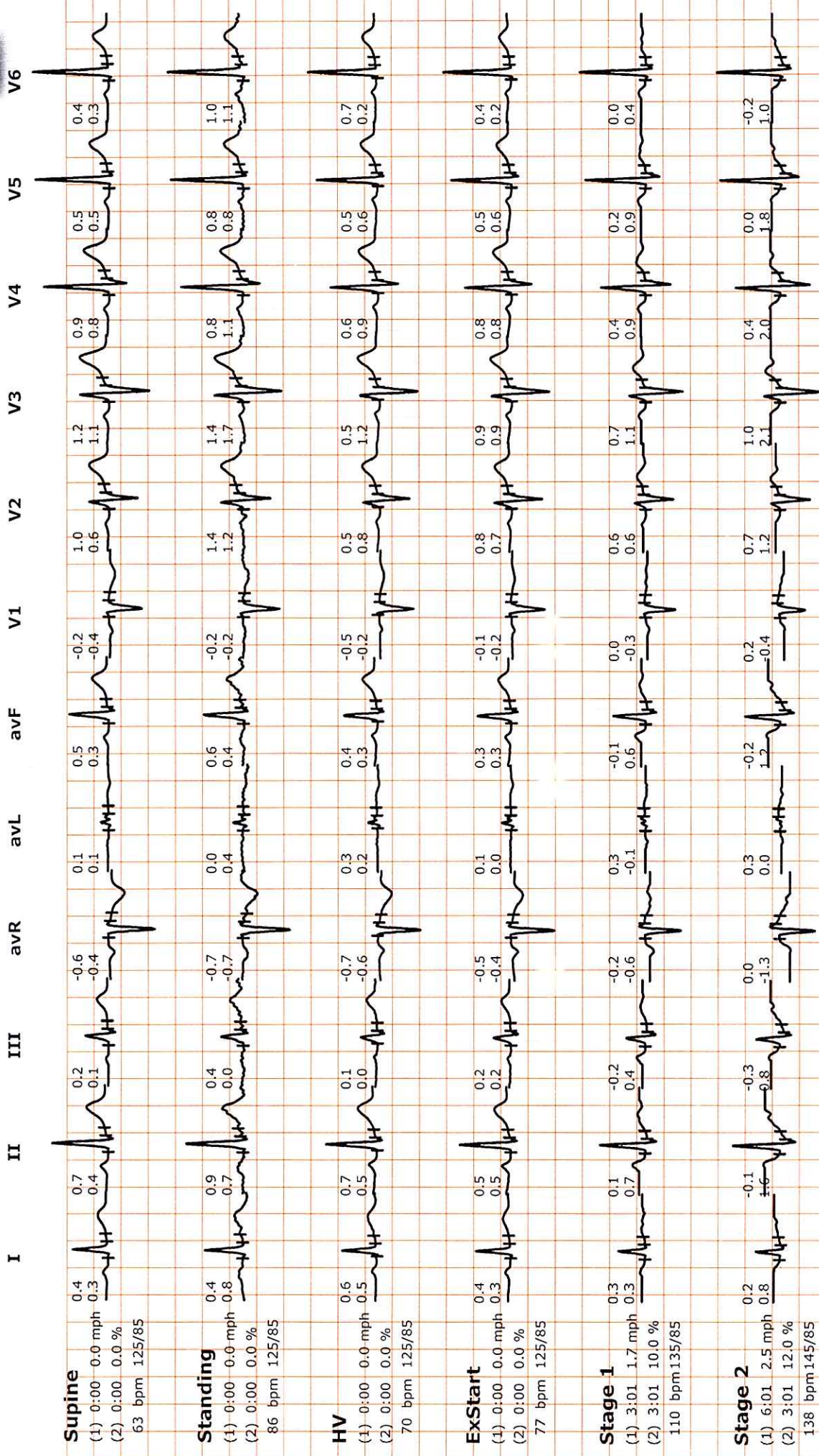


I	0.1	0.4	0.3	1.2	0.2	0.8	0.2	-0.2	avR	-0.2	-0.8	avL	-0.1	-0.2	avF	0.3	1.0
V1	0.0	-0.4	V2	0.5	0.6	V3	0.8	1.3	V4	0.5	1.1	V5	0.2	1.0	V6	0.1	0.5



Average

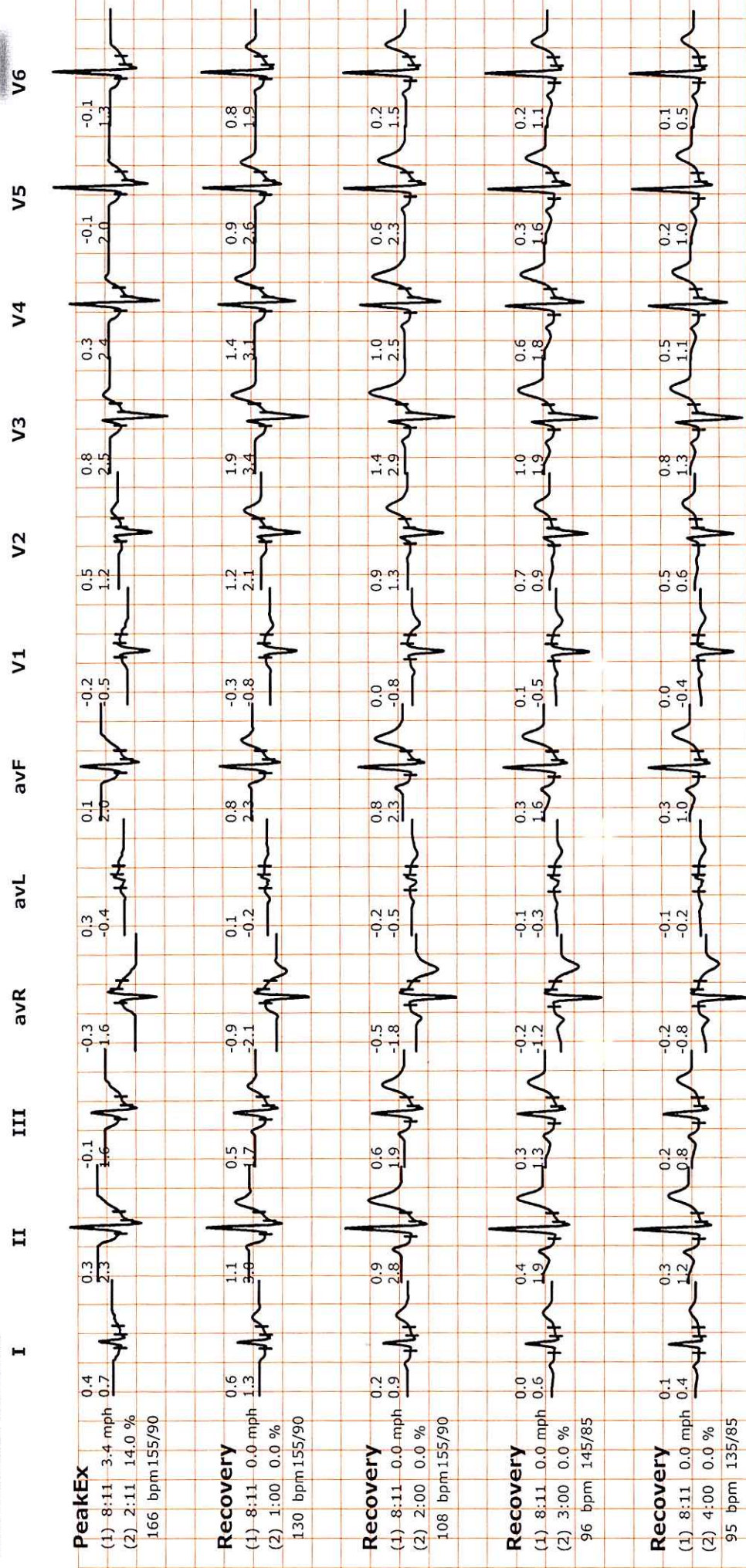
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 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur
 10010/MR JAT LAL CHAND PARMESHWAR 34 Yrs/Male 0 Kg/0 Cms
 Date: 09-Jul-2022 10:04:08 AM





Average

P3 HEALTH SOLUTIONS LLP
 B-14, Vidhyadhar Nagar Enclave, Phase -2, Jaipur
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 Date: 09-Jul-2022 10:04:08 AM





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Central Spine, Vidhyadhar Nagar, Jaipur - 302023
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NAME :- Mr. JAT LALCHAND PARMESHWAR	Patient ID :-12221341	Date :- 09/07/2022	09:21:44
Age :- 34 Yrs 5 Mon 15 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- MEDIWHEEL		

Final Authentication : 09/07/2022 17:44:33

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
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FULL BODY HEALTH CHECKUP BELOW 40 MALE

HAEMOGARAM

HAEMOGLOBIN (Hb)	17.0	g/dL	13.0 - 17.0
TOTAL LEUCOCYTE COUNT	7.30	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	61.0	%	40.0 - 80.0
LYMPHOCYTE	29.0	%	20.0 - 40.0
EOSINOPHIL	4.0	%	1.0 - 6.0
MONOCYTE	6.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	5.44	$\times 10^6/uL$	4.50 - 5.50
HEMATOCRIT (HCT)	51.50 H	%	40.00 - 50.00
MEAN CORP VOLUME (MCV)	95.0	fL	83.0 - 101.0
MEAN CORP HB (MCH)	31.4	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	33.2	g/dL	31.5 - 34.5
PLATELET COUNT	201	$\times 10^3/uL$	150 - 410
RDW-CV	14.3 H	%	11.6 - 14.0
MENTZER INDEX	17.46 H		0.00 - 0.00

A complete blood picture (CBP) is a kind of blood test that is done to assess a person's overall health and diagnose a wide range of health disorders like leukemia, anemia and other infections.

A complete blood count (CBC) is a complete blood test that diagnose many components and features of a persons blood which includes: -

- *Red Blood Cells (RBC), which carry oxygen -
- *White Blood Cells (WBC), which help in fighting against infections -
- *Hemoglobin, which is the oxygen carrying protein in the red blood cells -
- *Hematocrit (HCT), the proportion of RBC to the fluid component, or plasma present in blood -
- *Platelets, which aid in blood clotting

(CBC): Methodology: TLC,TRBC,PCV,PLT Impedance method, HB Calorimetric method, and MCH,MCV,MCHC,MENTZER INDEX are calculated. InstrumentName: MINDRAY BC-3000 Plus 3 part automatic analyzer,

ADIYTA

Technologist

Page No: 1 of 16

Tanu

DR. TANU RUNGTA

MD (Pathology)

RMC No. 17226



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HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

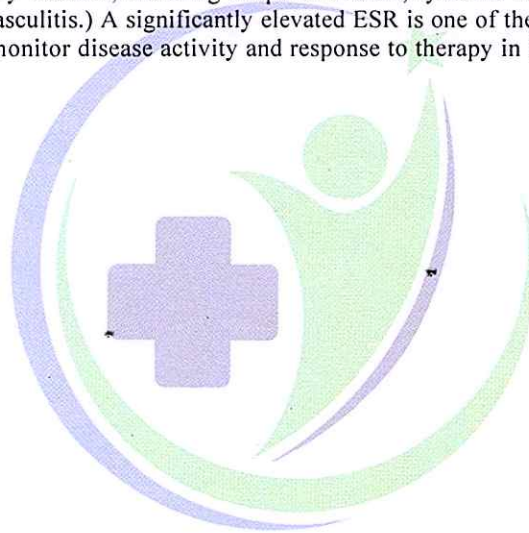
Method:- Westergreen

08

mm in 1st hr

00 - 15

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases. ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein. ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



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Page No: 2 of 16

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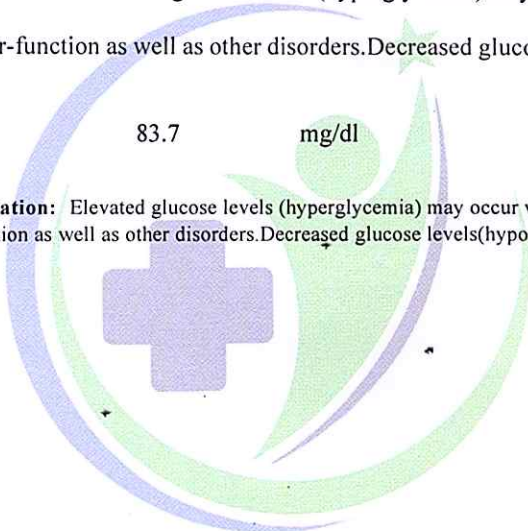
BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
FASTING BLOOD SUGAR (Plasma) Method:- GOD POD	76.1	mg/dl	70.0 - 115.0
Impaired glucose tolerance (IGT)	111 - 125 mg/dL		
Diabetes Mellitus (DM)	> 126 mg/dL		

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .

BLOOD SUGAR PP (Plasma) 83.7 mg/dl 70.0 - 140.0
Method:- GOD PAP

Instrument Name: MISPA PLUS Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .



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Page No: 4 of 16

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Final Authentication : 09/07/2022 17:44:33

HAEMATOTOLOGY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

GLYCOSYLATED HEMOGLOBIN (HbA1C)
Method:- Nephelometry methodology

5.7 %

Reference normal value (NGSP) :-
4.6 % - 6.2 % HbA1c
ADA recommended reference range :-
5.7 %- 6.4 % HbA1c (High risk group)
Above 6.5 % HbA1c (Diabetics)

MEAN PLASMA GLUCOSE
Method:- Calculated Parameter

112 mg/dL

Instrument name: ARKRAY's ADAMS Lite HA 8380V, JAPAN.

Test Interpretation:

HbA1C is formed by the condensation of glucose with n-terminal valine residue of each beta chain of HbA to form an unstable schiff base. It is the major fraction, constituting approximately 80% of HbA1c. Formation of glycosylated hemoglobin (GHb) is essentially irreversible and the concentration in the blood depends on both the lifespan of the red blood cells (RBC) (120 days) and the blood glucose concentration. The GHb concentration represents the integrated values for glucose over the period of 6 to 8 weeks. GHb values are free of day to day glucose fluctuations and are unaffected by recent exercise or food ingestion. Concentration of plasma glucose concentration in GHb depends on the time interval, with more recent values providing a larger contribution than earlier values. The interpretation of GHb depends on RBC having a normal life span. Patients with hemolytic disease or other conditions with shortened RBC survival exhibit a substantial reduction of GHb. High GHb have been reported in iron deficiency anemia. GHb has been firmly established as an index of long term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. The absolute risk of retinopathy and nephropathy are directly proportional to the mean of HbA1C. Genetic variants (e.g. HbS trait, HbC trait), elevated HbF and chemically modified derivatives of hemoglobin can affect the accuracy of HbA1C measurements. The effects vary depending on the specific Hb variant or derivative and the specific HbA1C method.

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Page No: 5 of 16

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Final Authentication : 09/07/2022 17:44:33

HAEMATOLOGY

BLOOD GROUP ABO
Method:- Haemagglutination reaction

"AB" POSITIVE



ADIYTA

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Age :- 34 Yrs 5 Mon 15 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Male	Lab/Hosp :-		
	Company :- MEDIWHEEL		

Final Authentication : 09/07/2022 17:44:33

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

LIPID PROFILE

TOTAL CHOLESTEROL 182.00 mg/dl
Desirable <200
Borderline 200-239
High > 240
Method:- CHOD-PAP methodology

InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

TRIGLYCERIDES 80.00 mg/dl
Normal <150
Borderline high 150-199
High 200-499
Very high >500
Method:- GPO-TOPS methodology

InstrumentName:MISPA PLUS **Interpretation :** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

DIRECT HDL CHOLESTEROL 40.00 mg/dl
Male 35-80
Female 42-88
Method:- Selective inhibition Method

Instrument Name:MISPA PLUS **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

LDL CHOLESTEROL 128.67 mg/dl
Optimal <100
Near Optimal/above optimal 100-129
Borderline High 130-159
High 160-189
Very High > 190
Method:- Calculated Method

VLDL CHOLESTEROL 16.00 mg/dl
0.00 - 80.00
Method:- Calculated

T.CHOLESTEROL/HDL CHOLESTEROL RATIO 4.55
0.00 - 4.90
Method:- Calculated

LDL / HDL CHOLESTEROL RATIO 3.22
0.00 - 3.50
Method:- Calculated

TOTAL LIPID 510.58 mg/dl
400.00 - 1000.00
Method:- CALCULATED

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.

2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended

3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.

Comments: 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all ADIYTA

Technologist
Page No: 7 of 16

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Sex :- Male	Lab/Hosp :-		
	Company :-	MEDIWHEEL	

Final Authentication : 09/07/2022 17:44:33

BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	0.75	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.15	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.60	mg/dl	0.30-0.70
SGOT Method:- IFCC	26.9	U/L	Men- Up to - 37.0 Female - Up to - 31.0
SGPT Method:- IFCC	24.8	U/L	Men- Up to - 40.0 Female- Up to - 31.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	95.00	U/L	80.00 - 306.00
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation: Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.	20.80	U/L	10.00 - 45.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	7.00	g/dl	5.10 - 8.00
SERUM ALBUMIN Method:- Bromocresol Green	4.05	g/dl	2.80 - 4.50
SERUM GLOBULIN Method:- CALCULATION	2.95	gm/dl	2.20 - 3.50
A/G RATIO	1.37		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc. Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

ADIYTA

Technologist

Page No: 9 of 16

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BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA 30.00 mg/dl 10.00 - 50.00
Method:- Urease/GLDH

InstrumentName: MISPA PLUS **Interpretation :** Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 1.17 mg/dl Males : 0.6-1.50 mg/dl
Method:- Jaffe's Method Females : 0.6 -1.40 mg/dl

Interpretation : Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 5.60 mg/dl 2.40 - 7.00

InstrumentName: HORIBA YUMIZEN CA60 Daytona plus **Interpretation:** Elevated Urate: High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Downs syndrome, Metabolic syndrome, Pregnancy, Gout.

SODIUM 136.0 mmol/L 135.0 - 148.0
Method:- ISE

Interpretation: Decreased sodium - Hyponatraemia Causes include: fluid or electrolyte loss, Drugs, Oedematous states, Legionnaire's disease and other chest infections, pseudonatremia, Hyperlipidaemias and paraproteinaemias, endocrine diseases, SIADH.

POTASSIUM 4.00 mmol/L 3.50 - 5.10
Method:- Ion-Selective Electrode with Serum

Interpretation: A. Elevated potassium (hyperkalaemia) Artefactual, Physiological, Drugs, Pathological states, Renal failure Adrenocortical insufficiency, metabolic acidoses, very high platelet or white cell counts B. Decreased potassium (hypokalaemia) Drugs, Liquoric, Diarrhoea and vomiting, Metabolic alkalosis, Corticosteroid excess, Oedematous state, Anorexia nervosa/bulimia

CHLORIDE 101.0 mmol/L 98.0 - 107.0
Method:- Ion-Selective Electrode with Serum
Interpretation: Used for Electrolyte monitoring.

SERUM CALCIUM 9.00 mg/dL 8.80 - 10.20
Method:- Arsenazo III Method

InstrumentName: MISPA PLUS **Interpretation:** Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia. Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN 7.00 g/dl 5.10 - 8.00
Method:- Direct Biuret Reagent

Tanu

Technologist
Page No: 10 of 16

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BIOCHEMISTRY

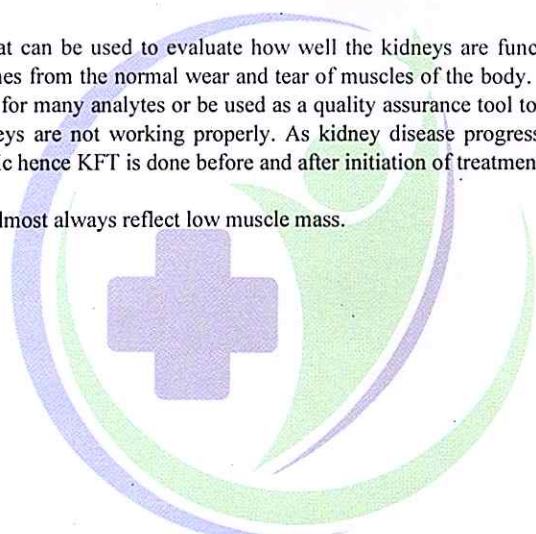
SERUM ALBUMIN Method:- Bromocresol Green	4.05	g/dl	2.80 - 4.50
SERUM GLOBULIN Method:- CALCULATION	2.95	gm/dl	2.20 - 3.50
A/G RATIO	1.37		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urea in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.



ADIYTA

Technologist
Page No: 11 of 16

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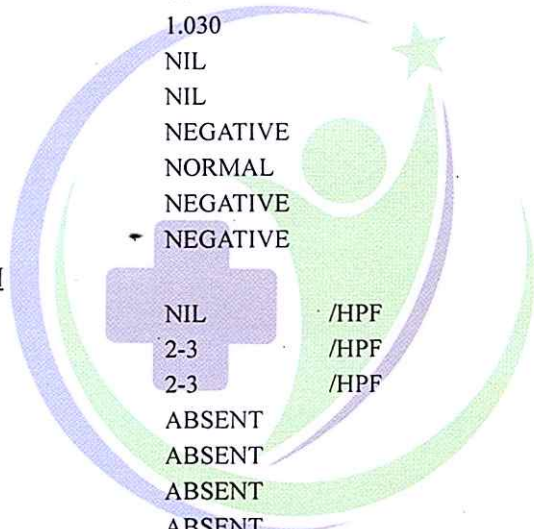


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CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION(PH)	6.0		5.0 - 7.5
SPECIFIC GRAVITY	1.030		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<u>MICROSCOPY EXAMINATION</u>			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT



ADIYTA

Technologist
Page No: 12 of 16

Tanu Rungta

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CLINICAL PATHOLOGY

URINE SUGAR (FASTING)
Collected Sample Received

Nil

Nil

URINE SUGAR PP
Collected Sample Received

Nil

Nil



ADIYTA

Technologist
Page No: 13 of 16

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P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

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TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
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THYROID-TRIODOOTHYRONINE T3

Method:- Chemiluminescence

Reference Range (T3)

0.90

ng/m

0.60 - 1.81 ng/ml

Premature Infants 26-30 Weeks ,3-4 days	0.24 - 1.32 ng/m
Full-Term Infants 1-3 days	0.89 - 4.05 ng/m
1 Week	0.91 - 3.00 ng/ml
1- 11 Months	0.85 - 2.50 ng/m
Prepubertal Children	1.19 - 2.18 ng/ml

NOTE: In pregnancy total T3,T4 increase to 1.5 times the normal range.

Clinical Information Primary malfunction of the thyroid gland may result in excessive(hyper) or low(hypo) release of T3 or T4. In addition, as TSH directly affect thyroid function,malfunction of the pituitary or the hypothalamus influences the thyroid gland activity.Disease in any portion of the thyroid-pituitary-hypothalamus system may influence the level of T3 and T4 in the blood,in Primary hypothyroidism,TSH levels are significantly elevated,while in secondary and tertiary hypothyroidism,TSH levels may be low.IN addition,In Euthyroid sick Syndrom,multiple alterations in serum thyroid function test findings have been recognized in patient with a wide variety of nonthyroid illness (NTI) serum without evidence of preexisting thyroid or hypothalamic- pituitary disease .

THYROID - THYROXINE (T4)

Method:- Chemiluminescence

InstrumentName: VITROS ECI **Interpretation :**The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy,that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4.Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

5.00

ug/dl

4.50 - 10.90 ug/dl

TSH

Method:- Chemiluminescence

1.500

μIU/mL

0-3 days 1.0-20.0
3 days-30 days 0.5-6.5
1month -18 years 0.5-6.0

Clinical Informaton:

The levels of thyroid hormone (T3 & T4) are low in case of Primary, Secondary and Tertiary hypothyroidism and sometimes in nonthyroidal illness also. Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance. T3 levels are also raised in T3 thyrotoxicosis. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism. In Pregnancy - Level Total T3 (ng/mL) Total T4 (μg/dl) TSH (μIU/ml)

1st Trimester 0.81-1.90 6.6-12.4 0.1-2.5

2nd Trimester 1.0-2.6 6.6-15.5 0.2-3.0

3rd Trimester 1.0-2.6 6.6-15.5 0.3-3.0

Note: TSH levels are subject to circadian variaton, reaching peak levels between 2-4 AM and at a minimum between 6-10 PM.

The variation is of the order of 50%. Hence time of the day has influence on the measured serum TSH concentrations.

InstrumentName: VITROS ECI **Interpretation:** Triiodothyronine (T3) contributes to the maintenance of the euthyroid state.A decrease in T3 concentration of up to 50% occurs in a variety of clinical situations, including acute and chronic disease. Although T3 results alone cannot be used to diagnose hypothyroidism, T3 concentration may be more sensitive than thyroxine (T4) for hyperthyroidism. Consequently, the total T3 assay can be

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Technologist

Page No: 15 of 16



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IMMUNOASSAY

used in conjunction with other assays to aid in the differential diagnosis of thyroid disease. T3 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, Free T3 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake, or T4 uptake can be used with the total T3 result to calculate the free T3 index and estimate the concentration of free T3.

InstrumentName: VITROS ECI **Interpretation :** The measurement of Total T4 aids in the differential diagnosis of thyroid disease. While >99.9% of T4 is protein-bound, primarily to thyroxine-binding globulin (TBG), it is the free fraction that is biologically active. In most patients, the total T4 concentration is a good indicator of thyroid status. T4 concentrations may be altered in some conditions, such as pregnancy, that affect the capacity of the thyroid hormone-binding proteins. Under such conditions, free T4 can provide the best estimate of the metabolically active hormone concentration. Alternatively, T3 uptake may be used with the total T4 result to calculate the free T4 index (FT4I) and estimate the concentration of free T4. Some drugs and some nonthyroidal patient conditions are known to alter TT4 concentrations in vivo.

InstrumentName: VITROS ECI **Interpretation :** TSH stimulates the production of thyroxine (T4) and triiodothyronine (T3) by the thyroid gland. The diagnosis of overt hypothyroidism by the finding of a low total T4 or free T4 concentration is readily confirmed by a raised TSH concentration. Measurement of low or undetectable TSH concentrations may assist the diagnosis of hyperthyroidism, where concentrations of T4 and T3 are elevated and TSH secretion is suppressed. These have the advantage of discriminating between the concentrations of TSH observed in thyrotoxicosis, compared with the low, but detectable, concentrations that occur in subclinical hyperthyroidism. The performance of this assay has not been established for neonatal specimens. Some drugs and some nonthyroidal patient conditions are known to alter TSH concentrations in vivo.

INTERPRETATION

PREGNANCY	REFERENCE RANGE FOR TSH IN uIU/mL (As per American Thyroid Association)
1st Trimester	0.10-2.50
2nd Trimester	0.20-3.00
3rd Trimester	0.30-3.00

*** End of Report ***

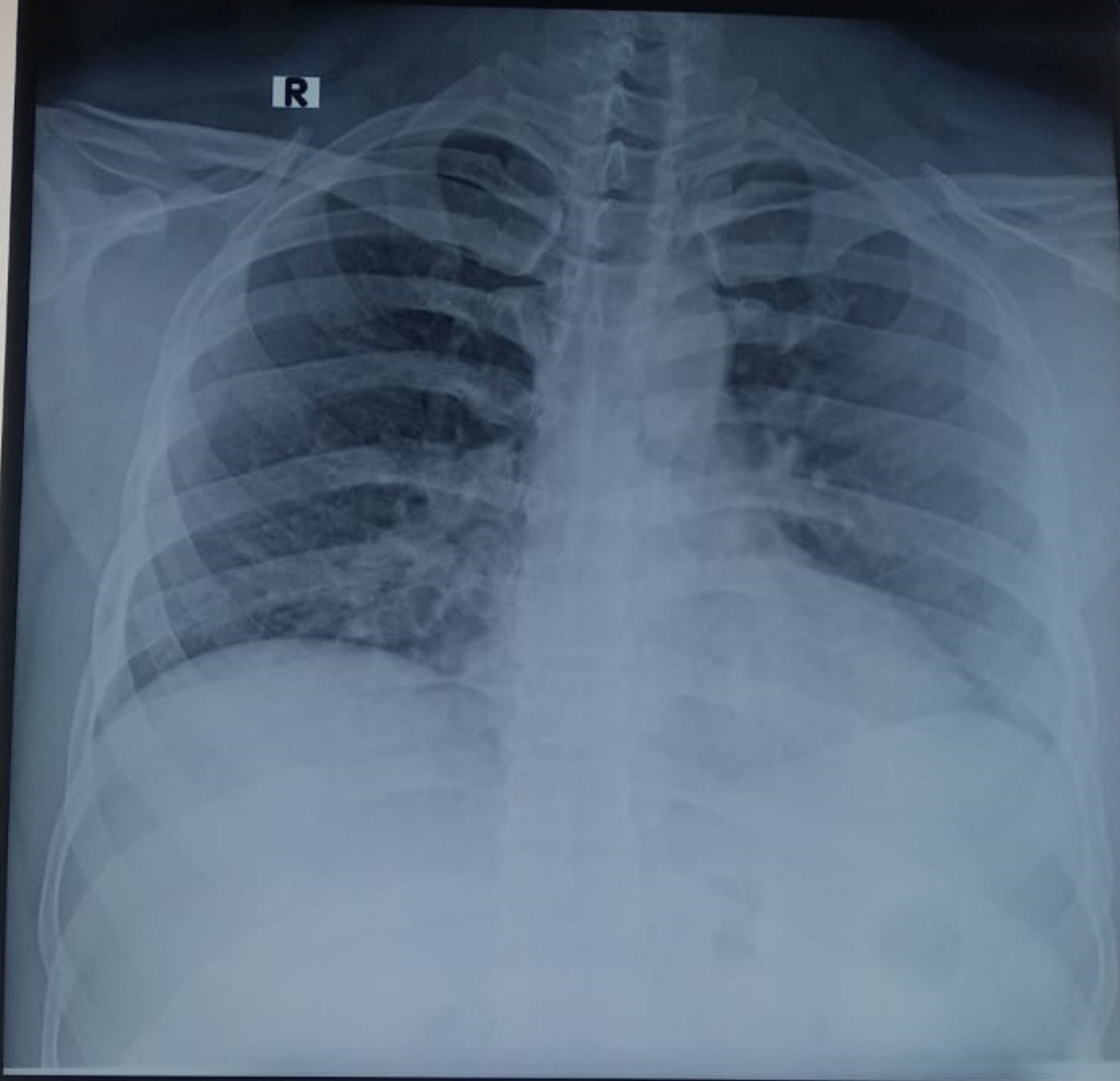
ADIYTA

Technologist

Page No: 16 of 16

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