

06/03/2024

Supriya Sonelkar
31 yrs | male

No fresh complaints.
headache on & off

No PIH,

No SIH.

LMP - 27/02/2024, irregular \therefore 8 months

O/H - G₂ P₁ A₁ L₁ D₀.

G₁ - male, 3 yrs, FTND, healthy

G₂ - MTP, 8 months ago

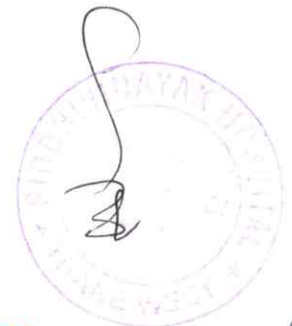
F/H - mother - } healthy.
father - }

BSP - 110/70 mmHg

r - 75/min

SpO₂ - 98%

PT is fit and can resume
her normal duties





Name - Mrs. Supriya Sonekar	Age - 31 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 06 /03/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





Sonography Colour Doppler 3D / 4D USG	
Name - Mrs. Supriya Sonekar	Age - 31 Y / F
Ref by Dr.- Siddhivinayak Hospital	Date - 06/03/2024

USG ABDOMEN & PELVIS

FINDINGS:

The liver dimension is normal in size. It appears normal in morphology with normal echogenicity. No evidence of intrahepatic ductal dilatation.

The GB-gallbladder is distended normally with no stones within.

The CBD- common bile duct is normal. The portal vein is normal.

The pancreas appears normal in morphology.

The spleen is normal in size (9.4 cm) and morphology

Both kidneys demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 9.8 x 4.2 cm.

The left kidney measures 10.4 x 4.8 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus : is normal in size.

Endometrium: 7.9 mm, it appears normal in morphology.

Right ovary is normal in size 2.9 x 2.9 cm .

Left ovary is normal in size 2.7 x 1.9 cm.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- No obvious significant abnormality detected.

DR. AMOL BENDRE
MBBS; DMRE

CONSULTANT RADIOLOGIST



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE

SUPRIYA SONEKAR

AGE

31

DATE -

06.03.2024

Specs : Without Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/9	6/12
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS

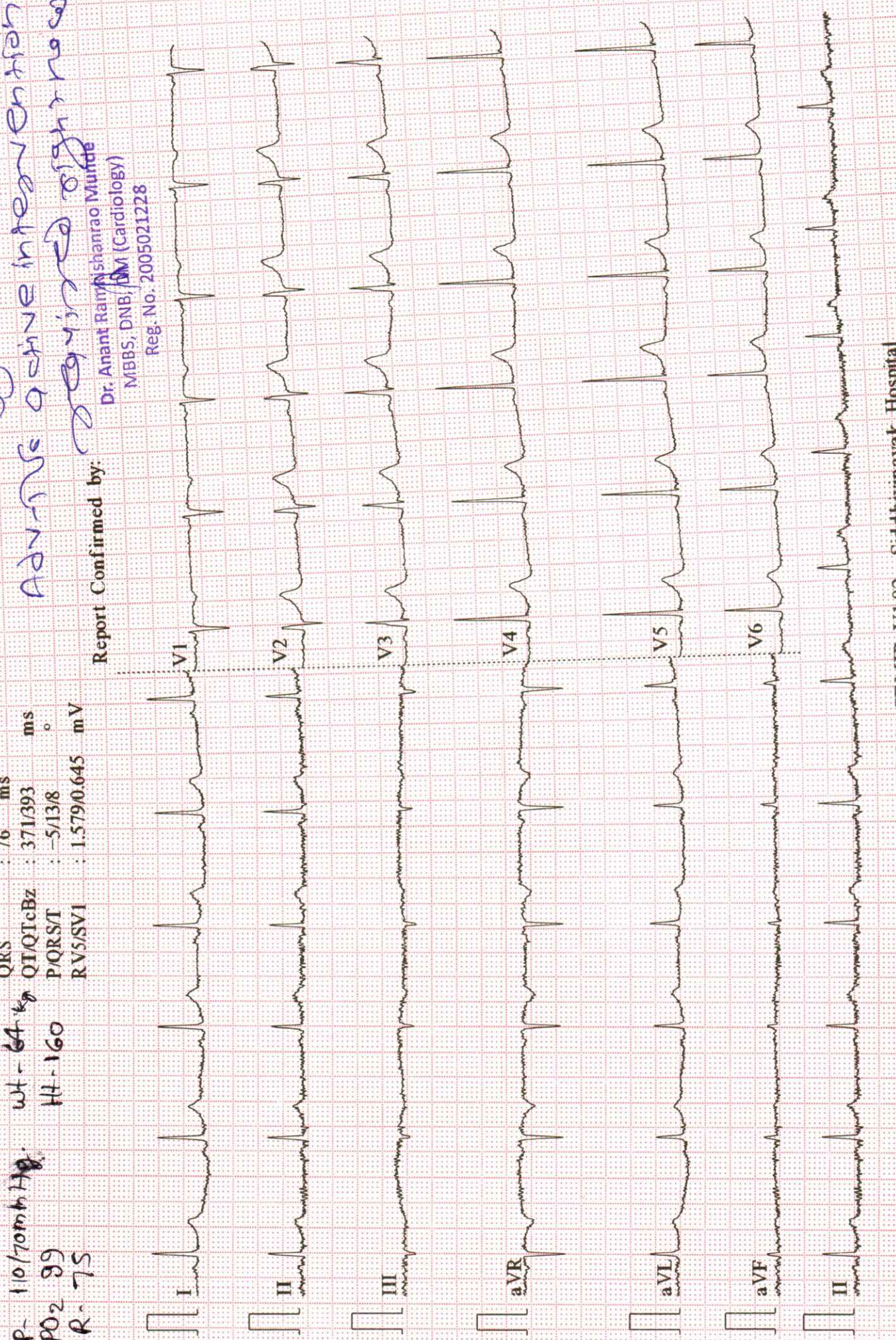
ID: 1037
 Female
 Supriya Suneekar
 31 Years
 BP- 110/70mmHg
 SP02 99
 PR- 75

06-03-2024 11:35:39 AM
 HR : 67 bpm
 P : 91 ms
 PR : 131 ms
 QRS : 76 ms
 QT/QTcBz : 371/393 ms
 PQRST : -5/13/8 °
 RV5/SVI : 1.579/0.645 mV

Diagnosis Information:
 Sinus Arrhythmia

TVSR
 No Significant ST-T changes
 Advise active intervention
 as required

Report Confirmed by:
 Dr. Anant Ramkrishnanrao Munde
 MBBS, DNB, DM (Cardiology)
 Reg. No. 2005021228





ECHOCARDIOGRAM

NAME	MRS. SUPRIYA SONEKAR
AGE/SEX	31 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	06/03/2024

2D/M-MODE ECHOCARDIOGRAPHY

<p>VALVES:</p> <p>MITRAL VALVE:</p> <ul style="list-style-type: none"> • AML: Normal • PML: Normal • Sub-valvular deformity: Absent <p>AORTIC VALVE: Normal</p> <ul style="list-style-type: none"> • No. of cusps: 3 <p>PULMONARY VALVE: Normal</p> <p>TRICUSPID VALVE: Normal</p>	<p>CHAMBERS:</p> <p>LEFT ATRIUM: Normal</p> <ul style="list-style-type: none"> • Left atrial appendage: Normal <p>LEFT VENTRICLE: Normal</p> <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal <p>RIGHT ATRIUM: Normal</p> <p>RIGHT VENTRICLE: Normal</p> <ul style="list-style-type: none"> • RWMA: No • Contraction: Normal
<p>GREAT VESSELS:</p> <ul style="list-style-type: none"> • AORTA: Normal • PULMONARY ARTERY: Normal 	<p>SEPTAE:</p> <ul style="list-style-type: none"> • IAS: Intact • IVS: Intact
<p>CORONARIES: Proximal coronaries normal</p>	<p>VENACAVAE:</p> <ul style="list-style-type: none"> • SVC: Normal • IVC: Normal and collapsing >20% with respiration
<p>CORONARY SINUS: Normal</p>	
<p>PULMONARY VEINS: Normal</p>	<p>PERICARDIUM: Normal</p>

MEASUREMENTS:

AORTA		LEFT VENTRICLE STUDY		RIGHT VENTRICLE STUDY	
PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE	PARAMETER	OBSERVED VALUE
Aortic annulus	21 mm	Left atrium	32 mm	Right atrium	mm
Aortic sinus	mm	LVIDd	43.3 mm	RVd (Base)	mm
Sino-tubular junction	mm	LVIDs	26.6 mm	RVEF	%
Ascending aorta	mm	IVSd	6.4 mm	TAPSE	mm
Arch of aorta	mm	LVPWd	6.4 mm	MPA	mm
Desc. thoracic aorta	mm	LVEF	69 %	RVOI	mm
Abdominal aorta	mm	LVOT	mm	IVC	13.5 mm



COLOR - FLOW & DOPPLER ECHOCARDIOGRAPHY

NAME	MRS. SUPRIYA SONEKAR
AGE/SEX	31 YRS/F
REFERRED BY	SIDDHIVINAYAK HOSPITAL
DATE OF EXAMINATION	06/03/2024

	MITRAL	TRICUSPID	AORTIC	PULMONARY
FLOW VELOCITY (m/s)			1.28	1.01
PPG (mmHg)				
MPG (mmHg)				
VALVE AREA (cm ²)				
DVI (ms)				
PR END DIASTOLIC VELOCITY (m/s)				
ACCELERATION/ DECELERATION TIME (ms)				
PHT (ms)				
VENA CONTRACTA (mm)				
REGURGITATION		TRJV= m/s PASP= mmHg		
E/A				
E/E'				

FINAL IMPRESSION: NORMAL STUDY

- No RWMA
- Normal LV systolic function (LVEF 69 %)
- Good RV systolic function
- Normal diastolic function
- All cardiac valves are normal
- All cardiac chambers are normal
- IAS/IVS intact
- No pericardial effusion/ clot/vegetations

ADVICE: Nil

ECHOCARDIOGRAPHER:

Dr. ANANT MUNDE

DNB, DM (CARDIOLOGY)

INTERVENTIONAL CARDIOLOGIST

Dr. Anant Ramkishanrao Munde

MBBS, DNB, DM (Cardiology)

Reg. No. 2005021228



Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	193.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	49.8	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	98.1	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	20	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	124	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	2.49		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	3.88		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	11.8	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	35.4	%	36 - 46
RBC COUNT	4.39	x10 ⁶ /uL	4.5 - 5.5
MCV	81	fl	80 - 96
MCH	26.9	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	14.9	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	7190	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	46	%	40 - 80
LYMPHOCYTES	48	%	20 - 40
EOSINOPHILS	02	%	0 - 6
MONOCYTES	04	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	184000	/cumm	150000 - 450000
MPV	14.9	fl	6.5 - 11.5
PDW	16.2	%	9.0 - 17.0
PCT	0.270	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Lymphocytosis		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	35ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent	/ HPF	Absent
PUS CELLS	1-2	/ HPF	0 - 5
EPITHELIAL	0-2	/ HPF	0 - 5
CASTS	Absent		

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name	: Mrs. SUPRIYA SONEKAR (A)	Collected On	: 6/3/2024 11:03 am
Lab ID.	: 185883	Received On	: 6/3/2024 11:13 am
Age/Sex	: 31 Years / Female	Reported On	: 6/3/2024 5:46 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
-----------	---------	------	-----------------

TFT (THYROID FUNCTION TEST)

SPECIMEN	Serum		
T3	97.22	ng/dl	84.63 - 201.8
T4	8.93	µg/dl	5.13 - 14.06
TSH	3.60	µIU/ml	0.270 - 4.20

DONE ON FULLY AUTOMATED ANALYSER COBAS e411.

INTERPRETATION T3 (Triiodo Thyronine) T4 (Thyroxine)

AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 years	105-269	1-4 months	7.2-14.4
6-10 years	94-241	4-12months	7.8-16.5
11-15 years	82-213	1-5 years	7.3-15.0
15-20 years	80-210	5-10 years	6.4-13.3
		11-15 years	5.6-11.7

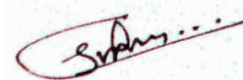
TSH(Thyroid stimulating hormone)

AGE	RANGES
0-14 Days	1.0-39
2 weeks -5 months	1.7-9.1
6 months-20 years	0.7-6.4
Pregnancy	
1st Trimester	0.1-2.5
2nd Trimester	0.20-3.0
3rd Trimester	0.30-3.0

INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Checked By
 Priyanka_Deshmukh



DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 5 8 8 3 *

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>BLOOD GROUP</u>			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'B'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
----- END OF REPORT -----			

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	15.1	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	7.06	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.76	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	3.2	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	140.0	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.0	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	99.1	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	3.6	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	10	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	7.28	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	4.2	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	3.08	g/dl	1.9 - 3.5
A/G RATIO calculated	1.36		0 - 2

NOTE

BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200)
ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mrs. SUPRIYA SONEKAR (A)
Lab ID. : 185883
Age/Sex : 31 Years / Female
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS

Collected On : 6/3/2024 11:03 am
Received On : 6/3/2024 11:13 am
Reported On : 6/3/2024 5:46 pm
Report Status : FINAL



* 1 8 5 8 8 3 *

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	WHOLE BLOOD EDTA
RBC	Normocytic, Normochromic
WBC	Total leukocytes count count is normal on smear. Lymphocyte count is increased on smear. NEUTROPHILS:46% LYMPHOCYTES:48% EOSINOPHILS:02% MONOCYTES :04% BASOPHILS :00%
PLATELET	Adequate on smear
HEMOPARASITE	No parasite seen.

Result relates to sample tested, Kindly correlate with clinical findings.
----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	0.72	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.34	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	0.38	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	15.7	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	11.0	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	62.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	7.28	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	4.2	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	3.08	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.36		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
SHAISTA Q

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
Lab ID. : 185883 Received On : 6/3/2024 11:13 am
Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 5 8 8 3 *

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	32	mm/1hr.	0 - 20

METHOD - WESTERGREIN

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name	: Mrs. SUPRIYA SONEKAR (A)	Collected On	: 6/3/2024 11:03 am
Lab ID.	: 185883	Received On	: 6/3/2024 11:13 am
Age/Sex	: 31 Years / Female	Reported On	: 6/3/2024 5:46 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



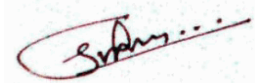
BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.6	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	114.0	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	84.4	mg/dL	70 - 110
BLOOD GLUCOSE PP	74.3	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting speciman. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

Checked By
 Priyanka_Deshmukh



DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. SUPRIYA SONEKAR (A) Collected On : 6/3/2024 11:03 am
 Lab ID. : 185883 Received On : 6/3/2024 11:13 am
 Age/Sex : 31 Years / Female Reported On : 6/3/2024 5:46 pm
 Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
-----------	---------	------	-----------------

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT 11.1 U/L 5 - 55

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
 Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

