Patient Ref. No. 31000004506341

Cert. No. MC-2396

CLIENT CODE : C000138363

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
P S Srijan Tech Park Building,DN-52,Unit No.2,Ground Floor,Sector V,
Salt Lake,
KOLKATA, 700091
WEST BENGAL, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : customercare.saltlake@srl.in

PATIENT NAME : SMRUTI SWAIN PATIENT ID : **SMRUF29128831**

ACCESSION NO : **0031VI020613** AGE : 33 Years SEX : Female ABHA NO :

DRAWN : 24/09/2022 08:15:00 RECEIVED : 24/09/2022 08:35:11 REPORTED : 12/10/2022 18:25:47

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	13.3		12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY				
RED BLOOD CELL COUNT	**5.20**	**High**	3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL COUNT	7.86		4.0 - 10.0	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	214		150 - 410	thou/µL
METHOD : ELECTRONIC IMPEDENCE & MICROSCOPY				
RBC AND PLATELET INDICES				
HEMATOCRIT	40.3		36 - 46	%
METHOD : CALCULATED				
MEAN CORPUSCULAR VOL	**77.6**	**Low**	83 - 101	fL
METHOD : ELECTRICAL IMPEDANCE				
MEAN CORPUSCULAR HGB.	**25.5**	**Low**	27.0 - 32.0	pg
METHOD : CALCULATED				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	32.9		31.5 - 34.5	g/dL
METHOD : CALCULATED				
MENTZER INDEX	14.9			
RED CELL DISTRIBUTION WIDTH	**15.5**	**High**	11.6 - 14.0	%
METHOD : ELECTRICAL IMPEDANCE				
MEAN PLATELET VOLUME	**12.9**	**High**	6.8 - 10.9	fL
METHOD : CALCULATED				
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	65		40 - 80	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE NEUTROPHIL COUNT	5.11		2.0 - 7.0	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED				
LYMPHOCYTES	21		20 - 40	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE LYMPHOCYTE COUNT	1.65		1 - 3	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	3.1			

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EOSINOPHILS	5		1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.39		0.02 - 0.50	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED				
MONOCYTES	9		2 - 10	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE MONOCYTE COUNT	0.71		0.20 - 1.00	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED				
BASOPHILS	0		0 - 2	%
METHOD : FLOWCYTOMETRY, ELECTRONIC IMPEDANCE & MICROSCOPY.				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
METHOD : FLOWCYTOMETRY & CALCULATED				
MORPHOLOGY				
RBC	PREDOMINANTLY NORMOCYTIC NORMOCHROMIC WITH MILD ANISOCYTOSIS, FEW MICROCYTES SEEN.			
METHOD : MICROSCOPIC EXAMINATION				
WBC	NO IMMATURE CELLS SEEN.			
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS	ADEQUATE			
METHOD : MICROSCOPIC EXAMINATION				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	8		0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	**108**	**High**	74 - 100	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	**6.1**	**High**	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HPLC				
MEAN PLASMA GLUCOSE	**128.4**	**High**	< 116.0	mg/dL

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SRL LIMITED - KOLKATA REF. LAB **PATIENT REP**
Bio-Rad Variant II Turbo CDM 5.4 S/N : 16043 **V2TURBO_A1c**

Patient Data

Sample ID:	3106488771
Patient ID:	0031VI020613
Name:	SMRUTISWAIN
Physician:	
Sex:	
DOB:	

Comments:

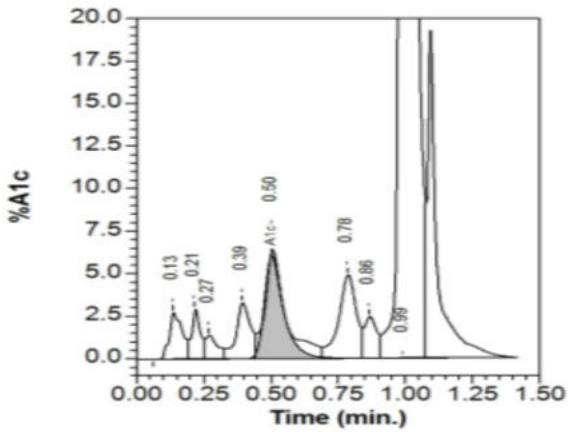
Analysis Data

Analysis Performed:	24/SEP/2022 11:42:55
Injection Number:	2991
Run Number:	186
Rack ID:	
Tube Number:	6
Report Generated:	24/SEP/2022 12:22:02
Operator ID:	

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.5	0.133	24990
A1b	---	1.1	0.215	18049
F	---	0.7	0.268	11819
LA1c	---	1.9	0.394	32179
A1c	6.1*	---	0.502	82465
P3	---	3.6	0.784	60411
P4	---	1.3	0.865	21227
Ao	---	85.1	0.991	1434262

*Values outside of expected ranges Total Area: 1,685,403

HbA1c (NGSP) = 6.1* %



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GLUCOSE, POST-PRANDIAL, PLASMA				
GLUCOSE, POST-PRANDIAL, PLASMA	123		140 Normal 140 - 199 Pre-diabetic > or = 200 Diabetic	mg/dL
METHOD : ENZYMATIC (HEXOKINASE/G-6-PDH)				
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL	195		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC ASSAY				
TRIGLYCERIDES	136		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : GLYCEROL PHOSPHATE OXIDASE				
HDL CHOLESTEROL	48		Low : < 40 High : > / = 60	mg/dL
METHOD : ACCELERATOR SELECTIVE DETERGENT METHODOLOGY				
CHOLESTEROL LDL	120			mg/dL
NON HDL CHOLESTEROL	**147**	**High**	Desirable: Less than 130 Above Desirable: 130-159 Borderline High: 160-189 High: 190 -219 Very High: >or = 220	mg/dL
METHOD : CALCULATED				
CHOL/HDL RATIO	4.1			
LDL/HDL RATIO	2.5			
VERY LOW DENSITY LIPOPROTEIN	27.2			mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.27		0.2 - 1.2	mg/dL
METHOD : DIAZONIUM SALT				
BILIRUBIN, DIRECT	0.12		0.0 - 0.5	mg/dL
METHOD : DIAZO REACTION				
BILIRUBIN, INDIRECT	0.15		0.1 - 1.0	mg/dL
METHOD : CALCULATED				
TOTAL PROTEIN	7.3		6.0 - 8.30	g/dL
METHOD : BIURET				

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ALBUMIN	4.5		3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN	2.8		2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO	1.6		1 - 2.1	RATIO
METHOD : CALCULATED PARAMETER				
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	21		5 - 34	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALANINE AMINOTRANSFERASE (ALT/SGPT)	23		0 - 55	U/L
METHOD : ENZYMATIC (NADH (WITHOUT P-5'-P)				
ALKALINE PHOSPHATASE	79		40 - 150	U/L
METHOD : PARA-NITROPHENYL PHOSPHATE				
GAMMA GLUTAMYL TRANSFERASE (GGT)	24		8 -33	U/L
METHOD : L-GAMMA-GLUTAMYL-4-NITROANALIDE /GLYCYLGLYCINE KINETIC METHOD				
LACTATE DEHYDROGENASE	128		125 - 220	U/L
METHOD : IFCC LACTATE TO PYRUVATE				
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	**6**	**Low**	7.0 - 18.7	mg/dL
METHOD : UREASE METHOD				
CREATININE, SERUM				
CREATININE	0.66		0.57 - 1.11	mg/dL
METHOD : KINETIC ALKALINE PICRATE				
BUN/CREAT RATIO				
BUN/CREAT RATIO	9.09		5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID	4.6		2.6 - 6.0	mg/dL
METHOD : URICASE				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	7.3		6.0 - 8.3	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN	4.5		3.5 - 5.2	g/dL
METHOD : COLORIMETRIC (BROMCRESOL GREEN)				
GLOBULIN				
GLOBULIN	2.8		2.0 - 3.5	g/dL

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METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	140	136 - 145	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
POTASSIUM	4.80	3.5 - 5.1	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
CHLORIDE	104	98 - 107	mmol/L
METHOD : ION SELECTIVE ELECTRODE TECHNOLOGY INDIRECT			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	**SLIGHTLY HAZY**		
SPECIFIC GRAVITY	1.010	1.003 - 1.035	
METHOD : DIPSTICK			
Comments			
NOTE: URINE SAMPLE RECEIVED ON - 28/09/2022			
CHEMICAL EXAMINATION, URINE			
PH	7.0	4.7 - 7.5	
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : DIPSTICK			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : DIPSTICK			
LEUKOCYTE ESTERASE	**DETECTED (+)**	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			

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PUS CELL (WBC'S)	**5-7**	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	**DETECTED (+)**	NOT DETECTED	

Comments

URINALYSIS: MICROSCOPIC EXAMINATION IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.
.

THYROID PANEL, SERUM

T3	110.6	35 - 193	ng/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
T4	5.53	4.87 - 11.71	µg/dL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			
TSH 3RD GENERATION	2.515	0.350 - 4.940	µIU/mL
METHOD : TWO-STEP CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY			

PAPANICOLAOU SMEAR

SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY
SPECIMEN ADEQUACY	SMEARS ARE SATISFACTORY FOR EVALUATION.
MICROSCOPY	SMEARS STUDIED ARE SATISFACTORY FOR EVALUATION AND SHOW MAINLY SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS AND PARABASAL CELLS. FEW METAPLASTIC CELLS ARE SEEN. MONILIA AND T. VAGINALIS ARE ABSENT. DYSPLASTIC AND MALIGNANT CELLS ARE ABSENT. MILD INFILTRATE OF INFLAMMATORY CELLS ARE SEEN IN THE SMEARS.

METHOD : MANUAL

INTERPRETATION / RESULT	NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY

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Comments

1) PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS. HENCE SHOULD BE INTERPRETED WITH CAUTION.
2) NO CYTOLOGIC EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

STOOL: OVA & PARASITE

COLOUR	BROWN		
METHOD : VISUAL			
CONSISTENCY	SEMI FORMED		
METHOD : MANUAL			
ODOUR	FAECAL		
METHOD : MANUAL			
MUCUS	**PRESENT**	NOT DETECTED	
METHOD : MANUAL			
VISIBLE BLOOD	ABSENT	ABSENT	
METHOD : VISUAL			
POLYMORPHONUCLEAR LEUKOCYTES	1-2	0 - 5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
MACROPHAGES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CHARCOT-LEYDEN CRYSTALS	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
ADULT PARASITE	NOT DETECTED		
METHOD : VISUAL			
OCCULT BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : MANUAL			

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Comments

NOTE : STOOL SAMPLE RECEIVED ON 28/09/2022.

*** ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**			
ABO GROUP	TYPE O		
METHOD : GEL CARD METHOD			
RH TYPE	POSITIVE		
METHOD : GEL CARD METHOD			
XRAY-CHEST			
IMPRESSION	NO ABNORMALITY DETECTED		
TMT OR ECHO			
TMT OR ECHO	Echo done - Normal		
ECG			
ECG	WITHIN NORMAL LIMITS		
MEDICAL HISTORY			
RELEVANT PRESENT HISTORY	NOT SIGNIFICANT		
RELEVANT PAST HISTORY	Covid		
RELEVANT PERSONAL HISTORY	NOT SIGNIFICANT		
RELEVANT FAMILY HISTORY	Parents - HTN, Diabetes		
OCCUPATIONAL HISTORY	NOT SIGNIFICANT		
HISTORY OF MEDICATIONS	NOT SIGNIFICANT		
ANTHROPOMETRIC DATA & BMI			
HEIGHT IN METERS	1.56		mts
WEIGHT IN KGS.	61		Kgs
BMI	25	BMI & Weight Status as follows: kg/sqmts Below 18.5: Underweight 18.5 - 24.9: Normal 25.0 - 29.9: Overweight 30.0 and Above: Obese	
GENERAL EXAMINATION			
MENTAL / EMOTIONAL STATE	NORMAL		
PHYSICAL ATTITUDE	NORMAL		
GENERAL APPEARANCE / NUTRITIONAL STATUS	HEALTHY		

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Cert. No. MC-2396

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Salt Lake,
KOLKATA, 700091
WEST BENGAL, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956
Email : customercare.saltlake@srl.in

PATIENT NAME : SMRUTI SWAIN PATIENT ID : **SMRUF29128831**

ACCESSION NO : **0031VI020613** AGE : 33 Years SEX : Female ABHA NO :

DRAWN : 24/09/2022 08:15:00 RECEIVED : 24/09/2022 08:35:11 REPORTED : 12/10/2022 18:25:47

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	Results	Biological Reference Interval	Units
BUILT / SKELETAL FRAMEWORK	AVERAGE		
FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
BREAST (FOR FEMALES)	NORMAL		
TEMPERATURE	NORMAL		
PULSE	76/min-REGULAR, ALL PERIPHERAL PULSES WELL FELT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	124/80 mm Hg		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
CENTRAL NERVOUS SYSTEM			

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HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		
JOINTS	NORMAL		
BASIC EYE EXAMINATION			
CONJUNCTIVA	NORMAL		
EYELIDS	NORMAL		
EYE MOVEMENTS	NORMAL		
DISTANT VISION RIGHT EYE WITH GLASSES	6/6		
DISTANT VISION LEFT EYE WITH GLASSES	6/6		
NEAR VISION RIGHT EYE WITH GLASSES	N6		
NEAR VISION LEFT EYE WITH GLASSES	N6		
BASIC ENT EXAMINATION			
EXTERNAL EAR CANAL	NORMAL		
TYMPANIC MEMBRANE	NORMAL		
NOSE	NO ABNORMALITY DETECTED		
SINUSES	NORMAL		
THROAT	NO ABNORMALITY DETECTED		
TONSILS	NOT ENLARGED		
BASIC DENTAL EXAMINATION			
TEETH	NORMAL		
GUMS	HEALTHY		
SUMMARY			
RELEVANT HISTORY	NOT SIGNIFICANT		
RELEVANT GP EXAMINATION FINDINGS	NOT SIGNIFICANT		
RELEVANT LAB INVESTIGATIONS	Rased FBS(108), HbA1C(6.1)		
RELEVANT NON PATHOLOGY DIAGNOSTICS	Grade I fatty liver in USG.		

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

REMARKS / RECOMMENDATIONS

On examination and investigations the candidate is found to be raised FBS (108), HbA1C(6.1)
Grade I fatty liver in USG

Should follow the given advice:
1. Avoid fat, oil and high carbohydrate diet
2. Repeat FBS, PPBS and HbA1c after 4 weeks
3. Regular walking
4. Drink plenty of water
5. Physician opinion

Comments

MEDICAL EXAMINATION DONE BY:

DR. DEBIKA ROY, MBBS
CONSULTANT PHYSICIAN
WELLNESS CLINIC
SALT LAKE REF LAB, KOLKATA

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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

Grade I fatty liver

Interpretation(s)
BLOOD COUNTS,EDTA WHOLE BLOOD-
The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.
RBC AND PLATELET INDICES-
Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT - NLR-
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.
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, Vasculities, 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(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia 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. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.
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 sothat 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; sulfonylureas,tolbutamide, and other oral hypoglycemic agents.
NOTE:
Hypoglycemia is defined as a glucoseof < 50 mg/dL in men and< 40 mg/dL in women.
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.

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High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1.Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2.Diagnosing diabetes.
3.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 patients metabolic control has remained continuously within the target range.
1.eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
I.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.
II.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
III.Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
IV.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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
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 Glyosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c
LIVER FUNCTION PROFILE, SERUM-
LIVER FUNCTION PROFILE
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels 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, Paget's disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilson's disease.GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.Serum total protein,also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstrom's disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.Human serum albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
CREATININE, SERUM-Higher than normal level may be due to:
- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

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Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
URIC ACID, SERUM-
Causes of Increased levels
Dietary
• High Protein Intake.
• Prolonged Fasting,
• Rapid weight loss.
Gout
Lesch nyhan syndrome.
Type 2 DM.
Metabolic syndrome.

Causes of decreased levels
• Low Zinc Intake
• OCP's
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels
• Drink plenty of fluids
• Limit animal proteins
• High Fibre foods
• Vit C Intake
• Antioxidant rich foods
TOTAL PROTEIN, SERUM-
Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage),Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic 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.
ELECTROLYTES (NA/K/CL), SERUM-
Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,
MICROSCOPIC EXAMINATION, URINE-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

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Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
THYROID PANEL, SERUM-Triiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.
In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in Pregnancy	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
First Trimester	6.6 - 12.4	0.1 - 2.5	81 - 190
2nd Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
3rd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260

Below mentioned are the guidelines for age related reference ranges for T3 and T4.

	T3 (ng/dL)	T4 (µg/dL)
New Born:	75 - 260	1-3 day: 8.2 - 19.9
.		1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.
Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:
1. Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
2. Gowenlock A.H. Varley''''s Practical Clinical Biochemistry, 6th Edition.
3. Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition
STOOL: OVA & PARASITE-
Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc
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.
MEDICAL
HISTORY-**********
THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOLABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

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****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession
TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

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Patient Ref. No. 31000004506341

Cert. No. MC-2396

CLIENT CODE : C000138363

CLIENT'S NAME AND ADDRESS :
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PATIENT NAME : SMRUTI SWAIN PATIENT ID : **SMRUF29128831**

ACCESSION NO : **0031VI020613** AGE : 33 Years SEX : Female ABHA NO :

DRAWN : 24/09/2022 08:15:00 RECEIVED : 24/09/2022 08:35:11 REPORTED : 12/10/2022 18:25:47

REFERRING DOCTOR : SELF CLIENT PATIENT ID :

Test Report Status **Final**	**Results**	**Units**

Dr. Chaitali Ray, PhD
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Pathologist

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