Patient Ref. No. 666000002284956

CLIENT CODE : CA00010147 - MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
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Tel : 9446425900
Email : thrissur.ddrc@srl.in

PATIENT NAME : ANANDAN M R PATIENT ID : **ANANM1211634177**

ACCESSION NO : **4177VK001286** AGE : 59 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 12/11/2022 15:25 REPORTED : 14/11/2022 16:49

REFERRING DOCTOR : DR. A M ANTO CLIENT PATIENT ID :

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units
MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT	RESULT PENDING		
TREADMILL TEST	RESULT PENDING		
DENTAL CHECK UP			
DENTAL CHECK UP	NOT DONE		
OPTHAL			
OPTHAL	COMPLETED		
PHYSICAL EXAMINATION			
PHYSICAL EXAMINATION	COMPLETED		

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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT			
SERUM BLOOD UREA NITROGEN			
BLOOD UREA NITROGEN	8	Adult(<60 yrs) : 6 to 20	mg/dL
BUN/CREAT RATIO			
BUN/CREAT RATIO	11.4	5 - 15	
CREATININE, SERUM			
CREATININE	0.70	18 - 60 yrs : 0.9 - 1.3	mg/dL
GLUCOSE, POST-PRANDIAL, PLASMA			
GLUCOSE, POST-PRANDIAL, PLASMA	140	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
GLUCOSE, FASTING, PLASMA			
GLUCOSE, FASTING, PLASMA	100	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD			
GLYCOSYLATED HEMOGLOBIN (HBA1C)	6.2	Normal : 4.0 - 5.6%.% Non-diabetic level : < 5.7%. Diabetic : >6.5% Glycemic control goal More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%. Glycemic targets in CKD :- If eGFR > 60 : < 7%. If eGFR < 60 : 7 - 8.5%.	
MEAN PLASMA GLUCOSE	**131.2** **High**	< 116.0	mg/dL
CORONARY RISK PROFILE (LIPID PROFILE), SERUM			
CHOLESTEROL	141	Desirable : < 200 Borderline : 200-239 High : >or= 240	mg/dL
TRIGLYCERIDES	132	Normal : < 150 High : 150-199 Hypertriglyceridemia : 200-499 Very High : > 499	mg/dL
HDL CHOLESTEROL	40	General range : 40-60	mg/dL

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DIRECT LDL CHOLESTEROL	81		Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	101		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	3.5		3.30 - 4.40	
LDL/HDL RATIO	2.0		0.5 - 3.0	
VERY LOW DENSITY LIPOPROTEIN	26.4		< or = 30.0	mg/dL
LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	1.85		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	**0.66**	**High**	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT	**1.19**	**High**	0.00 - 1.00	mg/dL
TOTAL PROTEIN	6.7		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.9		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	**1.8**	**Low**	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	**2.7**	**High**	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	25		Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	34		Adults : < 45	U/L
ALKALINE PHOSPHATASE	57		Adult(<60yrs) : 40 - 130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	21		Adult (male) : < 60	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	6.7		Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	2.7		Adults : 3.4-7	mg/dL
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP	O			
RH TYPE	POSITIVE			
BLOOD COUNTS				
HEMOGLOBIN	15.0		13.0 - 17.0	g/dL

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RED BLOOD CELL COUNT	4.83		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	8.45		4.0 - 10.0	thou/µL
PLATELET COUNT	266		150 - 410	thou/µL
RBC AND PLATELET INDICES				
HEMATOCRIT	41.8		40 - 50	%
MEAN CORPUSCULAR VOL	86.6		83 - 101	fL
MEAN CORPUSCULAR HGB.	31.1		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	**35.9**	**High**	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	**14.3**	**High**	11.6 - 14.0	%
MEAN PLATELET VOLUME	9.4		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	40		40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.38		2.0 - 7.0	thou/µL
LYMPHOCYTES	27		20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.28		1 - 3	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	36.7			
EOSINOPHILS	**31**	**High**	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	**2.62**	**High**	0.02 - 0.50	thou/µL
MONOCYTES	02		2 - 10	%
ABSOLUTE MONOCYTE COUNT	**0.17**	**Low**	0.20 - 1.00	thou/µL
BASOPHILS	00		< 1 - 2	%
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	05		0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDING			
SUGAR URINE - POST PRANDIAL				
SUGAR URINE - POST PRANDIAL	NOT DETECTED		NOT DETECTED	
PROSTATE SPECIFIC ANTIGEN, SERUM				
PROSTATE SPECIFIC ANTIGEN	0.950		< 0.01 - 4.00	ng/mL
THYROID PANEL, SERUM				
T3	108.87		Adult : 60-181	ng/dL
T4	9.50		3.2 - 12.6	µg/dl
TSH 3RD GENERATION	2.300		50-80 Yrs : 0.35 - 4.5	µIU/mL
URINE ANALYSIS				

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COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
PH	5.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.015	1.003 - 1.035	
GLUCOSE	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
WBC	2-3	0-5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
CHEMICAL EXAMINATION, URINE			
PROTEIN	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
EPITHELIAL CELLS	0-1	0-5	/HPF
BACTERIA	NOT DETECTED	NOT DETECTED	
SUGAR URINE - FASTING			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	

Interpretation(s)
SERUM BLOOD UREA NITROGEN-
Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• 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
GLUCOSE, POST-PRANDIAL, PLASMA-
ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-
Glycosylated hemoglobin (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. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood, the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.
Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythemia or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.
Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia, increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.
"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.''

References
1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.
CORONARY RISK PROFILE (LIPID PROFILE), SERUM-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
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

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Test Report Status **Preliminary**	Results	Units

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.
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
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.
BLOOD COUNTS-
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-
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.
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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

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"
SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST
PROSTATE SPECIFIC ANTIGEN, SERUM-
Prostate Specific Antigen (PSA) is a single-chain glycoprotein normally found in the cytoplasm of the epithelial cells lining the acini and ducts of the prostate gland. PSA is detected in the serum of males with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis. PSA is not detected (or detected at very low levels) in the serum of males without prostate tissue (because of radical prostatectomy or cystoprostatectomy) or in the serum of most females.

The fact that PSA is unique to prostate tissue makes it a suitable marker for monitoring men with cancer of the prostate. PSA is also useful for determining possible recurrence after therapy when used in conjunction with other diagnostic indices. PSA levels increase in men with cancer of the prostate. After radical prostatectomy PSA levels routinely fall to a very low level, which may not be seen in patients undergoing radiation therapy. Monitoring PSA levels appears to be useful in detecting residual

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disease and early recurrence of tumor. Therefore, serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and in the monitoring of the effectiveness of therapy.

PSA levels should not be interpreted as absolute evidence of the presence or the absence of malignant disease. Before treatment, patients with confirmed prostate carcinoma frequently have levels of PSA within the range observed in healthy individuals. Elevated levels of PSA can be observed in the patients with nonmalignant diseases. Measurement of PSA should always be used in conjunction with other diagnostic procedures, including information from the patient's clinical evaluation. The concentration of total PSA in a given specimen determined with assays from different manufacturers can vary due to differences in assay methods, calibration, and reagent specificity. Values obtained with different assay method cannot be used interchangeably.

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed. Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA levels persisting upto 3 weeks.
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
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.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

Scan to View Details

Scan to View Report

Patient Ref. No. 666000002284956

CLIENT CODE : CA00010147 - MEDIWHEEL

CLIENT'S NAME AND ADDRESS :
MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED
F701A, LADO SARAI, NEW DELHI,
SOUTH DELHI, DELHI,
SOUTH DELHI 110030
DELHI INDIA
8800465156

DDRC SRL DIAGNOSTICS
Capital City,26/548/5,6,Ground Floor,Korappath Lane,Round North,Thrissur
TRICHUR, 680020
KERALA, INDIA
Tel : 9446425900
Email : thrissur.ddrc@srl.in

PATIENT NAME : ANANDAN M R PATIENT ID : **ANANM1211634177**

ACCESSION NO : **4177VK001286** AGE : 59 Years SEX : Male ABHA NO :

DRAWN : RECEIVED : 12/11/2022 15:25 REPORTED : 14/11/2022 16:49

REFERRING DOCTOR : DR. A M ANTO CLIENT PATIENT ID :

Test Report Status **Preliminary**	**Results**	**Units**

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

ECG WITH REPORT

REPORT
COMPLETED

USG ABDOMEN AND PELVIS

REPORT
COMPLETED

CHEST X-RAY WITH REPORT

REPORT
COMPLETED

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

DR.HARI SHANKAR, MBBS MD
HEAD - Biochemistry & Immunology

BIJI K S
LAB TECHNICIAN

DR. SINDHU GEORGE
QUALITY MANAGER

MANJU SHAJI
RADIOGRAPHER

Scan to View Details

Scan to View Report

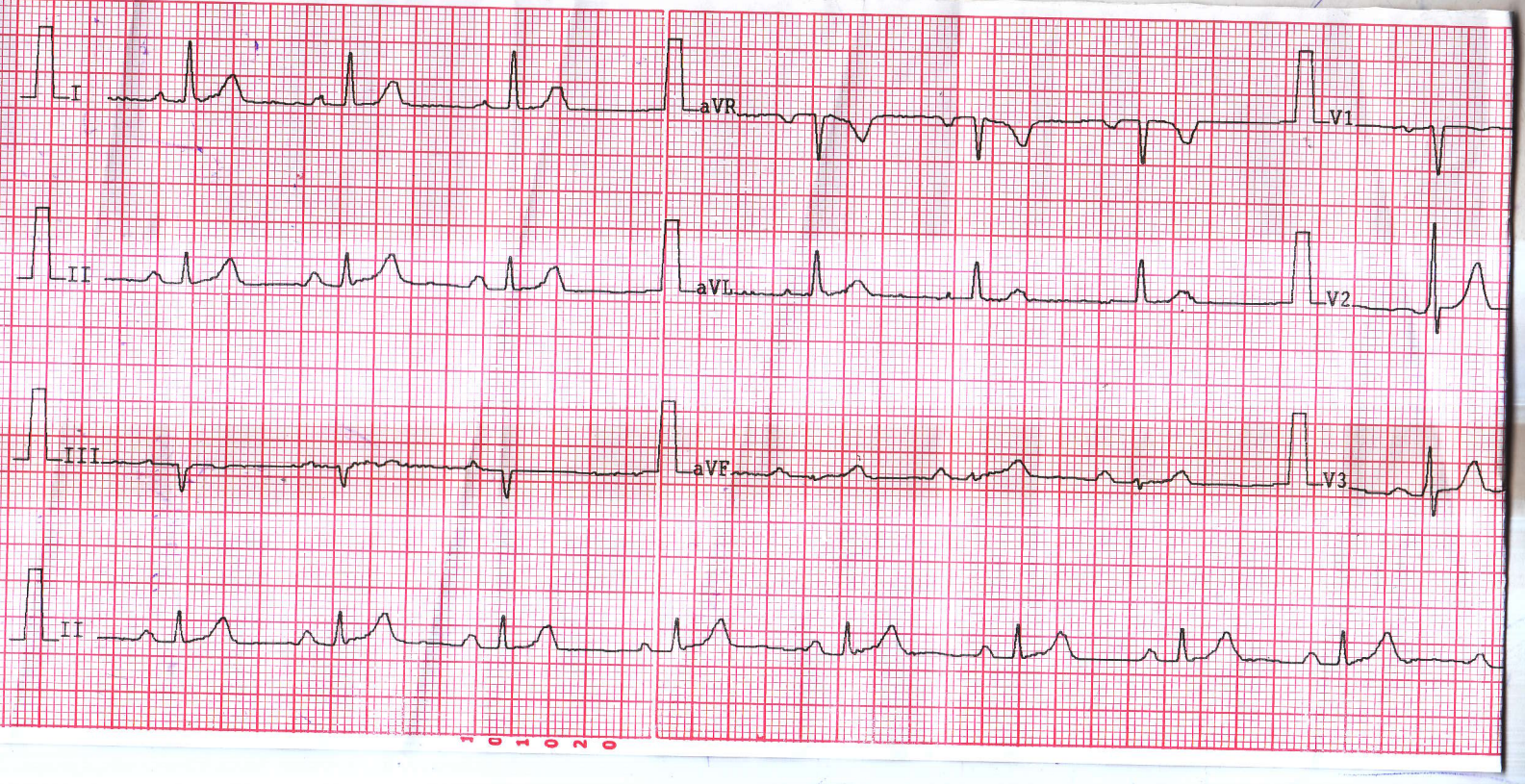
DDRC SRL
CHAVAKKAD

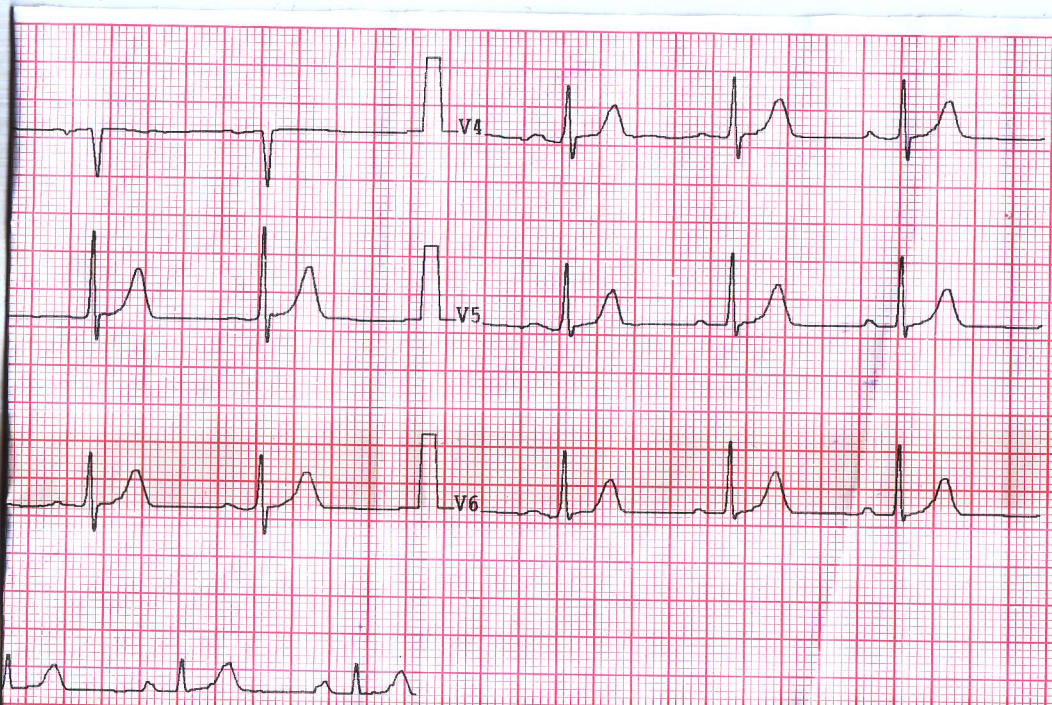
PATIENT INFORMATION: -

ID:- 1221 CASE:-
NAME:- ANANDHAN
AGE:- 59 GENDER:- M SMOKER:-No
HEIGHT:- ..cms WEIGHT:- Kg.
DOCTOR:- SELF
REF:-
DATE/TIME:-12/11/2022 10:31:32

ECG SETTINGS: -

PRINTING MODE:-AUTO 3*1
GAIN(mm/mV):- 10
SPEED(mm/Sec):-25
FILTER(Hz):- 0.05 -35
NOTCH/BLC:- ON/ON
RHYTHM LEAD:- II





OBSERVATIONS :-

HEART RATE	:	65 bpm
R-R	:	923 ms
P-R	:	188 ms
P DUR	:	108 ms
QRS	:	72 ms
T DUR	:	186ms
ST DUR	:	120 ms
QT	:	378 ms
QTc	:	387 ms
P AXIS	:	53 °
R AXIS	:	01 °
T AXIS	:	31 °
ST AXIS	:	05 °

REMARKS :-

INTERPRETATION :-

SINUS RHYTHM ANANDAN-M.R.

ecg wnl

Dr. PRAMOD. V. K.
MD(Medicine), DM(Cardio)
Reg. No: 27265
Consultant Cardiologist
ISWHI

DIAGNOSTICS (P) LTD. ★ DDRC SRL
CAPITAL CITY
THRISSUR
680 020

Name: ANANDHAN M R	**Age/Sex: 59 Y/ M**
Date: 12.11.2022	**AC 1286**

CHEST X-RAY (PA View):

Trachea is central.

Cardiac shadow appears normal in size and configuration.

Both lung fields are clear.

Bilateral costophrenic and cardiophrenic angles are clear.

No focal consolidation, effusion, pulmonary edema, or pneumothorax.

Both hila appear normal.

Bony thorax and soft tissues are unremarkable.

IMPRESSION:

- **No significant abnormality detected.**

DDRC SRL DIAGNOSTICS (P) LTD. CAPITAL CITY THRISSUR 680 020

DR. JESWIN PAULSON DMRD
CONSULTANT RADIOLOGIST

Dr. J... MBBS, DMRD
Reg. No. 43581
Consultant Radiologist

Patient Name: Mr. ANANDAN	**Age: 59 Y**	**Sex: Male**
Ref. Consultant:	**AC No: 4177VK**	**Date: 12.11.2022**
Clinical details:		

USG ABDOMEN

Liver measures 11.6 cm, normal in size and **shows mild diffuse increase in echogenicity.** No focal lesions seen. PV and CBD are normal in course and calibre. No dilatation of intrahepatic biliary radicles seen. Subphrenic spaces are normal.

Gall bladder is distended and appears normal. No calculus or mass seen.

Spleen measures 8.1 cm, normal in size and echotexture. No focal or diffuse lesions seen.

Pancreas: Head and body visualized, normal in size and echotexture. No focal lesions seen. No duct dilatation or calcification seen. Tail is obscured.

Right kidney measures 7.8 x 3.3 cm and left kidney measures 9 x 3.9 cm. Both kidneys are normal in size and cortical echogenicity. Cortico medullary differentiation is maintained. No calculus or dilatation of pelvicalyceal system on both sides.

Urinary bladder is distended and appears normal. No calculus or mass seen.

Prostate measures 17 cc, normal in size and echotexture.

No ascites. No definite evidence of any abnormal bowel dilatation / wall thickening seen.

IMPRESSION

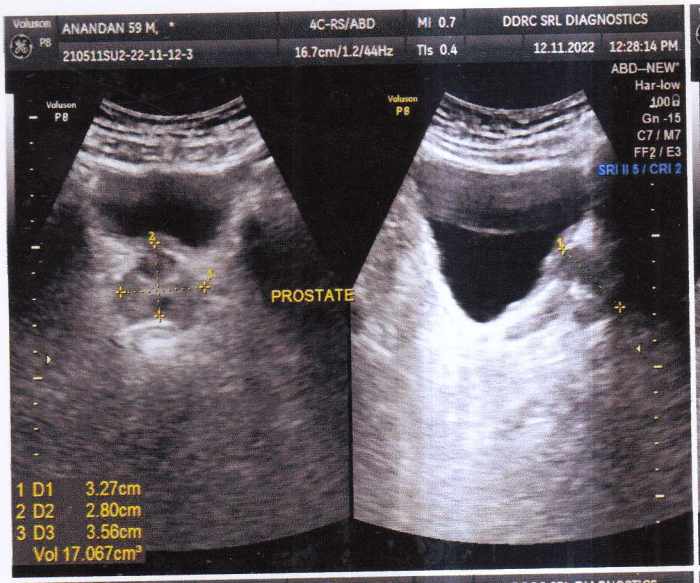
- **Grade I fatty infiltration of liver.**

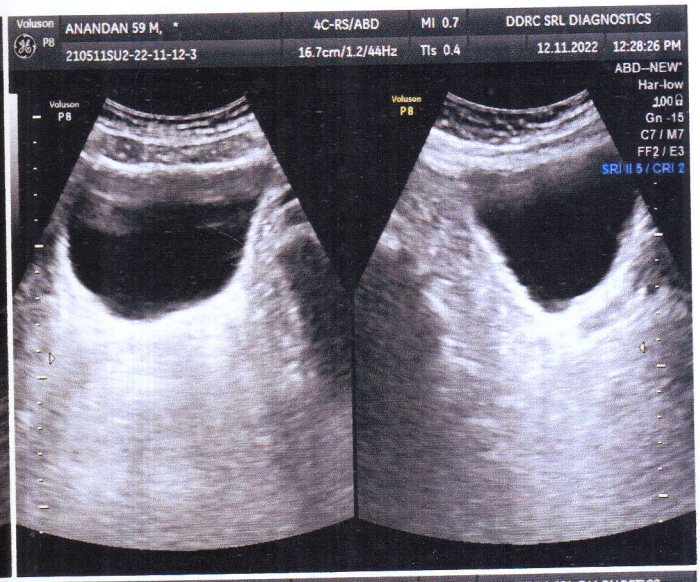
DR. JESWIN PAULSON DMRD
CONSULTANT RADIOLOGIST

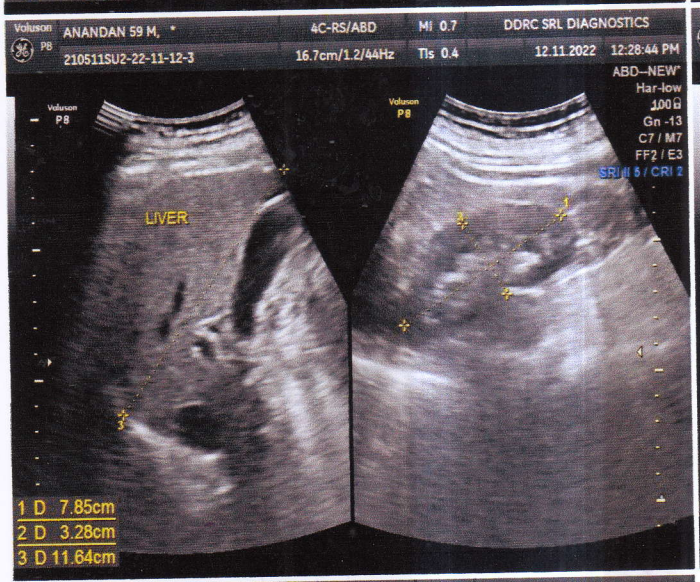
Thanks for your referral. Ultrasound reports need not be fully accurate. It has to be correlated clinically and with relevant investigations.

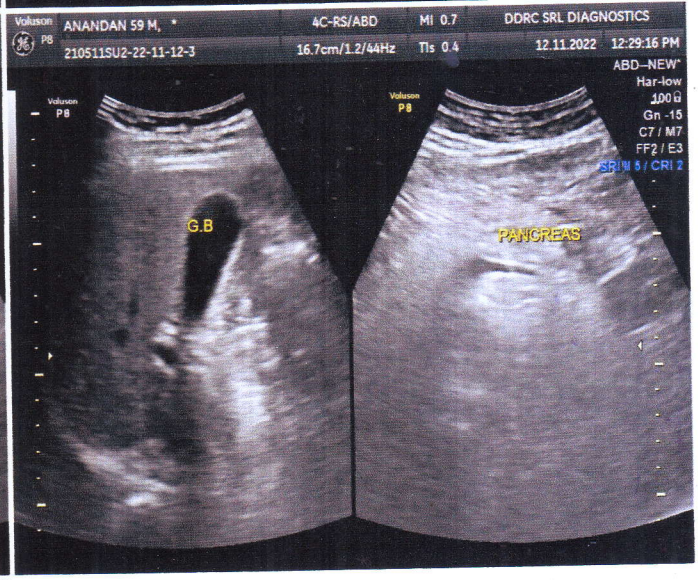
Dr. Jeswin Paulson MBBS, DMRD
Reg. No. 43581
Consultant Radiologist

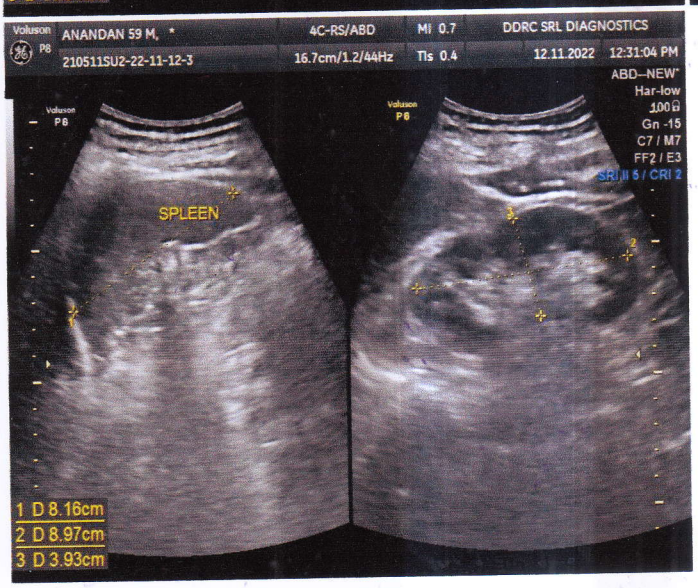
Patient name	Mr. ANANDAN 59 M	Age/Sex	59 Years / Male
Patient ID	210511SU2-22-11-12-3	Visit No	1
Referred by	Dr. SELF	Visit Date	12/11/2022











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Dental cheque up, eye chequeup, and papsmear test - not Interested

by

Ajitha

Ajitha

DDRC SRL DIAGNOSTICS (P) LTD. CAPITAL CITY THRISSUR 680 020

INDIAN UNION
DRIVING LICENCE

No.: 8/9183/2013 Date: 05/03/2019
Name :ANANDAN M R
S/W/D of :RAMU
Address :134(1/260)MOOLIPPARAMBIL HOUSE
23,KANATTUKARA
THRISSUR MUNICIPALITY

Date of Birth :04/04/1959
Blood Group :B-

Category	Valid from	Valid To
Non-Transport	02/03/2019	01/03/2024
Transport		

He is licensed to drive throughout India,vehicle of the following description

Class of Vehicle	With effect from	Testing Authority
M/C with gr	26/08/2013	LA,TCR

C 4263132

Date of First Issue :26/08/2013
Badge No. & Date :

Signature of Holder

P.V.Mohankumar
Asst.LA,THRISSUR

ANANDAN. MR

Age. 59.

Mob. 9946787067

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