Hiranandani
HOSPITAL
(A Fortis Network Hospital)

**Hiranandani Fortis Hospital**
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

# BMI CHART

Date: 08/10/2022

Name: Rita Mishra Age: 32 yrs Sex: M (F)

BP: 100/60 Height (cms): 165 cm Weight(kgs): 59 kg BMI: _____

| WEIGHT lbs | 100 | 105 | 100 | 115 | 120 | 125 | 130 | 135 | 140 | 145 | 150 | 155 | 160 | 165 | 170 | 175 | 180 | 185 | 190 | 195 | 200 | 205 | 210 | 215 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| kgs | 45.5 | 47.7 | 50.50 | 52.3 | 54.5 | 56.8 | 59.1 | 61.4 | 63.6 | 65.9 | 68.2 | 70.5 | 72.7 | 75.0 | 77.3 | 79.5 | 81.8 | 84.1 | 86.4 | 88.6 | 90.9 | 93.2 | 95.5 | 97.7 |
| HEIGHT in/cm | Underweight | | | | | Healthy | | | | | Overweight | | | | | Obese | | | | | Extremely Obese | | | |
| 5'0" - 152.4 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 |
| 5'1" - 154.9 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 36 | 37 | 38 | 39 | 40 |
| 5'2" - 157.4 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 33 | 34 | 35 | 36 | 37 | 38 | 39 |
| 5'3" - 160.0 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |
| 5'4" - 162.5 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 31 | 32 | 33 | 34 | 35 | 36 | 37 |
| 5'5" - 165.1 | 16 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 30 | 30 | 31 | 32 | 33 | 34 | 35 | 35 |
| 5'6" - 167.6 | 16 | 17 | 17 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 34 | 34 |
| 5'7" - 170.1 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 29 | 29 | 30 | 31 | 32 | 33 | 33 |
| 5'8" - 172.7 | 15 | 16 | 16 | 17 | 18 | 19 | 19 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 32 | 32 |
| 5'9" - 176.2 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 31 | 31 |
| 5'10" - 177.8 | 14 | 15 | 15 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 | 30 |
| 5'11" - 180.3 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 28 | 28 | 29 | 30 |
| 6'0" - 182.8 | 13 | 14 | 14 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 | 29 |
| 6'1" - 185.4 | 13 | 13 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 | 28 |
| 6'2" - 187.9 | 12 | 13 | 14 | 14 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 19 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 27 | 27 |
| 6'3" - 190.5 | 12 | 13 | 13 | 14 | 15 | 15 | 16 | 16 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 21 | 22 | 23 | 23 | 24 | 25 | 25 | 26 | 26 |
| 6'4" - 193.0 | 12 | 12 | 13 | 14 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 18 | 19 | 20 | 20 | 21 | 22 | 22 | 23 | 23 | 24 | 25 | 25 | 26 |

**Doctors Notes:**

Signature

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
Board Line: 022 - 39199222 | Fax: 022 - 39199220
Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
www.fortishealthcare.com |
CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

| | | | | | |
|---|---|---|---|---|---|
| **UHID** | **12051216** | **Date** | **08/10/2022** | | |
| **Name** | **Mrs.Ritu Mishra** | **Sex** | **Female** | **Age** | **32** |
| **OPD** | **PAP** | **Health Check Up** | | | |

32yrs | P2L2.

Drug allergy:
Sys illness:

LMP: 26.8.22 PMC: 3-5 | 35-40 days.

Pt asked to do a UPT

UPT → negative .

Pap = cyt ug (H) pap

- Breasts exmn (N)

Adv

- F/u ē reports
- Pap smear 3yrly
- Self breast exmn monthly
- Contraceptive advice given

Advice

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|---|---|---|---|---|---|
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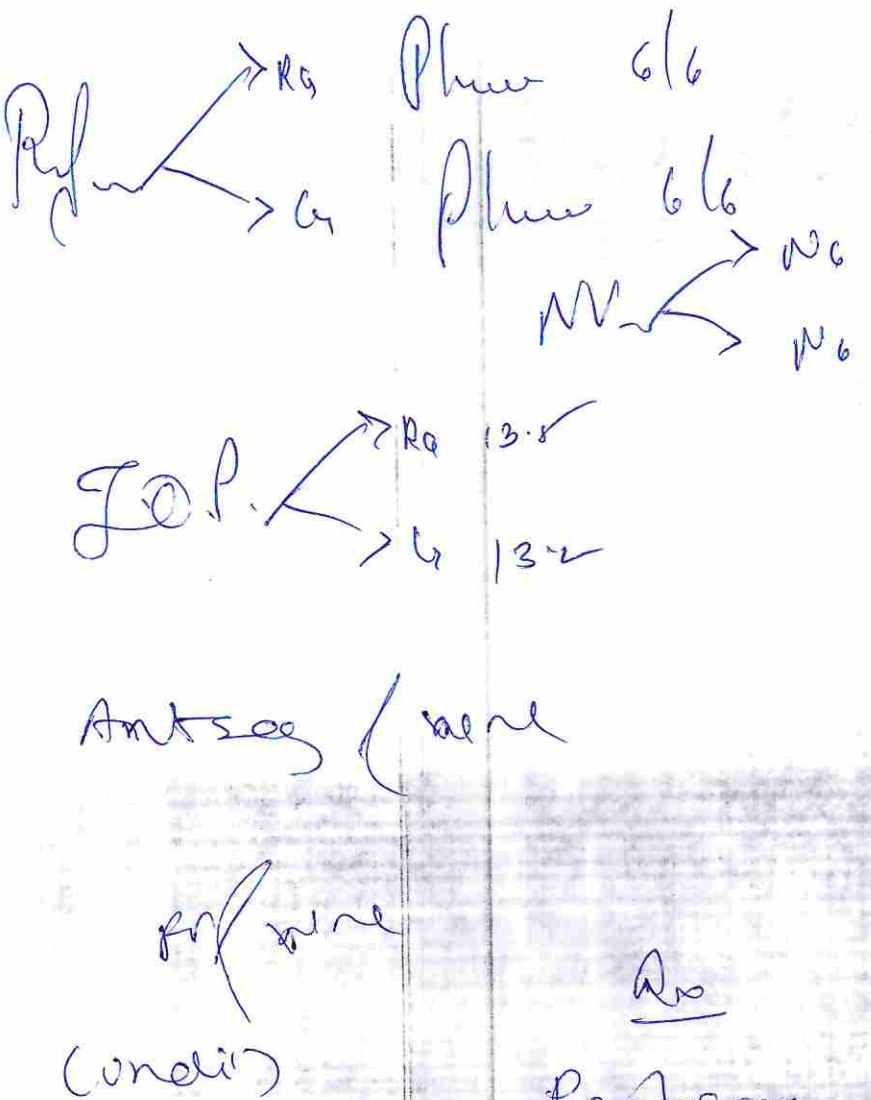
| **Name** | **Mrs.Ritu Mishra** | **Sex** | **Female** | **Age** | **32** |
| **OPD** | **Opthal 14** | **Health Check Up** | | | |

Drug allergy:
Sys illness:



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| | | | | | |
|---|---|---|---|---|---|
| **UHID** | **12051216** | **Date** | **08/10/2022** | | |
| **Name** | **Mrs.Ritu Mishra** | **Sex** | **Female** | **Age** | **32** |
| **OPD** | **Dental 12** | **Health Check Up** | | | |

Drug allergy:
Sys illness:

1) Decayed $\frac{8\ 7\ 6}{7} \mid \frac{7\ 8}{8}$

2) Class - II ##

3) Calculus +

Adv

1) Filli cys

2) Oral prophylaxis

BAI

# LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **KIDNEY PANEL - 1** | | | |
| **SERUM BLOOD UREA NITROGEN** | | | |
| BLOOD UREA NITROGEN | 6 | 6 - 20 | mg/dL |
| METHOD : UREASE - UV | | | |
| **CREATININE EGFR- EPI** | | | |
| CREATININE | 0.72 | 0.60 - 1.10 | mg/dL |
| METHOD : ALKALINE PICRATE KINETIC JAFFES | | | |
| AGE | 32 | | years |
| GLOMERULAR FILTRATION RATE (FEMALE) | 113.86 | Refer Interpretation Below | mL/min/1.73m2 |
| METHOD : CALCULATED PARAMETER | | | |
| **BUN/CREAT RATIO** | | | |
| BUN/CREAT RATIO | 8.33 | 5.00 - 15.00 | |
| METHOD : CALCULATED PARAMETER | | | |
| **URIC ACID, SERUM** | | | |
| URIC ACID | 3.2 | 2.6 - 6.0 | mg/dL |
| METHOD : URICASE UV | | | |
| **TOTAL PROTEIN, SERUM** | | | |
| TOTAL PROTEIN | 7.9 | 6.4 - 8.2 | g/dL |
| METHOD : BIURET | | | |
| **ALBUMIN, SERUM** | | | |
| ALBUMIN | 3.9 | 3.4 - 5.0 | g/dL |
| METHOD : BCP DYE BINDING | | | |
| **GLOBULIN** | | | |
| GLOBULIN | 4.0 | 2.0 - 4.1 | g/dL |
| METHOD : CALCULATED PARAMETER | | | |
| **ELECTROLYTES (NA/K/CL), SERUM** | | | |
| SODIUM | 138 | 136 - 145 | mmol/L |
| METHOD : ISE INDIRECT | | | |
| POTASSIUM | 3.96 | 3.50 - 5.10 | mmol/L |
| METHOD : ISE INDIRECT | | | |
| CHLORIDE | 102 | 98 - 107 | mmol/L |
| METHOD : ISE INDIRECT | | | |

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

**SRL Ltd**
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Tel : 022-39199222,022-49723322, Fax :
CIN - U74899PB1995PLC045956
Email : -

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Patient Ref. No. 22000000800584

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

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

• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• Liver disease
• SIADH.

CREATININE EGFR- EPI-
GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.
The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

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,

**HAEMATOLOGY**

**PATIENT NAME : MRS.RITU MISHRA**

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ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

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**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | Units |
|---|---|---|---|
| **ERYTHRO SEDIMENTATION RATE, BLOOD** | | | |
| SEDIMENTATION RATE (ESR) | **28** | **High** 0 - 20 | mm at 1 hr |
| METHOD : WESTERGREN METHOD | | | |
| **CBC-5, EDTA WHOLE BLOOD** | | | |
| **BLOOD COUNTS, EDTA WHOLE BLOOD** | | | |
| HEMOGLOBIN | 12.7 | 12.0 - 15.0 | g/dL |
| METHOD : SPECTROPHOTOMETRY | | | |
| RED BLOOD CELL COUNT | 4.56 | 3.8 - 4.8 | mil/µL |
| METHOD : ELECTRICAL IMPEDANCE | | | |
| WHITE BLOOD CELL COUNT | 5.70 | 4.0 - 10.0 | thou/µL |
| METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY | | | |
| PLATELET COUNT | 274 | 150 - 410 | thou/µL |
| METHOD : ELECTRICAL IMPEDANCE | | | |
| **RBC AND PLATELET INDICES** | | | |
| HEMATOCRIT | 36.4 | 36 - 46 | % |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN CORPUSCULAR VOLUME | **79.7** | **Low** 83 - 101 | fL |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN CORPUSCULAR HEMOGLOBIN | 27.8 | 27.0 - 32.0 | pg |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION | **34.8** | **High** 31.5 - 34.5 | g/dL |
| METHOD : CALCULATED PARAMETER | | | |
| MENTZER INDEX | 17.5 | | |
| RED CELL DISTRIBUTION WIDTH | 13.7 | 11.6 - 14.0 | % |
| METHOD : CALCULATED PARAMETER | | | |
| MEAN PLATELET VOLUME | **11.1** | **High** 6.8 - 10.9 | fL |
| METHOD : CALCULATED PARAMETER | | | |
| **WBC DIFFERENTIAL COUNT - NLR** | | | |
| NEUTROPHILS | 70 | 40 - 80 | % |
| METHOD : FLOW CYTOMETRY | | | |
| ABSOLUTE NEUTROPHIL COUNT | 3.99 | 2.0 - 7.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | |
| LYMPHOCYTES | 22 | 20 - 40 | % |
| METHOD : FLOW CYTOMETRY | | | |

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**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
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BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | | Biological Reference Interval | Units |
|---|---|---|---|---|
| ABSOLUTE LYMPHOCYTE COUNT | 1.25 | | 1.0 - 3.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| NEUTROPHIL LYMPHOCYTE RATIO (NLR) | 3.2 | | | |
| METHOD : CALCULATED PARAMETER | | | | |
| EOSINOPHILS | 3 | | 1 - 6 | % |
| METHOD : FLOW CYTOMETRY | | | | |
| ABSOLUTE EOSINOPHIL COUNT | 0.17 | | 0.02 - 0.50 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| MONOCYTES | 5 | | 2 - 10 | % |
| METHOD : FLOW CYTOMETRY | | | | |
| ABSOLUTE MONOCYTE COUNT | 0.29 | | 0.2 - 1.0 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| BASOPHILS | 0 | | 0 - 2 | % |
| METHOD : FLOW CYTOMETRY | | | | |
| ABSOLUTE BASOPHIL COUNT | **0** | **Low** | 0.02 - 0.10 | thou/µL |
| METHOD : CALCULATED PARAMETER | | | | |
| DIFFERENTIAL COUNT PERFORMED ON: | EDTA SMEAR | | | |
| **MORPHOLOGY** | | | | |
| RBC | PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD MICROCYTOSIS | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| WBC | NORMAL MORPHOLOGY | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| PLATELETS | ADEQUATE | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |

**Interpretation(s)**
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"
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.

**SRL Ltd**
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
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MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322, Fax :
CIN - U74899PB1995PLC045956
Email : -

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Patient Ref. No. 22000000800584

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

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**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | |
|---|---|---|---|
| **IMMUNOHAEMATOLOGY** | | | |
| **ABO GROUP & RH TYPE, EDTA WHOLE BLOOD** | | | |
| ABO GROUP<br>METHOD : TUBE AGGLUTINATION | TYPE A | | |
| RH TYPE<br>METHOD : TUBE AGGLUTINATION | POSITIVE | | |

**Interpretation(s)**
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.

| | | | |
|---|---|---|---|
| **BIO CHEMISTRY** | | | |
| **LIVER FUNCTION PROFILE, SERUM** | | | |
| BILIRUBIN, TOTAL<br>METHOD : JENDRASSIK AND GROFF | 0.52 | 0.2 - 1.0 | mg/dL |
| BILIRUBIN, DIRECT<br>METHOD : JENDRASSIK AND GROFF | 0.12 | 0.0 - 0.2 | mg/dL |
| BILIRUBIN, INDIRECT<br>METHOD : CALCULATED PARAMETER | 0.40 | 0.1 - 1.0 | mg/dL |
| TOTAL PROTEIN<br>METHOD : BIURET | 7.9 | 6.4 - 8.2 | g/dL |
| ALBUMIN<br>METHOD : BCP DYE BINDING | 3.9 | 3.4 - 5.0 | g/dL |
| GLOBULIN<br>METHOD : CALCULATED PARAMETER | 4.0 | 2.0 - 4.1 | g/dL |
| ALBUMIN/GLOBULIN RATIO<br>METHOD : CALCULATED PARAMETER | 1.0 | 1.0 - 2.1 | RATIO |
| ASPARTATE AMINOTRANSFERASE (AST/SGOT)<br>METHOD : UV WITH P5P | **11** | **Low** 15 - 37 | U/L |
| ALANINE AMINOTRANSFERASE (ALT/SGPT)<br>METHOD : UV WITH P5P | 17 | < 34.0 | U/L |
| ALKALINE PHOSPHATASE | 74 | 30 - 120 | U/L |



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Patient Ref. No. 2200000080058

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | |
|---|---|---|---|
| METHOD : PNPP-ANP | | | |
| GAMMA GLUTAMYL TRANSFERASE (GGT) | 18 | 5 - 55 | U/L |
| METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE | | | |
| LACTATE DEHYDROGENASE | 131 | 100 - 190 | U/L |
| METHOD : LACTATE -PYRUVATE | | | |
| **GLUCOSE, FASTING, PLASMA** | | | |
| GLUCOSE, FASTING, PLASMA | 91 | 74 - 99 | mg/dL |
| METHOD : HEXOKINASE | | | |
| **GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD** | | | |
| GLYCOSYLATED HEMOGLOBIN (HBA1C) | 5.5 | Non-diabetic: < 5.7<br>Pre-diabetics: 5.7 - 6.4<br>Diabetics: > or = 6.5<br>ADA Target: 7.0<br>Action suggested: > 8.0 | % |
| METHOD : HB VARIANT (HPLC) | | | |
| MEAN PLASMA GLUCOSE | 111.2 | < 116.0 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |
| **CORONARY RISK PROFILE (LIPID PROFILE), SERUM** | | | |
| CHOLESTEROL | 148 | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |
| METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE | | | |
| TRIGLYCERIDES | 58 | < 150 Normal<br>150 - 199 Borderline High<br>200 - 499 High<br>>/=500 Very High | mg/dL |
| METHOD : ENZYMATIC ASSAY | | | |
| HDL CHOLESTEROL | 47 | < 40 Low<br>>/=60 High | mg/dL |
| METHOD : DIRECT MEASURE - PEG | | | |
| DIRECT LDL CHOLESTEROL | 92 | < 100 Optimal<br>100 - 129 Near or above optimal<br>130 - 159 Borderline High<br>160 - 189 High<br>>/= 190 Very High | mg/dL |
| METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT | | | |
| NON HDL CHOLESTEROL | 101 | Desirable: Less than 130<br>Above Desirable: 130 - 159 | mg/dL |

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Patient Ref. No. 2200000080058

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | |
|---|---|---|---|
| | | Borderline High: 160 - 189<br>High: 190 - 219<br>Very high: > or = 220 | |
| METHOD : CALCULATED PARAMETER<br>CHOL/HDL RATIO | **3.2** | **Low** 3.3 - 4.4 Low Risk<br>4.5 - 7.0 Average Risk<br>7.1 - 11.0 Moderate Risk<br>> 11.0 High Risk | |
| METHOD : CALCULATED PARAMETER<br>LDL/HDL RATIO | 2.0 | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |
| METHOD : CALCULATED PARAMETER<br>VERY LOW DENSITY LIPOPROTEIN | 11.6 | </= 30.0 | mg/dL |
| METHOD : CALCULATED PARAMETER | | | |

**Interpretation(s)**

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-norma 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

GLUCOSE, FASTING, PLASMA-

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: > or = 126 mg/dL

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 polycythemi 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



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**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval |
|---|---|---|

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.

## CLINICAL PATH

### URINALYSIS

**PHYSICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| COLOR | PALE YELLOW | |
| METHOD : PHYSICAL | | |
| APPEARANCE | **HAZY** | |
| METHOD : VISUAL | | |
| SPECIFIC GRAVITY | 1.020 | 1.003 - 1.035 |

METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

**CHEMICAL EXAMINATION, URINE**

| | | |
|---|---|---|
| PH | 6.0 | 4.7 - 7.5 |

METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

**PATIENT NAME : MRS.RITU MISHRA**

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ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Results | Biological Reference Interval | |
|---|---|---|---|
| PROTEIN | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE | | | |
| GLUCOSE | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD | | | |
| KETONES | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE | | | |
| BLOOD | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN | | | |
| BILIRUBIN | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT | | | |
| UROBILINOGEN | NORMAL | NORMAL | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRLICH REACTION) | | | |
| NITRITE | NOT DETECTED | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE | | | |
| LEUKOCYTE ESTERASE | **DETECTED (+++)** | NOT DETECTED | |
| METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY | | | |
| **MICROSCOPIC EXAMINATION, URINE** | | | |
| PUS CELL (WBC'S) | **DETECTED (LARGE NOs)** | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| EPITHELIAL CELLS | **20-30** | 0-5 | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| ERYTHROCYTES (RBC'S) | NOT DETECTED | NOT DETECTED | /HPF |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| CASTS | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| CRYSTALS | NOT DETECTED | | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| BACTERIA | **DETECTED** | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| YEAST | NOT DETECTED | NOT DETECTED | |
| METHOD : MICROSCOPIC EXAMINATION | | | |
| REMARKS | URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT | | |

**Interpretation(s)**
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



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Patient Ref. No. 2200000080(

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:55

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

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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

****End Of Report****

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

Rekha. N

**Dr. Rekha Nair, MD**
**Microbiologist**

**Dr.Akta Dubey**
**Counsultant Pathologist**



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Patient Ref. No. 2200000080

# LABORATORY REPORT

Cert. No. MC-2984

Fortis | SRL Diagnostics

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001492** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 10:20 RECEIVED : 08/10/2022 10:21 REPORTED : 08/10/2022 14:11

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

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

## SPECIALISED CHEMISTRY - HORMONE

### THYROID PANEL, SERUM

| | | | |
|---|---|---|---|
| T3 | 154.4 | 80 - 200 | ng/dL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |
| T4 | 12.33 | 5.1 - 14.1 | µg/dL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |
| TSH 3RD GENERATION | 1.890 | 0.270 - 4.200 | µIU/mL |
| METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY | | | |

**Interpretation(s)**
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

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Sirmukaddam 786

**Dr. Swapnil Sirmukaddam**
**Consultant Pathologist**

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# LABORATORY REPORT

Cert. No. MC-2275

Fortis

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**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001549** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 12:50 RECEIVED : 08/10/2022 12:50 REPORTED : 08/10/2022 13:57

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

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**BIO CHEMISTRY**

**GLUCOSE, POST-PRANDIAL, PLASMA**

| | | | |
|---|---|---|---|
| GLUCOSE, POST-PRANDIAL, PLASMA | 82 | 70 - 139 | mg/dL |

METHOD : HEXOKINASE

**Comments**

NOTE: - RECHECKED FOR POST PRANDIAL PLASMA GLUCOSE VALUES . TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

**Interpretation(s)**
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.

****End Of Report****

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**Dr.Akta Dubey**
**Counsultant Pathologist**

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CIN - U74899PB1995PLC045956
Email : -

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Patient Ref. No. 2200000080

# LABORATORY REPORT

Cert. No. MC-2275

**PATIENT NAME : MRS.RITU MISHRA**

PATIENT ID : **FH.12051216** CLIENT PATIENT ID : UID:12051216

ACCESSION NO : **0022VJ001631** AGE : 32 Years SEX : Female DATE OF BIRTH : 03/04/1990

DRAWN : 08/10/2022 15:58 RECEIVED : 08/10/2022 16:02 REPORTED : 10/10/2022 10:59

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :**

**CLINICAL INFORMATION :**

UID:12051216 REQNO-1305077
CORP-OPD
BILLNO-150122OPCR050219
BILLNO-150122OPCR050219

| Test Report Status **Final** | Units |
|---|---|

## CYTOLOGY

**PAPANICOLAOU SMEAR**

**PAPANICOLAOU SMEAR**

| | |
|---|---|
| TEST METHOD | CONVENTIONAL GYNEC CYTOLOGY |
| SPECIMEN TYPE | TWO UNSTAINED CERVICAL SMEARS RECEIVED |
| REPORTING SYSTEM | 2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY |
| SPECIMEN ADEQUACY | SATISFACTORY |
| METHOD : MICROSCOPIC EXAMINATION | |
| MICROSCOPY | SMEARS STUDIED SHOW SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS, OCCASIONAL SQUAMOUS METAPLASTIC CELLS, OCCASIONAL CLUSTERS OF ENDOCERVICAL CELLS IN THE BACKGROUND OF FEW POLYMORPHS. |
| INTERPRETATION / RESULT | NEGATIVE FOR INTRAEPITHELIAL LESION OR MALIGNANCY |

**Comments**

PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS, HENCE SHOULD BE INTERPRETED WITH CAUTION.

NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

****End Of Report****

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

**Dr.Akta Dubey**
**Counsultant Pathologist**

**SRL Ltd**
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322, Fax :
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Patient Ref. No. 22000000800723

32 Years Female

HC

NSR

| | | | |
|---|---|---|---|
| Rate | 75 | . Sinus rhythm | normal P axis, V-rate 50- 99 |
| | | . Borderline short PR interval | PR int <120mS |
| PR | 112 | | |
| QRSD | 94 | | |
| QT | 379 | | |
| QTc | 424 | | |

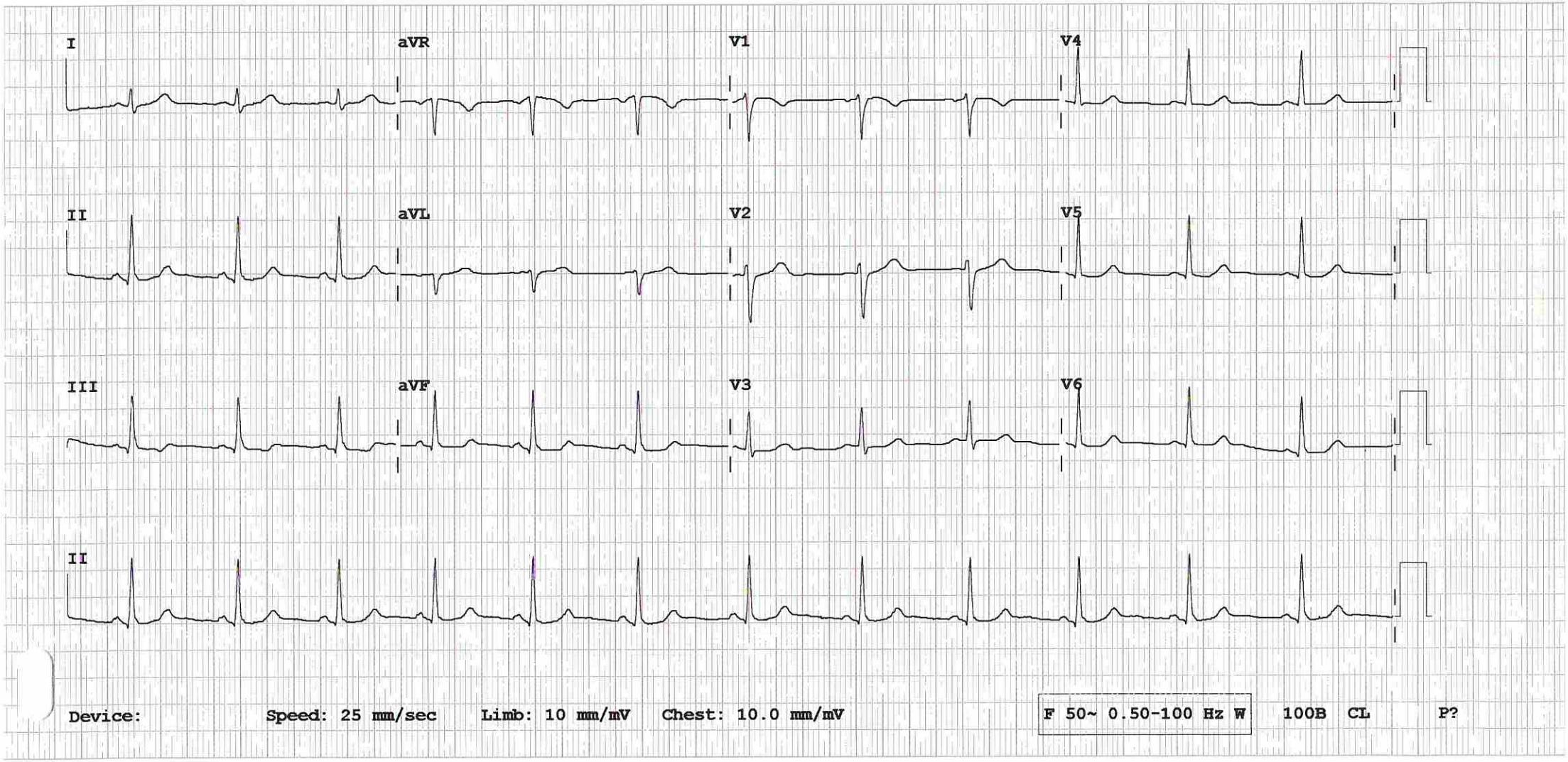
--AXIS--

| | |
|---|---|
| P | 52 |
| QRS | 83 |
| T | 30 |

- OTHERWISE NORMAL ECG -

12 Lead; Standard Placement

Unconfirmed Diagnosis




Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?

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CIN: U85100MH2005PTC 154823
GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL (A Fortis Network Hospital)

(For Billing/Reports & Discharge Summary only)

Date: 08/Oct/2022

## DEPARTMENT OF NIC

**Name: Mrs. Ritu Mishra**
**Age | Sex: 32 YEAR(S) | Female**
**Order Station : FO-OPD**
**Bed Name :**

**UHID | Episode No : 12051216 | 49895/22/1501**
**Order No | Order Date: 1501/PN/OP/2210/105577 | 08-Oct-2022**
**Admitted On | Reporting Date : 08-Oct-2022 13:08:46**
**Order Doctor Name : Dr.SELF .**

## ECHOCARDIOGRAPHY TRANSTHORACIC

### FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

### M-MODE MEASUREMENTS:

| | | |
|---|---|---|
| LA | 35 | mm |
| AO Root | 29 | mm |
| AO CUSP SEP | 18 | mm |
| LVID (s) | 31 | mm |

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| | | |
|---|---|---|
| LVID (d) | 43 | mm |
| IVS (d) | 09 | mm |
| LVPW (d) | 10 | mm |
| RVID (d) | 29 | mm |
| RA | 28 | mm |
| LVEF | 60 | % |

**DOPPLER STUDY:**

**E WAVE VELOCITY: 0.9 m/sec.**
**A WAVE VELOCITY:0.5 m/sec**
**E/A RATIO:1.4**

| | PEAK (mmHg) | MEAN (mmHg) | V max (m/sec) | GRADE OF REGURGITATION |
|---|---|---|---|---|
| MITRAL VALVE | N | | | Nil |
| AORTIC VALVE | 05 | | | Nil |
| TRICUSPID VALVE | N | | | Nil |
| PULMONARY VALVE | 2.0 | | | Nil |

**Final Impression :**

**Normal 2 Dimensional and colour doppler echocardiography study.**

**DR. PRASHANT PAWAR**
**DNB (MED) DNB ( CARDIOLOGY)**

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Date: 10/Oct/2022

## DEPARTMENT OF RADIOLOGY

**Name: Mrs. Ritu Mishra**
**Age | Sex: 32 YEAR(S) | Female**
**Order Station : FO-OPD**
**Bed Name :**

**UHID | Episode No : 12051216 | 49895/22/1501**
**Order No | Order Date: 1501/PN/OP/2210/105577 | 08-Oct-2022**
**Admitted On | Reporting Date : 10-Oct-2022 15:25:10**
**Order Doctor Name : Dr.SELF .**

### X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. ABHIJEET BHAMBURE**
**DMRD, DNB (Radiologist)**

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## DEPARTMENT OF RADIOLOGY

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**Age | Sex: 32 YEAR(S) | Female**
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**Order No | Order Date: 1501/PN/OP/2210/105577 | 08-Oct-2022**
**Admitted On | Reporting Date : 08-Oct-2022 16:08:39**
**Order Doctor Name : Dr.SELF .**

### US-WHOLE ABDOMEN

**LIVER** is normal in size (13.6 cm) and shows raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein is normal.

**GALL BLADDER** is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection.

**SPLEEN** is normal in size (10.4 cm) and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

**PANCREAS:** Head & body of pancreas appear unremarkable. Rest of the pancreas is obscured.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical mass/calculi.

**UTERUS** is normal in size, measuring 8.7 x 4.2 x 5.1 cm.
Endometrium measures 9.3 mm in thickness.

Both ovaries are normal.
Right ovary measures 1.7 x 1.5 x 2.8 cm, volume 4.0 cc.
Left ovary measures 3.2 x 2.1 x 2.5 cm, volume 9.4 cc.

No evidence of ascites.

**Impression:**

- **Fatty infiltration of liver.**
- **No other significant abnormality is detected.**

Pathade

**DR. YOGESH PATHADE**
**(MD Radio-diagnosis)**