

Health Check up Booking Request(bobE30619),Package Code(PKG10000236),Beneficiary Code(74824)

1 message

Mediwheel <wellness@mediwheel.in>
To: guptadiagnostickharar@gmail.com
Cc: mediwheelwellness@gmail.com

Wed, Feb 22, 2023 at 5:15 PM



Mediwheel
...Your wellness partner



011-41195959

Email:wellness@mediwheel.in

Dear Gupta Diagnostic Laboratories,
City : Mohali . Location : .Khanpur,

We have received the following request for Health Check up from

Name : MR. SINGH PARMINDER
Age : 43
Gender : Male
Member Relations : Employee
Package Name : Medi-Wheel Full Body Health Checkup Male Above 40
Package Code : PKG10000236
User Location : Punjab,KHARAR,140301
Contact Details : 8283852062
Booking Date : 22-02-2023
Appointment Date : 11-03-2023

Member Information			
Booked Member Name	Age	Gender	Cost(In INR)
MR. SINGH PARMINDER	43	Male	Cashless
Total amount to be paid			Cashless

Please login to your account to confirm the same. Also you mail us for confirmation

Package Name : Medi-Wheel Full Body Health Checkup Male Above 40 - Includes (40) Tests

Tests included in this Package : Ecg, TSH, X-ray Chest, Stress Test (tmt)/ 2d Echo, Blood Sugar Postprandial, Psa(for Male), Dental Consultation, Creatinine, Serum, A:g Ratio, Blood Group, Total Cholesterol, Triglycerides, Fasting Blood Sugar, Ultrasound Whole Abdomen , Glycosylated Haemoglobin (hba1c), Hdl, Vldl, Urine Analysis, LDL, Total Protine, General Consultation, HDL/ LDL ratio, GGT(Gamma-glutamyl Transferase), Eye Check-up consultation, ALP (ALKALINE PHOSPHATASE), Uric Acid, AST/ALT Ratio, Serum Protein, CBC with ESR, Stool Analysis, Urine Sugar Fasting, Urine Sugar PP, T3, T4, Cholesterol Total / HDL Ratio, BUN, BUN/Creatinine Ratio, Bilirubin Total & Direct and Indirect, Albumin, Globulin

Main Lab : Krishna Enclave,
Near Hotel Terrace
Kharar-Kurali Road, Khanpur.
Branch : Nangal Singa



GUPTA
DIAGNOSTIC LABORATORIES
An ISO 9001 : 2015 Certified Laboratory

LABORATORY REPORT

H- 174 cm

W- 85 kg

D.OB- 2-11-1977

Name - Parminder Singh

BP - $\frac{118}{83}$

P/S - 78

(Signature)

(Signature)
Dr. Gurnam Malhotra
Pathologist
P.M.C Reg. No. 49109



Timings: 06:30 am to 06:00 pm
Sunday: 06:30 am to 12:00 pm

NOT FOR MEDICO LEGAL PURPOSE

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44 Years

singh parminder
Male

03/11/2023 7:44:31 AM

GUPTA DIAGNOSTIC LABORATORIES
12 CHANNEL WITH INTERPRET (ECG)

Referring D> mediwheel

Rate 69 Sinus rhythm.....Normal P axis, V-rate 50-99

PR 153
QRSD 91
QT 369
QTc 396

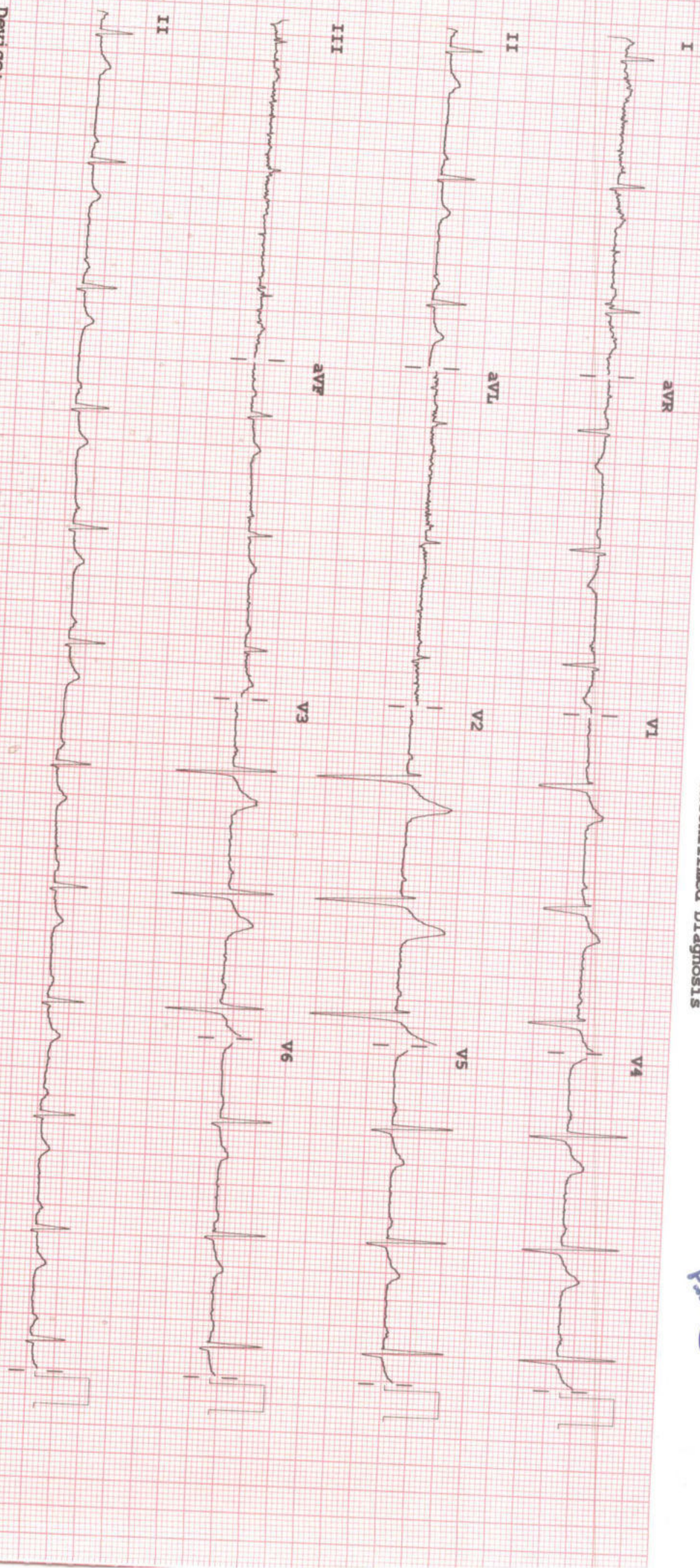
--AXIS--
P 31
QRS 48
T 49

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis

Dr. Gurpreet Parmalindhra
Pathologist
P.M.C. Reg. No. 49109



Device:

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

F 60~0.15-100 Hz

PH100B CL

P2

ARROW CE

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LABORATORY REPORT

Patient Name : Mr. PARMINDER SINGH	Age / Sex : 44 Yrs / Male
Consultant : WELLNESS	Lab No. : LR11546
Address : KHARAR	Mobile No : 8283852062
Sample Col Date : 11/03/2023	Report Date : 11/03/2023

TEST NAME	RESULT	UNITS	REF. RANGE
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BIOCHEMISTRY

BLOOD SUGAR-F METHOD : GOD-POD METHOD	87	mg/dl	(70 - 110)
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measurement of Glucose Concentration is Mainly used in the diagnosis and monitoring of treatment in diabetes mellitus. other application are the detection of neonatal hypoglycemia the exclusion of pancreatic islet cell carcinoma as well as the evaluation of carbohydrate metabolism in various disease.

SERUM CREATININE METHOD : JAFFE'S METHOD	1.02	mg/dl.	(0.6 - 1.4)
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HAEMATOLOGY

BLOOD GROUP

ABO/RH RH	"AB" NEGATIVE
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BIOCHEMISTRY

GAMMA GLUTAMYL TRANSFERASE	40.0	IU/L	(9 - 52)
SERUM URIC ACID METHOD : MODIFIED TRINDER METHOD	5.23	mg/dl	(3.5 - 7.2)
BUN	12.0	mg/dL	(6.0 - 20.0)

DR. NAVPREET BUTTER
MD

DR. GURVEEN MALHOTRA
PATHOLOGIST

NEHA GUPTA
B. SC. MLT

LAB TECHNOLOGIST



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BIOCHEMISTRY

LIVER FUNCTION TEST (L.F.T)

SERUM BILIRUBIN (TOTAL) METHOD : DIAZO METHOD	0.45	mg/dl	(0 - 1.2)
SERUM BILIRUBIN (DIRECT) METHOD : DIAZO METHOD	0.21	mg/dl	(0 - 0.4)
SERUM BILIRUBIN (INDIRECT) METHOD : CALCULATED	0.24	mg/dl	(0.1 - 0.8)
SGOT METHOD : IFCC METHOD	35	U/l.	(0 - 35)
SGPT METHOD : IFCC METHOD	40	U/l.	(5 - 40)
SERUM ALKALINE PHOSPHATASE METHOD : IFCC METHOD	123	U/l.	(39 - 137)
SERUM PROTEIN METHOD : BIURET METHOD	6.9	gms%	(6.2 - 8.0)
SERUM ALBUMIN METHOD : BCG DYE METHOD	4.0	gms%	(3.5 - 5.5)
GLOBULIN METHOD : CALCULATED	2.9	gm%	(2.3 - 3.5)
A/G RATIO METHOD : CALCULATED	1.38	Ratio	(1 - 1.8)

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BIOCHEMISTRY

LIPID PROFILE

SERUM CHOLESTEROL METHOD : CHOD-PAP METHOD (WITH LCF)	240(H)	mg/dl.	(120 - 200)
SERUM TRIGLYCERIDES METHOD : GPO-TRINDER METHOD	129	mg/dl.	(50 - 199)
SERUM HDL-CHOLESTEROL METHOD : PHOSPHOTUNGSTIC ACID METHOD	43.0	mg/dl.	(35 - 80)
LDL-CHOLESTEROL METHOD: CALCULATED	171.2(H)	mg/dl.	(60 - 130)
VLDL-CHOLESTEROL METHOD: CALCULATED	25.8	mg/dl.	(08 - 30)
CHL/HDL RATIO METHOD: CALCULATED	5.58	Ratio	(4 - 6)
LDL/HDL RATIO METHOD: CALCULATED	3.98	Ratio	(2 - 4)

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URINE ANALYSIS

URINE RE/ME

PHYSICAL EXAMINATION

PH	:	5.0
COLOUR	:	YELLOWISH
APPEARANCE	:	CLEAR
REACTION	:	ACIDIC
ALBUMIN	:	NIL
SUGAR	:	NIL
KETONE	:	NIL
GRAVITY	:	1.020

MICROSCOPIC EXAMINATION :

PUS CELLS	:	1-2/HPF
RED CELLS	:	NIL
EPITHELIAL CELLS	:	NIL
CRYSTALS (Ca. OXALATE)	:	NIL
AMORPHOUS DEPOSITS	:	NIL
GRANULAR CASTS	:	NIL
HYALINE CASTS	:	NIL
PROTEIN PPT	:	NIL
BILLIRUBIN	:	NIL
UROBILINOGEN	:	NIL

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*****END OF REPORT*****

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HAEMATOLOGY

GLYCOSYLATED HAEMOGLOBIN

HbA1c (Glycated Haemoglobin)	5.67	%	4.0-6.2 %
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mispa-I2 Nephelometric Method

REMARKS:

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy.

Mean Plasma Glucose 116.01 mg/dL
Calculated

Mean Plasma Glucose is based on estimated Average Glucose (eAG) value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

Reference Range (HbA1c) :

Good control : 4.5 - 6.4 %
Fair control : 6.5 - 7.4 %
Poor control : Above - 7.5 %

Reference Range (Average Blood Sugar) :

Excellent control : 90 - 120 mg/dl
Good control : 121 - 150 mg/dl
Average control : 151 - 180 mg/dl
Action suggested : 181 - 210 mg/dl
Panic value : > 211 mg/dl

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MISC

ECG

NORMAL SINUS RHYTHM

Khan
Dr. Gurveen Malhotra
Pathologist
P.M.C Reg. No. 49109

END OF REPORT

Butter
DR. NAVPREET BUTTER
MD

Malhotra
DR. GURVEEN MALHOTRA
PATHOLOGIST

Gupta
NEHA GUPTA
B. SC. MLT



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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE	10	mm 30 mint	(0 - 20)
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Interpretation :

High ESR is not diagnostic of any disease but just indicative of some inflammatory process ESR is to be used to monitor outcome of therapy. Microcytic anaemia can increase ESR can also be seen in apparently healthy adults.

None:

The erythrocyte sedimentation rate is the rate at which red blood cells sediment in a period of one hour. It is a common hematology test, and is a non-specific measure of inflammation.

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*****END OF REPORT*****

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HAEMATOLOGY

Complete Blood Counts

HAEMOGLOBIN	15.2	gm/dL	(12.5 - 17.0)
PCV	42.9	%	(35 - 50)
TOTAL LEUCOCYTE COUNT	6000	/cmm	(4000 - 11000)

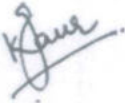
DIFFERENTIAL LEUCOCYTE COUNT


NEUTROPHILS	60	%	(40 - 70)
LYMPHOCYTES	35	%	(20 - 45)
MONOCYTES	04	%	(2 - 10)
EOSINOPHILS	01	%	(1 - 6)
BASOPHILS	00	%	(0 - 1)
RBC COUNT	4.73	m/cumm	(4.0 - 6.5)
MCV	90.6	fl	(76 - 96)
MCH	32.1(H)	ugm	(27 - 32)
MCHC	35.1	ugm	(32 - 36)
RDW	13.8	%	(11.0 - 16.0)
PLATELET COUNT(H3D PREMIER)	2.09.000	lacs/cmm	(1.5 - 4.5)
PCT	0.224	%	(0.108 - 0.282)
MPV	10.7	fL	(6.5 - 12.5)
PDW	16.0	%	(9.0 - 17.0)


(Done With 3 Part Fully Automatic Cell Counter BeneSphera H33s And SYSMEX XP100)

CBC INTERPRETATION

CBC is done on fully automated haematology Analyser .It generates various RBC's , WBC'S and PLATELETS parameters which are useful in diagnosing various types of Anemia ,WBC and Platelets disorder . CBC is coupled with manual cross-examination of PBF for confirmation for highly accurate results.


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MD


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भारत सरकार

Government of India



परमीन्दर सिंह

Parminder Singh

जन्म वर्ष / Year of Birth : 1977

पुरुष / Male



6689 6342 8749

आधार - आम आदमी का अधिकार

Handwritten signature
Dr. G. S. Malhotra
Pathologist
R.M.C Reg. No. 49109



Dr. Gurnam Malhotra
Dr. Gurnam Malhotra
Pathologist
P.M.C Reg. No. 49105

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ELISA TEST


PROSTATE SPECIFIC ANTIGEN	1.23	ng/ml	(< 6.5)
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DR. NAVPREET BUTTER
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HOME COLLECTION FOR CALLERS
24 Hrs

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LABORATORY REPORT

Name : Mr. PARMINDER SINGH	Patient UID. : 2510583
Age/Gender : 44 Yrs/Male	Visit No. : 37572303120001
Referred Client : LDPL7034-GUPTA DIAGNOSTIC LABORATO	Collected on : 11-Mar-2023 09:33AM
Referred By : GUPTA LAB	Received on : 12-Mar-2023 07:16AM
Doctor Name :	Reported on : 12-Mar-2023 09:31AM
Sample Type : Serum - 10254193	



Test Name	Results	Unit	Bio. Ref. Interval
IMMUNOLOGY			
THYROID PROFILE : T3, T4 & TSH(TFT)			
TRIODOTHYRONINE TOTAL (T3) <i>Methodology: ECLIA</i>	1.72	ng/mL	0.70-2.04
THYROXINE TOTAL (T4) <i>Methodology: ECLIA</i>	8.54	ug/dl	4.6-10.5
THYROID STIMULATING HORMONE (TSH) <i>Methodology: ECLIA</i>	1.276	μIU/ml	0.35-5.50

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis.

INTERPRETATION-Ultra Sensitive 4th generation assay

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Low TSH,high FT4 and TSH receptor antibody(TRAb) +ve seen in patients with Graves disease
- 3.Low TSH,high FT4 and TSH receptor antibody(TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter
- 4.HighTSH,Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimotos thyroiditis
- 5.HighTSH,Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency
- 6.Low TSH,Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism
- 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 9.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 10.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism .
- 11.Normal T3 & ↓ T4 along with ↑ TSH is seen in Hypothyroidism .
- 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypothyroidism .
- 13.Slightly ↑ T3 levels may be found in pregnancy and in estrogen therapy while ↓ levels may be encountered in severe illness , malnutrition , renal failure and during therapy with drugs like propranolol.
- 14.Although ↑ TSH levels are nearly always indicative of Primary Hypothroidism ,rarely they can result from TSH secreting pituitary tumours.

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

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved.TSH is an important marker for the diagnosis of thyroid dysfunction.Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

Nabl Scope

*** End Of Report ***

DR. MD ARIF
MBBS, MD(PATHOLOGY)
LAB DIRECTOR
24 Hrs
HOME COLLECTION SERVICE

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