



Patient Ref. No. 77700002364151

CLIENT CODE : C000138364

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
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AHMEDABAD, 380015
GUJRAT, INDIA
Tel : 079-48912999, 079-48913999, 079-48914999
Email : customercare.ahmedabad@srl.in

PATIENT NAME : DHANESH N. M

PATIENT ID : DHANM060392321

ACCESSION NO : 0321VI002079 AGE : 30 Years SEX : Male

ABHA NO :

DRAWN : 24/09/2022 00:00:00

RECEIVED : 24/09/2022 09:18:43

REPORTED : 27/09/2022 18:12:08

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**BLOOD COUNTS, EDTA WHOLE BLOOD**

HEMOGLOBIN	16.0	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	5.39	4.5 - 5.5	mil/ μ L
WHITE BLOOD CELL COUNT	6.48	4.0 - 10.0	thou/ μ L
PLATELET COUNT	187	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT	45.8	40.0 - 50.0	%
MEAN CORPUSCULAR VOL	85.0	83.0 - 101.0	fL
MEAN CORPUSCULAR HGB.	29.6	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.9	High 31.5 - 34.5	g/dL
MENTZER INDEX	15.8		
RED CELL DISTRIBUTION WIDTH	15.5	High 11.6 - 14.0	%
MEAN PLATELET VOLUME	8.4	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	59	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	3.82	2.0 - 7.0	thou/ μ L
LYMPHOCYTES	31	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.01	1.0 - 3.0	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.9		
EOSINOPHILS	2	1.0 - 6.0	%
ABSOLUTE EOSINOPHIL COUNT	0.13	0.02 - 0.50	thou/ μ L
MONOCYTES	7	2.0 - 10.0	%
ABSOLUTE MONOCYTE COUNT	0.45	0.2 - 1.0	thou/ μ L
BASOPHILS	1	0 - 1	%
ABSOLUTE BASOPHIL COUNT	0.06	0.02 - 0.10	thou/ μ L

DIFFERENTIAL COUNT PERFORMED ON:

EDTA SMEAR

MORPHOLOGY

RBC	NORMOCYTIC NORMOCHROMIC
WBC	NORMAL MORPHOLOGY
PLATELETS	ADEQUATE
REMARKS	NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITES ARE NOT DETECTED.



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PATIENT NAME : DHANESH N. M **PATIENT ID : DHANM060392321**

ACCESSION NO : **0321VI002079** AGE : 30 Years SEX : Male ABHA NO :

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ERYTHRO SEDIMENTATION RATE, BLOOD

SEDIMENTATION RATE (ESR) 04 0 - 14 mm at 1 hr

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA **102** **High** 74 - 99 mg/dL

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C) 4.2 Non-diabetic: < 5.7 %

Pre-diabetics: 5.7 - 6.4
 Diabetics: > or = 6.5
 ADA Target: 7.0
 Action suggested: > 8.0

MEAN PLASMA GLUCOSE 73.8 < 116.0 mg/dL

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA 95 70 - 140 mg/dL

CORONARY RISK PROFILE, SERUM

CHOLESTEROL 109 Desirable: < 200 mg/dL

BorderlineHigh: 200 - 239
 High: > or = 240

TRIGLYCERIDES 121 Desirable: < 150 mg/dL

BorderlineHigh: 150 - 199
 High: 200 - 499
 Very High: > or = 500

HDL CHOLESTEROL **35** **Low** < 40 Low mg/dL

> or = 60 High

CHOLESTEROL LDL 50 Adult levels: mg/dL

Optimal < 100
 Near optimal/above optimal: 100-129
 Borderline high : 130-159
 High : 160-189
 Very high : = 190

NON HDL CHOLESTEROL 74 Desirable: Less than 130 mg/dL

Above Desirable: 130 - 159
 Borderline High: 160 - 189
 High: 190 - 219
 Very high: > or = 220

CHOL/HDL RATIO 3.1

LDL/HDL RATIO 1.4

0.5 - 3.0 Desirable/Low Risk
 3.1 - 6.0 Borderline/Moderate Risk
 >6.0 High Risk

VERY LOW DENSITY LIPOPROTEIN 24.2 mg/dL

LIVER FUNCTION PROFILE, SERUM



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DIAGNOSTIC REPORT



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BILIRUBIN, TOTAL		1.71	High Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.59	High Upto 0.2	mg/dL
BILIRUBIN, INDIRECT		1.12	High 0.00 - 1.00	mg/dL
TOTAL PROTEIN		7.7	6.4 - 8.3	g/dL
ALBUMIN		5.6	High 3.5 - 5.2	g/dL
GLOBULIN		2.1	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO		2.7	High 1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		16	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		31	0 - 41	U/L
ALKALINE PHOSPHATASE		75	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		33	8 - 61	U/L
LACTATE DEHYDROGENASE		216	135 - 225	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN		10	6 - 20	mg/dL
CREATININE, SERUM				
CREATININE		0.74	0.70 - 1.30	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO		13.51	5.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		9.4	High 3.4 - 7.0	mg/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM		143.4	136- 145	mmol/L
POTASSIUM		4.05	3.50- 5.10	mmol/L
CHLORIDE		99.3	98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR		Yellow		
APPEARANCE		Clear		
SPECIFIC GRAVITY		1.020	1.003 - 1.035	
CHEMICAL EXAMINATION, URINE				
PH		5.5	4.7 - 7.5	
PROTEIN		NOT DETECTED	NOT DETECTED	
GLUCOSE		NOT DETECTED	NOT DETECTED	
KETONES		NOT DETECTED	NOT DETECTED	





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BLOOD		NOT DETECTED	NOT DETECTED	
BILIRUBIN		NOT DETECTED	NOT DETECTED	
UROBILINOGEN		NORMAL	NORMAL	
NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	

MICROSCOPIC EXAMINATION, URINE

PUS CELL (WBC'S)	0-1	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

REMARKS MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.

THYROID PANEL, SERUM

T3	137.7	80.00 - 200.00	ng/dL
T4	9.90	5.10 - 14.10	µg/dL
TSH 3RD GENERATION	1.040	0.270 - 4.200	µIU/mL

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE O
RH TYPE	POSITIVE

XRAY-CHEST

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO



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UPPER LIMB		NORMAL		
LOWER LIMB		NORMAL		
NECK		NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS		NOT ENLARGED OR TENDER		
THYROID GLAND		NOT ENLARGED		
TEMPERATURE		NORMAL		
PULSE		60/MIN		
RESPIRATORY RATE		NORMAL		

CARDIOVASCULAR SYSTEM

BP		126/70 MM HG (SITTING)		mm/Hg
PERICARDIUM		NORMAL		
APEX BEAT		NORMAL		
HEART SOUNDS		S1, S2 HEARD NORMALLY		
MURMURS		ABSENT		

RESPIRATORY SYSTEM

SIZE AND SHAPE OF CHEST		NORMAL		
MOVEMENTS OF CHEST		SYMMETRICAL		
BREATH SOUNDS INTENSITY		NORMAL		
BREATH SOUNDS QUALITY		VESICULAR (NORMAL)		
ADDED SOUNDS		ABSENT		

PER ABDOMEN

APPEARANCE		NORMAL		
LIVER		NOT PALPABLE		
SPLEEN		NOT PALPABLE		

CENTRAL NERVOUS SYSTEM

HIGHER FUNCTIONS		NORMAL		
CRANIAL NERVES		NORMAL		
CEREBELLAR FUNCTIONS		NORMAL		
SENSORY SYSTEM		NORMAL		
MOTOR SYSTEM		NORMAL		
REFLEXES		NORMAL		

MUSCULOSKELETAL SYSTEM

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SPINE

NORMAL

JOINTS

NORMAL

BASIC EYE EXAMINATION

DISTANT VISION RIGHT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

DISTANT VISION LEFT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

NEAR VISION RIGHT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

NEAR VISION LEFT EYE WITHOUT GLASSES WITHIN NORMAL LIMIT

COLOUR VISION NORMAL

SUMMARY

RELEVANT HISTORY NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS HDL:- LOW

RELEVANT NON PATHOLOGY DIAGNOSTICS

URIC ACID:- HIGH

USG ABDOMEN:- FATTY LIVER

REMARKS / RECOMMENDATIONS

ECG:- LEFT AXIS DEVIATION, WITHIN NORMAL LIMITS

URIC ACID:- HIGH

ADV:- PHYSICIAN OPINION

Comments

OUR PANEL DOCTORS FOR NON-PATHOLOGY TESTS:-

CHECK UP DONE BY:- DR. NAMRATA AGRAWAL (M.B.B.S)

REPORT REVIEWED BY:- DR. PRIYANK KAPADIYA (M.B.B.S DNB MEDICINE)

RADIOLOGIST:- DR. KALPANA MODI (M.D.RADIOLOGY) // DR. SAHIL N SHAH (M.D.RADIOLOGY)



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MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN****FATTY LIVER****Interpretation(s)****BLOOD COUNTS, EDTA WHOLE BLOOD-**

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

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"

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 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.

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 result 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



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there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

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)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM-

Causes of Increased levels

Dietary

- High Protein Intake.
- Prolonged Fasting,
- Rapid weight loss.

Gout

Lesch nyhan syndrome.

Type 2 DM.

Metabolic syndrome.

Causes of decreased levels

- Low Zinc Intake
- OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High Fibre foods
- Vit C Intake



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CLIENT CODE : C000138364

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
 F-703, LADO SARAI, MEHRAULI
 SOUTH WEST DELHI
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 Tel : 079-48912999, 079-48913999, 079-48914999
 Email : customercare.ahmedabad@srl.in

PATIENT NAME : DHANESH N. M

PATIENT ID : DHANM060392321

ACCESSION NO : 0321VI002079 **AGE :** 30 Years **SEX :** Male **ABHA NO :**

DRAWN : 24/09/2022 00:00:00 **RECEIVED :** 24/09/2022 09:18:43 **REPORTED :** 27/09/2022 18:12:08

REFERRING DOCTOR : DR. ACROFEMI HEALTHCARE LTD (MEDIWHEEL)

CLIENT PATIENT ID :

Test Report Status	Final	Results	Biological Reference Interval	Units
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• Antioxidant rich foods
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 hyperperfusion, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting.

MICROSCOPIC EXAMINATION, URINE-
 Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders
 Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever
 Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.
 Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
 Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
 Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
 Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
 Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
 Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

THYROID PANEL, SERUM-
 Triiodothyronine T3, is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.
 Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.
 Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in	TOTAL T4 (µg/dL)	TSH3G (µIU/mL)	TOTAL T3 (ng/dL)
Pregnancy	6.6 - 12.4	0.1 - 2.5	81 - 190
1st Trimester	6.6 - 15.5	0.2 - 3.0	100 - 260
2nd Trimester	6.6 - 15.5	0.3 - 3.0	100 - 260
3rd Trimester			

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
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
 Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.
 MEDICAL



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DIAGNOSTIC REPORTPatient Ref. No. **77700002364151**

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Email : customercare.ahmedabad@srl.in**PATIENT NAME : DHANESH N. M**PATIENT ID : **DHANM060392321**ACCESSION NO : **0321VI002079** AGE : 30 Years SEX : Male ABHA NO :

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HISTORY-*****

THIS REPORT CARRIES THE SIGNATURE OF OUR LABORATORY DIRECTOR. THIS IS AN INVIOABLE FEATURE OF OUR LAB MANAGEMENT SOFTWARE. HOWEVER, ALL EXAMINATIONS AND INVESTIGATIONS HAVE BEEN CONDUCTED BY OUR PANEL OF DOCTORS.

****End Of Report****Please visit www.srlworld.com for related Test Information for this accession**Dr.Sahil .N.Shah**
Consultant Radiologist**Dr.Priyank Kapadia**
Physician**Dr Kalpana Modi**
Radiologist**Dr.Miral Gajera**
Consultant Pathologist**CONDITIONS OF LABORATORY TESTING & REPORTING**

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the SRL Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
 - i. Specimen received is insufficient or inappropriate
 - ii. Specimen quality is unsatisfactory
 - iii. Incorrect specimen type
 - iv. Discrepancy between identification on specimen container label and test requisition form
5. SRL confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

SRL LimitedFortis Hospital, Sector 62, Phase VIII,
Mohali 160062

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