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Mr. Deeraj Dhanotia
Age - 34 Y/m

B.P - 120/80

P - 80 b/m

H - 183 c.m

Wt - 95 kg

APOLLO RAIPUR CLINIC

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EXAMINATION OF EYES :-(BY OPHTALMOLOGIST)

Patient Name Mr. Dheeraj Date 4/11/23

Sex/Age 34/M MR No ..... Employee Id .....

EXTERNAL EXAMINATION			
SQUINT	- NO		
NYSTAGMUS	- NO		
COLOUR VISION	- Normal		
FUNDUS:(RE):-	Well	(LE):-	Well
INDIVIDUAL COLOUR IDENTIFICATION			
DISTANT VISION:(RE):-	CPG 6/6	(LE):-	CPG 6/6
NEAR VISION:(RE):-	N/6	(LE):-	N/6
NIGHT BLINDNESS			

	SPH	CYL	AXIS	ADD
RIGHT				
LEFT				

REMARKS :- CPG { 6/6 / 6/6 } N { N/6 / N/6 }

Dr. Vikas Mishra
MBBS,MS(Ophthalmologist)
Reg. No. CGMC 621/2006

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Dr. Sweety Lath
BDS (Cosmetic Dental Surgeon)

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Dr. Vivek Lath
Chief Dental Consultant
BDS, MDS, Diplomate (WCOI, Japan)
Professor MCDRC - Durg
Reg. No. CGDC/14/PG/45

Mr. Dhiraj 4/11

34/M.

Cl. Pt can for multiple dental check up

D/L Stain + cal +

Adv oral prophy

APOLLO CLINIC RAIPUR

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Patient Name	: Mr. MR DHEERAJ DHANOTIA	**Age/Gender**	: 34 Y . Male
UHID/ MR No	: 7482	**OP Visit No**	: OPD-UNIT-II-2
Visit Date	: 04/11/2023	**Reported On**	: 05/11/2023 12:46PM
Sample Collected On	: 04/11/2023 03:48PM		
Ref. Doctor	: SELF		
Sponsor Name	:		

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
HEMOGRAM			
Haemoglobin(HB) Method: CELL COUNTER	14.2	gm/dl	12 - 17
Erythrocyte (RBC) Count Method: CELL COUNTER	5.02	mil./cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	42.60	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	84.9	fL	78.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	28.3	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	13.3	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	6.66	cells/cumm	3.50 - 10.00
Neutrophils Method: CELL COUNTER	45	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	50	%	15.0 - 45.0
Eosinophils Method: CELL COUNTER	01	%	1-6%
Monocytes	04	%	4.0 - 12.0
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report

Results are to be correlated clinically

Lab Technician / Technologist
path

DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

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HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count Method: CELL COUNTER	272	lacs/cu.mm	150-400
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	10	mm /HR	0 - 10
Blood Group (ABO Typing)			
Blood Group (ABO Typing)	O		
RhD factor (Rh Typing)	POSITIVE		

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
KFT - RENAL PROFILE - SERUM			
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	11	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	1.0	mg/dl	0.6-1.4
Uric Acid Method: Spectrophotomatric	3.8	mg/dL	2.6 - 7.2

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
HbA1c (Glycosalated Haemoglobin)	5.5	%	Non-diabetic:<=5.6, Pre-Diabetic:5.7-6.4, Diabetic:>=6.5

1.HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
2.HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Low glycated haemoglobin(below 4%) in a non-diabetic individual are often associated with systemic inflam

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2.HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Low glycated haemoglobin(below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia(especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
5. To estimate the eAG from the HbA1C value, the following equation is used: eAG(mg/dl) = 28.7*A1c-46.7
6. Interference of Haemoglobinopathies in HbA1c estimation.
A. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
B. Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status
C. Heterozygous state dete

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	125.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	78.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotomatric HDL Cholesterol	45.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotomatric LDL Cholesterol	64.40	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=190
Method: Spectrophotomatric VLDL Cholesterol	15.60	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	**2.78**		3.5-5
Methode: Spectrophotometric			

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Ref. Doctor	: SELF		
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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	1.2	mg/dl	0.1- 1.2
Bilirubin - Direct Method: Spectrophotometric	0.3	mg/dl	0.05-0.3
Bilirubin (Indirect) Mathod: Calculated	0.90	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	24	U/L	0 - 40
SGPT (ALT) Method: Spectrophotometric	28	U/L	0 - 41
ALKALINE PHOSPHATASE	75	U/L	25-147
Total Proteins Method: Spectrophotometric	6.9	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.5	mg/dl	3.4 - 5.0
Globulin Mathod: Calculated	2.4	g/dl	1.8 - 3.6
A/G Ratio Mathod: Calculated	1.87	%	1.1 - 2.2

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CLINICAL PATHOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
URINE ROUTINE EXAMINATION			
Physical Examination			
Volum of urine	30ML		
Appearance	Clear		Clear
Colour	Pale Yellow		Colourless
Specific Gravity	1.020		1.001 - 1.030
Reaction (pH)	6.0		
Chemical Examination			
Protein(Albumin) Urine	Absent		Absent
Glucose(Sugar) Urine	Absent		Absent
Blood	Absent		Absent
Leukocytes	Absent		Absent
Ketone Urine	Absent		Absent
Bilirubin Urine	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite (Urine)	Absent		Absent
Microscopic Examination			
RBC (Urine)	NIL	/hpf	0 - 2
Pus cells	2-4	/hpf	0 - 5
Epithelial Cell	2-4	/hpf	0 - 5
Crystals	Not Seen	/hpf	Not Seen
Bacteria	Not Seen	/hpf	Not Seen
Budding yeast	Not Seen	/hpf	

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Patient Name	: Mr.DHEERAJ DHANOTIA	Collected	: 05/Nov/2023 11:42AM
Age/Gender	: 34 Y 0 M 0 D /M	Received	: 05/Nov/2023 12:14PM
UHID/MR No	: DSUS.0000005447	Reported	: 05/Nov/2023 03:06PM
Visit ID	: DSUSOPV6268	Status	: Final Report
Ref Doctor	: APOLLO CLINIC	Client Name	: PUF APOLLO CLINIC SAMRIDDHI AR
IP/CP NO	:	Patient location	: Raipur,Raipur

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE TOTAL (T3, T4, TSH) , *SERUM*				
TRI-IODOTHYRONINE (T3, TOTAL)	1.12	ng/mL	0.6-1.81	CLIA
THYROXINE (T4, TOTAL)	8.30	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	1.250	µIU/mL	0.35-5.5	CLIA

Comment:

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 – 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma

*** End Of Report ***

Dr. SANDHYA VERMA
MBBS, MD,(Pathology)
Consultant Pathologist

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