Patient Ref. No. 251000000132867

CLIENT CODE : C000138404

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod,
Tonk Road
JAIPUR, 302015
Rajasthan, INDIA

PATIENT NAME : SANJAY CHAWLA PATIENT ID : **SANJM260488251**

ACCESSION NO : **0251VD002221** AGE : 34 Years SEX : Male

DRAWN : 26/04/2022 09:37 RECEIVED : 26/04/2022 11:03 REPORTED : 26/04/2022 14:03

REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012204260022

Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE				
BLOOD COUNTS,EDTA WHOLE BLOOD				
HEMOGLOBIN	15.4		13.0 - 17.0	g/dL
METHOD : CYANIDE FREE DETERMINATION				
RED BLOOD CELL COUNT	5.39		4.5 - 5.5	mil/µL
METHOD : ELECTRICAL IMPEDANCE				
WHITE BLOOD CELL COUNT	6.10		4.0 - 10.0	thou/µL
METHOD : ELECTRICAL IMPEDANCE				
PLATELET COUNT	224		150 - 410	thou/µL
METHOD : ELECTRONIC IMPEDANCE				
RBC AND PLATELET INDICES				
HEMATOCRIT	44.3		40 - 50	%
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR VOL	**82.0**	**Low**	83 - 101	fL
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HGB.	28.5		27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER				
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	**34.6**	**High**	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER				
MENTZER INDEX	15.2			
RED CELL DISTRIBUTION WIDTH	13.2		11.6 - 14.0	%
METHOD : CALCULATED PARAMETER				
MEAN PLATELET VOLUME	10.0		6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER				
WBC DIFFERENTIAL COUNT - NLR				
SEGMENTED NEUTROPHILS	58		40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT	3.54		2.0 - 7.0	thou/µL
LYMPHOCYTES	39		20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE LYMPHOCYTE COUNT	2.38		1.0 - 3.0	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.5			
EOSINOPHILS	02		1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE EOSINOPHIL COUNT	0.12		0.02 - 0.50	thou/µL
MONOCYTES	**01**	**Low**	2 - 10	%

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REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012204260022

Test Report Status **Preliminary**	Results		Biological Reference Interval	Units
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE MONOCYTE COUNT	**0.06**	**Low**	0.2 - 1.0	thou/µL
BASOPHILS	00		0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE BASOPHIL COUNT	**0**	**Low**	0.02 - 0.10	thou/µL
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR			
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)	02		0 - 14	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA	94		74 - 99	mg/dL
METHOD : GLUCOSE OXIDASE				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.1		Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)				
MEAN PLASMA GLUCOSE	99.7		< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA	RESULT PENDING			
CORONARY RISK PROFILE (LIPID PROFILE), SERUM.				
CHOLESTEROL	168		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES	136		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL CHOLESTEROL	45		< 40 Low >/=60 High	mg/dL
DIRECT LDL CHOLESTEROL	89		< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
NON HDL CHOLESTEROL	123		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL

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CHOL/HDL RATIO	3.7		3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	2.0		0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN	27.2		</= 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL	0.80		0 - 1	mg/dL
BILIRUBIN, DIRECT	**0.29**	**High**	0.00 - 0.25	mg/dL
BILIRUBIN, INDIRECT	0.51		0.1 - 1.0	mg/dL
TOTAL PROTEIN	8.0		6.4 - 8.2	g/dL
ALBUMIN	**4.8**	**High**	3.8 - 4.4	g/dL
GLOBULIN	3.2		2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.5		1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	29		0 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**45**	**High**	0 - 40	U/L
ALKALINE PHOSPHATASE	64		39 - 117	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	28		11 - 50	U/L
LACTATE DEHYDROGENASE	447		230 - 460	U/L
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN	15		5.0 - 18.0	mg/dL
CREATININE, SERUM				
CREATININE	0.86		0.8 - 1.3	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO	17.44			
URIC ACID, SERUM				
URIC ACID	6.6		3.4 - 7.0	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	8.0		6.4 - 8.3	g/dL
ALBUMIN, SERUM				
ALBUMIN	**4.8**	**High**	3.8 - 4.4	g/dL
GLOBULIN				
GLOBULIN	3.2		2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				

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SODIUM	140.32	137 - 145	mmol/L
POTASSIUM	4.19	3.6 - 5.0	mmol/L
CHLORIDE	101.5	98 - 107	mmol/L
URINALYSIS			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
PH	5.0	4.7 - 7.5	
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035	
GLUCOSE	NOT DETECTED	NOT DETECTED	
PROTEIN	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
THYROID PANEL, SERUM			
T3	98.9	60.0 - 181.0	ng/dL
T4	5.90	4.5 - 10.9	µg/dL
TSH 3RD GENERATION	1.350	0.550 - 4.780	µIU/mL
STOOL: OVA & PARASITE	RESULT PENDING		
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP	TYPE B		
RH TYPE	POSITIVE		

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.
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

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(<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.
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.
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

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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.
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-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.

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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,

URINALYSIS-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 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

Scan to View Details

Scan to View Report

Patient Ref. No. 251000000132867

CLIENT CODE : C000138404

CLIENT'S NAME AND ADDRESS :
ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, F-703, LADO SARAI, MEHRAULI
SOUTH WEST DELHI
NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
C/o Aakriti Labs Pvt Ltd, 3, Mahatma Gandhi Marg,Gandhi Nagar Mod,
Tonk Road
JAIPUR, 302015
Rajasthan, INDIA

PATIENT NAME : SANJAY CHAWLA PATIENT ID : **SANJM260488251**

ACCESSION NO : **0251VD002221** AGE : 34 Years SEX : Male

DRAWN : 26/04/2022 09:37 RECEIVED : 26/04/2022 11:03 REPORTED : 26/04/2022 14:03

REFERRING DOCTOR : SELF CLIENT PATIENT ID : 012204260022

Test Report Status **Preliminary**	Results	Biological Reference Interval	Units

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.

****End Of Report****

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

Dr. Akansha Jain
Consultant Pathologist

Scan to View Details

Scan to View Report

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

PATIENT NAME: MR SANJAY CHAWLA	AGE & SEX: 34 Y/M
REF. by: MEDIWHEEL	DATE: 26.04.2022

USG: WHOLE ABDOMEN (Male)

LIVER : Is normal in size and shape with **bright** echogenecity.
The IHBR and hepatic radicals are not dilated.
No evidence of focal echopoor/echorich lesion seen.
Portal vein diameter and common bile duct appear normal.

GALL BLADDER : Is normal in size,shape and echotexture.Walls are smooth and regular with normal thickness.There is no evidence of cholelithiasis.

PANCREAS : Is normal in size,shape and echotexture.Pancreatic duct is not dilated.
SPLEEN : Is normal in size,shape and echogenecity.Spleenic hilum is not dilated.

KIDNEYS : Right Kidney:-Size: 105x49 mm, Left Kidney:-Size: 100x45 mm.
Bilateral Kidneys are normal in size,shape and echotexture,
corticomedullary differentiation is fair and ratio appears normal.
Pelvi calyceal system is normal.No evidence of hydronephrosis/ nephrolithiasis.

URINARY BLADDER : Bladder walls are smooth,regular and normal thickness.
: No evidence of mass or stone in bladder lumen.

PROSTATE: Is normal in size, shape and echotexture,
measures: 31x26x22 mm, wt: 10 gms.
Its capsule is intact and no evidence of focal lesion.

SPECIFIC : No evidence of retroperitoneal mass or free fluid seen in peritoneal cavity.
: NO evidence of lymphadenopathy or mass lesion in retroperitoneum.
: Visualized bowel loop appear normal.Great vessels appear normal.

IMPRESSION:- Fatty liver

DR NEERA MEHTA
MBBS, DMRD
RMCNO.005807/14853

wellness partner

Aakriti Labs

3 Mahatma Gandhi Marg, Gandhi Nagar Mod
Tonk Road, Jaipur (Raj.) Ph.: 0141-2710661
www.aakritilabs.com
CIN NO.: U85195RJ2004PTC019563

Name	: **Mr. SANJAY CHAWLA**	Registration No:	30019
Age/Gender:	34 Y/Male	Registered	: 26/Apr/2022 09:37AM
Patient ID	: 012204260022	Analysed	: 26/Apr/2022 10:37AM
BarcodeNo	: 10044700	Reported	: 26/Apr/2022 10:37AM
Referred By :	Self	Panel	: Medi Wheel (ArcoFemi Healthcare Ltd)

DIGITAL X-RAY CHEST PA VIEW

Soft tissue shadow and bony cages are normal.

Trachea is central.

Bilateral lung field and both CP angle are clear.

Domes of diaphragm are normally placed.

Transverse diameter of heart appears with normal limits.

IMPRESSION:- NO OBVIOUS ABNORMALITY DETECTED.

*** End Of Report ***

Dr. Neera Mehta
M.B.B.S.,D.M.R.D.
RMCNO.005807/14853

AAKRITI LABS PVT.LTD.

507 / MR: SANJAY CHAWLA / 34 Yrs / M

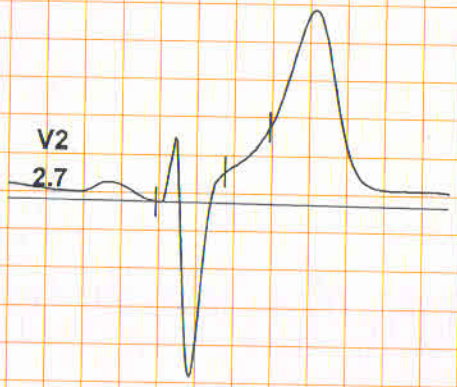
Standing

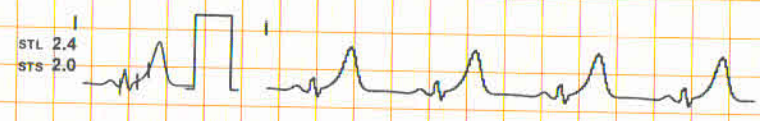
Date: 26-Apr-2022 10:06:11 AM METS: 1.0/ 78 bpm 41% of THR BP: 120/80 mmHg Raw ECG/ BLC On/ Notch On/ HF 0.05 Hz/LF 100 Hz

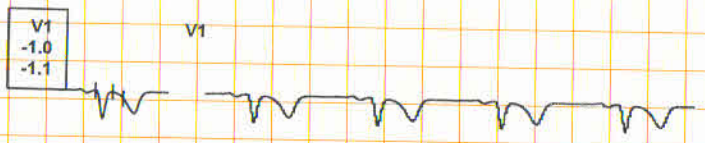
ExTime: 00:06 0.0 mph, 0.0%

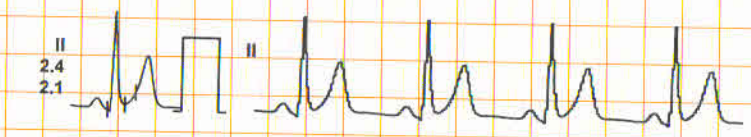
4X 80 mS Post J

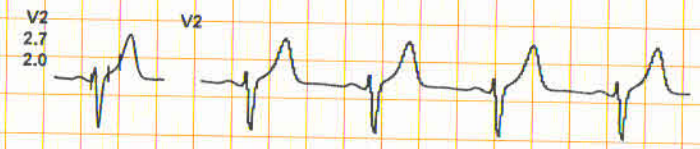
25 mm/Sec. 1.0 Cm/mV

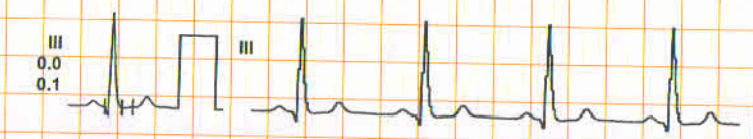


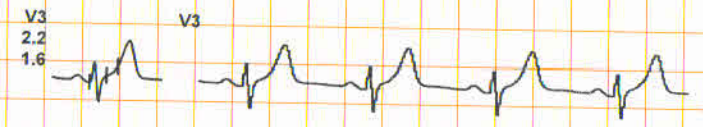


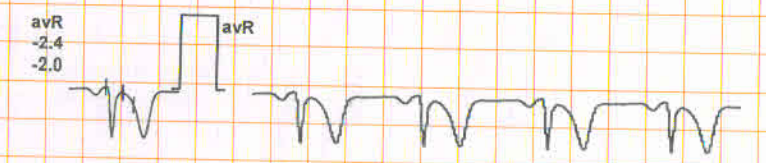


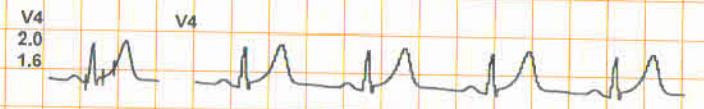


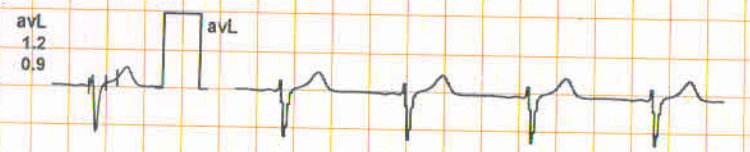


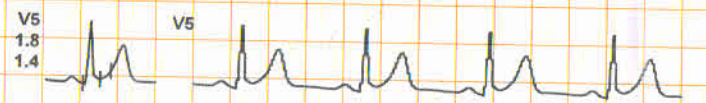


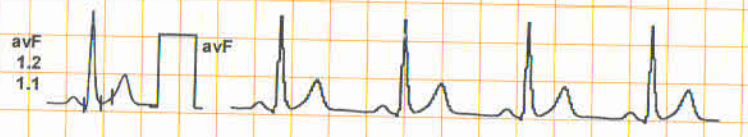


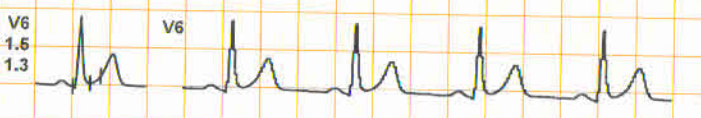


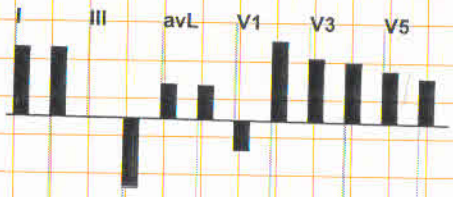












REMARKS:

Dr. NITIZ GOYAL
M.B.B.S., M.D.
RMC - 023319

(GEM211170525)Gemini A-DX by Allengers

BS PVT.LTD.

AGAR MARG,TONK ROAD , JAIPUR 302015

NJAY CHAWLA / 34 Yrs / M / 0 Cms / 0 Kg Date: 26-Apr-2022

Report

(GEM211170525)Gemini A-DX by Allengers

	Time	Duration	Belt Speed (mph)	Elevation	METs	Rate	% THR Achieved	BP	RPP	PVC	Comments
e	00:03	0:01	01.1	00.0	01.0	82	44 %	120/80	098	00	
nding	00:06	0:01	00.0	00.0	01.0	78	42 %	120/80	093	00	
W	00:30	0:01	00.0	00.0	01.0	114	61 %	120/80	136	00	
Warm Up	00:38	0:04	01.7	10.0	01.1	092	49 %	120/80	110	00	
ExStart	00:40	0:06	01.7	10.0	01.1	106	57 %	120/80	127	00	
BRUCE Stage 1	03:40	3:00	01.7	10.0	04.7	140	75 %	120/80	168	00	
PeakEx	05:37	1:57	02.5	12.0	06.3	158	85 %	120/80	189	00	
Recovery	06:36	1:00	00.0	00.0	01.0	112	60 %	120/80	134	00	
Recovery	07:36	2:00	00.0	00.0	01.0	098	53 %	140/85	137	00	
Recovery	08:36	3:00	00.0	00.0	01.0	098	53 %	130/80	127	00	
Recovery	08:53	3:16	00.0	00.0	01.0	092	49 %	130/80	119	00	

Findings :

Exercise Time : 04:58
Max HR Attained : 158 bpm 85% of Target 186
Max BP Attained : (Sys) 140/85
Max WorkLoad Attained : 6.3
Test End Reasons : Test Complete, Heart Rate Acheived

Report :

FINAL IMPRESSION - TEST IS NEGATIVE FOR INDUCIBLE ISCHAEMIA

Dr. NITIZ GOYAL
M.B.B.S., M.D.
RMC - 023319

Doctor : DR.NITIZ GOYAL