



CLIENT CODE : C000138381

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

SRL Ltd
SRL Wellness Centre, SCO. 13, Sector 16 Market, Faridabad
FARIDABAD, 121001
Haryana, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : SURABHI YADAV

PATIENT ID : FH.1024515

ACCESSION NO : 0071VI000792 AGE : 36 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 19/09/2022 16:25

REPORTED : 21/09/2022 16:02

REFERRING DOCTOR : SELF

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Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**BLOOD COUNTS,EDTA WHOLE BLOOD**

HEMOGLOBIN	12.8	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL COUNT	4.19	3.8 - 4.8	mil/ μ L
METHOD : IMPEDANCE			
WHITE BLOOD CELL COUNT	6.45	4.0 - 10.0	thou/ μ L
METHOD : IMPEDANCE			
PLATELET COUNT	155	150 - 410	thou/ μ L
METHOD : IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT	38.7	36 - 46	%
METHOD : CALCULATED			
MEAN CORPUSCULAR VOL	92.3	83 - 101	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN CORPUSCULAR HGB.	30.5	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.0	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	22.0		
RED CELL DISTRIBUTION WIDTH	16.1	High 11.6 - 14.0	%
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN PLATELET VOLUME	13.1	High 6.8 - 10.9	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			

WBC DIFFERENTIAL COUNT - NLR

SEGMENTED NEUTROPHILS	70	40 - 80	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	4.50	2.0 - 7.0	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED			
LYMPHOCYTES	25	20 - 40	%
METHOD : DHSS FLOWCYTOMETRY			
ABSOLUTE LYMPHOCYTE COUNT	1.58	1 - 3	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	2.9		
METHOD : CALCULATED			
EOSINOPHILS	1	1 - 6	%



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METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE EOSINOPHIL COUNT		0.07	0.02 - 0.50	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
MONOCYTES		4	2 - 10	%
METHOD : DHSS FLOWCYTOMETRY				
ABSOLUTE MONOCYTE COUNT		0.26	0.20 - 1.00	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
BASOPHILS		0	0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
DIFFERENTIAL COUNT PERFORMED ON:		EDTA SMEAR		
METHOD : MICROSCOPY				
ERYTHRO SEDIMENTATION RATE, BLOOD				
SEDIMENTATION RATE (ESR)		31	High 0 - 20	mm at 1 hr
METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)				
GLUCOSE, FASTING, PLASMA				
GLUCOSE, FASTING, PLASMA		89	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
METHOD : SPECTROPHOTOMETRY HEXOKINASE				
GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD				
GLYCOSYLATED HEMOGLOBIN (HBA1C)		5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : CAPILLARY ELECTROPHORESIS				
MEAN PLASMA GLUCOSE		105.4	< 116	mg/dL
METHOD : CALCULATED PARAMETER				
GLUCOSE, POST-PRANDIAL, PLASMA		RESULT PENDING		
CORONARY RISK PROFILE, SERUM				
CHOLESTEROL		136	Desirable cholesterol level < 200 Borderline high cholesterol 200 - 239 High cholesterol > / = 240	mg/dL



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TRIGLYCERIDES		114	Normal: < 150 Borderline high: 150 - 199 High: 200 - 499 Very High: >= 500	mg/dL
HDL CHOLESTEROL		42	Low HDL Cholesterol <40	mg/dL
CHOLESTEROL LDL		76	High HDL Cholesterol >= 60 Adult levels: Optimal < 100 Near optimal/above optimal: 100-129 Borderline high : 130-159 High : 160-189 Very high : = 190	mg/dL
NON HDL CHOLESTEROL		94	Desirable : < 130 Above Desirable : 130 -159 Borderline High : 160 - 189 High : 190 - 219 Very high : > / = 220	mg/dL
CHOL/HDL RATIO		3.0	Low Low Risk : 3.3 - 4.4 Average Risk : 4.5 - 7.0 Moderate Risk : 7.1 - 11.0 High Risk : > 11.0	
LDL/HDL RATIO		1.8	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		22.8	< OR = 30.0	mg/dL
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.6	Upto 1.2	mg/dL
BILIRUBIN, DIRECT		0.3	< 0.30	mg/dL
BILIRUBIN, INDIRECT		0.30	0.1 - 1.0	mg/dL
TOTAL PROTEIN		7.4	6.0 - 8.0	g/dL
ALBUMIN		4.5	3.97 - 4.94	g/dL
GLOBULIN		2.9	2.0 - 3.5	g/dL
ALBUMIN/GLOBULIN RATIO		1.5	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		17	< OR = 35	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		13	< OR = 35	U/L
ALKALINE PHOSPHATASE		81	35 - 104	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		23	0 - 40	U/L
LACTATE DEHYDROGENASE		137	125 - 220	U/L
SERUM BLOOD UREA NITROGEN				





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BLOOD UREA NITROGEN		5.2	Low 6 - 20	mg/dL
CREATININE, SERUM				
CREATININE		0.56	0.5 - 0.9	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO		9.30	8.0 - 15.0	
URIC ACID, SERUM				
URIC ACID		3.6	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.4	6.0 - 8.0	g/dL
ALBUMIN, SERUM				
ALBUMIN		4.5	3.97 - 4.94	g/dL
GLOBULIN				
GLOBULIN		2.9	2.0 - 3.5	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM		137	136 - 145	mmol/L
POTASSIUM		4.2	3.5 - 5.1	mmol/L
CHLORIDE		103	98 - 107	mmol/L
PHYSICAL EXAMINATION, URINE				
COLOR		PALE YELLOW		
APPEARANCE		CLEAR		
SPECIFIC GRAVITY		1.015	1.003 - 1.035	

Comments

NOTE :MICROSCOPIC EXAMINATION OF URINE IS PERFORMED ON CENTRIFUGED URINARY SEDIMENT.
IN NORMAL URINE SAMPLES CAST AND CRYSTALS ARE NOT DETECTED.

CHEMICAL EXAMINATION, URINE

PH	6.5	4.7 - 7.5
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	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



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LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
PUS CELL (WBC'S)		1-2	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	
THYROID PANEL, SERUM				
T3		111.0	80 - 200	ng/dL
T4		9.80	5.1 - 14.1	µg/dL
TSH 3RD GENERATION		3.740	0.27 - 4.2	µIU/mL
STOOL: OVA & PARASITE				
REMARK		SAMPLE NOT RECEIVED		
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD				
ABO GROUP		B		
RH TYPE		RH+		
XRAY-CHEST				
>>		BOTH THE LUNG FIELDS ARE CLEAR		
>>		BOTH THE COSTOPHRENIC AND CARIOPHRENIC ANGELS ARE CLEAR		
>>		BOTH THE HILA ARE NORMAL		
>>		CARDIAC AND AORTIC SHADOWS APPEAR NORMAL		
>>		BOTH THE DOMES OF THE DIAPHRAM ARE NORMAL		
>>		VISUALIZED BONY THORAX IS NORMAL		
IMPRESSION		NO ABNORMALITY DETECTED		
TMT OR ECHO		RESULT PENDING		
ECG		WITHIN NORMAL LIMITS		
ECG		WITHIN NORMAL LIMITS		
MEDICAL HISTORY		RESULT PENDING		
ANTHROPOMETRIC DATA & BMI		RESULT PENDING		
GENERAL EXAMINATION		RESULT PENDING		
CARDIOVASCULAR SYSTEM		RESULT PENDING		
RESPIRATORY SYSTEM		RESULT PENDING		
PER ABDOMEN		RESULT PENDING		





Patient Ref. No. 7100000304789

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CENTRAL NERVOUS SYSTEM		RESULT PENDING		
MUSCULOSKELETAL SYSTEM		RESULT PENDING		
BASIC EYE EXAMINATION		RESULT PENDING		
BASIC ENT EXAMINATION		RESULT PENDING		
BASIC DENTAL EXAMINATION		RESULT PENDING		
SUMMARY		RESULT PENDING		
FITNESS STATUS		RESULT PENDING		

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 (<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 glycosylated 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 glycosylated 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.



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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 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 (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



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- 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

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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 hyperfunction, 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

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:





Patient Ref. No. 7100000304789

CLIENT CODE : C000138381

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
F-703, LADO SARAI, MEHRAULI
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NEW DELHI 110030
DELHI INDIA
8800465156

SRL Ltd
SRL Wellness Centre, SCO. 13, Sector 16 Market, Faridabad
FARIDABAD, 121001
Haryana, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT NAME : SURABHI YADAV

PATIENT ID : FH.1024515

ACCESSION NO : 0071VI000792 AGE : 36 Years SEX : Female

ABHA NO :

DRAWN :

RECEIVED : 19/09/2022 16:25

REPORTED : 21/09/2022 16:02

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	<u>Preliminary</u>	Results	Biological Reference Interval	Units
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- Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
- Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
- Behrman R.E. Kliegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

STOOL: OVA & PARASITE-

Acute infective diarrhoea and gastroenteritis (diarrhoea with vomiting) are major causes of ill health and premature death in developing countries. Loss of water and electrolytes from the body can lead to severe dehydration which if untreated, can be rapidly fatal in young children, especially that are malnourished, hypoglycaemic, and generally in poor health.

Laboratory diagnosis of parasitic infection is mainly based on microscopic examination and the gross examination of the stool specimen. Depending on the nature of the parasite, the microscopic observations include the identification of cysts, ova, trophozoites, larvae or portions of adult structure. The two classes of parasites that cause human infection are the Protozoa and Helminths. The protozoan infections include amoebiasis mainly caused by Entamoeba histolytica and giardiasis caused by Giardia lamblia. The common helminthic parasites are Trichuris trichiura, Ascaris lumbricoides, Strongyloides stercoralis, Taenia sp. etc

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.



Scan to View Details



Scan to View Report



Patient Ref. No. 7100000304789

CLIENT CODE : C000138381

CLIENT'S NAME AND ADDRESS :

ACROFEMI HEALTHCARE LTD (MEDIWHEEL)
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Test Report Status	Preliminary	Results	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN**

NO ABNORMALITIES DETECTED.

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

Dr. Arpita Roy, MD
Section Head-Hematology

Dr. Mamta Kumari, MBBS, MD
Consultant Microbiologist

Dr. Chandan Hazarika
Microbiologist

Dr. Geeta
Pathologist



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