



MC-5333

PATIENT NAME : PALLAVI DHARMENDRA SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100

ACCESSION NO : 0251WD001243

PATIENT ID : PALLF140486251

CLIENT PATIENT ID: 012304140074

ABHA NO :

AGE/SEX : 37 Years Female

DRAWN : 14/04/2023 10:47:00

RECEIVED : 14/04/2023 11:58:54

REPORTED : 15/04/2023 19:46:42

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	11.7 Low	12.0 - 15.0	g/dL
METHOD : CYANIDE FREE DETERMINATION			
RED BLOOD CELL (RBC) COUNT	3.93	3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	6.70	4.0 - 10.0	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
PLATELET COUNT	182	150 - 410	thou/ μ L
METHOD : ELECTRONIC IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	35.3 Low	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	90.0	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.9	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.3	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	14.2 High	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	22.9		
MEAN PLATELET VOLUME (MPV)	10.4	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	50	40 - 80	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
LYMPHOCYTES	43 High	20 - 40	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
MONOCYTES	05	2 - 10	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			
EOSINOPHILS	02	1 - 6	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY			

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Patient Ref. No. 775000002907337



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BASOPHILS		00	0 - 2	%
METHOD : IMPEDANCE WITH HYDRO FOCUS AND MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		3.35	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.88	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.34	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.13	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.2		

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-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.


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HAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	07	0 - 20	mm at 1 hr
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METHOD : AUTOMATED (PHOTOMETRICAL CAPILLARY STOPPED FLOW KINETIC ANALYSIS)"

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

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.



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IMMUNOHAEMATOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

TYPE O

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

Interpretation(s)

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.

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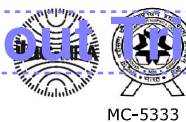


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BIOCHEMISTRY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	83	74 - 99	mg/dL
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METHOD : GLUCOSE OXIDASE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HIGH PERFORMANCE LIQUID CHROMATOGRAPHY (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG)	105.4	< 116.0	mg/dL
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METHOD : CALCULATED PARAMETER

GLUCOSE, POST-PRANDIAL, PLASMA RESULT PENDING

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	143	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
TRIGLYCERIDES	111	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
HDL CHOLESTEROL	42	< 40 Low >/=60 High	mg/dL
CHOLESTEROL LDL	79	< 100 Optimal 100 - 129 Near optimal/ above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL

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NON HDL CHOLESTEROL		101	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN CHOL/HDL RATIO		22.2 3.4	< /= 30.0 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	mg/dL
LDL/HDL RATIO		1.9	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
LIVER FUNCTION PROFILE, SERUM				
BILIRUBIN, TOTAL		0.57	0 - 1	mg/dL
BILIRUBIN, DIRECT		0.20	0.00 - 0.25	mg/dL
BILIRUBIN, INDIRECT		0.37	0.1 - 1.0	mg/dL
TOTAL PROTEIN		7.4	6.4 - 8.2	g/dL
ALBUMIN		4.3	3.8 - 4.4	g/dL
GLOBULIN		3.1	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO		1.4	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)		19	0 - 31	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)		14	0 - 31	U/L
ALKALINE PHOSPHATASE		70	39 - 117	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)		9	7 - 32	U/L
LACTATE DEHYDROGENASE		390	230 - 460	U/L
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		12	5.0 - 18.0	mg/dL
CREATININE, SERUM				
CREATININE		0.87	0.6 - 1.2	mg/dL
BUN/CREAT RATIO				

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BUN/CREAT RATIO		13.79		
URIC ACID, SERUM				
URIC ACID		5.0	2.4 - 5.7	mg/dL
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.4	6.4 - 8.3	g/dL
ALBUMIN, SERUM				
ALBUMIN		4.3	3.8 - 4.4	g/dL
GLOBULIN				
GLOBULIN		3.1	2.0 - 4.1	g/dL
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		145.0	137 - 145	mmol/L
POTASSIUM, SERUM		4.17	3.6 - 5.0	mmol/L
CHLORIDE, SERUM		106.2	98 - 107	mmol/L

Interpretation(s)**GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in: Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in: Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs-insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2. Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in


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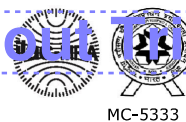
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- a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
- b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- c) HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

LIVER FUNCTION PROFILE, SERUM-

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, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons 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.

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, Waldenstroms 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 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

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include 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, Muscuophy

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, Multiple Sclerosis

TOTAL PROTEIN, SERUM- 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, Waldenstroms 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.

Dr. Akansha Jain
Consultant Pathologist



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



Line No. 775000002907337



MC-5333

PATIENT NAME : PALLAVI DHARMENDRA SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100

ACCESSION NO : 0251WD001243

PATIENT ID : PALLF140486251

CLIENT PATIENT ID: 012304140074

ABHA NO :

AGE/SEX : 37 Years Female

DRAWN : 14/04/2023 10:47:00

RECEIVED : 14/04/2023 11:58:54

REPORTED : 15/04/2023 19:46:42

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW

APPEARANCE CLEAR

CHEMICAL EXAMINATION, URINE

PH	5.5	4.7 - 7.5
SPECIFIC GRAVITY	1.010	1.003 - 1.035
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
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	1-2	0-5	/HPF
EPITHELIAL CELLS	3-5	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

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Dr. Akansha Jain
Consultant Pathologist



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Rajasthan, INDIAPrinted On: 15/04/2023 19:46:42
Printed By: 775000002907337



MC-5333

PATIENT NAME : PALLAVI DHARMENDRA SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100ACCESSION NO : **0251WD001243**

PATIENT ID : PALLF140486251

CLIENT PATIENT ID: 012304140074

ABHA NO :

AGE/SEX : 37 Years Female

DRAWN : 14/04/2023 10:47:00

RECEIVED : 14/04/2023 11:58:54

REPORTED : 15/04/2023 19:46:42

Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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CYTOLOGY

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**PAPANICOLAOU SMEAR**

TEST METHOD

SAMPLE NOT RECEIVED



Dr. Akansha Jain
Consultant Pathologist



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Report No. 775000002907337



MC-5333

PATIENT NAME : PALLAVI DHARMENDRA SINGH

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000049066

SRL JAIPUR WELLNESS CORPORATE WALK IN
AAKRITI LABS PVT LTD. A-430, AGRASEN MARG
JAIPUR 302017
9314660100

ACCESSION NO : 0251WD001243

PATIENT ID : PALLF140486251

CLIENT PATIENT ID: 012304140074

ABHA NO :

AGE/SEX : 37 Years Female

DRAWN : 14/04/2023 10:47:00

RECEIVED : 14/04/2023 11:58:54

REPORTED : 15/04/2023 19:46:42

Test Report Status	<u>Preliminary</u>	Results	Biological Reference Interval	Units
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CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

PHYSICAL EXAMINATION,STOOL

COLOUR SAMPLE NOT RECEIVED

Dr. Abhishek Sharma
Consultant Microbiologist



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MC-5333

PATIENT NAME : PALLAVI DHARMENDRA SINGH

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9314660100

ACCESSION NO : 0251WD001243

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Test Report Status	Preliminary	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3	114.54	60.0 - 181.0	ng/dL
T4	11.70 High	4.5 - 10.9	µg/dL
TSH (ULTRASENSITIVE)	1.702	0.550 - 4.780	µIU/mL

End Of Report

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

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.

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Mohali 160062

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 Dr. Akansha Jain
 Consultant Pathologist


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Aakriti Labs

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



Name : Mrs. PALLAVI DHARMENDRA SINGH

Registration No: 55866

Age/Gender: 37 Y/Female

Registered : 14/Apr/2023 10:47AM

Patient ID : 012304140074

Analysed : 14/Apr/2023 01:53PM

BarcodeNo : 10082480

Reported : 14/Apr/2023 01:53PM

Referred By : Self

Panel : MEDI WHEEL (ARCOFEMI
HEALTHCARE LTD)

USG: WHOLE ABDOMEN (Female)

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

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 echogenicity. Splenic hilum is not dilated.

KIDNEYS : 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 is partially filled as patient not willing to hold urine.

BLADDER : Pre void vol : 75 ml

UTERUS : Uterus and ovaries could not be seen due to partially filled bladder


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: Mild fatty liver

*** End Of Report ***

Page 1 of 1




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



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CIN No. U85195RJ2004PTC019563



Name	: Mrs. PALLAVI DHARMENDRA SINGH	Registration No:	55866
Age/Gender:	37 Y/Female	Registered	: 14/Apr/2023 10:47AM
Patient ID	: 012304140074	Analysed	: 15/Apr/2023 11:44AM
BarcodeNo	: 10082480	Reported	: 15/Apr/2023 11:44AM
Referred By	: Self	Panel	: MEDI WHEEL (ARCOFEMI HEALTHCARE LTD)

DIGITAL X-RAY CHEST PA VIEW

Metallic artifacts are seen.

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 ***

Page 1 of 1




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



FWNL
NS
 DR. NITIZ GOYAL
 M.B.B.S., M.D.
 RMC - 023319



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CIN No. U85195RJ2004PTC019563

NAME	MRS PALLAVI DHARMENDRA SINGH	AGE	37Y	SEX	FEMALE
REF BY	MEDI WHEEL	DATE	14/04/2023	REG NO	

ECHOCARDIOGRAM REPORT

WINDOW- POOR/ADEQUATE/GOODVALVE

MITRAL	NORMAL	TRICUSPID	NORMAL
AORTIC	NORMAL	PULMONARY	NORMAL

2D/M-MOD

IVSD mm	8.5	IVSS mm	10.1	AORTA mm	28.8
LVID mm	40.6	LVIS mm	26.7	LA mm	30.8
LVPWD mm	8.8	LVPWS mm	10.1	EF%	60%

CHAMBERS

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

DOPPLER STUDY MITRAL

PEAK VELOCITY m/s E/A	0.69/0.56	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
MVA cm2 (PLANIMETERY)		MVA cm2 (PHT)	
MR			

AORTIC

PEAK VELOCITY m/s	1.74	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
AR			

TRICUSPID

PEAK VELOCITY m/s	0.79	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
TR		PASP mmHg	

PULMONARY

PEAK VELOCITY m/s	1.42	PEAK GRADIANT MmHg	
MEAN VELOCITY m/s		MEAN GRADIANT MmHg	
PR		RVEDP mmHg	

IMPRESSION

- NORMAL LV SYSTOLIC & DIASTOLIC FUNCTION
- NO RWMA LVEF 60%
- NORMAL RV FUNCTION
- NORMAL CHAMBER DIMENSIONS
- NORMAL VALVULAR ECHO
- INTACT IAS / IVS
- NO THROMBUS, NO VEGETATION, NORMAL PERICARDIUM.
- IVC NORMAL

CONCLUSION : FAIR LV FUNCTION.


Cardiologist



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www.aakritilabs.com
CIN No. U85195RJ2004PTC019563

(7)

Name - Pallavi
Age - 37/F
Address - Jaipur

Vn $\left\{ \begin{array}{l} 6/9 \\ 6/9 \end{array} \right.$


Refraction :-

R \rightarrow -0.50 sph

L \rightarrow -0.75 sph

Colour vision : NAD

fundus : NAD


Dr. RAKESH SHARMA
M.S. OPHTH. OPTH
FICLLP

