

PATIENT NAME : RITESH KUMAR SINGH

REF. DOCTOR : SELF

CODE/NAME &amp; ADDRESS : C000138376

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

ACCESSION NO : 0062WA001222

PATIENT ID : RITEM08088962

CLIENT PATIENT ID:

ABHA NO :

AGE/SEX : 33 Years Male

DRAWN :

RECEIVED : 14/01/2023 08:13:18

REPORTED : 16/01/2023 13:48:37

Test Report Status **Final**

Results

Biological Reference Interval Units

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****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**

TMT OR ECHO NEGATIVE

**ECG**

ECG WITHIN NORMAL LIMITS

**MEDICAL HISTORY**

RELEVANT PRESENT HISTORY NOT SIGNIFICANT  
 RELEVANT PAST HISTORY NOT SIGNIFICANT  
 RELEVANT PERSONAL HISTORY MARRIED, 01 CHILD, VEG.  
 RELEVANT FAMILY HISTORY NOT SIGNIFICANT  
 OCCUPATIONAL HISTORY BANKER.  
 HISTORY OF MEDICATIONS NOT SIGNIFICANT

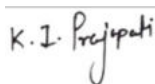
**ANTHROPOMETRIC DATA & BMI**

HEIGHT IN METERS 1.74 mts  
 WEIGHT IN KGS. 81.65 Kgs  
 BMI 27

BMI & Weight Status as follows:  
 Below 18.5: Underweight  
 18.5 - 24.9: Normal  
 25.0 - 29.9: Overweight  
 30.0 and Above: Obese

**GENERAL EXAMINATION**

MENTAL / EMOTIONAL STATE NORMAL  
 PHYSICAL ATTITUDE NORMAL  
 GENERAL APPEARANCE / NUTRITIONAL STATUS HEALTHY  
 BUILT / SKELETAL FRAMEWORK AVERAGE



Dr. Kamlesh I Prajapati  
 Consultant Pathologist

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**PERFORMED AT :**

SRL Ltd  
 PLOT NO.160,POCKET D-11 SECTOR 8, ROHINI

NEW DELHI, 110085  
 NEW DELHI, INDIA  
 Tel : 9111591115, Fax :  
 CIN - U74899PB1995PLC045956



Patient Ref. No. 775000002143060

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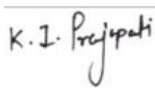
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FACIAL APPEARANCE	NORMAL		
SKIN	NORMAL		
UPPER LIMB	NORMAL		
LOWER LIMB	NORMAL		
NECK	NORMAL		
NECK LYMPHATICS / SALIVARY GLANDS	NOT ENLARGED OR TENDER		
THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
BREAST (FOR FEMALES)	NORMAL		
TEMPERATURE	NORMAL		
PULSE	68/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
<b>CARDIOVASCULAR SYSTEM</b>			
BP	109/68 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	S1, S2 HEARD NORMALLY		
MURMURS	ABSENT		
<b>RESPIRATORY SYSTEM</b>			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
<b>PER ABDOMEN</b>			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
HERNIA	ABSENT		
ANY OTHER COMMENTS	NIL		



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**CENTRAL NERVOUS SYSTEM**

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

**MUSCULOSKELETAL SYSTEM**

SPINE	NORMAL
JOINTS	NORMAL

**BASIC EYE EXAMINATION**

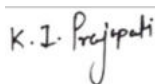
CONJUNCTIVA	NORMAL
EYELIDS	NORMAL
EYE MOVEMENTS	NORMAL
CORNEA	NORMAL
DISTANT VISION RIGHT EYE WITH GLASSES	6/6
DISTANT VISION LEFT EYE WITH GLASSES	6/9
NEAR VISION RIGHT EYE WITH GLASSES	N/6
NEAR VISION LEFT EYE WITH GLASSES	N/6
COLOUR VISION	NORMAL

**BASIC ENT EXAMINATION**

EXTERNAL EAR CANAL	B/L- PRESENCE OF WAX
TYMPANIC MEMBRANE	NORMAL
NOSE	NO ABNORMALITY DETECTED
SINUSES	NORMAL
THROAT	NORMAL
TONSILS	NOT ENLARGED

**BASIC DENTAL EXAMINATION**

TEETH	NORMAL
GUMS	HEALTHY
ANY OTHER COMMENTS	NIL

**SUMMARY**


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RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

WITHIN NORMAL LIMITS

RELEVANT NON PATHOLOGY DIAGNOSTICS

USG ABD - GB CALCULUS

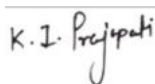
REMARKS / RECOMMENDATIONS

EAR PROPHYLAXIS; SURG. SPL. CONSULTATION

**FITNESS STATUS**

FITNESS STATUS

FIT (WITH MEDICAL ADVICE) (AS PER REQUESTED PANEL OF TESTS)


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**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****ULTRASOUND ABDOMEN****ULTRASOUND ABDOMEN****ULTRASOUND WHOLE ABDOMEN**

Liver is normal in size, outline and shows grade I fatty changes. No obvious focal parenchymal lesion/biliary dilatation is seen. Hepatic veins and portal venous radicals are normal.

**Gall bladder is partially distended and shows a soft calculus in the lumen, measuring ~ 8.5mm.**

Common bile duct is not dilated. Portal vein is normal in course and caliber.

**Pancreas**

Pancreas is normal in size, outline and echotexture. No evidence of any focal lesion or calcification is seen.

Pancreatic duct is not dilated.

**Spleen**

Spleen is normal in size, outline and echotexture. No focal lesion/ calcification is seen.

**Kidneys**

Both kidneys are normal in size, outline and echotexture. Corticomedullary differentiation is well maintained.

Parenchymal thickness is normal. No mass lesion, calculus or hydronephrosis is seen.

No significant retroperitoneal lymphadenopathy/ascites is seen.

**Urinary Bladder**

Urinary bladder is well distended with normal outline.

**Prostate**

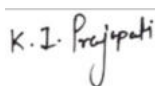
Prostate is normal in size.

*Correlate clinically*

**Interpretation(s)**

MEDICAL

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



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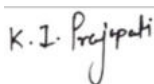
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\*\*\*\*\*  
 FITNESS STATUS-Conclusion on an individual's Fitness, which is commented upon mainly for Pre employment cases, is based on multi factorial findings and does not depend on any one single parameter. The final Fitness assigned to a candidate will depend on the Physician's findings and overall judgement on a case to case basis, details of the candidate's past and personal history; as well as the comprehensiveness of the diagnostic panel which has been requested for .These are then further correlated with details of the job under consideration to eventually fit the right man to the right job.

Basis the above, SRL classifies a candidate's Fitness Status into one of the following categories:

- Fit (As per requested panel of tests) - SRL Limited gives the individual a clean chit to join the organization, on the basis of the General Physical Examination and the specific test panel requested for.
- Fit (with medical advice) (As per requested panel of tests) - This indicates that although the candidate can be declared as FIT to join the job, minimal problems have been detected during the Pre- employment examination. Examples of conditions which could fall in this category could be cases of mild reversible medical abnormalities such as height weight disproportions, borderline raised Blood Pressure readings, mildly raised Blood sugar and Blood Lipid levels, Hematuria, etc. Most of these relate to sedentary lifestyles and come under the broad category of life style disorders. The idea is to caution an individual to bring about certain lifestyle changes as well as seek a Physician's consultation and counseling in order to bring back to normal the mildly deranged parameters. For all purposes the individual is FIT to join the job.
- Fitness on Hold (Temporary Unfit) (As per requested panel of tests) - Candidate's reports are kept on hold when either the diagnostic tests or the physical findings reveal the presence of a medical condition which warrants further tests, counseling and/or specialist opinion, on the basis of which a candidate can either be placed into Fit, Fit (With Medical Advice), or Unfit category. Conditions which may fall into this category could be high blood pressure, abnormal ECG, heart murmurs, abnormal vision, grossly elevated blood sugars, etc.
- Unfit (As per requested panel of tests) - An unfit report by SRL Limited clearly indicates that the individual is not suitable for the respective job profile e.g. total color blindness in color related jobs.



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## HAEMATOLOGY - CBC

## MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE

## BLOOD COUNTS, EDTA WHOLE BLOOD

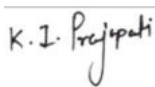
HEMOGLOBIN (HB)	15.5	13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	5.23	4.5 - 5.5	mil/ $\mu$ L
METHOD : IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	7.40	4.0 - 10.0	thou/ $\mu$ L
METHOD : CELL COUNTER			
PLATELET COUNT	257	150 - 410	thou/ $\mu$ L
METHOD : CELL COUNTER+MICROSCOPY			

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	46.2	40 - 50	%
METHOD : CELL COUNTER			
MEAN CORPUSCULAR VOLUME (MCV)	88.0	83 - 101	fL
METHOD : CELL COUNTER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.7	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	33.6	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	12.2	11.6 - 14.0	%
METHOD : CELL COUNTER			
MENTZER INDEX	16.8		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	10.5	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	56	40 - 80	%
METHOD : IMPEDENCE / MICROSCOPY			
LYMPHOCYTES	35	20 - 40	%
METHOD : IMPEDENCE / MICROSCOPY			
MONOCYTES	2	2 - 10	%
METHOD : IMPEDENCE / MICROSCOPY			
EOSINOPHILS	<b>7 High</b>	1 - 6	%


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METHOD : IMPEDEANCE / MICROSCOPY				
BASOPHILS		0	0 - 2	%
METHOD : MICROSCOPIC EXAMINATION				
ABSOLUTE NEUTROPHIL COUNT		4.14	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.59	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		<b>0.15 Low</b>	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		<b>0.52 High</b>	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		<b>0 Low</b>	0.02 - 0.10	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.6		
METHOD : CALCULATED PARAMETER				

**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 CHECK UP BELOW 40 MALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R 12 0 - 14 mm at 1 hr

METHOD : WESTERGREN METHOD

## 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

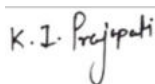
## LIMITATIONS

**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 CHECK UP BELOW 40 MALE****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP

TYPE A

METHOD : TUBE AGGLUTINATION

RH TYPE

POSITIVE

METHOD : TUBE AGGLUTINATION

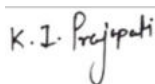
**Interpretation(s)**

ABO GROUP &amp; 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.



**Dr. Kamlesh I Prajapati**  
Consultant Pathologist

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**PERFORMED AT :**

SRL Ltd  
PLOT NO.160,POCKET D-11 SECTOR 8, ROHINI

NEW DELHI, 110085  
NEW DELHI, INDIA  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956



Patient Ref. No. 775000002143060

**PATIENT NAME : RITESH KUMAR SINGH**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000138376**

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

**ACCESSION NO : 0062WA001222**

**PATIENT ID : RITEM08088962**

**CLIENT PATIENT ID:**

**ABHA NO :**

**AGE/SEX : 33 Years Male**

**DRAWN :**

**RECEIVED : 14/01/2023 08:13:18**

**REPORTED : 16/01/2023 13:48:37**

Test Report Status	Final	Results	Biological Reference Interval	Units
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**BIOCHEMISTRY**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR)	87	74 - 99	mg/dL
---------------------------	----	---------	-------

METHOD : HEXOKINASE

**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	5.3	Non-diabetic Adult < 5.7 Pre-diabetes 5.7 - 6.4 Diabetes diagnosis: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
-------	-----	--	---

METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	105.4	< 116.0	mg/dL
--------------------------------	-------	---------	-------

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR)	122	70 - 140	mg/dL
---------------------------------	-----	----------	-------

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	198	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
--------------------	-----	---	-------

METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE

TRIGLYCERIDES	115	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
---------------	-----	--	-------

METHOD : ENZYMATIC, END POINT

HDL CHOLESTEROL	58	< 40 Low >=60 High	mg/dL
-----------------	----	-----------------------	-------

METHOD : DIRECT MEASURE POLYMER-POLYANION

CHOLESTEROL LDL	<b>117 High</b>	< 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	<b>140 High</b>	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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METHOD : CALCULATED

VERY LOW DENSITY LIPOPROTEIN	23.0	</= 30.0	mg/dL
------------------------------	------	----------	-------

CHOL/HDL RATIO	3.4		
----------------	-----	--	--

LDL/HDL RATIO	2.0	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
---------------	-----	--	--

**Interpretation(s)**

**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.64	0.2 - 1.0	mg/dL
------------------	------	-----------	-------

METHOD : DIAZOTIZATION

BILIRUBIN, DIRECT	0.16	0.0 - 0.2	mg/dL
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METHOD : DIAZOTIZATION

BILIRUBIN, INDIRECT	0.48	0.1 - 1.0	mg/dL
---------------------	------	-----------	-------

METHOD : CALCULATED PARAMETER

TOTAL PROTEIN	6.8	6.4 - 8.2	g/dL
---------------	-----	-----------	------

ALBUMIN	4.4	3.4 - 5.0	g/dL
---------	-----	-----------	------

METHOD : BROMOCRESOL PURPLE

GLOBULIN	2.4	2.0 - 4.1	g/dL
----------	-----	-----------	------

METHOD : CALCULATED PARAMETER

ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.1	RATIO
------------------------	-----	-----------	-------

METHOD : CALCULATED PARAMETER

ASPARTATE AMINOTRANSFERASE (AST/SGOT)	18	15 - 37	U/L
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METHOD : UV WITH P5P

ALANINE AMINOTRANSFERASE (ALT/SGPT)	<b>68 High</b>	< 45.0	U/L
-------------------------------------	----------------	--------	-----

METHOD : UV WITH P5P

ALKALINE PHOSPHATASE	95	30 - 120	U/L
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METHOD : PNPP - AMP BUFFER

GAMMA GLUTAMYL TRANSFERASE (GGT)	54	15 - 85	U/L
----------------------------------	----	---------	-----

METHOD : G-GLUTAMYL-CARBOXY-NITROANILIDE

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LACTATE DEHYDROGENASE

136

100 - 190

U/L

METHOD : LACTATE -PYRUVATE

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN

9

6 - 20

mg/dL

METHOD : UREASE - UV

**CREATININE, SERUM**

CREATININE

0.67 Low

0.90 - 1.30

mg/dL

METHOD : ALKALINE PICRATE KINETIC, IFCC-IDMS STANDARDIZED

**BUN/CREAT RATIO**

BUN/CREAT RATIO

13.43

5.00 - 15.00

**URIC ACID, SERUM**

URIC ACID

5.3

3.5 - 7.2

mg/dL

METHOD : URICASE/CATALASE UV

**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN

6.8

6.4 - 8.2

g/dL

METHOD : BIURET

**ALBUMIN, SERUM**

ALBUMIN

4.4

3.4 - 5.0

g/dL

METHOD : BROMOCRESOL PURPLE (BCP) DYE-BINDING

**GLOBULIN**

GLOBULIN

2.4

2.0 - 4.1

g/dL

METHOD : CALCULATED PARAMETER

**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM

140

136 - 145

mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM

4.59

3.50 - 5.10

mmol/L

METHOD : ISE INDIRECT

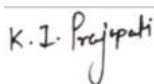
CHLORIDE, SERUM

100

98 - 107

mmol/L

METHOD : ISE INDIRECT

**Interpretation(s)**

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Consultant Pathologist

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**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, sulfonureas, 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 :**

I. 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.

II. Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).

III. 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.

IV. Interference of hemoglobinopathies in HbA1c estimation is seen in

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

GLUCOSE, POST-PRANDIAL, PLASMA-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. Additional test HbA1c

**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

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Consultant Pathologist



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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
- 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

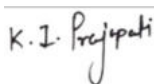
**Causes of decreased levels-** Low Zinc intake, OCP, Multiple Sclerosis

**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.



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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**PHYSICAL EXAMINATION, URINE**

**COLOR** PALE YELLOW  
METHOD : MANUAL

**APPEARANCE** CLEAR  
METHOD : MANUAL

**CHEMICAL EXAMINATION, URINE**

**PH** 7.0 4.7 - 7.5  
METHOD : DIPSTICK

**SPECIFIC GRAVITY** 1.010 1.003 - 1.035  
METHOD : DIPSTICK

**PROTEIN** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK / MANUAL

**GLUCOSE** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK / MANUAL

**KETONES** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK / MANUAL

**BLOOD** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK

**BILIRUBIN** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK / MANUAL

**UROBILINOGEN** NORMAL NORMAL  
METHOD : DIPSTICK / MANUAL

**NITRITE** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK

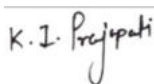
**LEUKOCYTE ESTERASE** NOT DETECTED NOT DETECTED  
METHOD : DIPSTICK

**MICROSCOPIC EXAMINATION, URINE**

**RED BLOOD CELLS** NOT DETECTED NOT DETECTED /HPF  
METHOD : MICROSCOPIC EXAMINATION

**PUS CELL (WBC'S)** 0-1 0-5 /HPF  
METHOD : MICROSCOPIC EXAMINATION

**EPITHELIAL CELLS** 0-1 0-5 /HPF  
METHOD : MICROSCOPY



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CASTS

METHOD : MICROSCOPY

NOT DETECTED

CRYSTALS

METHOD : MICROSCOPY

NOT DETECTED

BACTERIA

NOT DETECTED

NOT DETECTED

YEAST

METHOD : MICROSCOPY

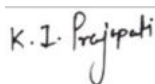
NOT DETECTED

NOT DETECTED

REMARKS

NOTE:- MICROSCOPIC EXAMINATION OF URINE IS PERFORMED BY  
CENTRIFUGE  
URINARY SEDIMENT.

METHOD : MANUAL

**Interpretation(s)**


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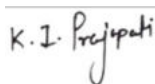
## CLINICAL PATH - STOOL ANALYSIS

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE****PHYSICAL EXAMINATION,STOOL**

COLOUR	BROWN	
CONSISTENCY	SEMI FORMED	
MUCUS	ABSENT	NOT DETECTED
VISIBLE BLOOD	ABSENT	ABSENT
ADULT PARASITE	NOT DETECTED	

**MICROSCOPIC EXAMINATION,STOOL**

PUS CELLS	1-2		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	

**Comments****Interpretation(s)**

Dr. Kamlesh I Prajapati  
Consultant Pathologist

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PLOT NO.160,POCKET D-11 SECTOR 8, ROHININEW DELHI, 110085  
NEW DELHI, INDIA  
Tel : 9111591115, Fax :  
CIN - U74899PB1995PLC045956

Patient Ref. No. 775000002143060

**PATIENT NAME : RITESH KUMAR SINGH**

**REF. DOCTOR : SELF**

**CODE/NAME & ADDRESS : C000138376**

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

**ACCESSION NO : 0062WA001222**

**PATIENT ID : RITEM08088962**

**CLIENT PATIENT ID:**

**ABHA NO :**

**AGE/SEX : 33 Years Male**

**DRAWN :**

**RECEIVED : 14/01/2023 08:13:18**

**REPORTED : 16/01/2023 13:48:37**

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

**SPECIALISED CHEMISTRY - HORMONE**

**MEDI WHEEL FULL BODY HEALTH CHECK UP BELOW 40 MALE**

**THYROID PANEL, SERUM**

T3	107.30	80.00 - 200.00	ng/dL
T4	7.17	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE)	2.290	0.270 - 4.200	µIU/mL

**Interpretation(s)**

**Triiodothyronine T3 , Thyroxine T4, and Thyroid Stimulating Hormone TSH** are thyroid hormones which affect 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.

Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism.

In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hyperthyroidism, TSH levels are low.

Measurement of Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of 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. It is advisable to detect Free T3, Free T4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

Sr. No.	TSH	Total T4	FT4	Total T3	Possible Conditions
1	High	Low	Low	Low	(1) Primary Hypothyroidism (2) Chronic autoimmune Thyroiditis (3) Post Thyroidectomy (4) Post Radio-Iodine treatment
2	High	Normal	Normal	Normal	(1) Subclinical Hypothyroidism (2) Patient with insufficient thyroid hormone replacement therapy (3) In cases of Autoimmune/Hashimoto thyroiditis (4). Isolated increase in TSH levels can be due to Subclinical inflammation, drugs like amphetamines, Iodine containing drug and dopamine antagonist e.g. domperidone and other physiological reasons.
3	Normal/Low	Low	Low	Low	(1) Secondary and Tertiary Hypothyroidism
4	Low	High	High	High	(1) Primary Hyperthyroidism (Graves Disease) (2) Multinodular Goitre (3) Toxic Nodular Goitre (4) Thyroiditis (5) Over treatment of thyroid hormone (6) Drug effect e.g. Glucocorticoids, dopamine, T4 replacement therapy (7) First trimester of Pregnancy
5	Low	Normal	Normal	Normal	(1) Subclinical Hyperthyroidism
6	High	High	High	High	(1) TSH secreting pituitary adenoma (2) TRH secreting tumor
7	Low	Low	Low	Low	(1) Central Hypothyroidism (2) Euthyroid sick syndrome (3) Recent treatment for Hyperthyroidism
8	Normal/Low	Normal	Normal	High	(1) T3 thyrotoxicosis (2) Non-Thyroidal illness
9	Low	High	High	Normal	(1) T4 Ingestion (2) Thyroiditis (3) Interfering Anti TPO antibodies

REF: 1. TIETZ Fundamentals of Clinical chemistry 2. Guidelines of the American Thyroid association during pregnancy and Postpartum, 2011.

**Dr. Kamlesh I Prajapati**  
Consultant Pathologist



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PLOT NO.160,POCKET D-11 SECTOR 8, ROHINI



**Patient Ref. No. 775000002143060**

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Test Report Status **Final**

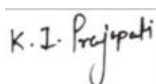
Results

Biological Reference Interval Units

**NOTE: It is advisable to detect Free T3,FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.TSH is not affected by variation in thyroid - binding protein. TSH has a diurnal rhythm, with peaks at 2:00 - 4:00 a.m. And troughs at 5:00 - 6:00 p.m. With ultradian variations.**

**\*\*End Of Report\*\***Please visit [www.srlworld.com](http://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.

**SRL Limited**Fortis Hospital, Sector 62, Phase VIII,  
Mohali 160062


**Dr. Kamlesh I Prajapati**  
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