

PATIENT NAME : LEELAVATI LAHANE

REF. DOCTOR : DR. BANK OF BARODA

ACCESSION NO : 0063WD000563	AGE/SEX : 38 Years Female
PATIENT ID : LEELF09038563	DRAWN : 14/04/2023 08:51:38
CLIENT PATIENT ID:	RECEIVED : 14/04/2023 08:52:55
ABHA NO :	REPORTED : 15/04/2023 09:42:29

Test Report Status	Final	Results	Biological Reference Interval	Units
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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE**XRAY-CHEST**

IMPRESSION NO ABNORMALITY DETECTED

TMT OR ECHO

TMT OR ECHO TMT DONE

ECG

ECG SINUS TACHYCARDIA REST WITHIN NORMAL LIMITS

MEDICAL HISTORY

RELEVANT PRESENT HISTORY NOT SIGNIFICANT

RELEVANT PAST HISTORY NOT SIGNIFICANT

RELEVANT PERSONAL HISTORY UNMARRIED.

RELEVANT FAMILY HISTORY DIABETES.

OCCUPATIONAL HISTORY ANNUAL

HISTORY OF MEDICATIONS NOT SIGNIFICANT

ANTHROPOMETRIC DATA & BMI

HEIGHT IN METERS 1.58 mts

WEIGHT IN KGS. 62 Kgs

BMI 25 BMI & Weight Status as follows/sqmts

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

FACIAL APPEARANCE NORMAL

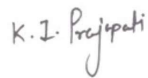
SKIN NORMAL

UPPER LIMB NORMAL

LOWER LIMB NORMAL

NECK NORMAL

NECK LYMPHATICS / SALIVARY GLANDS NOT ENLARGED OR TENDER



Dr. Kamlesh I Prajapati
Consultant Pathologist

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Email : customercare.palammarg@srl.in



Patient Ref. No. 775000002904561

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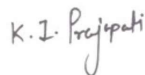
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THYROID GLAND	NOT ENLARGED		
CAROTID PULSATION	NORMAL		
TEMPERATURE	NORMAL		
PULSE	120/MIN REGULAR, ALL PERIPHERAL PULSES WELL FELT, NO CAROTID BRUIT		
RESPIRATORY RATE	NORMAL		
CARDIOVASCULAR SYSTEM			
BP	140/70 MM HG (SITTING)		mm/Hg
PERICARDIUM	NORMAL		
APEX BEAT	NORMAL		
HEART SOUNDS	NORMAL		
MURMURS	ABSENT		
RESPIRATORY SYSTEM			
SIZE AND SHAPE OF CHEST	NORMAL		
MOVEMENTS OF CHEST	SYMMETRICAL		
BREATH SOUNDS INTENSITY	NORMAL		
BREATH SOUNDS QUALITY	VESICULAR (NORMAL)		
ADDED SOUNDS	ABSENT		
PER ABDOMEN			
APPEARANCE	NORMAL		
VENOUS PROMINENCE	ABSENT		
LIVER	NOT PALPABLE		
SPLEEN	NOT PALPABLE		
CENTRAL NERVOUS SYSTEM			
HIGHER FUNCTIONS	NORMAL		
CRANIAL NERVES	NORMAL		
CEREBELLAR FUNCTIONS	NORMAL		
SENSORY SYSTEM	NORMAL		
MOTOR SYSTEM	NORMAL		
REFLEXES	NORMAL		
MUSCULOSKELETAL SYSTEM			
SPINE	NORMAL		



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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

6/6

NEAR VISION RIGHT EYE WITH GLASSES

N6

NEAR VISION LEFT EYE WITH GLASSES

N6

COLOUR VISION

NORMAL

BASIC ENT EXAMINATION

EXTERNAL EAR CANAL

NORMAL

TYMPANIC MEMBRANE

NORMAL

NOSE

NO ABNORMALITY DETECTED

SINUSES

NORMAL

THROAT

NO ABNORMALITY DETECTED

TONSILS

NOT ENLARGED

SUMMARY

RELEVANT HISTORY

NOT SIGNIFICANT

RELEVANT GP EXAMINATION FINDINGS

NOT SIGNIFICANT

RELEVANT LAB INVESTIGATIONS

DERANGED CBC (LOW HB)

RELEVANT NON PATHOLOGY DIAGNOSTICS

REPORT ATTACHED

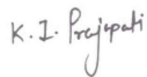
REMARKS / RECOMMENDATIONS

PHYSICIAN CONSULT

FITNESS STATUS

FITNESS STATUS

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



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MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

ULTRASOUND ABDOMEN

ULTRASOUND ABDOMEN

NO ABNORMALITIES DETECTED

Interpretation(s)

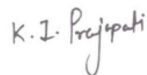
MEDICAL

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

 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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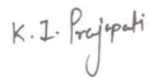
Test Report Status **Final**

Results

Biological Reference Interval Units

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 LimitedFortis Hospital, Sector 62, Phase VIII,
Mohali 160062

Dr. Kamlesh I Prajapati
 Consultant Pathologist

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HAEMATOLOGY - CBC

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	8.8 Low	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : IMPEDANCE	4.01	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : IMPEDANCE	7.82	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : IMPEDANCE	300	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CALCULATED	28.3 Low	36 - 46	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : DERIVED FROM IMPEDANCE MEASURE	70.6 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	22.0 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC) METHOD : CALCULATED PARAMETER	31.1 Low	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : DERIVED FROM IMPEDANCE MEASURE	17.8 High	11.6 - 14.0	%
MENTZER INDEX	17.6		
MEAN PLATELET VOLUME (MPV) METHOD : DERIVED FROM IMPEDANCE MEASURE	11.2 High	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

NEUTROPHILS METHOD : DHSS FLOWCYTOMETRY	69	40 - 80	%
LYMPHOCYTES METHOD : DHSS FLOWCYTOMETRY	21	20 - 40	%
MONOCYTES METHOD : DHSS FLOWCYTOMETRY	8	2 - 10	%
EOSINOPHILS METHOD : DHSS FLOWCYTOMETRY	2	1 - 6	%

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LAB DIRECTOR

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Pathologist

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BASOPHILS		0	0 - 2	%
METHOD : IMPEDANCE				
ABSOLUTE NEUTROPHIL COUNT		5.38	2.0 - 7.0	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE LYMPHOCYTE COUNT		1.66	1 - 3	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE MONOCYTE COUNT		0.60	0.20 - 1.00	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE EOSINOPHIL COUNT		0.18	0.02 - 0.50	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : DHSS FLOWCYTOMETRY, CALCULATED				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		3.2		
METHOD : CALCULATED				

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 46 High 0 - 20 mm at 1 hr

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

B

METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE

RH TYPE

RH+

METHOD : HEMAGGLUTINATION REACTION ON SOLID PHASE

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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BIOCHEMISTRY**MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE****GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR)	105 High	Normal 75 - 99 Pre-diabetics: 100 - 125 Diabetic: > or = 126	mg/dL
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METHOD : SPECTROPHOTOMETRY HEXOKINASE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.4	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
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METHOD : CAPILLARY ELECTROPHORESIS

ESTIMATED AVERAGE GLUCOSE(EAG)	108.3	< 116	mg/dL
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METHOD : CALCULATED PARAMETER



Dr. Rashmi Rasi Datta-MD,FIMSA
DMC-64289
Consultant Biochemist & Section
Head



Dr. Anurag Bansal
LAB DIRECTOR

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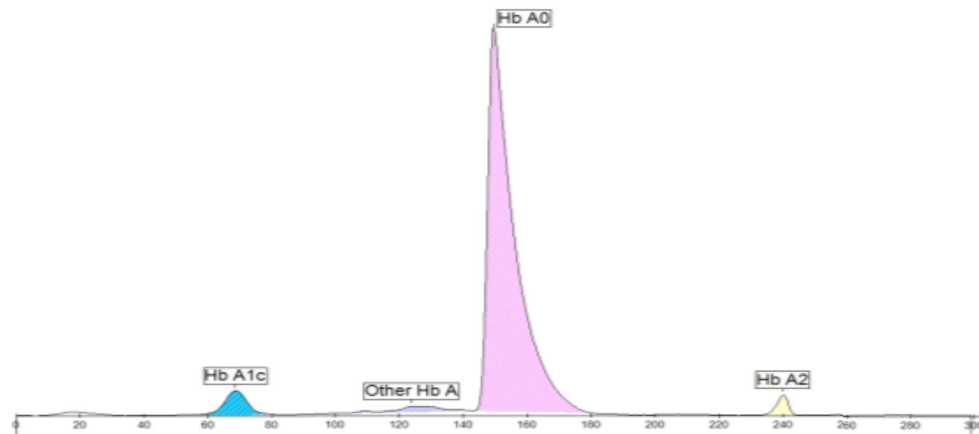
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Sample num. **91** Date **14/04/2023**

ID : **6315100713**

Depart :

Birth :



A1c Haemoglobin Electrophoresis

Fractions	%	mmol/mol	Cal. %
Hb A1c	-	36	5.4
Other Hb A	2.6		
Hb A0	90.5		
Hb A2	2.1		

HbA1c % cal : **5.4 %**
 HbA1c mmol/mol : **36 mmol/mol**



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 DMC-64289
 Consultant Biochemist & Section Head



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 LAB DIRECTOR



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 Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956



Patient Ref. No. 775000002904561

PATIENT NAME : LEELAVATI LAHANE

REF. DOCTOR : DR. BANK OF BARODA

ACCESSION NO : 0063WD000563

AGE/SEX : 38 Years Female

PATIENT ID : LEELF09038563

DRAWN : 14/04/2023 08:51:38

CLIENT PATIENT ID:

RECEIVED : 14/04/2023 08:52:55

ABHA NO :

REPORTED : 15/04/2023 09:42:29

Test Report Status	Final	Results	Biological Reference Interval	Units
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GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)

102

70 - 139

mg/dL

METHOD : SPECTROPHOTOMETRY, HEXOKINASE

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL

153

Desirable : < 200
Borderline : 200 - 239
High : > / = 240

mg/dL

METHOD : ENZYMATIC COLORIMETRIC ASSAY

TRIGLYCERIDES

84

Normal: < 150
Borderline high: 150 - 199
High: 200 - 499
Very High: > / = 500

mg/dL

METHOD : ENZYMATIC COLORIMETRIC ASSAY

HDL CHOLESTEROL

57

At Risk: < 40
Desirable: > or = 60

mg/dL

METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY

CHOLESTEROL LDL

90

Adult levels:
Optimal < 100
Near optimal/above optimal:
100-129
Borderline high : 130-159
High : 160-189
Very high : = 190

mg/dL

METHOD : HOMOGENEOUS ENZYMATIC COLORIMETRIC ASSAY

NON HDL CHOLESTEROL

96

Desirable : < 130
Above Desirable : 130 -159
Borderline High : 160 - 189
High : 190 - 219
Very high : > / = 220

mg/dL

METHOD : CALCULATED PARAMETER

VERY LOW DENSITY LIPOPROTEIN

16.8

< OR = 30.0

mg/dL

METHOD : CALCULATED PARAMETER

CHOL/HDL RATIO

2.7 LowLow Risk : 3.3 - 4.4
Average Risk : 4.5 - 7.0
Moderate Risk : 7.1 - 11.0
High Risk : > 11.0

METHOD : CALCULATED PARAMETER



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LDL/HDL RATIO	1.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk		
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METHOD : CALCULATED PARAMETER

Interpretation(s)**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.3	Upto 1.2	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD			
BILIRUBIN, DIRECT	0.1	< 0.30	mg/dL
METHOD : COLORIMETRIC DIAZO METHOD			
BILIRUBIN, INDIRECT	0.20	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.6	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			
ALBUMIN	4.1	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			
GLOBULIN	3.5	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	19	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	16	< OR = 35	U/L
METHOD : SPECTROPHOTOMETRY, WITH PYRIDOXAL PHOSPHATE ACTIVATION-IFCC			
ALKALINE PHOSPHATASE	93	35 - 104	U/L
METHOD : SPECTROPHOTOMETRY, PNPP, AMP BUFFER - IFCC			
GAMMA GLUTAMYL TRANSFERASE (GGT)	14	0 - 40	U/L
METHOD : ENZYMIC COLORIMETRIC ASSAY STANDARDIZED AGAINST IFCC / SZASZ			
LACTATE DEHYDROGENASE	178	125 - 220	U/L
METHOD : SPECTROPHOTOMETRY, LACTATE TO PYRUVATE - UV-IFCC			

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	12.0	6 - 20	mg/dL
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METHOD : SPECTROPHOTOMETRY, KINETIC TEST WITH UREASE AND GLUTAMATE DEHYDROGENASE

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Patient Ref. No. 775000002904561



MC-5297

PATIENT NAME : LEELAVATI LAHANE

REF. DOCTOR : DR. BANK OF BARODA

ACCESSION NO : **0063WD000563**
 PATIENT ID : LEELF09038563
 CLIENT PATIENT ID:
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CREATININE, SERUM

CREATININE	0.70	0.5 - 0.9	mg/dL
METHOD : SPECTROPHOTOMETRIC, JAFFE'S KINETICS			

BUN/CREAT RATIO

BUN/CREAT RATIO	17.14 High	8.0 - 15.0	
METHOD : CALCULATED PARAMETER			

URIC ACID, SERUM

URIC ACID	4.0	2.4 - 5.7	mg/dL
METHOD : SPECTROPHOTOMETRY, URICASE			

TOTAL PROTEIN, SERUM

TOTAL PROTEIN	7.6	6.0 - 8.0	g/dL
METHOD : SPECTROPHOTOMETRY, BIURET			

ALBUMIN, SERUM

ALBUMIN	4.1	3.97 - 4.94	g/dL
METHOD : SPECTROPHOTOMETRY, BROMOCRESOL GREEN(BCG) - DYE BINDING			

GLOBULIN

GLOBULIN	3.5	2.0 - 3.5	g/dL
METHOD : CALCULATED PARAMETER			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	139	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.6	3.5 - 5.1	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	104	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Sodium	Potassium	Chloride
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<p>Decreased in: CCF, cirrhosis, vomiting, diarrhea, excessive sweating, salt-losing nephropathy, adrenal insufficiency, nephrotic syndrome, water intoxication, SIADH. Drugs: thiazides, diuretics, ACE inhibitors, chlorpropamide, carbamazepine, antidepressants (SSRI), antipsychotics.</p>	<p>Decreased in: Low potassium intake, prolonged vomiting or diarrhea, RTA types I and II, hyperaldosteronism, Cushing's syndrome, osmotic diuresis (e.g., hyperglycemia), alkalosis, familial periodic paralysis, trauma (transient). Drugs: Adrenergic agents, diuretics.</p>	<p>Decreased in: Vomiting, diarrhea, renal failure combined with salt deprivation, over-treatment with diuretics, chronic respiratory acidosis, diabetic ketoacidosis, excessive sweating, SIADH, salt-losing nephropathy, porphyria, expansion of extracellular fluid volume, adrenal insufficiency, hyperaldosteronism, metabolic alkalosis. Drugs: chronic laxative, corticosteroids, diuretics.</p>
<p>Increased in: Dehydration (excessive sweating, severe vomiting or diarrhea), diabetes mellitus, diabetes insipidus, hyperaldosteronism, inadequate water intake. Drugs: steroids, licorice, oral contraceptives.</p>	<p>Increased in: Massive hemolysis, severe tissue damage, rhabdomyolysis, acidosis, dehydration, renal failure, Addison's disease, RTA type IV, hyperkalemic familial periodic paralysis. Drugs: potassium salts, potassium-sparing diuretics, NSAIDs, beta-blockers, ACE inhibitors, high-dose trimethoprim-sulfamethoxazole.</p>	<p>Increased in: Renal failure, nephrotic syndrome, RTA, dehydration, overtreatment with saline, hyperparathyroidism, diabetes insipidus, metabolic acidosis from diarrhea (Loss of HCO₃⁻), respiratory alkalosis, hyperadrenocorticism. Drugs: acetazolamide, androgens, hydrochlorothiazide, salicylates.</p>
<p>Interferences: Severe lipemia or hyperproteinemia, if sodium analysis involves a dilution step can cause spurious results. The serum sodium falls about 1.6 mEq/L for each 100 mg/dL increase in blood glucose.</p>	<p>Interferences: Hemolysis of sample, delayed separation of serum, prolonged fist clenching during blood drawing, and prolonged tourniquet placement. Very high WBC/PLT counts may cause spurious. Plasma potassium levels are normal.</p>	<p>Interferences: Test is helpful in assessing normal and increased anion gap metabolic acidosis and in distinguishing hypercalcemia due to hyperparathyroidism (high serum chloride) from that due to malignancy (Normal serum chloride)</p>

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

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HbA1c Estimation can get affected due to :

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

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, Muscuopathy

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.



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Patient Ref. No. 775000002904561



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REF. DOCTOR : DR. BANK OF BARODA

ACCESSION NO : 0063WD000563	AGE/SEX : 38 Years Female
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CLINICAL PATH - URINALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

MICROSCOPIC EXAMINATION, URINE

REMARKS

TEST CANCELLED AS SPECIMEN NOT RECEIVED

Interpretation(s)

Dr. Anurag Bansal
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Patient Ref. No. 775000002904561



PATIENT NAME : LEELAVATI LAHANE

REF. DOCTOR : DR. BANK OF BARODA

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Test Report Status **Final**

Results

Biological Reference Interval Units

CLINICAL PATH - STOOL ANALYSIS

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

MICROSCOPIC EXAMINATION,STOOL

REMARK

TEST CANCELLED AS SPECIMEN NOT RECEIVED

METHOD : MICROSCOPIC EXAMINATION

Interpretation(s)

Dr. Mamta Kumari
Consultant Microbiologist

Sr. Microbiologist
Microbiologist

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Test Report Status **Final**

Results

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SPECIALISED CHEMISTRY - HORMONE

MEDI WHEEL FULL BODY HEALTH CHECKUP BELOW 40FEMALE

THYROID PANEL, SERUM

T3 135.0 Non-Pregnant Women ng/dL
80.0 - 200.0
Pregnant Women
1st Trimester: 105.0 - 230.0
2nd Trimester: 129.0 - 262.0
3rd Trimester: 135.0 - 262.0

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

T4 7.75 Non-Pregnant Women µg/dL
5.10 - 14.10
Pregnant Women
1st Trimester: 7.33 - 14.80
2nd Trimester: 7.93 - 16.10
3rd Trimester: 6.95 - 15.70

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

TSH (ULTRASENSITIVE) 3.160 Non Pregnant Women µIU/mL
0.27 - 4.20
Pregnant Women
1st Trimester: 0.33 - 4.59
2nd Trimester: 0.35 - 4.10
3rd Trimester: 0.21 - 3.15

METHOD : ELECTROCHEMILUMINESCENCE IMMUNO ASSAY

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.

Below mentioned are the guidelines for Pregnancy related reference ranges for 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
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PATIENT NAME : LEELAVATI LAHANE

REF. DOCTOR : DR. BANK OF BARODA

ACCESSION NO : **0063WD000563**
 PATIENT ID : LEELF09038563
 CLIENT PATIENT ID:
 ABHA NO :

AGE/SEX : 38 Years Female
 DRAWN : 14/04/2023 08:51:38
 RECEIVED : 14/04/2023 08:52:55
 REPORTED : 15/04/2023 09:42:29

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

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.
NOTE: It is advisable to detect Free T3, Free T4 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.



Dr. Rashmi Rasi Datta-MD, FIMSA
 DMC-64289
 Consultant Biochemist & Section
 Head



Dr. Anurag Bansal
 LAB DIRECTOR

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View Details



View Report

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Patient Ref. No. 775000002904561