



## BMI CHART

Date: 7/4/2

Name: Mr. Dinesh Kumar Age: 38 yrs Sex: (M) F

BP: 120/80 mmHg Height (cms): 174 cm Weight(kgs): 78 kg BMI: 25

WEIGHT lbs kgs	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
	45.5	47.7	50.0	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese			Extremely Obese					
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

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UHID	5591459	Date	07/04/2023		
Name	Mr. Dinesh Kumar	Sex	Male	Age	38
OPD	Opthal 14				

cls. No.

Drug allergy: → Not Known  
 Sys illness: → No  
 Habit: → No

Hcr. No

Unif V. → RG 6/6.  
 → LG 6/6

MV → RG  
 → LG

Ref → RG → Plane 6/6.  
 → LG → Plane 6/6

MV → RG No  
 → LG No

I.O.P. → RG → 14.3.  
 → LG → 15.8

*(Handwritten signature)*

C.V.P.  
 20-20 rule  
 ↓  
 20mi / 30mi  
 ↓  
 20pc / 30pc  
 (sent)



UHID	5591459	Date	07/04/2023		
Name	Mr. Dinesh Kumar	Sex	Male	Age	38
OPD	Dental 12		7387696540		

Drug allergy:  
 Sys illness:

Cavous  $\frac{8}{8} / \frac{8}{8}$

Class I Ellis Parotom  $\frac{1}{1}$

stains + calculus +

Metmet

Adv. filling  $\frac{8}{8} / \frac{1.5}{8}$

Adv oral prophylaxis

Dr Disha Khera



PATIENT NAME : MR.DINESH KUMAR

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

ACCESSION NO : 0022WD001417  
 PATIENT ID : FH.5591459  
 CLIENT PATIENT ID: UID:5591459  
 ABHA NO :

AGE/SEX : 38 Years Male  
 DRAWN : 07/04/2023 09:36:00  
 RECEIVED : 07/04/2023 09:36:47  
 REPORTED : 07/04/2023 13:35:42

CLINICAL INFORMATION :

UID:5591459 REQNO-1457203  
 CORP-OPD  
 BILLNO-150123OPCR020277  
 BILLNO-150123OPCR020277

Test Report Status	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	12.7 Low	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	3.94 Low	4.5 - 5.5	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHES)CYTOMETRY	4.83	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	191	150 - 410	thou/ $\mu$ L
<b>RBC AND PLATELET INDICES</b>			
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	37.4 Low	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	94.8	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	32.1 High	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	33.9	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	15.5 High	11.6 - 14.0	%
MENTZER INDEX	24.1		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	12.0 High	6.8 - 10.9	fL
<b>WBC DIFFERENTIAL COUNT</b>			
NEUTROPHILS METHOD : FLOWCYTOMETRY	58	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	32	20 - 40	%

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Patient Ref. No. 22000000839434



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<b>CODE/NAME &amp; ADDRESS : C000045507 - FORTIS</b>		<b>ACCESSION NO : 0022WD001417</b>	<b>AGE/SEX : 38 Years Male</b>
FORTIS VASHI-CHC -SPLZD		<b>PATIENT ID : FH.5591459</b>	<b>DRAWN : 07/04/2023 09:36:00</b>
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MONOCYTES		5	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		5	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		2.80	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.55	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.24	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.24	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)		1.8		
METHOD : CALCULATED PARAMETER				
<b>MORPHOLOGY</b>				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

**Interpretation(s)**  
 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.

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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. Yeng, et al.; International Immunopharmacology 94 (2020) 106504)  
 This ratio element is a calculated parameter and out of NABL scope.

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**HAEMATOLOGY**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD**

<b>E.S.R</b>	06	0 - 14	mm at 1 hr
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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 ESR in first trimester is 0-40 mm/hr (52 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** : Polikilocytosis, (Sickle Cells, 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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	<b>PATIENT ID : FH.5591459</b>	<b>DRAWN : 07/04/2023 09:36:00</b>	
	<b>CLIENT PATIENT ID: UID:5591459</b>	<b>RECEIVED : 07/04/2023 09:36:47</b>	
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**IMMUNOHAEMATOLOGY**

**ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

<b>ABO GROUP</b>	<b>TYPE A</b>
METHOD : TUBE AGGLUTINATION	
<b>RH TYPE</b>	<b>POSITIVE</b>
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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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	0.84	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.23 High	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.61	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.8	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	4.3	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.5	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.2	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH PSP	21	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH PSP	28	< 45.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	76	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE	30	15 - 85	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE-PYRUVATE	118	100 - 190	U/L

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	94	74 - 99	mg/dL
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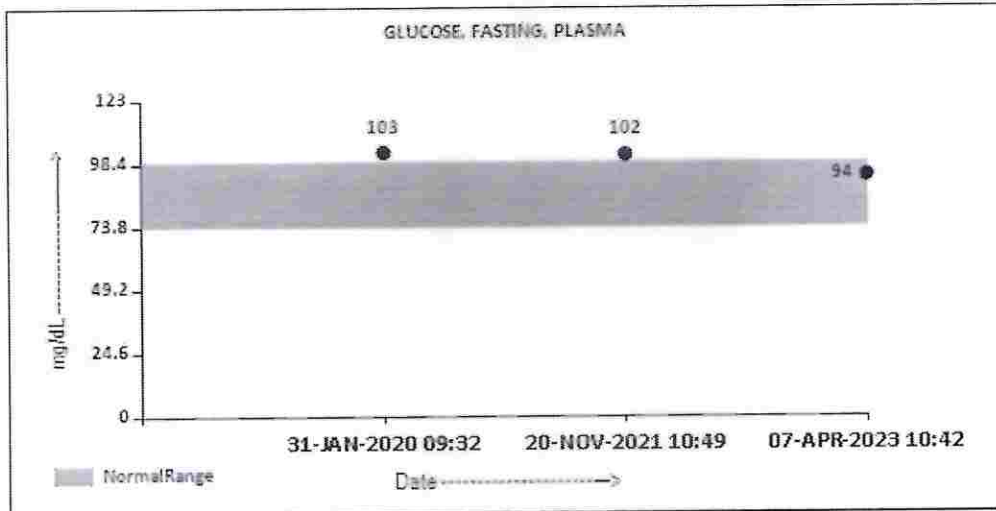
ACCESSION NO : 0022WD001417  
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C 5.2 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)

METHOD : HB VARIANT (HPLC)

ESTIMATED AVERAGE GLUCOSE(EAG) 102.5 < 116.0 mg/dL  
 METHOD : CALCULATED PARAMETER

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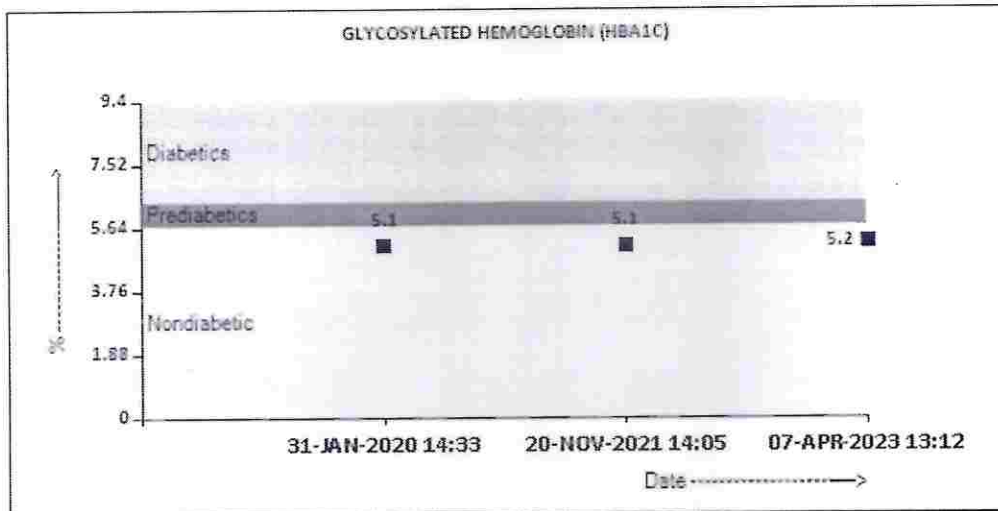
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN 7 6 - 20 mg/dL  
 METHOD : UREASE - UV

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 Tel : 022-39199222,022-49723322,  
 CIN - U74899PB1995PLC045956  
 Email : -



Patient Ref. No. 22000000839434



PATIENT NAME : MR.DINESH KUMAR

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

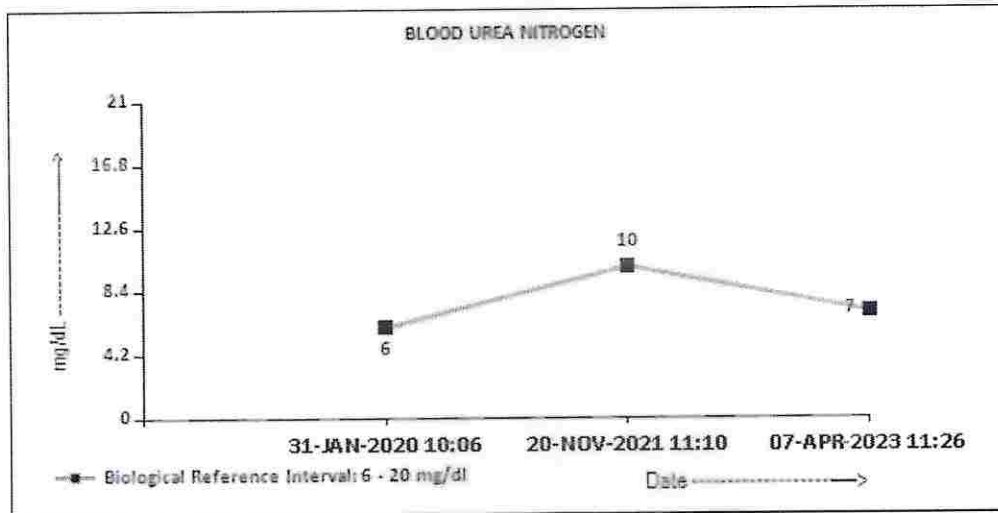
ACCESSION NO : 0022WD001417  
 PATIENT ID : FH.5591459  
 CLIENT PATIENT ID: UID:5591459  
 ABHA NO :

AGE/SEX : 38 Years Male  
 DRAWN : 07/04/2023 09:36:00  
 RECEIVED : 07/04/2023 09:36:47  
 REPORTED : 07/04/2023 13:35:42

CLINICAL INFORMATION :

UID:5591459 REQNO-1457203  
 CORP-OPD  
 BILLNO-150123OPCR020277  
 BILLNO-150123OPCR020277

Test Report Status	Final	Results	Biological Reference Interval	Units
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CREATININE EGFR- EPI

CREATININE	0.79 Low	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	38		years
GLOMERULAR FILTRATION RATE (MALE)	116.61	Refer Interpretation Below	mL/min/1.73m <sup>2</sup>
METHOD : CALCULATED PARAMETER			

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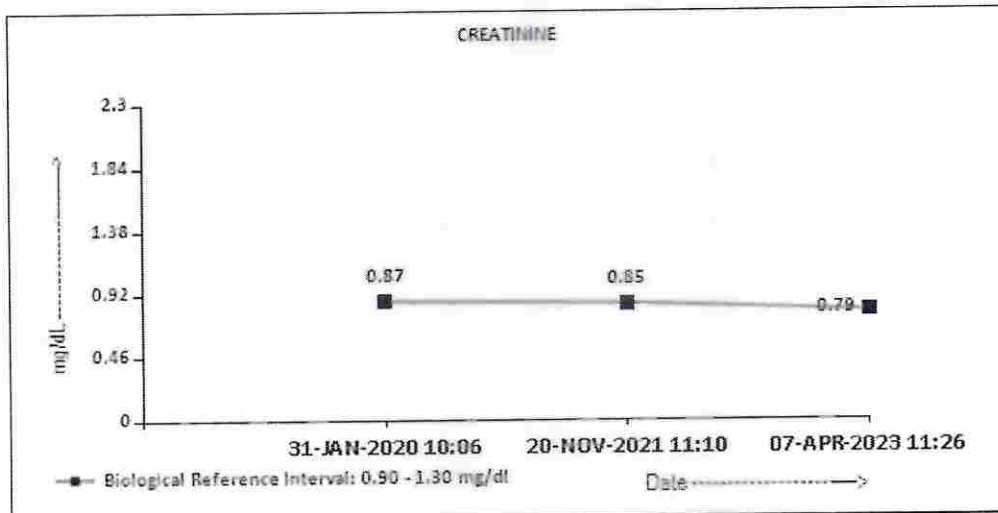
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BUN/CREAT RATIO

BUN/CREAT RATIO 8.86 5.00 - 15.00  
METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 5.8 3.5 - 7.2 mg/dL  
METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.8 6.4 - 8.2 g/dL  
METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.3 3.4 - 5.0 g/dL  
METHOD : BCP DYE BINDING

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GLOBULIN

GLOBULIN	3.5	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	138	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.87	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE, SERUM	103	98 - 107	mmol/L
METHOD : ISE INDIRECT			

Interpretation(s)

Interpretation(s)

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 Hypophosphatemia, 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

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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

**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 glyceemic 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,Glyceemic 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 patients 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.Fruktosamine 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,urama, 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

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

**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 EGFR- EPI-GFR—** Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test.

Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

**URIC ACID, SERUM-Causes of Increased levels:-**Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM, Metabolic

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 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

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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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**BIOCHEMISTRY - LIPID**

<b>LIPID PROFILE, SERUM</b>				
<b>CHOLESTEROL, TOTAL</b>	120	< 200 Desirable 200 - 239 Borderline High >= 240 High		mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE				
<b>TRIGLYCERIDES</b>	84	< 150 Normal 150 - 199 Borderline High 200 - 499 High >= 500 Very High		mg/dL
METHOD : ENZYMATIC ASSAY				
<b>HDL CHOLESTEROL</b>	41	< 40 Low >= 60 High		mg/dL
METHOD : DIRECT MEASURE - PEG				
<b>LDL CHOLESTEROL, DIRECT</b>	99	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >= 190 Very High		mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT				
<b>NON HDL CHOLESTEROL</b>	79	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220		mg/dL
METHOD : CALCULATED PARAMETER				
<b>VERY LOW DENSITY LIPOPROTEIN</b>	16.8	<= 30.0		mg/dL
METHOD : CALCULATED PARAMETER				
<b>CHOL/HDL RATIO</b>	<b>2.9 Low</b>	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk		
METHOD : CALCULATED PARAMETER				
<b>LDL/HDL RATIO</b>	2.4	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk		
METHOD : CALCULATED PARAMETER				

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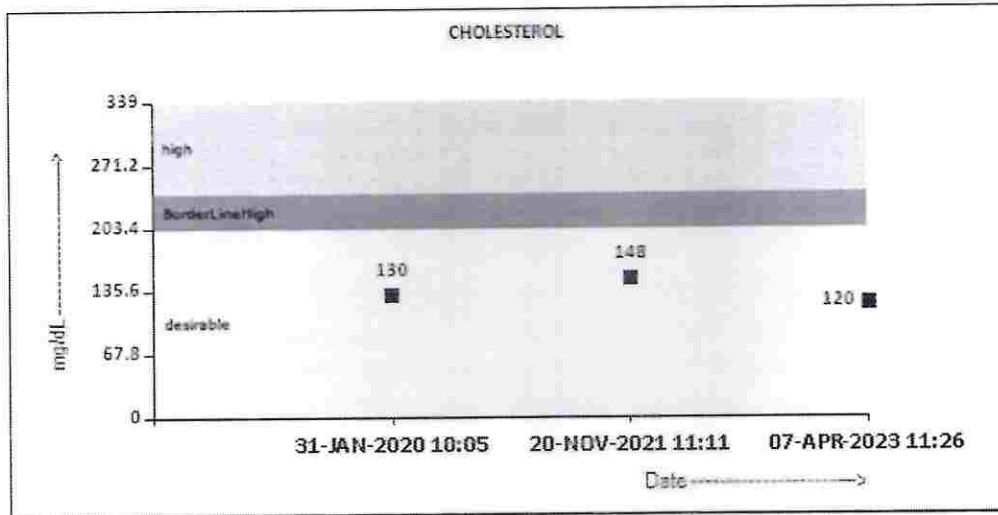
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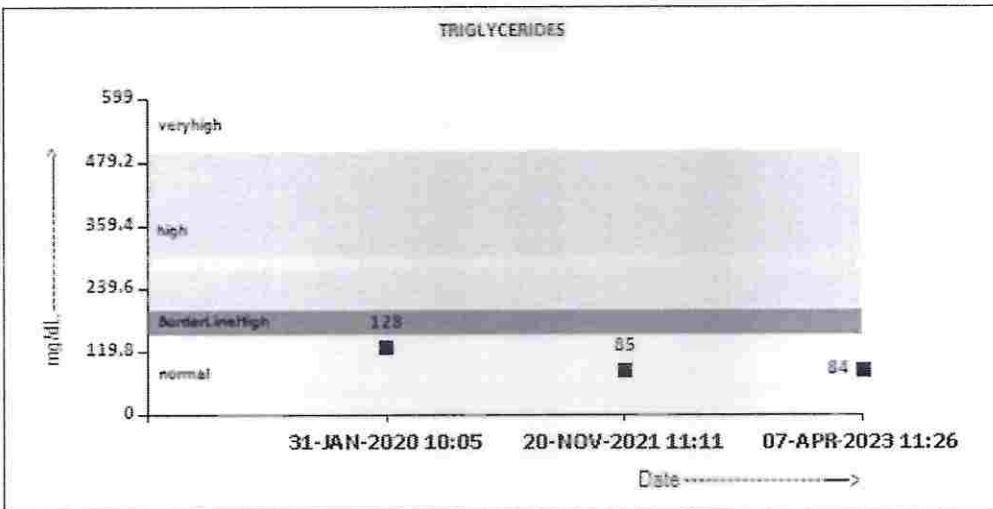
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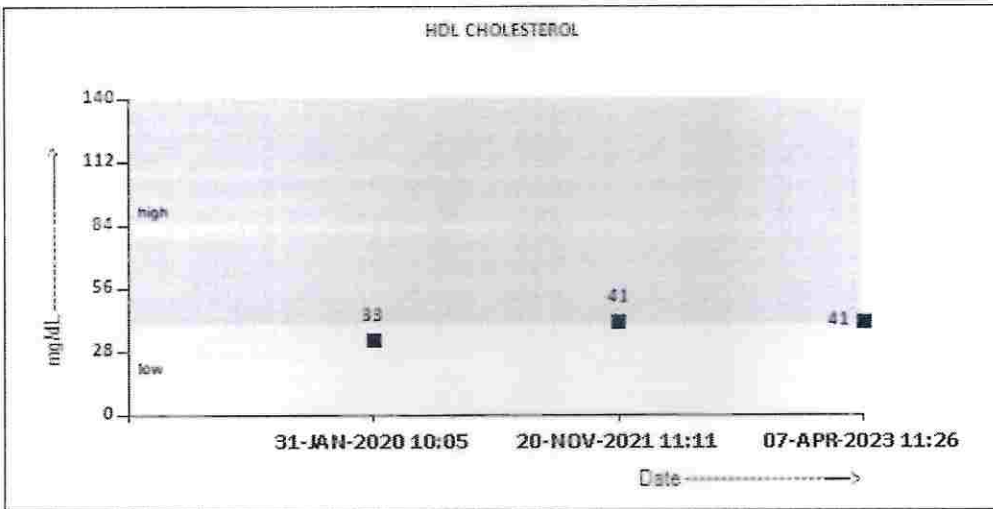
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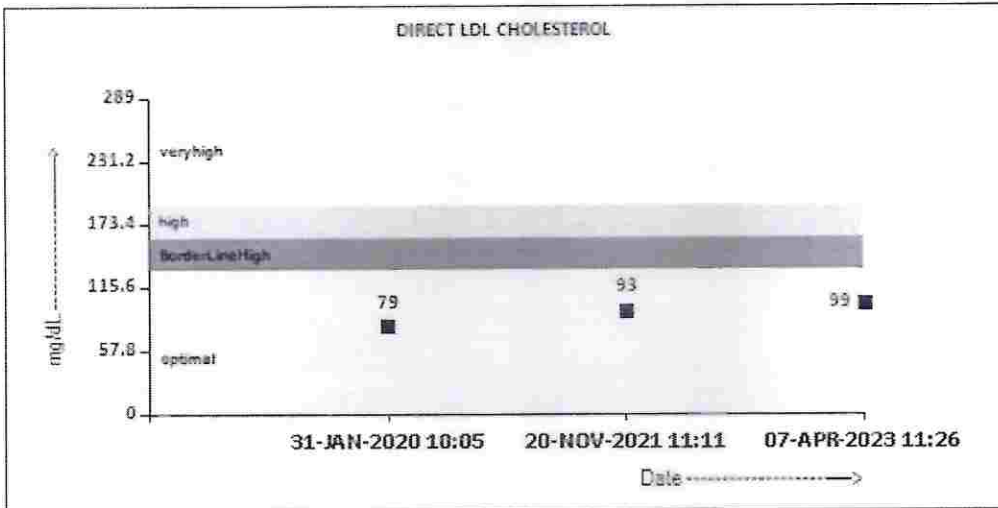
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<b>CODE/NAME &amp; ADDRESS : C000045507 - FORTIS</b>	<b>ACCESSION NO : 0022WD001417</b>	<b>AGE/SEX : 38 Years Male</b>
<b>FORTIS VASHI-CHC -SPLZD</b>	<b>PATIENT ID : FH.5591459</b>	<b>DRAWN : 07/04/2023 09:36:00</b>
<b>FORTIS HOSPITAL # VASHI,</b>	<b>CLIENT PATIENT ID: UID:5591459</b>	<b>RECEIVED : 07/04/2023 09:36:47</b>
<b>MUMBAI 440001</b>	<b>ABHA NO :</b>	<b>REPORTED : 07/04/2023 13:35:42</b>

**CLINICAL INFORMATION :**  
 UID:5591459 REQNO-1457203  
 CORP-OPD  
 BILLNO-150123OPCR020277  
 BILLNO-150123OPCR020277

Test Report Status	Results	Biological Reference Interval	Units
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Interpretation(s)

*Akta Dubey*

Dr.Akta Dubey  
 Counsultant Pathologist



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SRL Ltd  
 HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10,  
 NAVI MUMBAI, 400703  
 MAHARASHTRA, INDIA  
 Tel : 022-39199222,022-49723322,  
 CIN - U74899PB1995PLC045956  
 Email :-



Patient Ref. No. 22000000839434



MC-2275

PATIENT NAME : MR.DINESH KUMAR

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS  
 FORTIS VASHI-CHC -SPLZD  
 FORTIS HOSPITAL # VASHI,  
 MUMBAI 440001

ACCESSION NO : 0022WD001417  
 PATIENT ID : FH,5591459  
 CLIENT PATIENT ID: UID:5591459  
 ABHA NO :

AGE/SEX : 38 Years Male  
 DRAWN : 07/04/2023 09:36:00  
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CLINICAL INFORMATION :

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 CORP-OPD  
 BILLNO-150123OPCR020277  
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Test Report Status	Final	Results	Biological Reference Interval	Units
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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW  
 METHOD : PHYSICAL

APPEARANCE CLEAR  
 METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH 6.0 4.7 - 7.5  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY <=1.005 1.003 - 1.035  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD

KETONES NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD DETECTED (TRACE) IN URINE  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN

BILIRUBIN NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT

UROBILINOGEN NORMAL NORMAL  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)

NITRITE NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE

LEUKOCYTE ESTERASE NOT DETECTED NOT DETECTED  
 METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY

MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS 1 - 2 NOT DETECTED /HPF

*Dubey*  
 Dr.Akta Dubey  
 Consultant Pathologist

*Rekha N*  
 Dr. Rekha Nair, MD  
 Microbiologist



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Patient Ref. No. 22000000839434



<b>PATIENT NAME : MR.DINESH KUMAR</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000045507 - FORTIS</b>		<b>ACCESSION NO : 0022WD001417</b>	
FORTIS VASHI-CHC -SPLZD		AGE/SEX : 38 Years Male	
FORTIS HOSPITAL # VASHI,		DRAWN : 07/04/2023 09:36:00	
MUMBAI 440001		RECEIVED : 07/04/2023 09:36:47	
		REPORTED : 07/04/2023 13:35:42	
		PATIENT ID : FH.5591459	
		CLIENT PATIENT ID: UID:5591459	
		ABHA NO :	

**CLINICAL INFORMATION :**

UID:5591459 REQNO-1457203  
CORP-OPD  
BILLNO-150123OPCR020277  
BILLNO-150123OPCR020277

Test Report Status	Final	Results	Biological Reference Interval	Units
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		URINARY MICROSCOPIC EXAMINATION IS DONE BY URINARY CENTRIFUGED SEDIMENTS		
<b>Interpretation(s)</b>				

**\*\*End Of Report\*\***

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Dr. Akta Dubey  
Consultant Pathologist

Dr. Rekha Nair, MD  
Microbiologist



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Patient Ref. No. 22000000839434



<b>PATIENT NAME : MR.DINESH KUMAR</b>		<b>REF. DOCTOR :</b>	
<b>CODE/NAME &amp; ADDRESS : C000045507 - FORTIS</b>		<b>ACCESSION NO : 0022WD001465</b>	
FORTIS VASHI-CHC -SPLZD		AGE/SEX : 38 Years Male	
FORTIS HOSPITAL # VASHI,		DRAWN : 07/04/2023 11:56:00	
MUMBAI 440001		RECEIVED : 07/04/2023 12:05:08	
		REPORTED : 07/04/2023 13:27:27	
		PATIENT ID : FH.5591459	
		CLIENT PATIENT ID: UID:5591459	
		ABHA NO :	

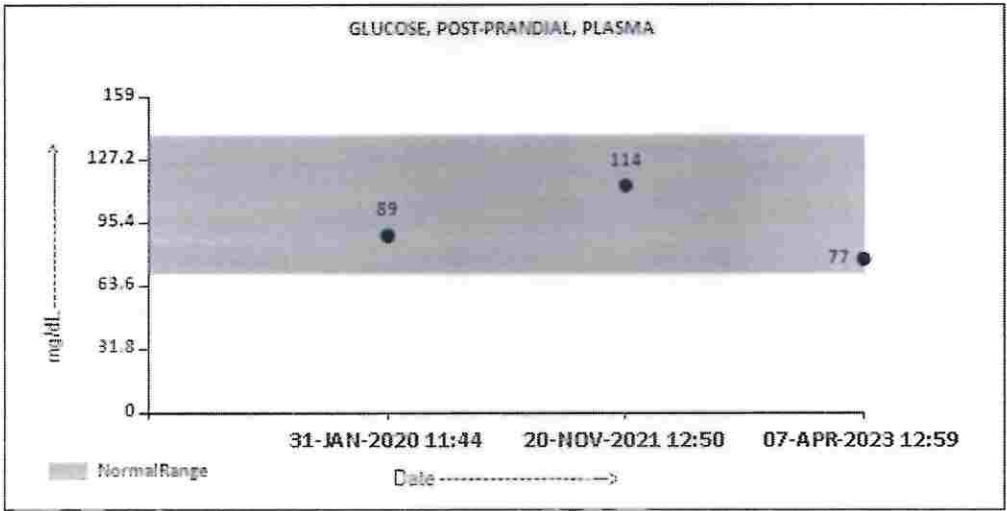
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 CORP-OPD  
 BILLNO-150123OPCR020277  
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**BIOCHEMISTRY**

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR)	77	70 - 139	mg/dL
METHOD : HEXOKINASE			



**Comments**

NOTE : - POST PRANDIAL PLASMA GLUCOSE VALUES, TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

**Interpretation(s)**  
 GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

**\*\*End Of Report\*\***

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*Akta Dubey*  
**Dr.Akta Dubey**  
 Consultant Pathologist



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 Email : -



Patient Ref. No. 22000000839482





PATIENT NAME : MR.DINESH KUMAR

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS  
FORTIS VASHI-CHC -SPLZD  
FORTIS HOSPITAL # VASHI,  
MUMBAI 440001

ACCESSION NO : 0022WD001417  
PATIENT ID : FH.5591459  
CLIENT PATIENT ID: UID:5591459  
ABHA NO :

AGE/SEX : 38 Years Male  
DRAWN : 07/04/2023 09:36:00  
RECEIVED : 07/04/2023 09:36:47  
REPORTED : 07/04/2023 14:05:33

CLINICAL INFORMATION :

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CORP-OPD  
BILLNO-150123OPCR020277  
BILLNO-150123OPCR020277

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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	91.92	80 - 200	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
T4	5.21	5.1 - 14.1	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			
TSH (ULTRASENSITIVE)	1.750	0.270 - 4.200	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY			

Interpretation(s)

Dr. Swapnil Sirmukaddam  
Consultant Pathologist



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NAVI MUMBAI, 410210  
MAHARASHTRA, INDIA  
Tel : 9111591115,  
CIN - U74899PB1995PLC045956



Patient Ref. No. 22000000839434



<b>PATIENT NAME : MR.DINESH KUMAR</b>		<b>REF. DOCTOR : SELF</b>	
<b>CODE/NAME &amp; ADDRESS : C000045507 - FORTIS</b>		<b>ACCESSION NO : 0022WD001417</b>	<b>AGE/SEX : 38 Years Male</b>
FORTIS VASHI-CHC -SPLZD		<b>PATIENT ID : FH.5591459</b>	<b>DRAWN : 07/04/2023 09:36:00</b>
FORTIS HOSPITAL # VASHI,		<b>CLIENT PATIENT ID: UID:5591459</b>	<b>RECEIVED : 07/04/2023 09:36:47</b>
MUMBAI 440001		<b>ABHA NO :</b>	<b>REPORTED : 07/04/2023 14:05:33</b>

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**SPECIALISED CHEMISTRY - TUMOR MARKER**

**PROSTATE SPECIFIC ANTIGEN, SERUM**

PROSTATE SPECIFIC ANTIGEN	0.896	< 1.4	ng/mL
---------------------------	-------	-------	-------

METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

**Interpretation(s)**

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.  
 - PSA is not detected (or detected at very low levels) in the patients without prostate tissue ( because of radical prostatectomy or cystoprostatectomy) and also in the female patient.  
 - It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.  
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.  
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.  
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.  
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide lives-

Age of male	Reference range (ng/ml)
40-49 years	0-2.5
50-59 years	0-3.5
60-69 years	0-4.5
70-79 years	0-6.5

(\* conventional reference level (< 4 ng/ml) is already mentioned in report,which covers all agegroup with 95% prediction interval)  
 PSA values determined on patient samples by different testing procedures cannot be directly compared with one another and could be the cause of erroneous medical interpretations.Recommended follow up on same platform as patient result can vary due to differences in assay method and reagent specificity.

References- Teltz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

**\*\*End Of Report\*\***

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**Dr. Swapnil Sirmukaddam**  
 Consultant Pathologist



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 NAVI MUMBAI, 410210  
 MAHARASHTRA, INDIA  
 Tel : 9111591115,  
 CIN - U74899PB1995PLC045956



**Patient Ref. No. 2200000839434**

5591459  
38 Years

DINESH KUMAR  
Male

4/7/2023 10:48:09 AM

HC

Normal 

Rate 64 . Sinus rhythm.....normal P axis, V-rate 50- 99  
. ST elev, probable normal early repol pattern.....ST elevation, age<55

PR 144  
QRS 99  
QT 377  
QTc 389

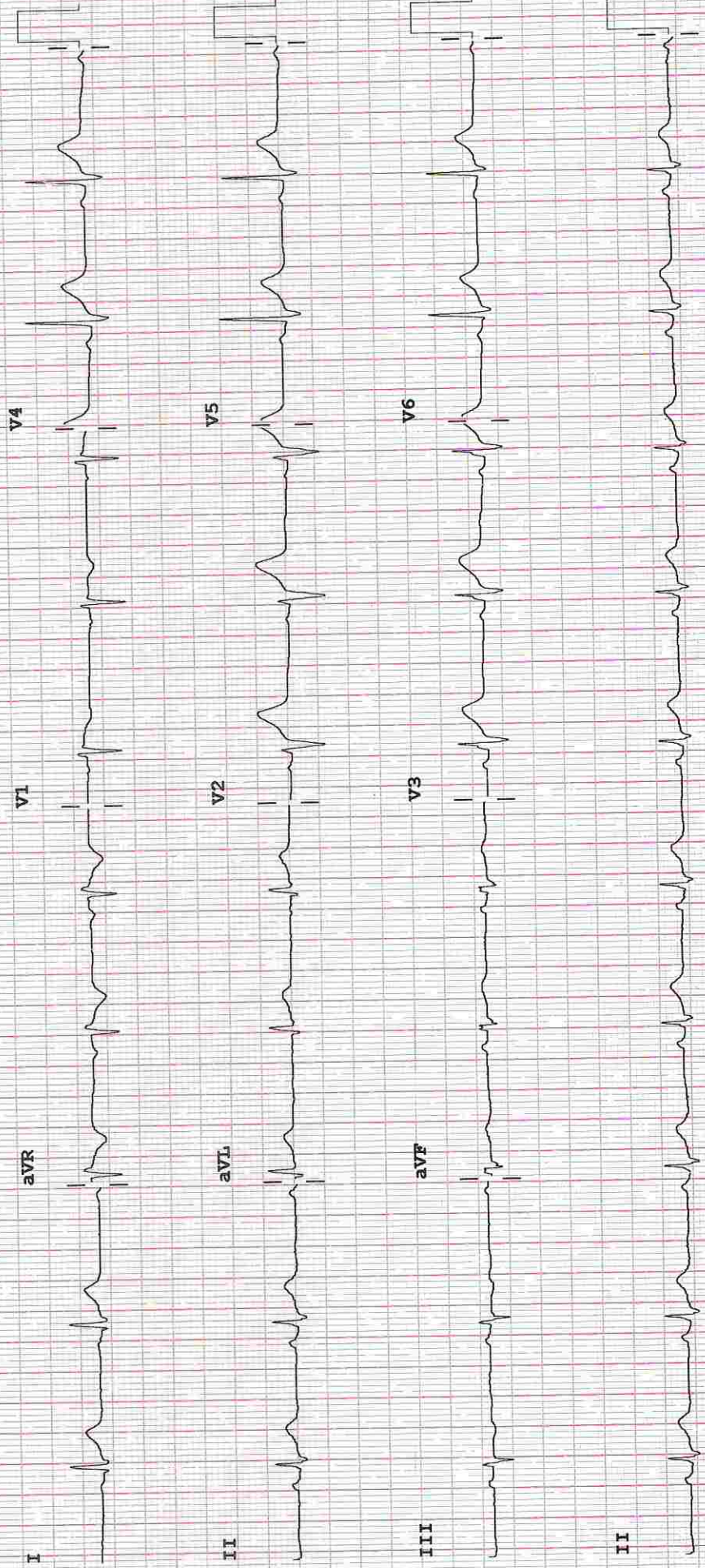
--AXIS--

P 56  
QRS 7  
T 15

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV F 50~ 0.50-100 Hz W 100B CL P?



(For Billing/Reports & Discharge Summary only)

Date: 07/Apr/2023

DEPARTMENT OF NIC

Name: Mr. Dinesh Kumar  
Age | Sex: 38 YEAR(S) | Male  
Order Station : FO-OPD  
Bed Name :

UHID | Episode No : 5591459 | 20437/23/1501  
Order No | Order Date: 1501/PN/OP/2304/42798 | 07-Apr-2023  
Admitted On | Reporting Date : 07-Apr-2023 14:13:01  
Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

**FINDINGS:**

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction.
- No left ventricle Hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

**M-MODE MEASUREMENTS:**

LA	28	mm
AO Root	27	mm
AO CUSP SEP	17	mm
LVID (s)	41	mm
LVID (d)	56	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	13	mm
RA	30	mm
LVEF	60	%



(For Billing/Reports &amp; Discharge Summary only)

## DEPARTMENT OF NIC

Date: 07/Apr/2023

Name: Mr. Dinesh Kumar

Age | Sex: 38 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5591459 | 20437/23/1501

Order No | Order Date: 1501/PN/OP/2304/42798 | 07-Apr-2023

Admitted On | Reporting Date : 07-Apr-2023 14:13:01

Order Doctor Name : Dr.SELF.

**DOPPLER STUDY:**

E WAVE VELOCITY: 0.9 m/sec.

A WAVE VELOCITY: 0.5 m/sec

E/A RATIO: 0.8

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	06			Nil
TRICUSPID VALVE	N			Nil
PULMONARY VALVE	03			Nil

**Final Impression :**

- Normal 2 Dimensional and colour doppler echocardiography study.

  
**DR. PRASHANT PAWAR**  
 DNB(MED), DNB ( CARDIOLOGY)



DEPARTMENT OF RADIOLOGY

Date: 07/Apr/2023

Name: Mr. Dinesh Kumar

UHID | Episode No : 5591459 | 20437/23/1501

Age | Sex: 38 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2304/42798 | 07-Apr-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 07-Apr-2023 16:28:25

Bed Name :

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

**Findings:**

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

**DR. ABHIJEET BHAMBURE**  
DMRD, DNB (Radiologist)



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 07/Apr/2023

Name: Mr. Dinesh Kumar

UHID | Episode No : 5591459 | 20437/23/1501

Age | Sex: 38 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2304/42798 | 07-Apr-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 07-Apr-2023 10:33:44

Bed Name :

Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

**LIVER** is normal in size and shows mildly raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein appears normal.

**GALL BLADDER** is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection. **CBD** appears normal in caliber.

**SPLEEN** is normal in size and echogenicity.

**BOTH KIDNEYS** are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis. Right kidney measures 9.4 x 4.1 cm. Left kidney measures 9.2 x 4.8 cm.

**PANCREAS** is normal in size and morphology. No evidence of peripancreatic collection.

**URINARY BLADDER** is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical mass/calculi.

**PROSTATE** is normal in size & echogenicity. It measures ~ 17.3 cc in volume.

No evidence of ascites.

**IMPRESSION:**

- Grade I fatty infiltration of liver.

  
**DR. ADITYA NALAWADE**  
**M.D. (Radiologist)**