नाम
Name Rohit Kumar Prasad

कर्मचारी कूट सं.
Employee Code No. 161967

जारीकर्ता प्राधिकारी
Issuing Authority

धारक के हस्ताक्षर
Signature of Holder

To,

The Coordinator,
Mediwheel (Arcofemi Healthcare Limited)
Helpline number: 011- 41195959

Dear Sir / Madam,

Sub: Annual Health Checkup for the employees of Bank of Baroda

This is to inform you that the following spouse of our employee wishes to avail the facility of Cashless Annual Health Checkup provided by you in terms of our agreement.

PARTICULARS OF HEALTH CHECK UP BENEFICIARY	
NAME	MONICA GUPTA
DATE OF BIRTH	27-10-1988
PROPOSED DATE OF HEALTH CHECKUP FOR EMPLOYEE SPOUSE	09-03-2024
BOOKING REFERENCE NO.	23M161967100095478S
SPOUSE DETAILS	
EMPLOYEE NAME	MR. PRASAD ROHIT KUMAR
EMPLOYEE EC NO.	161967
EMPLOYEE DESIGNATION	RELATIONSHIP MANAGER (NTB)
EMPLOYEE PLACE OF WORK	HIMMATNAGAR,MOTIPURA
EMPLOYEE BIRTHDATE	27-03-1987

This letter of approval / recommendation is valid if submitted along with copy of the Bank of Baroda employee id card. This approval is valid from **02-03-2024** till **31-03-2024**.The list of medical tests to be conducted is provided in the annexure to this letter. Please note that the said health checkup is a **cashless facility** as per our tie up arrangement. We request you to attend to the health checkup requirement of our employee's spouse and accord your top priority and best resources in this regard. The EC Number and the booking reference number as given in the above table shall be mentioned in the invoice, invariably.

2

We solicit your co-operation in this regard.

Yours faithfully,

Sd/-

Chief General Manager
HRM Department
Bank of Baroda

(Note: This is a computer generated letter. No Signature required. For any clarification, please contact Mediwheel (Arcofemi Healthcare Limited))

SUGGESTIVE LIST OF MEDICAL TESTS

Aashka Hospitals Ltd.
Between Sargasan and Reliance Cross Roads
Sargasan, Gandhinagar - 382421. Gujarat, India
Phone: 079-29750750, +91-7575006000 / 9000
Emergency No.: +91-7575007707 / 9879752777
www.aashkahospitals.in
CIN: L85110GJ2012PLC072647

aashka HOSPITAL

DR.TAPAS RAVAL
MBBS . D.O
(FELLOW IN PHACO & MEDICAL RATINA)
REG.NO.G-21350

UHID: Date: Time:

Patient Name: Monica Gupta
Age /Sex: 36
Height: 162
Weight: 53

History:
Company Heathy check
Pt has glasses . 6-7 years

Allergy History:

Nutritional Screening: Well-Nourished / Malnourished / Obese

Examination:
VA < 6/60
6/60

VA c correction
6/6
6/6
N6

Colour vision normal

Diagnosis:
Refractive error

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Eye examination:

	RIGHT			LEFT		
	S	C	A	S	C	A
D						
N						

Other Advice:

Follow-up:

Consultant's Sign:

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CIN: L85110GJ2012PLC072647

aashka HOSPITAL

Dr. MAULIK VYAS
M.B.B.S., D.T.C.D., T.D.D.
Reg.no: G-0749
CHEST PHYSICIAN, ALLERGY SPECIALIST and INTERVENTIONAL PULMONOLOGIST

NAME: MONICA GUPTA

Date: 23/3/2024

AGE: 36y+. SEX: F

Height: Weight:

Pulse= 86/min.

B.P. = 100/70 mm Hg

R.R.= 18/min

Chief Complains:

TG = 192 mg/dl.

Spo2= 99%.

VitD3 - 12.7%, BUN = 20.3 mg/dl.

Temp= (N).

R.B.S.= 103 mg/dl.

Body built / Nutritional status: ok.

Sleep cycle: (N).

Any known allergies: None.

E.C.G.: (N).

K/C/O: - DM-II, HTN, Thyroid, Hyperlipidemia, Asthma, COPD, TB, Cancer, ILD, etc.

None

Provisional Diagnosis: "FIT FOR DUTY".

*General Examination: -

Clubbing:

Cyanosis: (N)

Edema:

- Lymph node enlargement: None

*On Examination:-

-Breath sounds: Normal Breath sound/ Wheezing/Crackles/Stridor/Rhonchi/Plural friction rub.

- Chest movements: (N)

- Air entry: AE = BE.

Rx,

Tab. Shelcal A 0—0—1 × (1) months.

Adv:- (1) Inform Lol.

(2). Inform Lol.

M.B.SHAH

Advices

1) Chest X-ray (PA).

2) USG Abdomen.

3) HRCT Thorax (P/ Contrast).

4) Skin Prick test for Allergy / Allergy Screening Tests (By IMMUNO-BIA).

5) Pulmonary Function Test (PFT) with / without DLCO.

6) Bronchoscopy (Flexible / Rigid).

7) Pleural fluid examination (Biochemical / Hematological / Bacteriological / TB-fungal culture / Cytological).

8) Sputum Examination (Routine / Microscopic / Microbiological).

9) Blood Investigations-

- CBC, PS For MP, CRP, ESR, SGPT, S. Creatinine, Electrolytes, HIV, HBsAg, Dengue NS1, Urine(R/M), Widal test, VDRL test, Liver Function test, Kidney Function test, Lipid profile, Thyroid profile (T3, T4, TSH).

-ABG (arterial blood gas).

-D-Dimer level.

-Procalcitonin level.

-Alpha antitrypsin level.

-Total and specific IgE level.

-Angiotensin converting enzyme.

*Tumor markers -

-CEA (carcino embryonic antigen).

-Neuron specific enolase (NSE) (Small cell carcinoma).

-SCC (Squamous cell carcinoma antigen).

CYFRA 21-1 (Non small cell carcinoma).

Mesothelin (Malignant mesothelioma).

10) Follow up after ____ days/months.

11) Inform SOS.

12) Admission.

Dr. [illegible]

aaSHKa HOSPITAL

Cytological examination- Pap smear request form

Name: Monica. Gupta. Age: 23/3/24

Complaints:

nilll

No of deliveries: I LSCS/0/3yrs.

Last Delivery:

LSCS: 3yrs

History of abortion:

non

H/O medical conditions associated:

DM	—
HTN	—
Thyroid	—

Last abortions:

MH: 4-5/25-30 Reg: 18yrs.

LMP: 2/3/24

P/A:

P/S:

P/V: Pap taken

Sample:-

Vagina	
Cervix	✓

Doctors Sign:-

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CIN: L85110GJ2012PLC072647

aashka HOSPITAL

PATIENT NAME:MONICA GUPTA
GENDER/AGE:Female / 35 Years **DATE:23/03/24**
DOCTOR:
OPDNO:OSP23635

SONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: Liver appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen. No evidence of dilated IHBR is seen. Intrahepatic portal radicles appear normal. No evidence of solid or cystic mass lesion is seen.

GALL BLADDER: Gall bladder is physiologically distended and appears normal. No evidence of calculus or changes of cholecystitis are seen. No evidence of pericholecystic fluid collection is seen. CBD appears normal.

PANCREAS: Pancreas appears normal in size and shows normal parenchymal echoes. No evidence of pancreatitis or pancreatic mass lesion is seen.

SPLEEN: Spleen appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen.

KIDNEYS: Both kidneys are normal in size, shape and position. Both renal contours are smooth. Cortical and central echoes appear normal. Bilateral cortical thickness appears normal. No evidence of renal calculus, hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 10.1 x 4.6 cms in size.
Left kidney measures about 10.6 x 4.8 cms in size.

No evidence of suprarenal mass lesion is seen on either side.

Aorta, IVC and para aortic region appears normal.
No evidence of ascites is seen.

BLADDER: Bladder is normally distended and appears normal. No evidence of bladder calculus, diverticulum or mass lesion is seen. Prevoid bladder volume measures about 190 cc.

UTERUS: Uterus is anteverted and appears normal in size, shape and position. Endometrial and myometrial echoes appear normal. Endometrial thickness measures about 6 mm. No evidence of uterine mass lesion is seen.

COMMENT: Normal sonographic appearance of liver, GB, pancreas, spleen, kidneys, para aortic region, bladder and uterus.

DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

MONIKA - GUPTA.

23.03.2024 12:04:34 PM
AASHKA HOSPITAL LTD.
SARGASAN
GANDHINAGAR

Location: 1
Order Number:
Indication:
Medication 1:
Medication 2:
Medication 3:

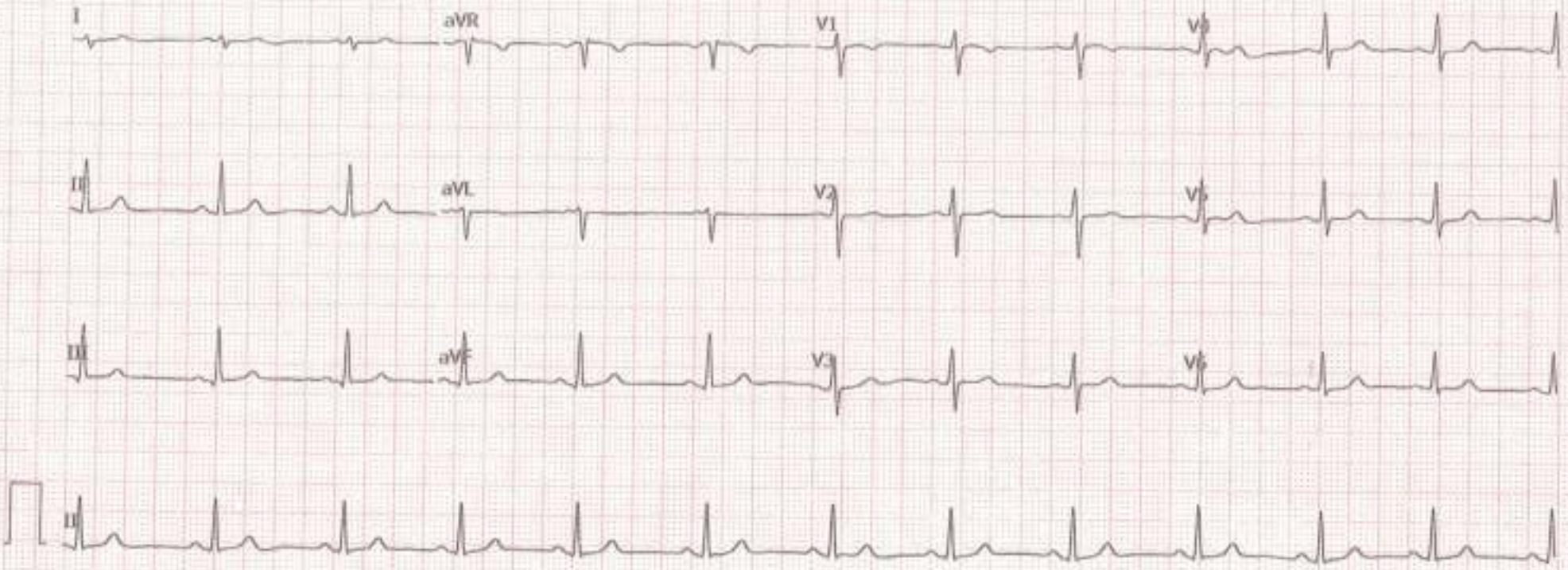
Room:

73 bpm
-/- mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS :	76 ms
QT / QTcBaz :	356 / 392 ms
PR :	130 ms
P :	96 ms
RR / PP :	824 / 821 ms
P / QRS / T :	56 / 93 / 79 degrees

Normal sinus rhythm
Rightward axis
Borderline ECG



GE MAC2000 1.1 125L™ v241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz Unconfirmed
4x2.5x3.25_R1 1/1

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aashka HOSPITAL

PATIENT NAME:MONICA GUPTA
GENDER/AGE:Female / 35 Years
DOCTOR:
OPDNO:OSP23635

DATE:23/03/24

X-RAY CHEST PA

Both lung fields show increased broncho-vascular markings.
No evidence of collapse, consolidation, mediastinal lymph adenopathy, soft tissue infiltration or pleural effusion is seen.
Both hilar shadows and C.P. angles are normal.
Heart shadow appears normal in size. Aorta appears normal.
Bony thorax and both domes of diaphragm appear normal.
No evidence of cervical rib is seen on either side.

DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

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aashka HOSPITAL

PATIENT NAME:MONICA GUPTA
GENDER/AGE:Female / 35 Years
DOCTOR:DR.HASIT JOSHI
OPDNO:OSP23635

DATE:23/03/24

2D-ECHO

MITRAL VALVE	: MILD MVP	
AORTIC VALVE	: NORMAL	
TRICUSPID VALVE	: NORMAL	
PULMONARY VALVE	: NORMAL	
AORTA	: 28mm	
LEFT ATRIUM	: 27mm	
LV Dd / Ds	: 40/28mm	EF 55%
IVS / LVPW / D	: 10/9mm	
IVS	: INTACT	
IAS	: FLOPPY	
RA	: NORMAL	
RV	: NORMAL	
PA	: NORMAL	
PERICARDIUM	: NORMAL	
VEL	: PEAK	MEAN
M/S	: Gradient mm Hg	Gradient mm Hg
MITRAL	: 0.9/0.7m/s	
AORTIC	: 1.15m/s	
PULMONARY	: 1.0m/s	
COLOUR DOPPLER	: MILD MR/TR	
RVSP	: 29mmHg	
CONCLUSION	: NORMAL LV SIZE / SYSTOLIC FUNCTION.	

CARDIOLOGIST
DR.HASIT JOSHI (9825012235)

LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:

Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	:	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	:	Acc. Remarks	: Normal	Ref Id2	: 0232411332

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Blood Glucose Fasting & Postprandial			
Plasma Glucose - F	103.11	mg/dL	70.0 - 100
Blood Urea Nitrogen (BUN)			
BUN (Blood Urea Nitrogen)	20.3	mg/dL	7.00 - 18.70
Lipid Profile			
HDL Cholesterol	38.9	mg/dL	48 - 77
Triglyceride	192.39	mg/dL	<150
Chol/HDL	4.39		0 - 4.1
Liver Function Test			
S.G.P.T.	12.31	U/L	14 - 59
S.G.O.T.	14.22	U/L	15 - 37
25 OH Cholecalciferol (D2+D3)	12.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 160 Toxicity

Abnormal Result(s) Summary End

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT

Name	: MONICA GUPTA		Sex/Age : Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL		Dis. At :	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 09:34	Acc. Remarks	: Normal	Ref Id2	: O232411332

HAEMOGRAM REPORT

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
HB AND INDICES				
Haemoglobin	12.3	G%	12.0 - 15.0	
RBC (Electrical Impedance)	4.03	millions/cumm	3.80 - 4.80	
PCV(Calc)	38.00	%	36.00 - 46.00	
MCV (RBC histogram)	94.3	fL	83.00 - 101.00	
MCH (Calc)	30.6	pg	27.00 - 32.00	
MCHC (Calc)	32.4	gm/dL	31.50 - 34.50	
RDW (RBC histogram)	14.30	%	11.00 - 16.00	
TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)				
Total WBC Count	6300	/µL	4000.00 - 10000.00	

	[%]		EXPECTED VALUES	[Abs.]		EXPECTED VALUES
Neutrophil	63.0	%	40.00 - 70.00	3969	/µL	2000.00 - 7000.00
Lymphocyte	28.0	%	20.00 - 40.00	1764	/µL	1000.00 - 3000.00
Eosinophil	5.0	%	1.00 - 6.00	315	/µL	20.00 - 500.00
Monocytes	4.0	%	2.00 - 10.00	252	/µL	200.00 - 1000.00
Basophil	0.0	%	0.00 - 2.00	0	/µL	0.00 - 100.00

PLATELET COUNT (Optical)			
Platelet Count	194000	/µL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	2.25		0.78 - 3.53
SMEAR STUDY			
RBC Morphology	Normocytic Normochromic RBCs.		
WBC Morphology	Total WBC count within normal limits.		
Platelet	Platelets are adequate in number.		
Parasite	Malarial Parasite not seen on smear.		

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Asshka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23835
Report Date and Time	: 23-Mar-2024 10:20	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR *Westergren Method*	08	mm after 1hr	3 - 20	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:

Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23835
Report Date and Time	: 23-Mar-2024 09:34	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
HAEMATOLOGY INVESTIGATIONS				
BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology) (Both Forward and Reverse Group)				
ABO Type	A			
Rh Type	POSITIVE			

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	PL ID	: 3455156
Bill. Loc.	: Aashka hospital			PL Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Plasma Fluoride F, Plasma Fluoride PP	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 13:04	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS		UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS					
Blood Glucose Level (Fasting & Post Prandial)					
Plasma Glucose - F	H	103.11	mg/dL	70.0 - 100	
Plasma Glucose - PP		100.63	mg/dL	70.0 - 140.0	

Reference range has been changed as per recent guidelines of ISPAD 2018.

<100 mg/dL : Normal level

100-<126 mg/dL: Impaired fasting glucoseer guidelines

>=126 mg/dL: Probability of Diabetes, Confirm as per guidelines

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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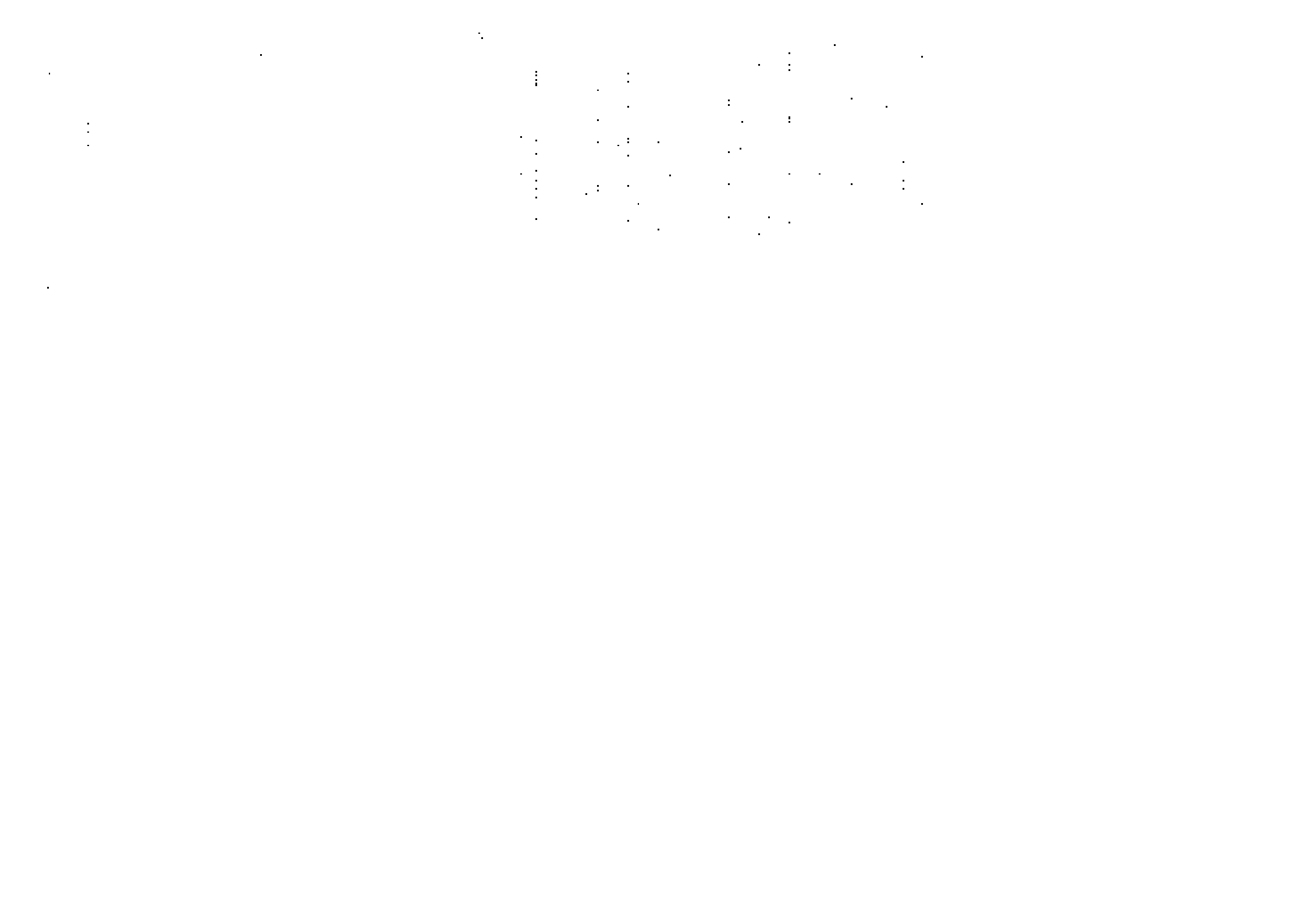

LABORATORY REPORT

Name	: MONICA GUPTA		Sex/Age : Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL		Dis. At :	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Whole Blood EDTA	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 09:43	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C	5.03	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) Calculated	97.66	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy,comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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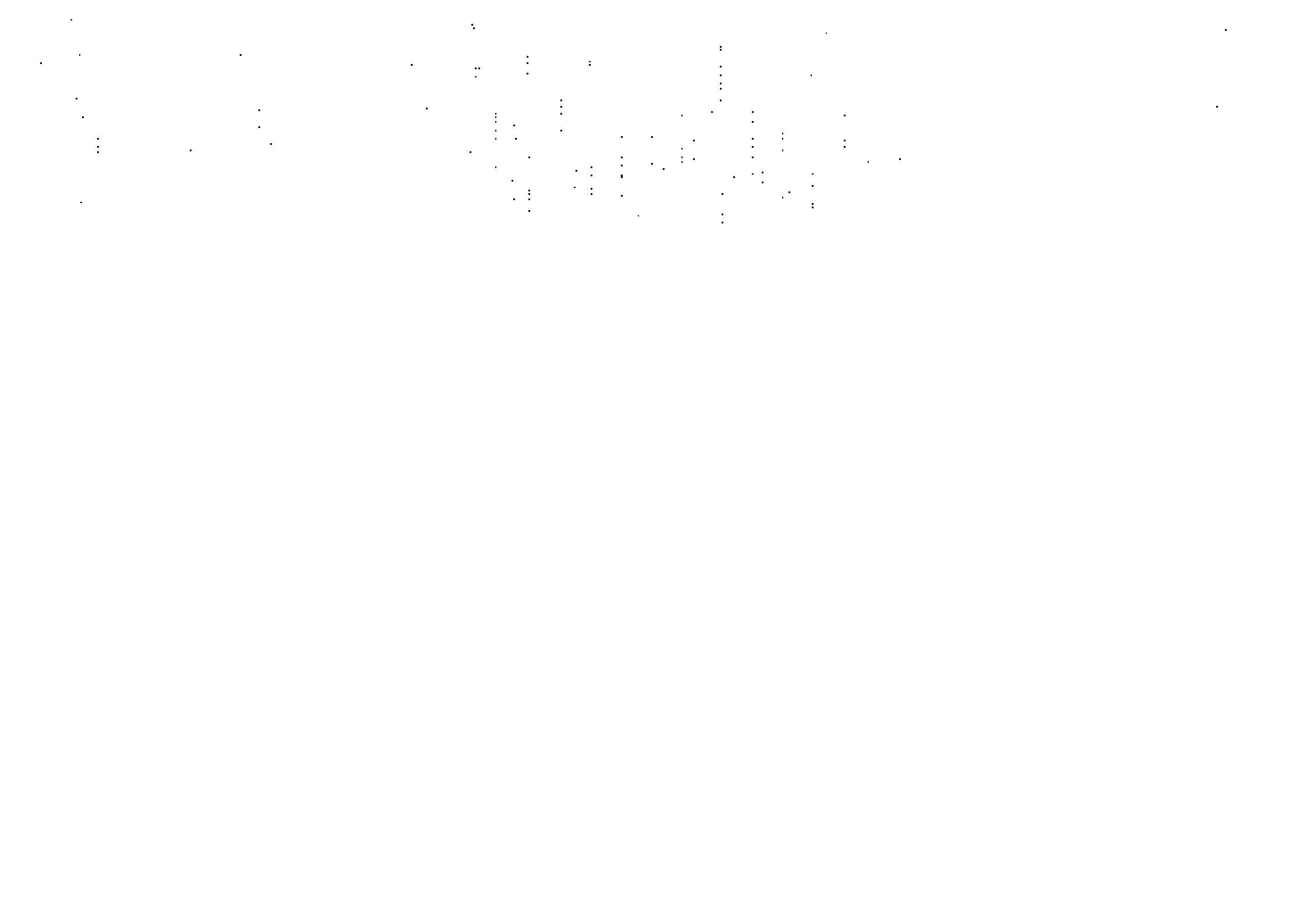

LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Serum	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 11:29	Acc. Remarks	: Normal	Ref Id2	: 0232411332

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS					
Lipid Profile					
Cholesterol *Colorimeric, CHOD-POD*		170.89	mg/dL	110 - 200	
HDL Cholesterol	L	38.9	mg/dL	46 - 77	
Triglyceride *Glycerol Phosphate Oxidase*	H	192.39	mg/dL	<150	
VLDL *Calculated*		38.48	mg/dL	10 - 40	
Chol/HDL *Calculated*	H	4.39		0 - 4.1	
LDL Cholestarol *Calculated*		93.51	mg/dL	0.00 - 100.00	

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal<100	Desirable<200	Low<40	Normal<150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-189	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment
- For LDL Cholesterol level Please consider direct LDL value
  Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed
- Detail test interpretation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh A-Abnormal)

Dr. Shreya Shah
M.D. (Pathologist)

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LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Serum	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 11:30	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS					
Liver Function Test					
S.G.P.T. *UV with P5P*	L	12.31	U/L	14 - 59	
S.G.O.T. *UV with P5P*	L	14.22	U/L	15 - 37	
Alkaline Phosphatase *Enzymatic, PNPP,AMP*		78.57	U/L	46 - 116	
Gamma Glutamyl Transferase *L-Gamma-glutamyl-3-Carboxy-4-nitroanilide Substrate*		10.98	U/L	0 - 38	
Proteins (Total) *Colorimetric, Biuret*		8.30	gm/dL	6.40 - 8.30	
Albumin *Bromocresol purple*		5.00	gm/dL	3.4 - 5	
Globulin *Calculated*		3.30	gm/dL	2 - 4.1	
A/G Ratio *Calculated*		1.5		1.0 - 2.1	
Bilirubin Total *Photometry*		0.74	mg/dL	0.3 - 1.2	
Bilirubin Conjugated *Diazotization reaction*		0.21	mg/dL	0 - 0.50	
Bilirubin Unconjugated *Calculated*		0.53	mg/dL	0 - 0.8	

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Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Serum	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref id1	: OSP23635
Report Date and Time	: 23-Mar-2024 13:09	Acc. Remarks	: Normal	Ref id2	: O232411332

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BUN (Blood Urea Nitrogen) GLDH	H	20.3	mg/dL	7.00 - 18.70	
Uric Acid Uricase		3.62	mg/dL	2.6 - 6.2	
Creatinine		0.74	mg/dL	0.50 - 1.50	
25 OH Cholecalciferol (D2+D3)	L	12.7	ng/mL	20 - 32 Normal Level 10 - 20 Insufficiency < 10 Deficiency > 150 Toxicity	

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Coeliac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

INTERPRETATION

- Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.
- Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.
- Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH- VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D.
- Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients.CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Report Date and Time	: 23-Mar-2024 13:09	Acc. Remarks	: Normal	Ref Id2	: O232411332

VITAMIN B - 12

Vitamin B - 12 Level	352.0	pg/mL	180 - 914

Introduction :
Vitamin B12, a member of the corrin family, a a cofactor for the formation of myelin, and along with folate, is required for DNA synthesis. Levels above 300 or 400 are rarely associated with B12 deficiency induced hematological or neurological disease.

Clinical Significance :
Causes of Vitamin B12 deficiency can be divided into three classes: Nutritional, malabsorption syndromes and gastrointestinal causes. B12 deficiency can cause Megaloblastic anemia (MA), nerve damage and degeneration of the spinal cord. Lack of B12 even mild deficiencies damages the myelin sheath. The nerve damage caused by a lack of B12 may become permanently debilitating.
The relationship between B12 and MA is not always clear that some patients with MA will have normal B12 levels; conversely, many individuals with B12 deficiency are not afflicted with MA.

Decreased in:
Iron deficiency, normal near-term pregnancy, vegetarianism, partial gastrectomy/ileal damage, celiac disease, use of oral contraception, parasitic competition, pancreatic deficiency, treated epilepsy and advancing age.

Increased in:
Renal failure, liver disease and myeloproliferative diseases.
Variations due to age Increases: with age.
Temporarily increased after Drug.
Falsely high in Deteriorated sample.

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Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Serum	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 10:20	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Thyroid Function Test				
Triiodothyronine (T3)	81.94	ng/dL	70 - 204	
Thyroxine (T4) CMIA	5.86	ng/dL	4.87 - 11.72	
TSH CMIA	3.22	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTH and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipent hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a supressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.
Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy	Reference range (microIU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

Note (LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Serum	Mobile No	:
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Report Date and Time	: 23-Mar-2024 10:20	Acc. Remarks	: Normal	Ref Id2	: O232411332

Interpretation Note:
Ultra sensitive-thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test). When the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.
Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.
Normal ranges of TSH & thyroid hormone vary according trimesper in pregnancy.

TSH ref range in Pregnacy	Reference range (microIU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.5-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

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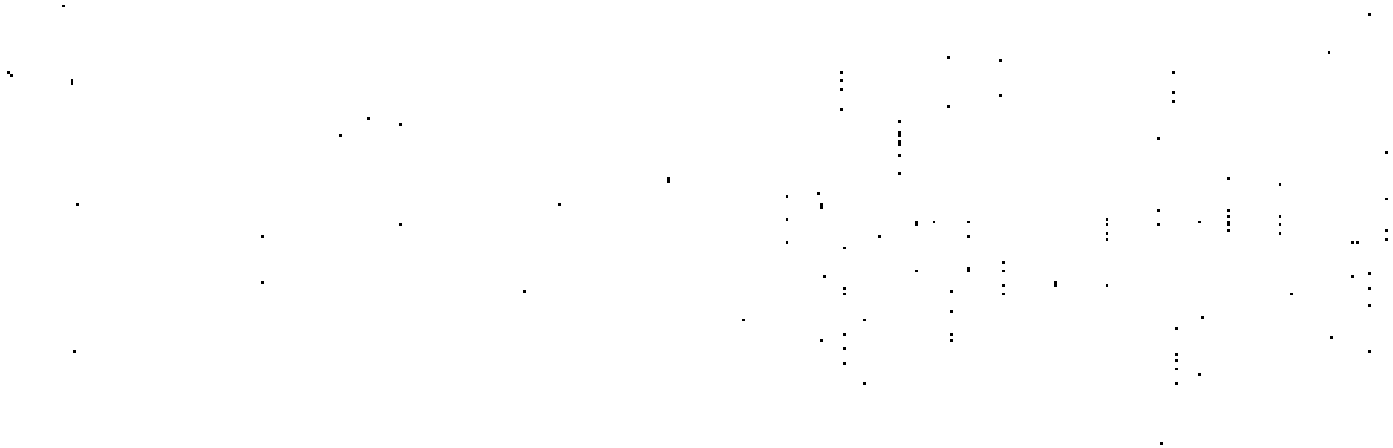

LABORATORY REPORT

Name	: MONICA GUPTA		Sex/Age : Female/ 36 Years	Case ID	: 40302200637
Ref.By	: HOSPITAL		Dis. At :	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:
Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Spot Urine	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23636
Report Date and Time	: 23-Mar-2024 09:41	Acc. Remarks	: Normal	Ref Id2	: O232411332

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
URINE EXAMINATION (STRIP METHOD AND FLOWCYTOMETRY)				
Physical examination				
Colour	Pale yellow			
Transparency	Clear			
Chemical Examination By Sysmex UC-3500				
Sp.Gravity	>1.025		1.005 - 1.030	
pH	6.00		5 - 8	
Leucocytes (ESTERASE)	Negative		Negative	
Protein	Negative		Negative	
Glucose	Negative		Negative	
Ketone Bodies Urine	Negative		Negative	
Urobilinogen	Negative		Negative	
Bilirubin	Negative		Negative	
Blood	Negative		Negative	
Nitrite	Negative		Negative	
Flowcytometric Examination By Sysmex UF-5000				
Leucocyte	Nil	/HPF	Nil	
Red Blood Cell	Nil	/HPF	Nil	
Epithelial Cell	Present +	/HPF	Present(+)	
Bacteria	Nil	/uL	Nil	
Yeast	Nil	/uL	Nil	
Cast	Nil	/HPF	Nil	
Crystals	Nil	/HPF	Nil	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT

Name	: MONICA GUPTA	Sex/Age	: Female/ 36 Years	Case ID	: 40302200537
Ref.By	: HOSPITAL	Dis. At	:	Pt. ID	: 3455156
Bill. Loc.	: Aashka hospital			Pt. Loc	:

Reg Date and Time	: 23-Mar-2024 09:17	Sample Type	: Spot Urine	Mobile No	:
Sample Date and Time	: 23-Mar-2024 09:18	Sample Coll. By	:	Ref Id1	: OSP23635
Report Date and Time	: 23-Mar-2024 09:41	Acc. Remarks	: Normal	Ref Id2	: O232411332

Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Result/Notifications				
			Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Pus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

End Of Report

For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

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