
Bank of Baroda

नाम कमला देवी यादव

Name Kamla Devi Yadav

कार्यकारी कूट क्र.

E.C.No 117532



जारीकर्ता अधिकारी
Issuing Author





धारक के हस्ताक्षर
Holder's Signature



Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291



• B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
• +91 141 4824885 • maxcarediagnostics1@gmail.com

General Physical Examination

Date of Examination: 08/07/23

Name: KAMLADEVI YADAV Age: 30YRS DOB: 05/02/1993 Sex: Female

Referred By: BANK OF BARODA

Photo ID: ID CARD ID #: 117532

Ht: 158 (cm)

Wt: 63 (Kg)

Chest (Expiration): 84 (cm)

Abdomen Circumference: 80 (cm)

Blood Pressure: 108/68 mm Hg

PR: 78/min

RR: 17/min

Temp: Alebrile

BMI 25

Eye Examination:

With glass
R/E - GIG'NIG'NCB
L/E - GIG'NIG'NCB

Other:

NO

On examination he/she appears physically and mentally fit: Yes/No

Signature Of Examinee:

Kamla

Name of Examinee:

MRS. KAMLA DEVI YADAV

Signature Medical Examiner:

[Signature]
Dr. U. C. GUPTA
MBBS, MD (Physician)
RMC No. 291

Name Medical Examiner:

DR. U. C. GUPTA



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

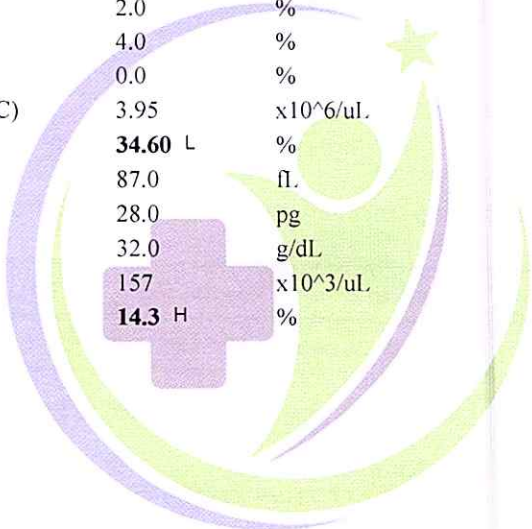


NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/07/2023 18:03:38

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
FULL BODY HEALTH CHECKUP BELOW 40 FEMAL			
HAEMOGARAM			
HAEMOGLOBIN (Hb)	11.1 L	g/dl.	12.0 - 15.0
TOTAL LEUCOCYTE COUNT	5.50	/cumm	4.00 - 10.00
DIFFERENTIAL LEUCOCYTE COUNT			
NEUTROPHIL	61.0	%	40.0 - 80.0
LYMPHOCYTE	33.0	%	20.0 - 40.0
EOSINOPHIL	2.0	%	1.0 - 6.0
MONOCYTE	4.0	%	2.0 - 10.0
BASOPHIL	0.0	%	0.0 - 2.0
TOTAL RED BLOOD CELL COUNT (RBC)	3.95	$\times 10^6/uL$.	3.80 - 4.80
HEMATOCRIT (HCT)	34.60 L	%	36.00 - 46.00
MEAN CORP VOLUME (MCV)	87.0	fL.	83.0 - 101.0
MEAN CORP HB (MCH)	28.0	pg	27.0 - 32.0
MEAN CORP HB CONC (MCHC)	32.0	g/dL	31.5 - 34.5
PLATELET COUNT	157	$\times 10^3/uL$.	150 - 410
RDW-CV	14.3 H	%	11.6 - 14.0



VIKARANTJI

Technologist
Page No: 1 of 17

Tanu

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023

09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

HAEMATOLOGY

Erythrocyte Sedimentation Rate (ESR)

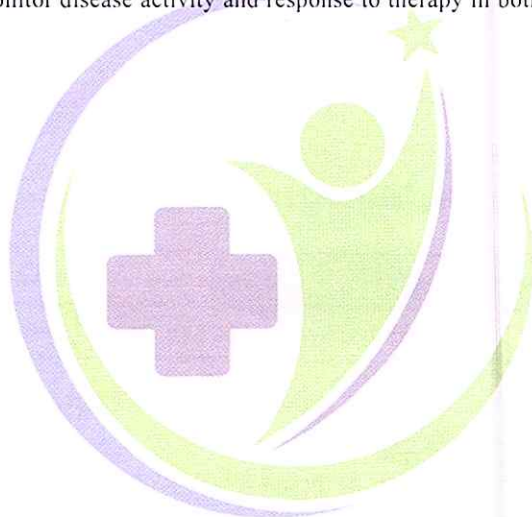
Method:- Westergreen

20

mm in 1st hr

00 - 20

The erythrocyte sedimentation rate (ESR or sed rate) is a relatively simple, inexpensive, non-specific test that has been used for many years to help detect inflammation associated with conditions such as infections, cancers, and autoimmune diseases.ESR is said to be a non-specific test because an elevated result often indicates the presence of inflammation but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other tests, such as C-reactive protein.ESR is used to help diagnose certain specific inflammatory diseases, including temporal arteritis, systemic vasculitis and polymyalgia rheumatica. (For more on these, read the article on Vasculitis.) A significantly elevated ESR is one of the main test results used to support the diagnosis.This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as



VIKARANTJI

Technologist

Page No: 2 of 17

Tanu

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023

09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

(CBC): **Methodology:** TLC,DLC Fluorescent Flow cytometry, HB SLS method,TRBC,PCV,PLT Hydrodynamically focused Impedance. and MCH,MCV,MCHC,MENTZER INDEX are calculated. **InstrumentName:** Sysmex 6 part fully automatic analyzer XN-L,Japan



VIKARANTJI

Page No: 3 of 17

Print Copy



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank
 Central Spine, Vidhyadhar Nagar, Jaipur - 302023
 +91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023

09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

FASTING BLOOD SUGAR (Plasma)

97.7

mg/dl

70.0 - 115.0

Method:- GOD POD

Impaired glucose tolerance (IGT)

111 - 125 mg/dL

Diabetes Mellitus (DM)

> 126 mg/dL

Instrument Name: HORIBA CA60 Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .

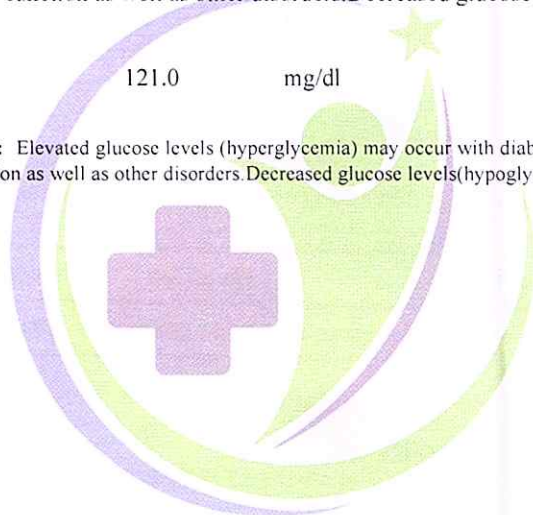
BLOOD SUGAR PP (Plasma)

121.0

mg/dl

70.0 - 140.0

Method:- GOD PAP



Instrument Name: HORIBA Interpretation: Elevated glucose levels (hyperglycemia) may occur with diabetes, pancreatic neoplasm, hyperthyroidism and adrenal cortical hyper-function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy or various liver diseases .

VIKARANTJI

Technologist

Page No: 4 of 17

DR. TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/07/2023 18:03:38

HAEMATOLOGY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

GLYCOSYLATED HEMOGLOBIN (HbA1C)

Method:- CAPILLARY with EDTA

5.1 mg%

Non-Diabetic < 6.0
Good Control 6.0-7.0
Weak Control 7.0-8.0
Poor control > 8.0

MEAN PLASMA GLUCOSE

Method:- Calculated Parameter

100 mg/dL

68 - 125

INTERPRETATION

AS PER AMERICAN DIABETES ASSOCIATION (ADA)

Reference Group HbA1c in %

Non diabetic adults >=18 years < 5.7

At risk (Prediabetes) 5.7 - 6.4

Diagnosing Diabetes >= 6.5

CLINICAL NOTES

In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia. The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings. Some of the factors that influence HbA1c and its measurement [Adapted from Gallagher et al]

1. Erythropoiesis

- Increased HbA1c: iron, vitamin B12 deficiency, decreased erythropoiesis.
- Decreased HbA1c: administration of erythropoietin, iron, vitamin B12, reticulocytosis, chronic liver disease.

2. Altered Haemoglobin-Genetic or chemical alterations in hemoglobin: hemoglobinopathies, HbF, methemoglobin, may increase or decrease HbA1c

3. Glycation

- Increased HbA1c: alcoholism, chronic renal failure, decreased intraerythrocytic pH
- Decreased HbA1c: certain hemoglobinopathies, increased intra-erythrocyte pH

4. Erythrocyte destruction

- Increased HbA1c: increased erythrocyte life span: Splenectomy.
- Decreased A1c: decreased RBC life span: hemoglobinopathies, splenomegaly, rheumatoid arthritis or drugs such as antiretrovirals, ribavirin & dapsone.

5. Others

- Increased HbA1c: hyperbilirubinemia, carbamylated hemoglobin, alcoholism, large doses of aspirin, chronic opiate use, chronic renal failure
- Decreased HbA1c: hypertriglyceridemia, reticulocytosis, chronic liver disease, aspirin, vitamin C and E, splenomegaly, rheumatoid arthritis or drugs

Note:

- Shortened RBC life span -HbA1c test will not be accurate when a person has a condition that affects the average lifespan of red blood cells (RBCs), such as hemolytic anemia or blood loss. When the lifespan of RBCs in circulation is shortened, the A1c result is falsely low and is an unreliable measurement of a person's average glucose over time
- Abnormal forms of hemoglobin - The presence of some hemoglobin variants, such as hemoglobin S in sickle cell anemia, may affect certain methods for measuring A1c. In these cases, fructosamine can be used to monitor glucose control.

Advised:

- To follow patient for glycemic control test like fructosamine or glycated albumin may be performed instead.
 - Hemoglobin HPLC screen to analyze abnormal hemoglobin variant.
- estimated Average Glucose (eAG) : based on value calculated according to National Glycohemoglobin Standardization Program (NGSP) criteria.

VIKARANTJI

Technologist

Page No: 5 of 17

Tanu

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023 09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

HAEMATOLOGY

BLOOD GROUP ABO

Method:- Haemagglutination reaction

"A" POSITIVE



VIKARANTJI

Technologist

Page No: 6 of 17

DR. TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV Patient ID :-1223637 Date :- 08/07/2023 09:06:55
Age :- 30 Yrs 5 Mon 2 Days Ref. By Doctor:-BANK OF BARODA
Sex :- Female Lab/Hosp :-
Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

LIPID PROFILE

TOTAL CHOLESTEROL 117.00 mg/dl
Desirable <200
Borderline 200-239
High > 240
Method:- CHOD-PAP methodology

InstrumentName:MISPA PLUS **Interpretation:** Cholesterol measurements are used in the diagnosis and treatments of lipid lipoprotein metabolism disorders.

TRIGLYCERIDES 99.50 mg/dl
Normal <150
Borderline high 150-199
High 200-499
Very high >500
Method:- GPO-PAP

InstrumentName:Radox Rx Imola **Interpretation :** Triglyceride measurements are used in the diagnosis and treatment of diseases involving lipid metabolism and various endocrine disorders e.g. diabetes mellitus, nephrosis and liver obstruction.

DIRECT HDL CHOLESTEROL 30.00 mg/dl
MALE- 30-70
FEMALE - 30-85
Method:- Direct clearance Method

Instrument Name:Rx Daytona plus **Interpretation:** An inverse relationship between HDL-cholesterol (HDL-C) levels in serum and the incidence/prevalence of coronary heart disease (CHD) has been demonstrated in a number of epidemiological studies. Accurate measurement of HDL-C is of vital importance when assessing patient risk from CHD. Direct measurement gives improved accuracy and reproducibility when compared to precipitation methods.

LDL CHOLESTEROL 70.42 mg/dl
Optimal <100
Near Optimal/above optimal 100-129
Borderline High 130-159
High 160-189
Very High > 190
Method:- Calculated Method

VLDL CHOLESTEROL 19.90 mg/dl
0.00 - 80.00
Method:- Calculated

T.CHOLESTEROL/HDL CHOLESTEROL RATIO 3.90
0.00 - 4.90
Method:- Calculated

LDL / HDL CHOLESTEROL RATIO 2.35
0.00 - 3.50
Method:- Calculated

TOTAL LIPID 382.53 L mg/dl
400.00 - 1000.00
Method:- CALCULATED

1. Measurements in the same patient can show physiological& analytical variations. Three serialsamples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.

2. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status.Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended

3. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol

VIKARANTJI

Technologist

Page No: 7 of 17

Tanu

DR.TANU RUNGTA
MD (Pathology)
RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023 09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

transport, the process by which cholesterol is eliminated from peripheral tissues.

Comments: 1- ATP III suggested the addition of Non HDL Cholesterol (Total Cholesterol – HDL Cholesterol) as an indicator of all atherogenic lipoproteins (mainly LDL & VLDL). The Non HDL Cholesterol is used as a secondary target of therapy in persons with triglycerides ≥ 200 mg/dL. The goal for Non HDL Cholesterol in those with increased triglyceride is 30 mg/dL above that set for LDL Cholesterol.

2 -For calculation of CHD risk, history of smoking, any medication for hypertension & current B.P. levels are required.



VIKARANTJI

Technologist

Page No: 8 of 17

DR. TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

LIVER PROFILE WITH GGT

SERUM BILIRUBIN (TOTAL) Method:- DMSO/Diazo	0.60	mg/dL	Infants : 0.2-8.0 mg/dL Adult - Up to - 1.2 mg/dL
SERUM BILIRUBIN (DIRECT) Method:- DMSO/Diazo	0.19	mg/dL	Up to 0.40 mg/dL
SERUM BILIRUBIN (INDIRECT) Method:- Calculated	0.41	mg/dl	0.30-0.70
SGOT Method:- IFCC	16.1	U/L	0.0 - 40.0
SGPT Method:- IFCC	22.3	U/L	0.0 - 35.0
SERUM ALKALINE PHOSPHATASE Method:- DGKC - SCE	45.50	U/L	42.00 - 110.00
SERUM GAMMA GT Method:- Szasz methodology Instrument Name Randox Rx Imola Interpretation: Elevations in GGT levels are seen earlier and more pronounced than those with other liver enzymes in cases of obstructive jaundice and metastatic neoplasms. It may reach 5 to 30 times normal levels in intra-or post-hepatic biliary obstruction. Only moderate elevations in the enzyme level (2 to 5 times normal) are observed with infectious hepatitis.	18.20	U/L	5.00 - 32.00
SERUM TOTAL PROTEIN Method:- Direct Biuret Reagent	8.01	g/dl	6.00 - 8.40
SERUM ALBUMIN Method:- Bromocresol Green	5.20	g/dl	3.50 - 5.50
SERUM GLOBULIN Method:- CALCULATION	2.81	gm/dl	2.20 - 3.50
A/G RATIO	1.85		1.30 - 2.50

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

Note :- These are group of tests that can be used to detect the presence of liver disease, distinguish among different types of liver disorders, gauge the extent of known liver damage, and monitor the response to treatment. Most liver diseases cause only mild symptoms initially, but these diseases must be detected early. Some tests are associated with functionality (e.g., albumin), some with cellular integrity (e.g., transaminase), and some with conditions linked to the biliary tract (gamma-glutamyl transferase and alkaline phosphatase). Conditions with elevated levels of ALT and AST include hepatitis A,B ,C ,paracetamol toxicity etc. Several biochemical tests are useful in the evaluation and management of patients with hepatic dysfunction. Some or all of these measurements are also carried out (usually about twice a year for routine cases) on those individuals taking certain medications, such as anticonvulsants, to ensure that the medications are not adversely impacting the person's liver.

VIKARANTJI

Technologist
Page No: 9 of 17

Tanu

DR. TANU RUNGTA
MD (Pathology)
RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnosticsl@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023

09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

RFT / KFT WITH ELECTROLYTES

SERUM UREA 34.00 mg/dl 10.00 - 50.00
Method:- Urease/GLDH

InstrumentName: HORIBA CA 60 **Interpretation :** Urea measurements are used in the diagnosis and treatment of certain renal and metabolic diseases.

SERUM CREATININE 0.89 mg/dl Males : 0.6-1.50 mg/dl
Method:- Jaffe's Method Females : 0.6 -1.40 mg/dl

Interpretation :
Creatinine is measured primarily to assess kidney function and has certain advantages over the measurement of urea. The plasma level of creatinine is relatively independent of protein ingestion, water intake, rate of urine production and exercise. Depressed levels of plasma creatinine are rare and not clinically significant.

SERUM URIC ACID 2.88 mg/dl 2.40 - 7.00

InstrumentName: HORIBA YUMIZEN CA60 Daytona plus **Interpretation. Elevated Urate:** High purine diet, Alcohol, Renal insufficiency, Drugs, Polycythaemia vera, Malignancies, Hypothyroidism, Rare enzyme defects, Downs syndrome, Metabolic syndrome, Pregnancy, Gout

SODIUM 142.7 mmol/L 135 - 150
Method:- Ion-Selective Electrode with Serum

Interpretation:
Electrolytes are minerals that are found in body tissues and blood in the form of dissolved salts. As electrically charged particles, electrolytes help move nutrients into and wastes out of the body's cells, maintain a healthy water balance, and help stabilize the body's acid/base (pH) level. The electrolyte panel measures the blood levels of the main electrolytes in the body: *

* **Sodium**—most of the body's sodium is found in the fluid outside of the body's cells, where it helps to regulate the amount of water in the body. *

POTASSIUM 4.26 mmol/L 3.5 - 5.5
Method:- Ion-Selective Electrode with Serum

* **Potassium**—this electrolyte is found mainly inside the body's cells. A small but vital amount of potassium is found in the plasma, the liquid portion of the blood. Potassium plays an important role in regulating muscle contraction. Monitoring potassium is important as small changes in the potassium level can affect the heart's rhythm and ability to contract

CHLORIDE 100.3 mmol/L 98 - 106
Method:- Ion-Selective Electrode with Serum

VIKARANTJI

Technologist

Page No: 10 of 17

Tanu

DR. TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnosticsl@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 08/07/2023 18:03:38

BIOCHEMISTRY

* **Chloride**—this electrolyte moves in and out of the cells to help maintain electrical neutrality (concentrations of positively charged cations and negatively charged anions must be equal) and its level usually mirrors that of sodium. Due to its close association with sodium, chloride also helps to regulate the distribution of water in the body

SERUM CALCIUM	8.77	mg/dl	8.10 - 11.50
---------------	------	-------	--------------

Method:- Colorimetric method

InstrumentName:Rx Daytona plus **Interpretation:** Serum calcium levels are believed to be controlled by parathyroid hormone and vitamin D. Increases in serum PTH or vitamin D are usually associated with hypercalcemia .Hypocalcemia may be observed in hypoparathyroidism, nephrosis and pancreatitis.

SERUM TOTAL PROTEIN	8.01	g/dl	6.00 - 8.40
---------------------	------	------	-------------

Method:- Direct Biuret Reagent

SERUM ALBUMIN	5.20	g/dl	3.50 - 5.50
---------------	------	------	-------------

Method:- Bromocresol Green

SERUM GLOBULIN	2.81	gm/dl	2.20 - 3.50
----------------	------	-------	-------------

Method:- CALCULATION

A/G RATIO	1.85		1.30 - 2.50
-----------	------	--	-------------

Interpretation : Measurements obtained by this method are used in the diagnosis and treatment of a variety of diseases involving the liver, kidney and bone marrow as well as other metabolic or nutritional disorders.

INTERPRETATION

Kidney function tests are group of tests that can be used to evaluate how well the kidneys are functioning. Creatinine is a waste product that comes from protein in the diet and also comes from the normal wear and tear of muscles of the body. In blood, it is a marker of GFR .in urine, it can remove the need for 24-hourcollections for many analytes or be used as a quality assurance tool to assess the accuracy of a 24-hour collection Higher levels may be a sign that the kidneys are not working properly. As kidney disease progresses, the level of creatinine and urca in the bloodincreases. Certain drugs are nephrotoxic hence KFT is done before and after initiation of treatment with these drugs.

Low serum creatinine values are rare; they almost always reflect low muscle mass.

VIKARANTJI

Technologist

Page No: 11 of 17

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226

Print Copy



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



B-14, Vidhyadhar Enclave - II, Near Axis Bank
 Central Spine, Vidhyadhar Nagar, Jaipur - 302023
 +91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :- Mr.MEDIWHEEL		

Final Authentication : 08/07/2023 18:03:38

TOTAL THYROID PROFILE

IMMUNOASSAY

Test Name	Value	Unit	Biological Ref Interval
-----------	-------	------	-------------------------

THYROID-TRIIODOTHYRONINE T3	1.26	ng/mL	0.70 - 2.04
------------------------------------	------	-------	-------------

Method:- ECLIA

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↑ TSH level. 2.Low TSH, high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH, high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis 5.High TSH, Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH, Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑ serum TSH levels 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or ↑ T3 & 10.Normal T3 & T4 along with ↑ TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & ↑ T4 along with ↑ TSH is seen in Hypothyroidism . 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved. TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly. *** 5.10 - 14.10

THYROID THYRONINE (T4) 6.77 uIU/mL
 Method:- ECLIA

NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result. Transient increase in TSH levels or abnormal TSH levels can be seen in some non thyroidal conditions, simultaneous measurement of TSH with free T4 is useful in evaluating differential diagnosis

INTERPRETATION-Ultra Sensitive 4th generation assay 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↑ TSH level. 2.Low TSH, high FT4 and TSH receptor antibody (TRAb) +ve seen in patients with Graves disease 3.Low TSH, high FT4 and TSH receptor antibody (TRAb) -ve seen in patients with Toxic adenoma/Toxic Multinodular goiter 4.High TSH, Low FT4 and Thyroid microsomal antibody increased seen in patients with Hashimoto's thyroiditis 5.High TSH, Low FT4 and Thyroid microsomal antibody normal seen in patients with Iodine deficiency/Congenital T4 synthesis deficiency 6.Low TSH, Low FT4 and TRH stimulation test -Delayed response seen in patients with Tertiary hypothyroidism 7.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑ serum TSH levels 8.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis 9.Normal or ↑ T3 & 10.Normal T3 & T4 along with ↑ TSH indicate mild / Subclinical Hyperthyroidism .11.Normal T3 & ↑ T4 along with ↑ TSH is seen in Hypothyroidism . 12.Normal T3 & T4 levels with ↑ TSH indicate Mild / Subclinical Hypoth

DURING PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association) 1st Trimester : 0.10-2.50 uIU/mL 2nd Trimester : 0.20-3.00 uIU/mL 3rd Trimester : 0.30-3.00 uIU/mL The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.

REMARK-Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test. Abnormal thyroid test findings often found in critically ill patients should be repeated after the critical nature of the condition is resolved. TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age, and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly.

TSH 1.940 uIU/mL, 0.350 - 5.500
 Method:- ECLIA

4th Generation Assay, Reference ranges vary between laboratories

PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

1st Trimester : 0.10-2.50 uIU/mL
 2nd Trimester : 0.20-3.00 uIU/mL
 3rd Trimester : 0.30-3.00 uIU/mL

VIKARANTJI

Technologist

Page No: 15 of 17

Tanu

DR. TANU RUNGTA
 MD (Pathology)
 RMC No. 17226

Print Copy



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/07/2023 18:03:38

IMMUNOASSAY

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.
NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result.

INTERPRETATION

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 3.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 4.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

COMMENTS: Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.

Disclaimer-TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly

Reference ranges are from Teitz fundamental of clinical chemistry 8th ed (2018)

Test performed by Instrument : Beckman coulter Dxi 800

Note : The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

4th Generation Assay, Reference ranges vary between laboratories

PREGNANCY - REFERENCE RANGE for TSH IN uIU/mL (As per American Thyroid Association)

- 1st Trimester : 0.10-2.50 uIU/mL
- 2nd Trimester : 0.20-3.00 uIU/mL
- 3rd Trimester : 0.30-3.00 uIU/mL

The production, circulation, and disintegration of thyroid hormones are altered throughout the stages of pregnancy.
NOTE-TSH levels are subject to circadian variation, reaching peak levels between 2-4 AM and min between 6-10 PM. The variation is the order of 50% hence time of the day has influence on the measures serum TSH concentration. Dose and time of drug intake also influence the test result.

INTERPRETATION

- 1.Primary hyperthyroidism is accompanied by ↑serum T3 & T4 values along with ↓ TSH level.
- 2.Primary hypothyroidism is accompanied by ↓ serum T3 and T4 values & ↑serum TSH levels
- 3.Normal T4 levels accompanied by ↑ T3 levels and low TSH are seen in patients with T3 Thyrotoxicosis
- 4.Normal or ↓ T3 & ↑T4 levels indicate T4 Thyrotoxicosis (problem is conversion of T4 to T3)
- 5.Normal T3 & T4 along with ↓ TSH indicate mild / Subclinical Hyperthyroidism

COMMENTS: Assay results should be interpreted in context to the clinical condition and associated results of other investigations. Previous treatment with corticosteroid therapy may result in lower TSH levels while thyroid hormone levels are normal. Results are invalidated if the client has undergone a radionuclide scan within 7-14 days before the test.

Disclaimer-TSH is an important marker for the diagnosis of thyroid dysfunction. Recent studies have shown that the TSH distribution progressively shifts to a higher concentration with age ,and it is debatable whether this is due to a real change with age or an increasing proportion of unrecognized thyroid disease in the elderly

VIKARANTJI

Technologist

Page No: 16 of 17

DR. TANU RUNGTA
MD (Pathology)
RMC No. 17226



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV

Age :- 30 Yrs 5 Mon 2 Days

Sex :- Female

Patient ID :-1223637

Date :- 08/07/2023 09:06:55

Ref. By Doctor:-BANK OF BARODA

Lab/Hosp :-

Company :- Mr.MEDIWHEEL

Final Authentication : 08/07/2023 18:03:38

. Reference ranges are from Teitz fundamental of clinical chemistry 8th ed (2018)
Test performed by Instrument : Beckman coulter Dxi 800

Note : The result obtained relate only to the sample given/ received & tested. A single test result is not always indicative of a disease, it has to be correlated with clinical data for interpretation.

*** End of Report ***



VIKARANTJI

Technologist

Page No: 17 of 17

DR.TANU RUNGTA

MD (Pathology)

RMC No. 17226



B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME :- Mrs. KAMLA DEVI YADAV	Patient ID :-1223637	Date :- 08/07/2023	09:06:55
Age :- 30 Yrs 5 Mon 2 Days	Ref. By Doctor:-BANK OF BARODA		
Sex :- Female	Lab/Hosp :-		
	Company :-	Mr.MEDIWHEEL	

Final Authentication : 08/07/2023 18:03:38

CLINICAL PATHOLOGY

Test Name	Value	Unit	Biological Ref Interval
Urine Routine			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		PALE YELLOW
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION(PH)	6.0		5.0 - 7.5
SPECIFIC GRAVITY	1.015		1.010 - 1.030
PROTEIN	NIL		NIL
SUGAR	NIL		NIL
BILIRUBIN	NEGATIVE		NEGATIVE
UROBILINOGEN	NORMAL		NORMAL
KETONES	NEGATIVE		NEGATIVE
NITRITE	NEGATIVE		NEGATIVE
<u>MICROSCOPY EXAMINATION</u>			
RBC/HPF	NIL	/HPF	NIL
WBC/HPF	2-3	/HPF	2-3
EPITHELIAL CELLS	2-3	/HPF	2-3
CRYSTALS/HPF	ABSENT		ABSENT
CAST/HPF	ABSENT		ABSENT
AMORPHOUS SEDIMENT	ABSENT		ABSENT
BACTERIAL FLORA	ABSENT		ABSENT
YEAST CELL	ABSENT		ABSENT
OTHER	ABSENT		ABSENT

VIKARANTJI

Technologist

Page No: 12 of 17

DR.TANU RUNGTA

MD (Pathology)
RMC No. 17226

Print Copy



P3 HEALTH SOLUTIONS LLP

(ASSOCIATES OF MAXCARE DIAGNOSTICS)

B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com



NAME:	MRS. KAMLA DEVI YADAV	AGE/SEX	30 YRS/F
REF.BY	BANK OF BARODA	DATE	08/07/2023

CHEST X RAY (PA VIEW)

Bilateral lung fields appear clear.

Bilateral costo-phrenic angles appear clear.

Cardiothoracic ratio is normal.

Thoracic soft tissue and skeletal system appear unremarkable.

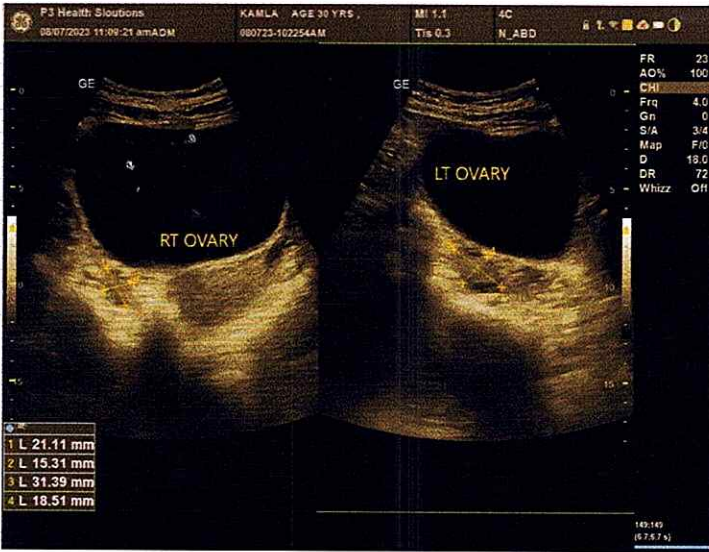
Soft tissue shadows appear normal.



IMPRESSION: No significant abnormality is detected.

Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437







B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

MRS. KAMLA DEVI YADAV	30 Y/F
Registration Date: 08/07/2023	Ref. by: BANK OF BARODA

ULTRASOUND OF WHOLE ABDOMEN

Liver is of normal size (138 mm). Echo-texture is normal. No focal space occupying lesion is seen within liver parenchyma. Intra hepatic biliary channels are not dilated. Portal vein diameter is normal.

Gall bladder is well distended. Wall is not thickened. No calculus or mass lesion is seen in gall bladder. Common bile duct is not dilated.

Pancreas is of normal size and contour. Echo-pattern is normal. No focal lesion is seen within pancreas.

Spleen is of normal size and shape. Echotexture is normal. No focal lesion is seen.

Kidneys are normally sited and are of normal size and shape. Cortico-medullary echoes are normal. No focal lesion is seen. Collecting system does not show any dilatation or calculus.

Right kidney is measuring approx. 95 mm.

Left kidney is measuring approx. 100 mm.

Urinary bladder does not show any calculus or mass lesion.

Uterus is anteverted and normal in size (measuring approx. 69 x 33 mm).

Myometrium shows normal echo -pattern. No focal space occupying lesion is seen. Endometrial echo is normal. Endometrial thickness is 4.4 mm.

Both ovaries are visualized and are normal. No adnexal mass lesion is seen.

No enlarged nodes are visualized. No retro-peritoneal lesion is identified.

No significant free fluid is seen in pouch of Douglas.

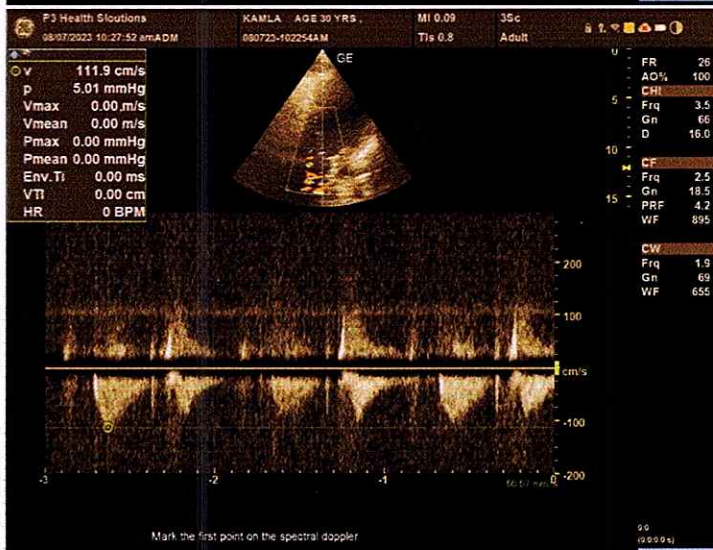
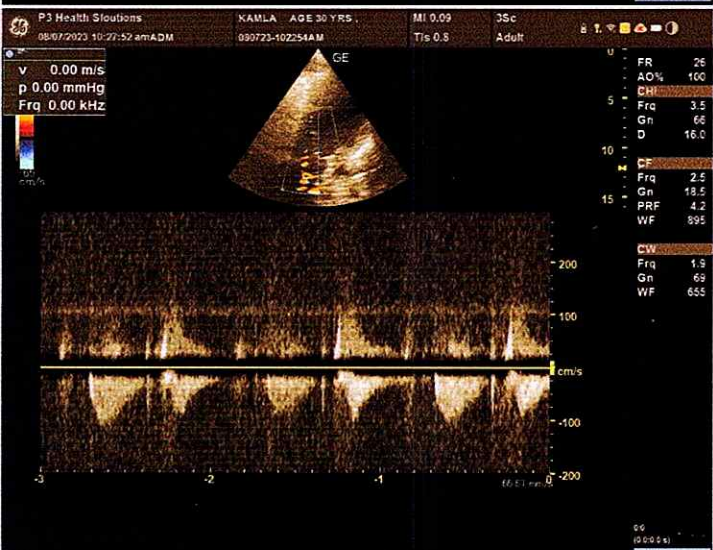
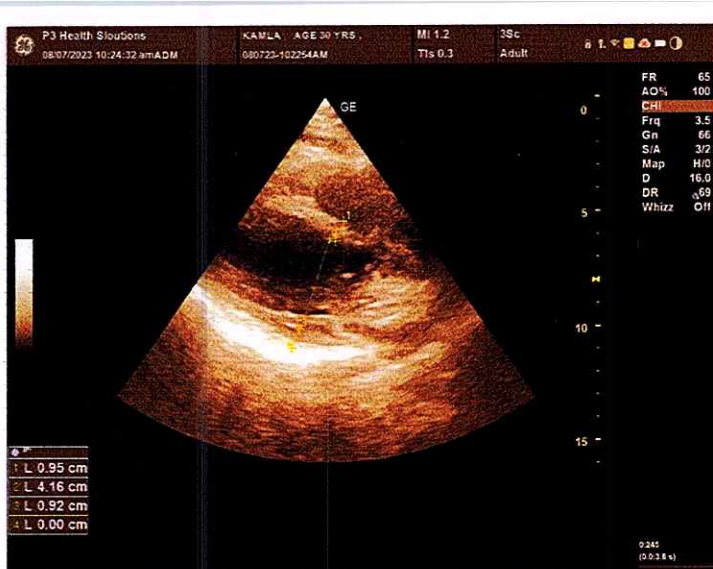
IMPRESSION:

- Solid abdominal organs appear normal.
- No free fluid or lymphadenopathy



Dr. Mukesh Sharma
M.B.B.S; M.D. (Radiodiagnosis)
RMC No. 43418/17437

Dr. MUKESH SHARMA
M.B.B.S., M.D.(Radiodiagnosis)
RMC No. : 43418/17437
P3 Health Solutions LLP





B-14, Vidhyadhar Enclave - II, Near Axis Bank
Central Spine, Vidhyadhar Nagar, Jaipur - 302023
+91 141 4824885 maxcarediagnostics1@gmail.com

MRS. KAMLA DEVI YADAV	30 Y/F
Registration Date: 08/07/2023	Ref. by: BANK OF BARODA

2D-ECHOCARDIOGRAPHY M.MODE WITH DOPPLER STUDY:
FAIR TRANSTHORACIC ECHOCARDIOGRAPHIC WINDOW MORPHOLOGY:

MITRAL VALVE	NORMAL	TRICUSPID VALVE	NORMAL
AORTIC VALVE	NORMAL	PULMONARY VALVE	NORMAL

M.MODE EXAMINATION:

AO	1.6	Cm	LA	2.6	cm	IVS-D	0.95	cm
IVS-S	1.2	cm	LVID	4.2	cm	LVSD	3.8	cm
LVPW-D	0.9	cm	LVPW-S	1.0	cm	RV		cm
RVWT		cm	EDV		ml	LVVS		ml
LVEF	60%		RWMA			ABSENT		

CHAMBERS:

LA	NORMAL	RA	NORMAL
LV	NORMAL	RV	NORMAL
PERICARDIUM	NORMAL		

COLOUR DOPPLER:

MITRAL VALVE					
E VELOCITY	0.88	m/sec	PEAK GRADIENT		Mm/hg
A VELOCITY	0.61	m/sec	MEAN GRADIENT		Mm/hg
MVA BY PHT		Cm2	MVA BY PLANIMETRY		Cm2
MITRAL REGURGITATION					ABSENT
AORTIC VALVE					
PEAK VELOCITY	1.10	m/sec	PEAK GRADIENT	5	mm/hg
AR VMAX		m/sec	MEAN GRADIENT		mm/hg
AORTIC REGURGITATION					ABSENT
TRICUSPID VALVE					
PEAK VELOCITY		m/sec	PEAK GRADIENT		mm/hg
MEAN VELOCITY		m/sec	MEAN GRADIENT		mm/hg
VMax VELOCITY					
TRICUSPID REGURGITATION					ABSENT
PULMONARY VALVE					
PEAK VELOCITY	0.80	M/sec.	PEAK GRADIENT		Mm/hg
MEAN VALOCITY			MEAN GRADIENT		Mm/hg
PULMONARY REGURGITATION					ABSENT

Impression—

- NORMAL LV SIZE & CONTRACTILITY.
- NO RWMA, LVEF 60%.
- NORMAL VALVULAR FUNCTION.
- NORMAL DIASTOLIC FUNCTION.
- NO CLOT, NO VEGETATION, NO PERICARDIAL EFFUSION.

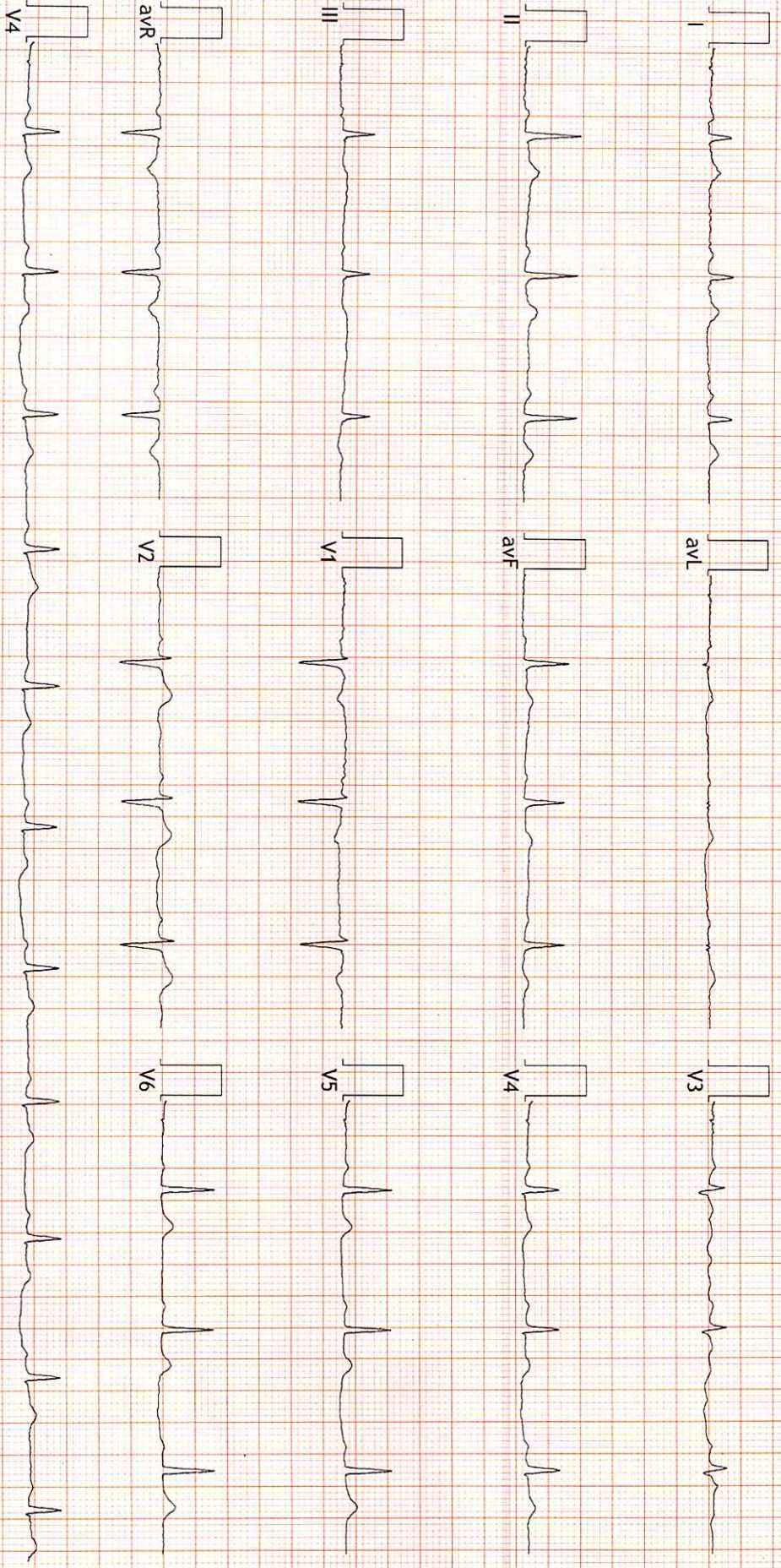

(Cardiologist)

P3 HEALTH SOLUTIONS LLP

B-14, Vidhyadhar nahar Enclave-II, Jaipur.
1323633/Mrs Kamla Devi Yadav 30Yrs-6Months/Female
Ref.: BANK OF BARODA Test Date: 08-Jul-2023(2:25:33 P)

Kgs/31 Cms BP: ___/___ mmHg
Notch: 50Hz 0.05Hz - 100Hz 10mm/mV 25mm/Sec

PR Interval: 160 ms
QRS Duration: 98 ms
QT/QTc: 275/289ms
P-QRS-T Axis: 31 - 59 - 21 (Deg)



FINDINGS: Normal Sinus Rhythm

Vent Rate : 66 bpm; PR Interval : 160 ms; QRS Duration: 98 ms; QT/QTc Int : 275/289 ms
P-QRS-T axis: 31 • 59 • 21 • (Deg)
Comments : Patient is normal Do exercise regularly Patient having milk allergy Sometimes looks unconscious

[Handwritten signature]

Dr. Naresh Mohanka
RMC No.: 35703
MBBS, DIP. CARDIO (ESCORTS)
D.E.M. (RCGP-UK)

Dr. Naresh Mohanka