

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 0 m 0 s

Stage Time : 0 m 34 s

HR: 92 bpm

Protocol: Bruce

Stage: Supine

Speed: 0 mph

Grade: 0 %

(THR: 148 bpm)

B.P: 110 / 70

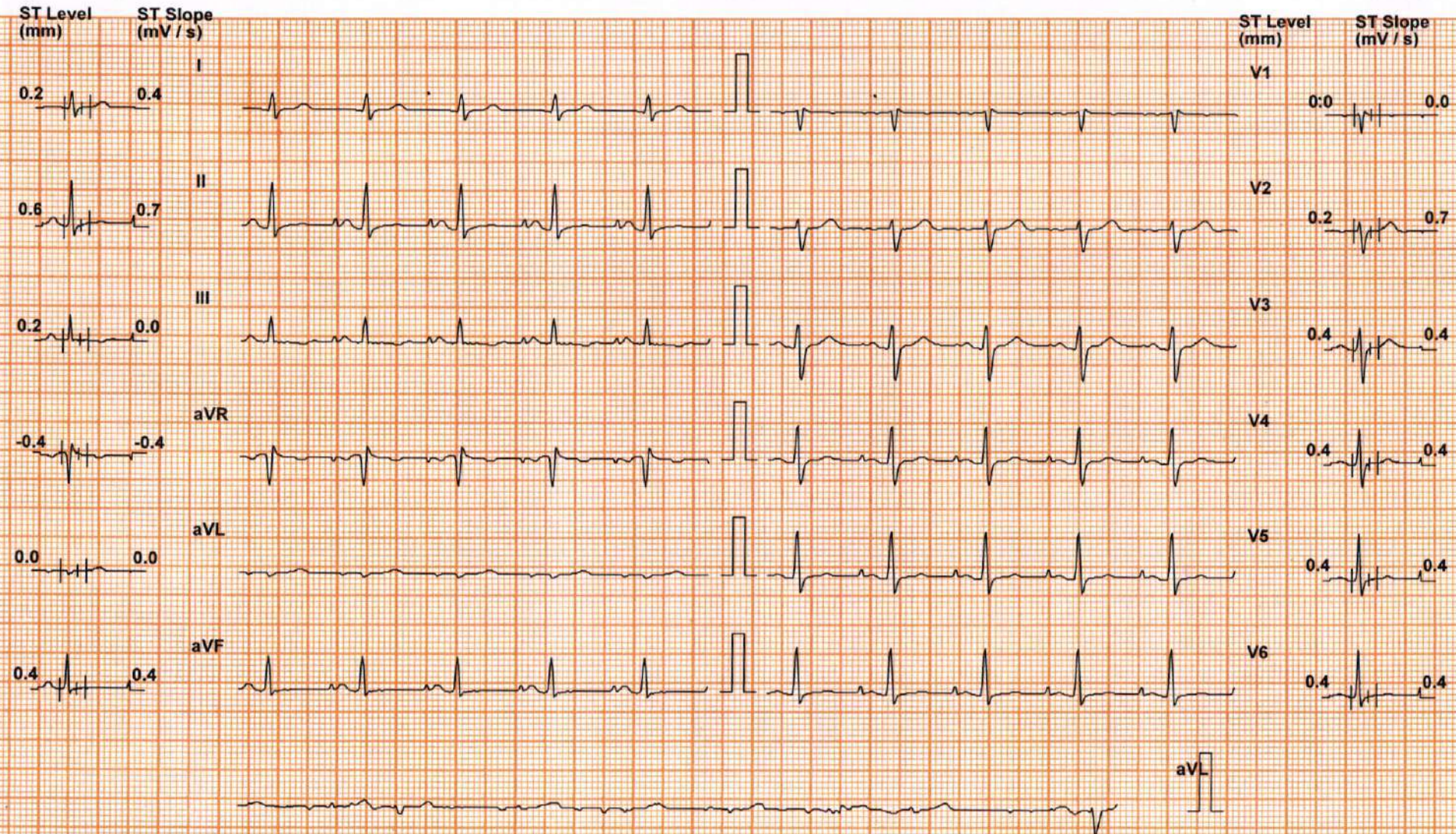


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 0 m 0 s

Stage Time : 0 m 5 s

HR: 82 bpm

Protocol: Bruce

Stage: Standing

Speed: 0 mph

Grade: 0 %

(THR: 148 bpm)

B.P: 110 / 70

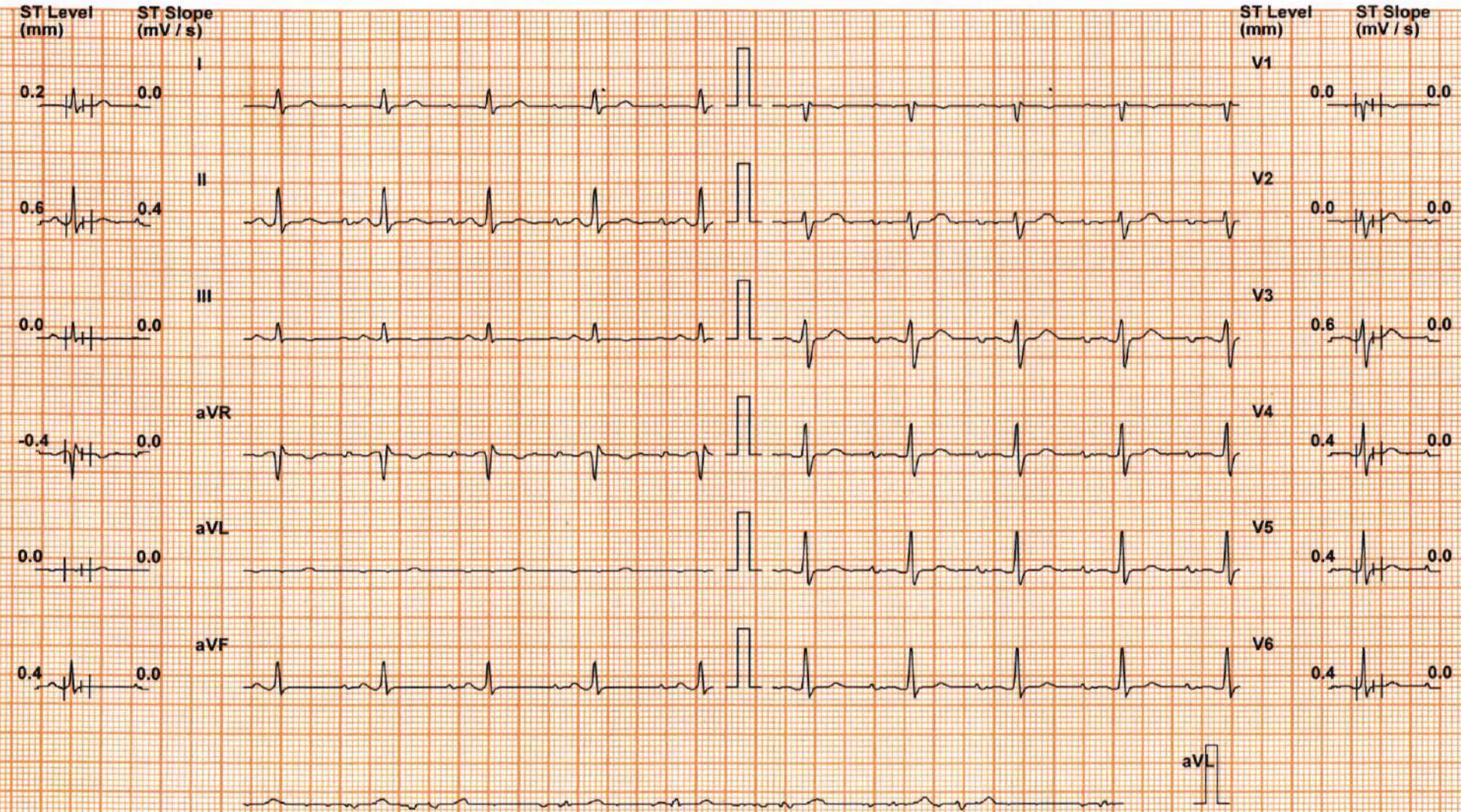


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 2 m 54 s Stage Time : 2 m 54 s **HR: 110 bpm**

Protocol: Bruce

Stage: 1

Speed: 1.7 mph

Grade: 10 %

(THR: 148 bpm)

B.P: 120 / 70

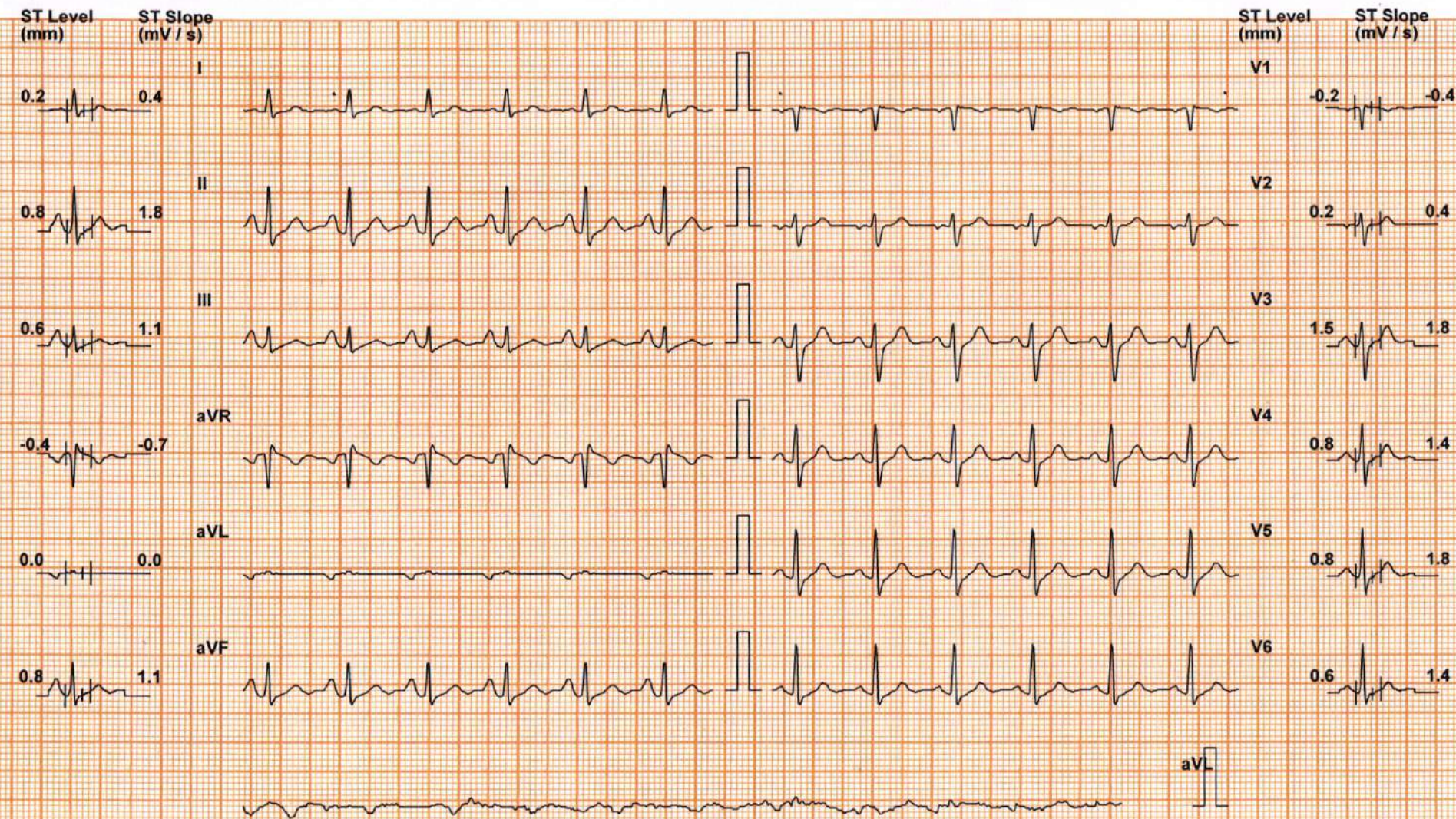


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 5 m 54 s Stage Time : 2 m 54 s **HR: 126 bpm**

Protocol: Bruce

Stage: 2

Speed: 2.5 mph

Grade: 12 %

(THR: 148 bpm)

B.P: 130 / 70

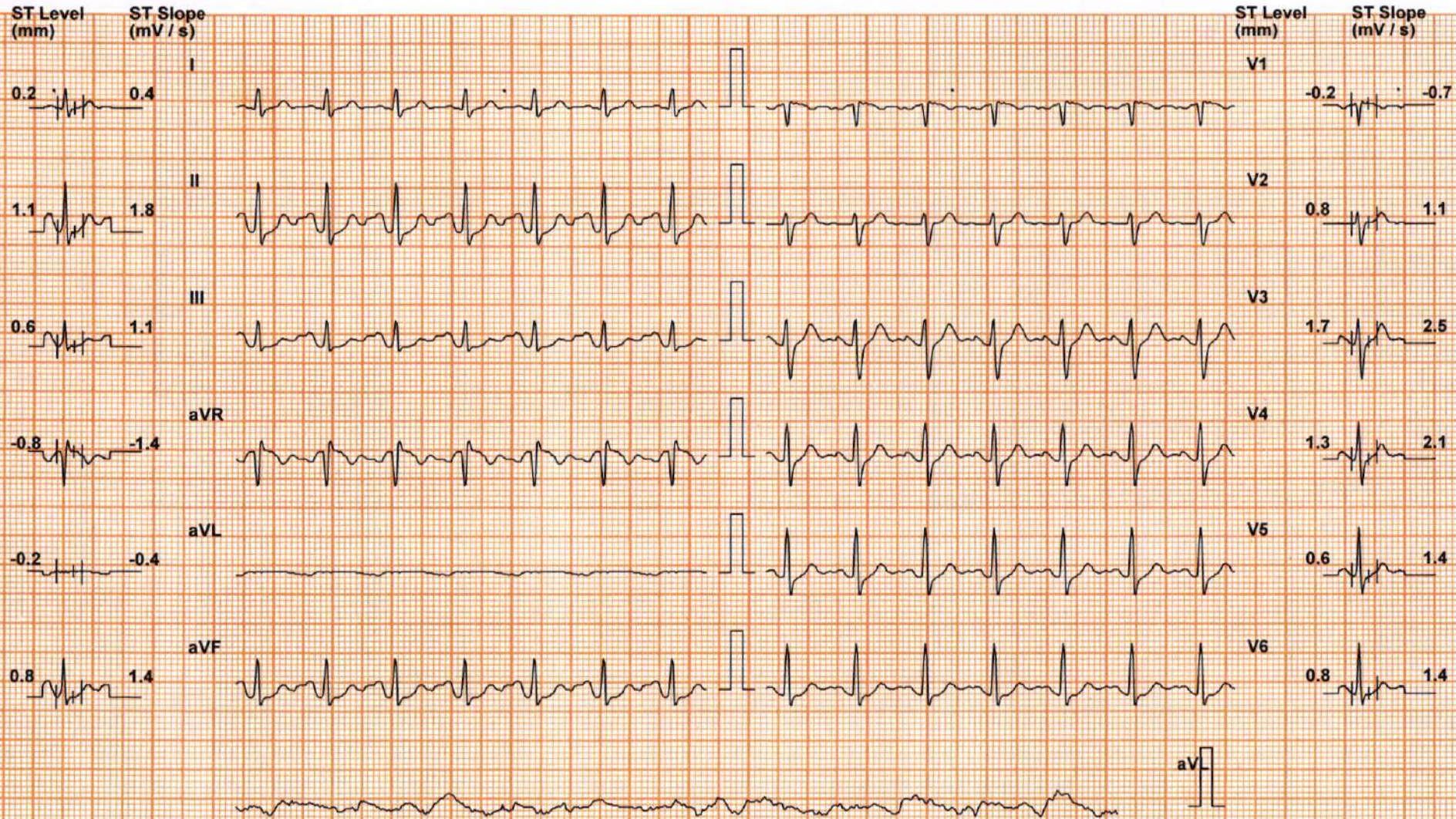


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 8 m 5 s

Stage Time : 2 m 5 s

HR: 146 bpm

Protocol: Bruce

Stage: Peak Ex

Speed: 3.4 mph

Grade: 14 %

(THR: 148 bpm)

B.P: 140 / 70

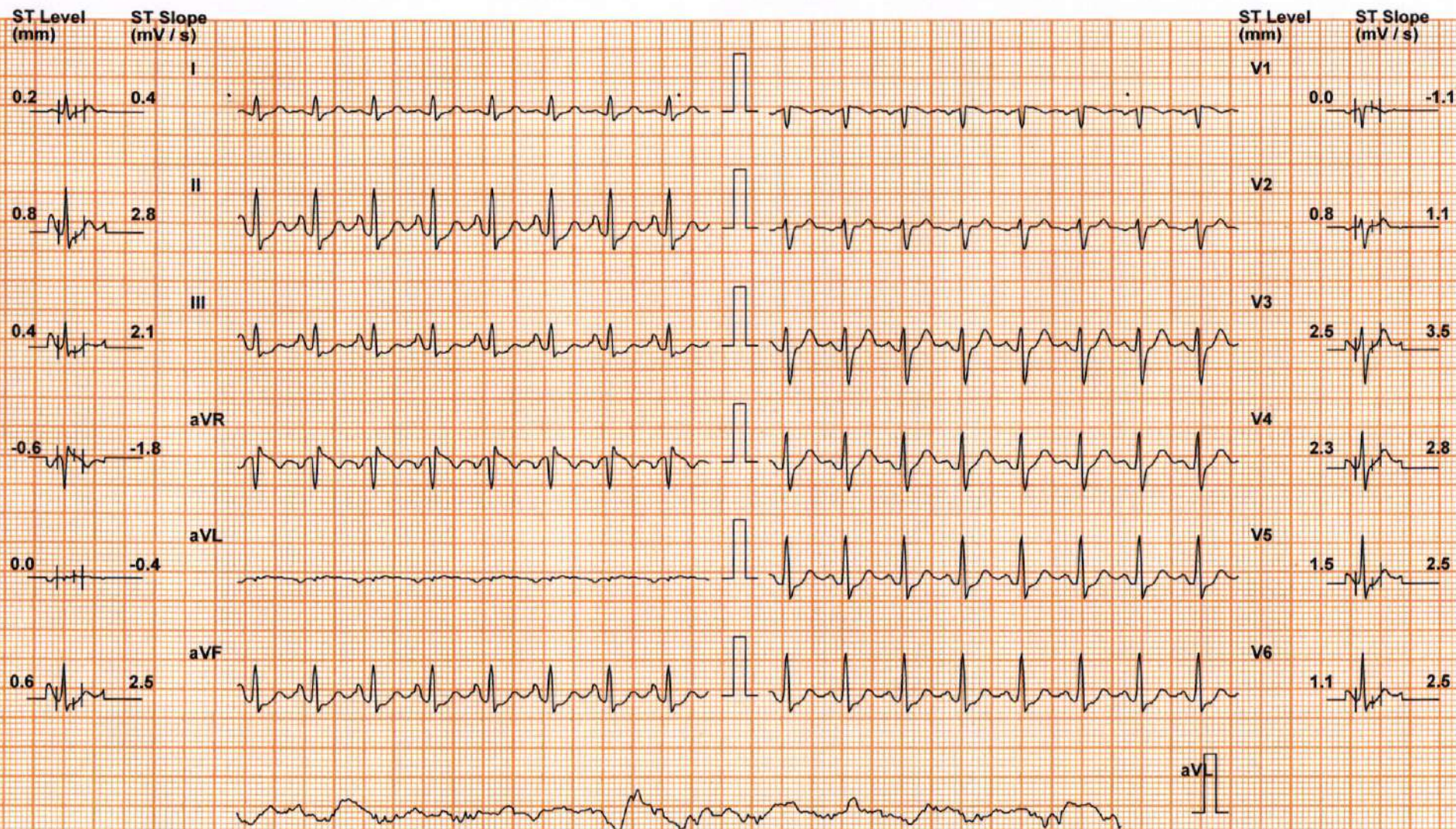


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 8 m 11 s

Stage Time : 0 m 54 s

HR: 134 bpm

Protocol: Bruce

Stage: Recovery(1)

Speed: 1 mph

Grade: 0 %

(THR: 148 bpm)

B.P: 170 / 70

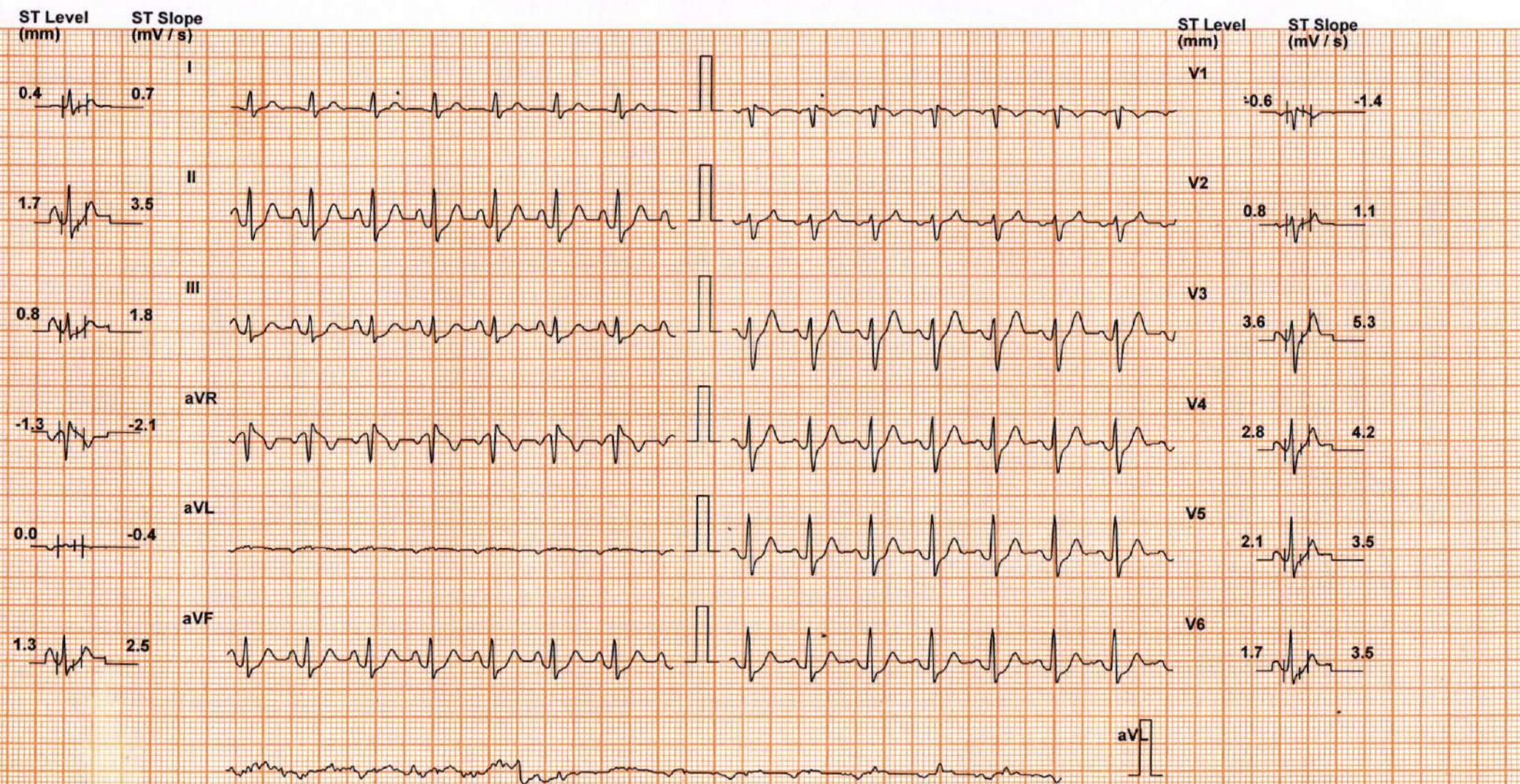


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandah V 4.7

Linked Median

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 8 m 11 s

Stage Time : 0 m 54 s

HR: 93 bpm

Protocol: Bruce

Stage: Recovery(2)

Speed: 0 mph

Grade: 0 %

(THR: 148 bpm)

B.P: 150 / 70

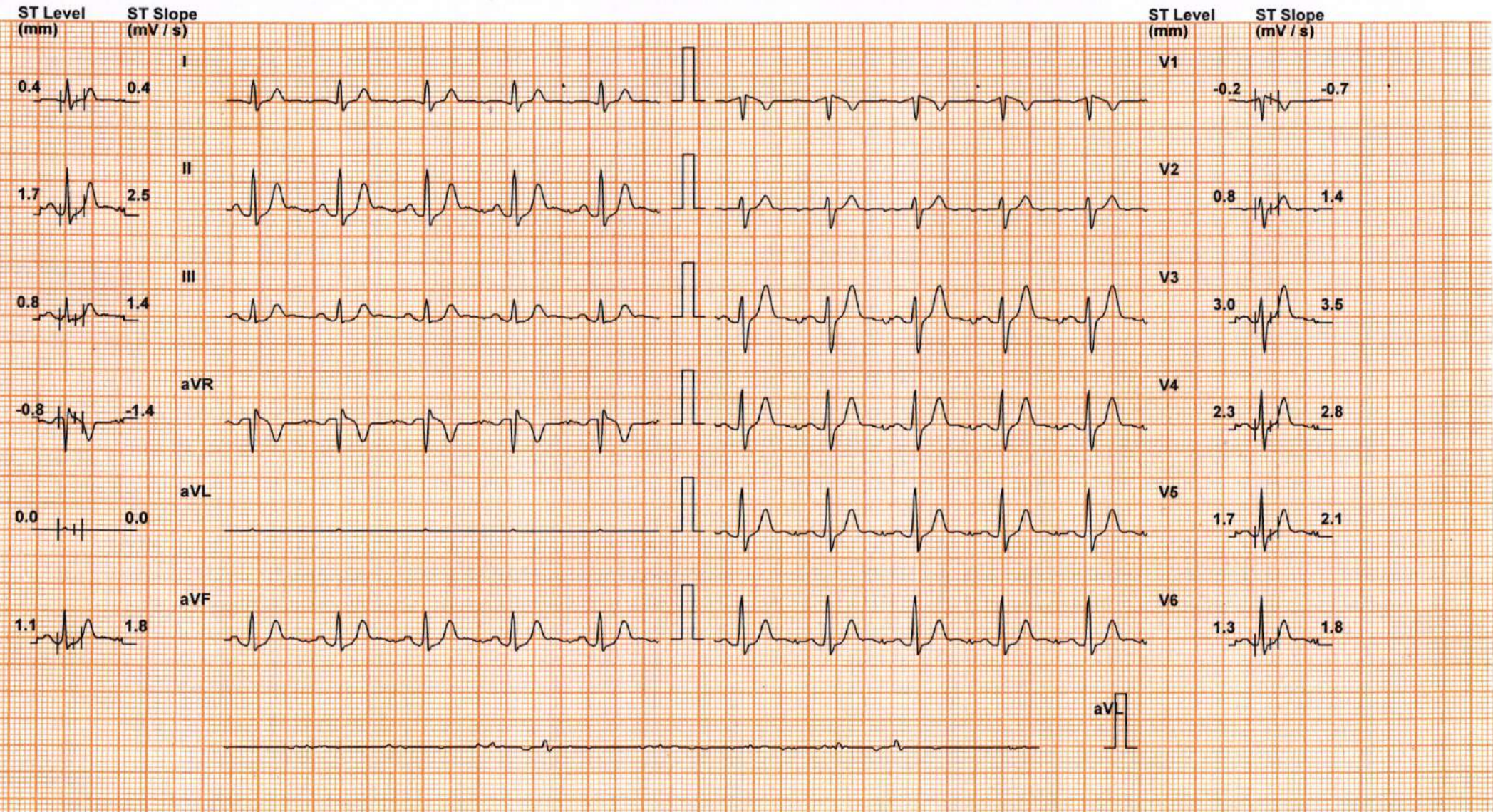


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Test Report

RAJESH RAMANKUTTY (44 M)

ID: WB009078

Date: 25-Feb-23

Exec Time : 8 m 11 s

Stage Time : 0 m 5 s

HR: 94 bpm

Protocol: Bruce

Stage: Recovery(3)

Speed: 0 mph

Grade: 0 %

(THR: 148 bpm)

B.P: 120 / 70

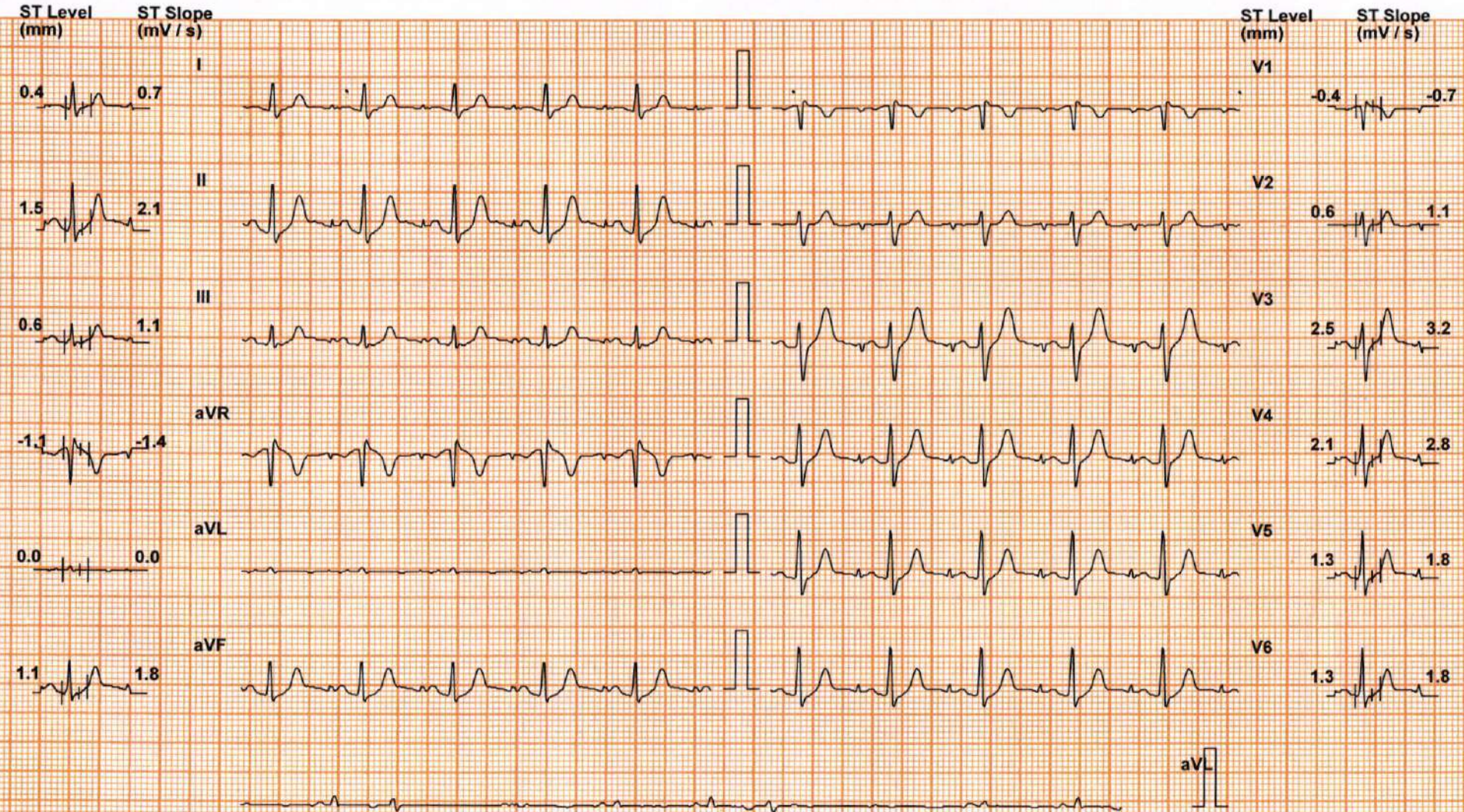


Chart Speed: 25 mm/sec

Filter: 35 Hz

Mains Filt: ON

Amp: 10 mm

Iso = R - 60 ms

J = R + 60 ms

Post J = J + 60 ms

Schiller Spandan V 4.7

Linked Median

DDRC SRL DIAGNOSTIC SERVICE PVT LTD

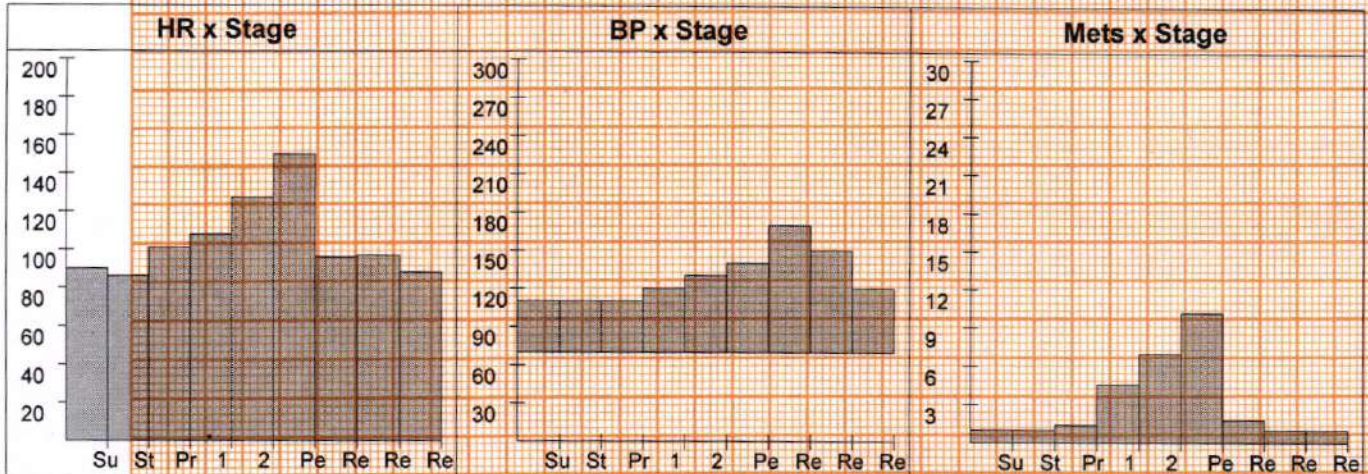
Patient Details **Date:** 25-Feb-23 **Time:** 10:34:32
Name: RAJESH RAMANKUTTY ID: WB009078
Age: 44 y **Sex:** M **Height:** 171 cms. **Weight:** 60 Kg.
Clinical History: NIL
Medications: NIL

Test Details

Protocol: Bruce **Pr.MHR:** 175 bpm **THR:** 148 (85 % of Pr.MHR) bpm
Total Exec. Time: 8 m 11 s **Max. HR:** 150 (86% of Pr.MHR) bpm **Max. Mets:** 10.20
Max. BP: 170 / 70 mmHg **Max. BP x HR:** 25500 mmHg/min **Min. BP x HR:** 6020 mmHg/min
Test Termination Criteria: Target HR attained

Protocol Details

Stage Name	Stage Time (min : sec)	Mets	Speed (mph)	Grade (%)	Heart Rate (bpm)	Max. BP (mm/Hg)	Max. ST Level (mm)	Max. ST Slope (mV/s)
Supine	0 : 40	1.0	0	0	90	110 / 70	-2.12 V2	-4.60 V2
Standing	0 : 11	1.0	0	0	86	110 / 70	-0.42 aVR	0.71 V2
1	3 : 0	4.6	1.7	10	108	120 / 70	-0.64 aVR	2.83 V2
2	3 : 0	7.0	2.5	12	127	130 / 70	-0.85 aVR	2.83 V3
Peak Ex	2 : 11	10.2	3.4	14	150	140 / 70	-1.06 aVR	4.60 V3
Recovery(1)	1 : 0	1.8	1	0	96	170 / 70	-1.70 aVR	5.66 V3
Recovery(2)	1 : 0	1.0	0	0	97	150 / 70	-1.06 aVR	3.89 V3
Recovery(3)	0 : 11	1.0	0	0	88	120 / 70	-0.85 aVR	2.12 V3



DDRC SRL DIAGNOSTIC SERVICE PVT LTD

Patient Details

Date: 25-Feb-23

Time: 10:34:32

Name: RAJESH RAMANKUTTY ID: WB009078

Age: 44 y

Sex: M

Height: 171 cms.

Weight: 60 Kg.

Interpretation

The patient exercised according to the Bruce protocol for 8 m 11 s achieving a work level of Max. METS : 10.20. Resting heart rate initially 90 bpm, rose to a max. heart rate of 150 (86% of Pr.MHR) bpm. Resting blood Pressure 110 / 70 mmHg, rose to a maximum blood pressure of 170 / 70 mmHg.No Angina,No Arrhythmia.

No significant ST changes
Test negative for inducible ischemia


Dr. George Thomas MD,FCSI,FIAE
Cardiologist



Ref. Doctor: MEDIWHEEL

Doctor: -----

(Summary Report edited by user)

NEF

MEDICAL EXAMINATION REPORT (MER)

If the examinee is suffering from an acute life threatening situation, you may be obliged to disclose the result of the medical examination to the examinee.

1. Name of the examinee	:	Mr./Mrs./Ms. <u>Rajesh Raman Kutty</u>
2. Mark of Identification	:	(Mole/Scar/any other (specify location)):
3. Age/Date of Birth	:	<u>7/8/1977 (45yrs)</u> Gender: F/M : <u>Male</u>
4. Photo ID Checked	:	(Passport/Election Card/PAN Card/Driving Licence/Company ID)

PHYSICAL DETAILS:

a. Height <u>173</u> (cms)	b. Weight <u>60</u> (Kgs)	c. Girth of Abdomen <u>82</u> (cms)
d. Pulse Rate <u>70</u> (/Min)	e. Blood Pressure:	Systolic <u>140</u> Diastolic <u>90</u>
	1 st Reading	
	2 nd Reading	

FAMILY HISTORY:

Relation	Age if Living	Health Status	If deceased, age at the time and cause
Father		/ NS	
Mother			
Brother(s)			
Sister(s)			

HABITS & ADDICTIONS: Does the examinee consume any of the following?

Tobacco in any form	Sedative	Alcohol
—	—	—

PERSONAL HISTORY

- a. Are you presently in good health and entirely free from any mental or Physical impairment or deformity. If No, please attach details. Hi ↑ BMI **Y/N**
- b. Have you undergone/been advised any surgical procedure? **Y/N**
- c. During the last 5 years have you been medically examined, received any advice or treatment or admitted to any hospital? **Y/N**
- d. Have you lost or gained weight in past 12 months? **Y/N**

Have you ever suffered from any of the following?

- Psychological Disorders or any kind of disorders of the Nervous System? **Y/N**
- Any disorders of Respiratory system? **Y/N**
- Any Cardiac or Circulatory Disorders? **Y/N**
- Enlarged glands or any form of Cancer/Tumour? **Y/N**
- Any Musculoskeletal disorder? **Y/N**
- Any disorder of Gastrointestinal System? **Y/N**
- Unexplained recurrent or persistent fever, and/or weight loss **Y/N**
- Have you been tested for HIV/HBsAg / HCV before? If yes attach reports **Y/N**
- Are you presently taking medication of any kind? Ayurvedic **Y/N**

- Any disorders of Urinary System? **Y/N**
- Any disorder of the Eyes, Ears, Nose, Throat or Mouth & Skin **Y/N**

FOR FEMALE CANDIDATES ONLY

- a. Is there any history of diseases of breast/genital organs? **Y/N**
- b. Is there any history of abnormal PAP Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports) **Y/N**
- c. Do you suspect any disease of Uterus, Cervix or Ovaries? **Y/N**
- d. Do you have any history of miscarriage/abortion or MTP **Y/N**
- e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc **Y/N**
- f. Are you now pregnant? If yes, how many months? **Y/N**

CONFIDENTIAL COMMENTS FROM MEDICAL EXAMINER

- Was the examinee co-operative? **Y/N**
- Is there anything about the examinee's health, lifestyle that might affect him/her in the near future with regard to his/her job? **Y/N**
- Are there any points on which you suggest further information be obtained? **Y/N**
- Based on your clinical impression, please provide your suggestions and recommendations below;


..... **NS**

.....


- Do you think he/she is **MEDICALLY FIT** or **UNFIT** for employment.

MEDICAL EXAMINER'S DECLARATION

I hereby confirm that I have examined the above individual after verification of his/her identity and the findings stated above are true and correct to the best of my knowledge.

Name & Signature of the Medical Examiner : 

Seal of Medical Examiner : 

Name & Seal of DDRC SRL Branch : 

Date & Time :

DDRC SRL Diagnostics Limited

Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036
Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

Regd. Office: 4th Floor, Prime Square, Plot No.1, Gaiwadi Industrial Estate, S.V. Road, Goregaon (West), Mumbai – 400062.


ഭാരത സർക്കാർ
Government of India
 രാജേഷ് രാമൻകുട്ടി
Rajesh Ramankutty


 ജനന തീയതി / DOB: 07/08/1977
 പുരുഷൻ / Male
6393 9146 4201



എന്റെ ആധാർ, എന്റെ ഐഡന്റിറ്റി




ഭാരതീയ സർവ്വീസേഷൻ തിരിച്ചറിയൽ അതോറിറ്റി
Unique Identification Authority of India

മേഖല: മലപ്പുറം ജില്ല, തിരുവിതാംകൂർ, തൃശ്ശൂർ, പാഡ്, കേരളം, 680699
Address: S/O: Ramankutty, Azhakath House, East Kodaly, East Kodaly, Vellikulangara, Thrissur, Pady, Kerala, 680699

6393 9146 4201

 1947
  help@uidai.gov.in
  www.uidai.gov.in

Handwritten signature in blue ink.

From

Rajesh Ramankutty

To

DDRC SRL

Sub: Medical checkup regarding

In the above connection, I would like to inform you
I don't require the following test/check

- ① Dental
- ② Molar Sample.

Thanking You



Rajesh
Yours truly
25/2/22
cochin



Patient Ref. No. 66600003527302

CLIENT CODE : CA00008282 - BANK OF BARODA
 CLIENT'S NAME AND ADDRESS:

BANK OF BARODA - MEDI ASSIST
 MEDI ASSIST HEALTHCARE SERVICE TOWER D, 4TH FLOOR, IBC
 KNOWLEDGE PARK, 4/1 BANNERGHATTA ROAD, BHAVANI NAGA
 BENGALURU
 BENGALURU 560029
 KARNATAKA INDIA
 9742187722



Cert. No. MC-2354

DDRC SRL DIAGNOSTICS
 DDRC SRL Tower, G-131, Panampilly Nagar,
 PANAMPALLY NAGAR, 682036
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

PATIENT NAME : RAJESH RAMANKUTTY

PATIENT ID : RAJEM2502784126

ACCESSION NO : 4126WB009078 AGE : 45 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 25/02/2023 08:59

REPORTED : 25/02/2023 16:00

REFERRING DOCTOR : DR. BOB

CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
Preliminary			

MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT*** TREADMILL TEST**

TREADMILL TEST

TEST COMPLETED

OPHTHAL

OPHTHAL

TEST COMPLETED



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CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	9	Adult(<60 yrs) : 6 to 20	mg/dL
METHOD : UREASE - UV			

BUN/CREAT RATIO

BUN/CREAT RATIO	8.49		
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CREATININE, SERUM

CREATININE	1.06	18 - 60 yrs : 0.9 - 1.3	mg/dL
METHOD : JAFFE KINETIC METHOD			

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	79	Diabetes Mellitus : > or = 200. Impaired Glucose tolerance/ Prediabetes : 140 - 199. Hypoglycemia : < 55.	mg/dL
METHOD : HEXOKINASE			

GLUCOSE FASTING, FLUORIDE PLASMA

GLUCOSE, FASTING, PLASMA	89	Diabetes Mellitus : > or = 126. Impaired fasting Glucose/ Prediabetes : 101 - 125. Hypoglycemia : < 55.	mg/dL
METHOD : HEXOKINASE			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	4.5	Normal : 4.0 - 5.6%. % Non-diabetic level : < 5.7%. Diabetic : >6.5%	
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 Glycemic control goal
 More stringent goal : < 6.5 %.
 General goal : < 7%.
 Less stringent goal : < 8%.

 Glycemic targets in CKD :-
 If eGFR > 60 : < 7%.
 If eGFR < 60 : 7 - 8.5%.

MEAN PLASMA GLUCOSE	82.5	< 116.0	mg/dL
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LIPID PROFILE, SERUM

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Test Report Status	Preliminary	Results	Units
CHOLESTEROL		168	mg/dL
METHOD : CHOD-POD			
TRIGLYCERIDES		55	mg/dL
HDL CHOLESTEROL		52	mg/dL
METHOD : DIRECT ENZYME CLEARANCE			
DIRECT LDL CHOLESTEROL		105	mg/dL
NON HDL CHOLESTEROL		116	mg/dL
VERY LOW DENSITY LIPOPROTEIN		11.0	mg/dL
CHOL/HDL RATIO		3.2	mg/dL
LDL/HDL RATIO		2.0	mg/dL

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

Normal : < 150
 High : 150-199
 Hypertriglyceridemia : 200-499
 Very High : > 499

General range : 40-60

Optimum : < 100
 Above Optimum : 100-139
 Borderline High : 130-159
 High : 160-189
 Very High : >or= 190

Desirable: Less than 130
 Above Desirable: 130 - 159
 Borderline High: 160 - 189
 High: 190 - 219
 Very high: > or = 220

Desirable value : 10 - 35

Low 3.3-4.4 Low Risk
 4.5-7.0 Average Risk
 7.1-11.0 Moderate Risk
 > 11.0 High Risk

0.5 - 3.0 Desirable/Low Risk
 3.1 - 6.0 Borderline/Moderate Risk
 >6.0 High Risk



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Interpretation(s)

1) Cholesterol levels help assess the patient risk status and to follow the progress of patient under treatment to lower serum cholesterol concentrations.

2) Serum Triglyceride (TG) are a type of fat and a major source of energy for the body. Both quantity and composition of the diet impact on plasma triglyceride concentrations. Elevations in TG levels are the result of overproduction and impaired clearance. High TG are associated with increased risk for CAD (Coronary artery disease) in patients with other risk factors, such as low HDL-C, some patient groups with elevated apolipoprotein B concentrations, and patients with forms of LDL that may be particularly atherogenic.

3) HDL-C plays a crucial role in the initial step of reverse cholesterol transport, this considered to be the primary atheroprotective function of HDL

4) LDL -C plays a key role in causing and influencing the progression of atherosclerosis and, in particular, coronary sclerosis. The majority of cholesterol stored in atherosclerotic plaques originates from LDL, thus LDL-C value is the most powerful clinical predictor.

5) Non HDL cholesterol: Non-HDL-C measures the cholesterol content of all atherogenic lipoproteins, including LDL hence it is a better marker of risk in both primary and secondary prevention studies. Non-HDL-C also covers, to some extent, the excess ASCVD risk imparted by the sdLDL, which is significantly more atherogenic than the normal large buoyant particles, an elevated non-HDL-C indirectly suggests greater proportion of the small, dense variety of LDL particles

Serum lipid profile is measured for cardiovascular risk prediction. Lipid Association of India recommends LDL-C as primary target and Non HDL-C as co-primary treatment target.

Risk Stratification for ASCVD (Atherosclerotic cardiovascular disease) by Lipid Association of India

Risk Category	
Extreme risk group	A. CAD with > 1 feature of high risk group B. CAD with > 1 feature of Very high risk group or recurrent ACS (within 1 year) despite LDL-C < or = 50 mg/dl or polyvascular disease
Very High Risk	1. Established ASCVD 2. Diabetes with 2 major risk factors or evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia
High Risk	1. Three major ASCVD risk factors. 2. Diabetes with 1 major risk factor or no evidence of end organ damage. 3. CKD stage 3B or 4. 4. LDL >190 mg/dl 5. Extreme of a single risk factor. 6. Coronary Artery Calcium - CAC >300 AU. 7. Lipoprotein a >= 50mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age > or = 45 years in males and > or = 55 years in females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by LAI in 2020.

Risk Group	Treatment Goals		Consider Drug Therapy	
	LDL-C (mg/dl)	Non-HDL (mg/dl)	LDL-C (mg/dl)	Non-HDL (mg/dl)



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PATIENT NAME : RAJESH RAMANKUTTY

PATIENT ID : RAJEM2502784126

ACCESSION NO : 4126WB009078 AGE : 45 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 25/02/2023 08:59

REPORTED : 25/02/2023 16:00

REFERRING DOCTOR : DR. BOB

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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Extreme Risk Group Category A	<50 (Optional goal < OR = 30)	< 80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	<OR = 30	<OR = 60	> 30	>60
Very High Risk	<50	<80	>OR= 50	>OR= 80
High Risk	<70	<100	>OR= 70	>OR= 100
Moderate Risk	<100	<130	>OR= 100	>OR= 130
Low Risk	<100	<130	>OR= 130*	>OR= 160

*After an adequate non-pharmacological intervention for at least 3 months.

References: Management of Dyslipidaemia for the Prevention of Stroke: Clinical Practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology, 2022, 20, 134-155.

LIVER FUNCTION TEST WITH GGT

BILIRUBIN, TOTAL METHOD : DIAZO METHOD	0.56	General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZO METHOD	0.26	General Range : < 0.3	mg/dL
BILIRUBIN, INDIRECT	0.30	0.00 - 0.60	mg/dL
TOTAL PROTEIN	6.9	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
ALBUMIN	4.6	20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.3	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	1.9	1.00 - 2.00	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	14	Adults : < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : IFCC WITHOUT PDP	15	Adults : < 45	U/L
ALKALINE PHOSPHATASE METHOD : IFCC	55	Adult(<60yrs) : 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	16	Adult (Male) : < 60	U/L
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN METHOD : BIURET	6.9	Ambulatory : 6.4 - 8.3 Recumbant : 6 - 7.8	g/dL
URIC ACID, SERUM			



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Patient Ref. No. 66600003527302

CLIENT CODE : CA00008282 - BANK OF BARODA

CLIENT'S NAME AND ADDRESS:

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ABHA NO :

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URIC ACID		5.2	mg/dL
METHOD : SPECTROPHOTOMETRY			
ABO GROUP & RH TYPE, EDTA WHOLE BLOOD			
ABO GROUP		O	
METHOD : GEL CARD METHOD			
RH TYPE		POSITIVE	
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN		14.6	g/dL
METHOD : NON CYANMETHEMOGLOBIN			
RED BLOOD CELL COUNT		4.25	mil/ μ L
METHOD : IMPEDANCE			
WHITE BLOOD CELL COUNT		4.35	thou/ μ L
METHOD : IMPEDANCE			
PLATELET COUNT		204	thou/ μ L
METHOD : IMPEDANCE			
RBC AND PLATELET INDICES			
HEMATOCRIT		43.1	%
METHOD : CALCULATED			
MEAN CORPUSCULAR VOL		101.2	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			
MEAN CORPUSCULAR HGB.		34.2	pg
METHOD : CALCULATED			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION		33.8	g/dL
METHOD : CALCULATED			
RED CELL DISTRIBUTION WIDTH		14.9	%
MENTZER INDEX		23.8	
MEAN PLATELET VOLUME		8.5	fL
METHOD : DERIVED FROM IMPEDANCE MEASURE			
WBC DIFFERENTIAL COUNT			
SEGMENTED NEUTROPHILS		55	%
METHOD : DHSS FLOWCYTOMETRY			
LYMPHOCYTES		36	%
METHOD : DHSS FLOWCYTOMETRY			
MONOCYTES		7	%
METHOD : DHSS FLOWCYTOMETRY			



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EOSINOPHILS		2	1 - 6 %
METHOD : DHSS FLOWCYTOMETRY			
BASOPHILS		0	0 - 2 %
METHOD : IMPEDANCE			
ABSOLUTE NEUTROPHIL COUNT		2.39	2.0 - 7.0 thou/ μ L
ABSOLUTE LYMPHOCYTE COUNT		1.57	1 - 3 thou/ μ L
ABSOLUTE MONOCYTE COUNT		0.30	0.20 - 1.00 thou/ μ L
ABSOLUTE EOSINOPHIL COUNT		0.09	0.02 - 0.50 thou/ μ L
ABSOLUTE BASOPHIL COUNT		0.00	0.00 - 0.10 thou/ μ L
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.5	
ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD			
SEDIMENTATION RATE (ESR)		04	0 - 14 mm at 1 hr
METHOD : WESTERGREEN METHOD			
* SUGAR URINE - POST PRANDIAL			
SUGAR URINE - POST PRANDIAL		NOT DETECTED	NOT DETECTED
PROSTATE SPECIFIC ANTIGEN, SERUM			
PROSTATE SPECIFIC ANTIGEN		0.582	Age Specific :- <49yrs : <2.5 50-59yrs : <3.5 60-69yrs : <4.5 >70yrs : <6.5 ng/mL
METHOD : ECLIA			
THYROID PANEL, SERUM			
T3		105.40	80 - 200 ng/dL
METHOD : ELECTROCHEMILUMINESCENCE			
T4		6.63	5.1 - 14.1 μ g/dl
METHOD : ELECTROCHEMILUMINESCENCE			
TSH 3RD GENERATION		1.330	21-50 yrs : 0.4 - 4.2 μ IU/mL
METHOD : ELECTROCHEMILUMINESCENCE			



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Interpretation(s)

Triiodothyronine T3, Thyroxine T4, and Thyroid Stimulating Hormone TSH are thyroid hormones which affect almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate.

Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated concentrations of T3, and T4 in the blood inhibit the production of TSH.

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

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

Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3. Measurement of the serum TT3 level is a more sensitive test for the diagnosis of hyperthyroidism, and measurement of TT4 is more useful in the diagnosis of hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the circulating hormone is free and biologically active. It is advisable to detect Free T3, FreeT4 along with TSH, instead of testing for albumin bound Total T3, Total T4.

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

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

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

PHYSICAL EXAMINATION, URINE

COLOR

PALE YELLOW

APPEARANCE

CLEAR

CHEMICAL EXAMINATION, URINE

PH

6.5

4.8 - 7.4

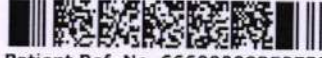


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PATIENT NAME : RAJESH RAMANKUTTY

PATIENT ID : RAJEM2502784126

ACCESSION NO : 4126WB009078 AGE : 45 Years SEX : Male

ABHA NO :

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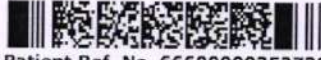
Test Report Status	Preliminary	Results	Units
SPECIFIC GRAVITY		1.015	1.015 - 1.030
PROTEIN		NOT DETECTED	NOT DETECTED
GLUCOSE		NOT DETECTED	NOT DETECTED
KETONES		NOT DETECTED	NOT DETECTED
BLOOD		NOT DETECTED	NOT DETECTED
BILIRUBIN		NOT DETECTED	NOT DETECTED
UROBILINOGEN		NORMAL	NORMAL
NITRITE		NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED /HPF
WBC		1-2	0-5 /HPF
EPITHELIAL CELLS		0-1	0-5 /HPF
CASTS		NOT DETECTED	
CRYSTALS		NOT DETECTED	
BACTERIA		NOT DETECTED	NOT DETECTED
YEAST		NOT DETECTED	NOT DETECTED



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Test Report Status	Preliminary	Results	Units
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Interpretation(s)

The following table describes the probable conditions, in which the analytes are present in urine

Presence of	Conditions
Proteins	Inflammation or immune illnesses
Pus (White Blood Cells)	Urinary tract infection, urinary tract or kidney stone, tumors or any kind of kidney impairment
Glucose	Diabetes or kidney disease
Ketones	Diabetic ketoacidosis (DKA), starvation or thirst
Urobilinogen	Liver disease such as hepatitis or cirrhosis
Blood	Renal or genital disorders/trauma
Bilirubin	Liver disease
Erythrocytes	Urological diseases (e.g. kidney and bladder cancer, urolithiasis), urinary tract infection and glomerular diseases
Leukocytes	Urinary tract infection, glomerulonephritis, interstitial nephritis either acute or chronic, polycystic kidney disease, urolithiasis, contamination by genital secretions
Epithelial cells	Urolithiasis, bladder carcinoma or hydronephrosis, ureteric stents or bladder catheters for prolonged periods of time
Granular Casts	Low intratubular pH, high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts	Physical stress, fever, dehydration, acute congestive heart failure, renal diseases
Calcium oxalate	Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of vitamin C, the use of vasodilator naftidofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit (Averrhoa carambola) or its juice
Uric acid	arthritis
Bacteria	Urinary infection when present in significant numbers & with pus cells.
Trichomonas vaginalis	Vaginitis, cervicitis or salpingitis

*** SUGAR URINE - FASTING**

SUGAR URINE - FASTING

NOT DETECTED

NOT DETECTED

*** PHYSICAL EXAMINATION, STOOL**

RESULT PENDING

*** CHEMICAL EXAMINATION, STOOL**

RESULT PENDING

*** MICROSCOPIC EXAMINATION, STOOL**

RESULT PENDING



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Interpretation(s)

Stool routine analysis is only a screening test for disorders of gastrointestinal tract like infection, malabsorption, etc. The following table describes the probable conditions, in which the analytes are present in stool.

PRESENCE OF	CONDITION
Pus cells	Pus in the stool is an indication of infection
Red Blood cells	Parasitic or bacterial infection or an inflammatory bowel condition such as ulcerative colitis
Parasites	Infection of the digestive system. Stool examination for ova and parasite detects presence of parasitic infestation of gastrointestinal tract. Various forms of parasite that can be detected include cyst, trophozoite and larvae. One negative result does not rule out the possibility of parasitic infestation. Intermittent shedding of parasites warrants examinations of multiple specimens tested on consecutive days. Stool specimens for parasitic examination should be collected before initiation of antidiarrheal therapy or antiparasitic therapy. This test does not detect presence of opportunistic parasites like Cyclospora, Cryptosporidia and Isospora species. Examination of Ova and Parasite has been carried out by direct and concentration techniques.
Mucus	Mucus is a protective layer that lubricates, protects & reduces damage due to bacteria or viruses.
Charcot-Leyden crystal	Parasitic diseases.
Ova & cyst	Ova & cyst indicate parasitic infestation of intestine.
Frank blood	Bleeding in the rectum or colon.
Occult blood	Occult blood indicates upper GI bleeding.
Macrophages	Macrophages in stool are an indication of infection as they are protective cells.
Epithelial cells	Epithelial cells that normally line the body surface and internal organs show up in stool when there is inflammation or infection.
Fat	Increased fat in stool may be seen in conditions like diarrhoea or malabsorption.
pH	Normal stool pH is slightly acidic to neutral. Breast-fed babies generally have an acidic stool.

ADDITIONAL STOOL TESTS :

- Stool Culture**:- This test is done to find cause of GI infection, make decision about best treatment for GI infection & to find out if treatment for GI infection worked.
- Fecal Calprotectin**: It is a marker of intestinal inflammation. This test is done to differentiate Inflammatory Bowel Disease (IBD) from Irritable Bowel Syndrome (IBS).
- Fecal Occult Blood Test (FOBT)**: This test is done to screen for colon cancer & to evaluate possible cause of unexplained anaemia.
- Clostridium Difficile Toxin Assay**: This test is strongly recommended in healthcare associated bloody or watery diarrhoea, due to overuse of broad spectrum antibiotics which alter the normal GI flora.
- Biofire (Film Array) GI PANEL**: In patients of Diarrhoea, Dysentery, Rice watery Stool, FDA approved, Biofire Film Array Test, (Real Time Multiplex PCR) is strongly recommended as it identifies organisms, bacteria, fungi, virus, parasite and other opportunistic pathogens, Vibrio cholera infections only in 3 hours. Sensitivity 96% & Specificity 99%.



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6. **Rota Virus Immunoassay:** This test is recommended in severe gastroenteritis in infants & children associated with watery diarrhoea, vomiting & abdominal cramps. Adults are also affected. It is highly contagious in nature.

Interpretation(s)

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
 Causes of decreased level include Liver disease, SIADH.

CREATININE, SERUM- Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

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

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 glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HbA1c), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
 - II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
 - III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
 - IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
 - a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy



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 KARNATAKA INDIA
 9742187722



Cert. No. MC-2354

DDRC SRL DIAGNOSTICS
 DDRC SRL Tower, G-131, Panampilly Nagar,
 PANAMPALLY NAGAR, 682036
 KERALA, INDIA
 Tel : 93334 93334
 Email : customercare.ddrc@srl.in

PATIENT NAME : RAJESH RAMANKUTTY

PATIENT ID : RAJEM2502784126

ACCESSION NO : 4126WB009078 AGE : 45 Years SEX : Male

ABHA NO :

DRAWN :

RECEIVED : 25/02/2023 08:59

REPORTED : 25/02/2023 16:00

REFERRING DOCTOR : DR. BOB

CLIENT PATIENT ID :

Test Report Status	Preliminary	Results	Units
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TOTAL PROTEIN, SERUM-Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
 Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

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

Causes of decreased levels-Low Zinc Intake,OCP, Multiple Sclerosis

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.

BLOOD COUNTS, EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13)

from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504 This ratio element is a calculated parameter and out of NABL scope.

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 BRU in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(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.

SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT'S TEST

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 is 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 lines-



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Patient Ref. No. 66600003527302

CLIENT CODE : CA00008282 - BANK OF BARODA

CLIENT'S NAME AND ADDRESS:

BANK OF BARODA - MEDI ASSIST
 MEDI ASSIST HEALTHCARE SERVICE TOWER D, 4TH FLOOR, IBC
 KNOWLEDGE PARK, 4/1 BANNERGHATTA ROAD, BHAVANI NAGA
 BENGALURU
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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)

References- Teitz ,textbook of clinical chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests
 SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST

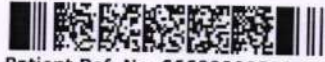


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MEDIWHEEL HEALTH CHECKUP ABOVE 40(M)TMT

* ECG WITH REPORT

REPORT

TEST COMPLETED

* USG ABDOMEN AND PELVIS

REPORT

TEST COMPLETED

* CHEST X-RAY WITH REPORT

REPORT

TEST COMPLETED

End Of Report

Please visit www.srlworld.com for related Test Information for this accession
 TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

DR.HARI SHANKAR, MBBS MD
 (Reg No - TCMC:62092)
 HEAD - Biochemistry &
 Immunology

DR.VIJAY K N, MBBS MD(PATH)
 (Reg No - KMC:91816)
 HEAD-HAEMATOLOGY &
 CLINICAL PATHOLOGY

DR.SMITHA PAULSON, MD
 (PATH), DPB
 (Reg No - TCMC:35960)
 LAB DIRECTOR & HEAD-
 HISTOPATHOLOGY &
 CYTOLOGY



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Scan to View Report

NAME: MR RAJESH RAMANKUTTY	STUDY DATE 25/02/2023
AGE / SEX : 45 YRS / M	REPORTING DATE 25/02/2023
REFERRED BY :BOB	ACC NO : 4126WB009078

X - RAY - CHEST PA VIEW

- Both the lung fields are clear.
- B/L hila and mediastinal shadows are normal.
- Cardiac silhouette appears normal.
- Cardio - thoracic ratio is normal.
- Bilateral CP angles and domes of diaphragm appear normal.

IMPRESSION: NORMAL STUDY

Kindly correlate clinically

Navneet
Dr. NAVNEET KAUR, MBBS,MD
Consultant Radiologist.



RAJESH RAMANKUTTY

Male 45 Years

Handwritten signature

HR	: 79	bpm
P	: 89	ms
PR	: 144	ms
QRS	: 75	ms
QT/QTc	: 343/394	ms
P/QRS/T	: 61/35/37	°
RV5/SV1	: 1025/0.549	mV

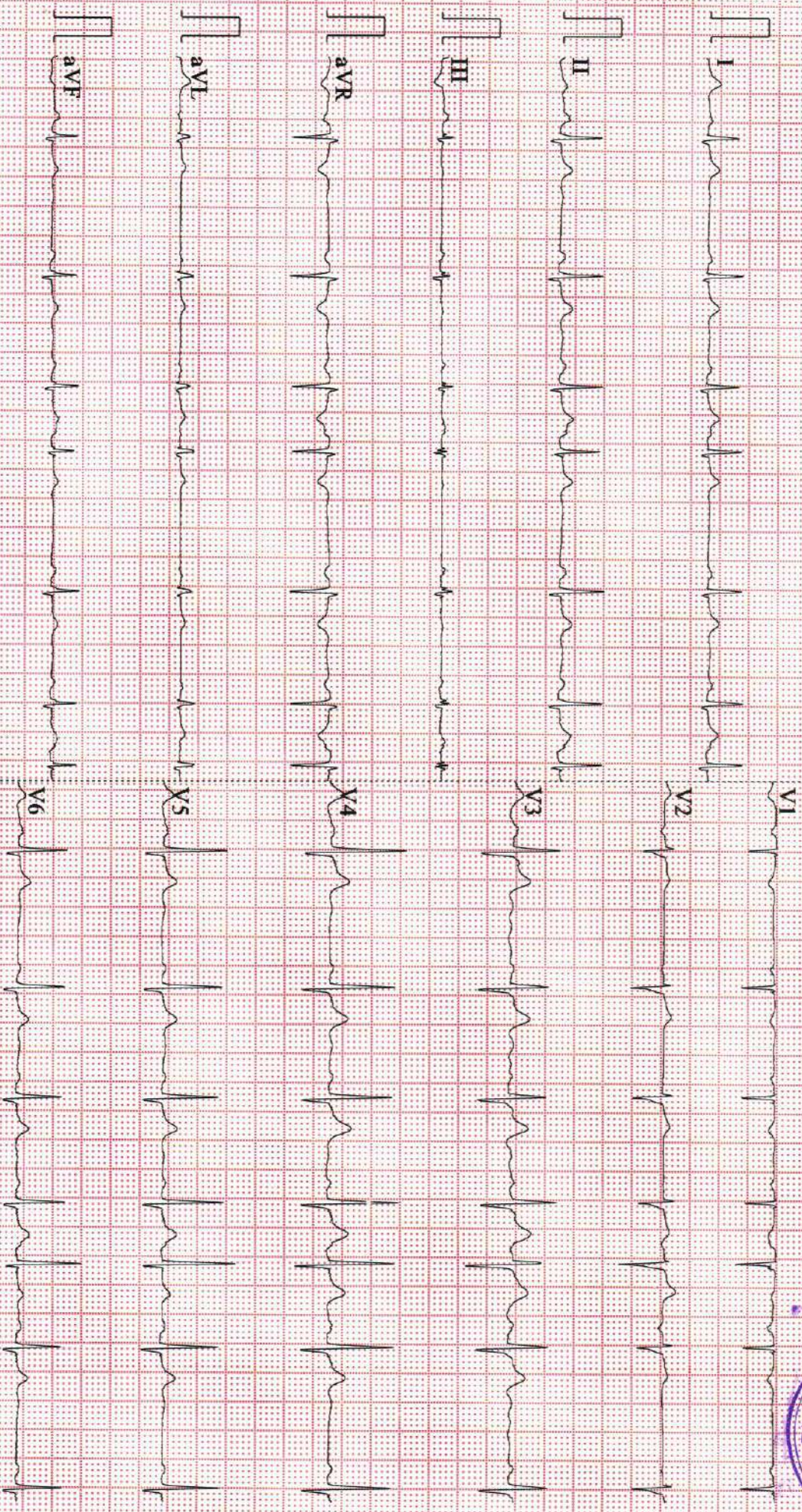
Diagnosis Information:

Functional premature beats

Handwritten signature

Technician : MAREETA
 Ref-Phys. : BOB - MEDI ASSIST
 Report Confirmed by:

DR GEORGE THOMAS
 MD FCSI, FIAE
 CARDIOLOGIST



Date...25.02.2023

OPHTHALMOLOGY REPORT

This is to certify that I have examined

Mr / Ms : Rajesh Ramankutty.....Aged...45.....and his / her

visual standards is as follows :

Visual Acuity:

For far vision

R: 6/6.....

L: 6/6.....

For near vision

R: N10.....

L: N10.....

*EDUX R N6
L N6*

Color Vision : Normal.....

.....



Nannu Elizabeth

Nannu Elizabeth


(Optometrist)

NAME	MR RAJESH RAMANKUTTY	AGE	45 YRS
SEX	MALE	DATE	February 25, 2023
REFERRAL	BANK OF BARODA	ACC NO	4126WB009078

USG ABDOMEN AND PELVIS

LIVER	Measures ~ 10.8 cm. Normal echotexture. Smooth margins and no obvious focal lesion within. No IHBR dilatation. Portal vein normal in caliber .
GB	Partially contracted.
SPLEEN	Measures ~ 9.8 cm, normal to visualized extent. Splenic vein normal.
PANCREAS	Normal to visualized extent. PD is not dilated.
KIDNEYS	RK: 8.6 x4.1 cm, appears normal in size and echotexture LK: 9.4 x 4.3 cm, appears normal in size and echotexture. No focal lesion / calculus within. Maintained corticomedullary differentiation and normal parenchymal thickness. No hydroureteronephrosis.
BLADDER	Normal wall caliber, no internal echoes/calculus within.
PROSTATE	Normal in volume (19 cc)and echopattern.
NODES/FLUID	Nil to visualized extent.
BOWEL	Visualized bowel loops appear normal.
IMPRESSION	⚡ No significant abnormality in the present study

Kindly correlate clinically.


Dr. NAVNEET KAUR MBBS . MD
 Consultant Radiologist

Thank you for referral. Your feedback will be appreciated.

NOTE: This report is only a professional opinion based on the real time image finding and not a diagnosis by itself. It has to be correlated and interpreted with clinical and other investigation findings. Review scan is advised, if this ultrasound opinion and other clinical findings / reports don't correlate.

