



DEPARTMENT OF RADIOLOGY

Date: 28/Jan/2023

Name: Mr. Akshay Rao

UHID | Episode No : 4609601 | 5562/23/1501

Age | Sex: 33 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2301/11372 | 28-Jan-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 28-Jan-2023 11:55:58

Bed Name :

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax are unremarkable.

DR. CHETAN KHADKE
M.D. (Radiologist)



DEPARTMENT OF RADIOLOGY

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Age | Sex: 33 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 4609601 | 5562/23/1501

Order No | Order Date: 1501/PN/OP/2301/11372 | 28-Jan-2023

Admitted On | Reporting Date : 28-Jan-2023 09:42:54

Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

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

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

SPLEEN is normal in size and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis. Right kidney measures 10.1 x 4.0 cm. Left kidney measures 10.0 x 4.5 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 8.4 cc in volume.

No evidence of ascites.

IMPRESSION:

- No significant abnormality is detected.


DR. CHETAN KHADKE
M.D. (Radiologist)

BMI CHART

Date: ___ / ___ / ___

Name: Akshay Rao

Age: ___ yrs

Sex: M / F

BP: 110/70 mmHg Height (cms): 173 cm Weight(kgs): 78.8 kg BMI: _____

WEIGHT lbs kgs	HEIGHT in/cm																																									
	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42																		
100	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42																		
105	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40																			
110	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40																			
115	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39																			
120	17	18	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38																			
125	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38																			
130	16	17	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37																			
135	16	17	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37																			
140	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37																			
145	15	16	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36																			
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170	14	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35																			
175	13	14	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34																			
180	13	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34																			
185	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34																			
190	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34																			
195	12	13	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																			
200	12	13	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																			
205	12	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																			
210	12	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																			
215	12	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33																			

Doctors Notes:

Signature

Hiranandani Healthcare Pvt. Ltd.
 Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
 Board Line: 022 - 39199222 | Fax: 022 - 39199220
 Emergency: 022 - 39199100 | Ambulance: 1255
 For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
 www.fortishealthcare.com |
 CIN : U85100MH2005PTC154823
 GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani
 HOSPITAL

UHID	4609601	Date	28/01/2023	
Name	Mr. Akshay Rao	Sex	Male	Age 32
OPD	Opthal 14			

Drug allergy: → Not known.
 Sys illness: No.

Qr. No.

Mr. No.

U. I. V. → R. 6/6.
 → L. 6/6.

M.V. → R. No
 → L. No.

I. O. P. → R. 13.5
 → L. 13.4

of: R/S,

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Hiranandani
 HOSPITAL

UHID	4609601	Date	28/01/2023
Name	Mr. Akshay Rao	Sex	Male
OPD	Dental 12	Age	32

Drug allergy:
 Sys illness:

Impacted $\frac{8}{8}$

Carries $\frac{6}{67}$

stains at calculus +

Treatment

Adv. surgical removal $\frac{8}{8}$

Adv. filling $\frac{6}{67}$

Adv. oral prophylaxis.

Dr. Disha Kete

LABORATORY REPORT



CLIENT CODE : C000045507
CLIENT'S NAME AND ADDRESS :
FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001
MAHARASHTRA INDIA

SRL Ltd
BHOO MI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR 4,
KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 9111591115,
CIN - U74899PB1995PLC045956

PATIENT ID : **FH.4609601**

PATIENT NAME : **MR.AKSHAY RAO**

ACCESSION NO : **0022WA005471** AGE : 33 Years SEX : Male
DRAWN : 28/01/2023 08:44:00 RECEIVED : 28/01/2023 08:44:05

ABHA NO :
REPORTED : 28/01/2023 14:10:22
CLIENT PATIENT ID : UID:4609601

REFERRING DOCTOR : SELF
CLINICAL INFORMATION :
UID:4609601 REQNO-1363889
CORP-OPD
BILLNO-150123OPCR005439
BILLNO-150123OPCR005439

Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM	Results	Biological Reference Interval	Units
T3 METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	108.30	80 - 200	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	7.49	5.1 - 14.1	µg/dL
TSH (ULTRASENSITIVE) METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	3.660	0.270 - 4.200	µIU/mL

Interpretation(s)



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DRAWN : 28/01/2023 08:44:00

RECEIVED : 28/01/2023 08:44:05

REPORTED : 28/01/2023 14:10:22

CLIENT PATIENT ID : UID:4609601

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM

PROSTATE SPECIFIC ANTIGEN	0.844	< 1.4	ng/mL
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METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatic hyperplasia (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.

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

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 chemiistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

786

Dr. Swapnil Sirmukaddam
Consultant Pathologist



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Page 2 0



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LABORATORY REPORT



Cert. No. MC-2275

CLIENT CODE : C000045507

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FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

SRL Ltd
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NAVI MUMBAI, 400703
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ABHA NO :

DRAWN : 28/01/2023 08:44:00

RECEIVED : 28/01/2023 08:44:05

REPORTED : 28/01/2023 13:56:16

CLIENT PATIENT ID : UID:4609601

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CORP-OPD

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Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

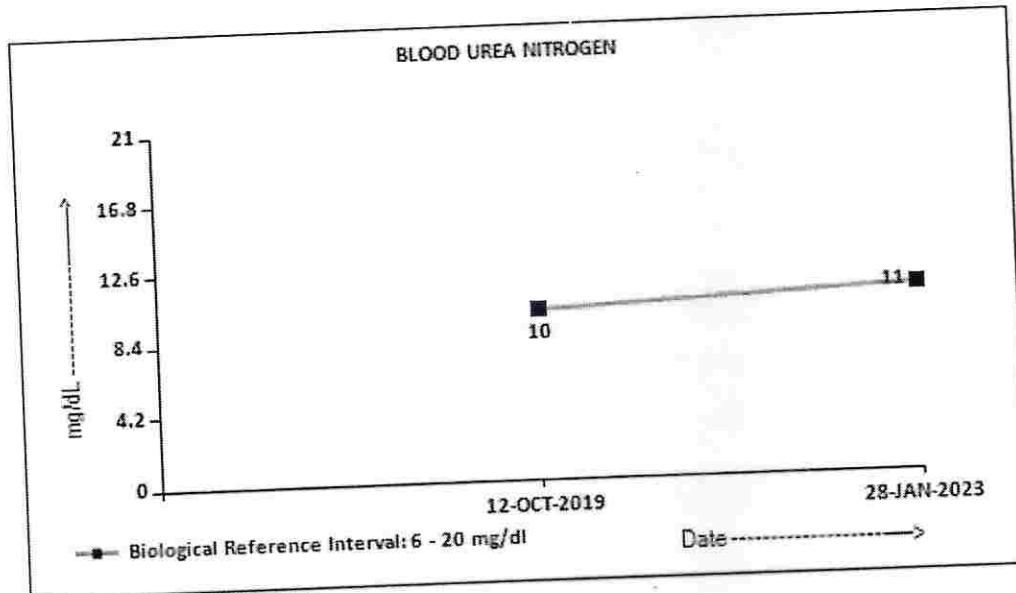
BLOOD UREA NITROGEN

11

6 - 20

mg/dL

METHOD : UREASE - UV



CREATININE EGFR- EPI

CREATININE

1.14

0.90 - 1.30

mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

33

years

GLOMERULAR FILTRATION RATE (MALE)

87.09

Refer Interpretation Below

mL/min/1

METHOD : CALCULATED PARAMETER



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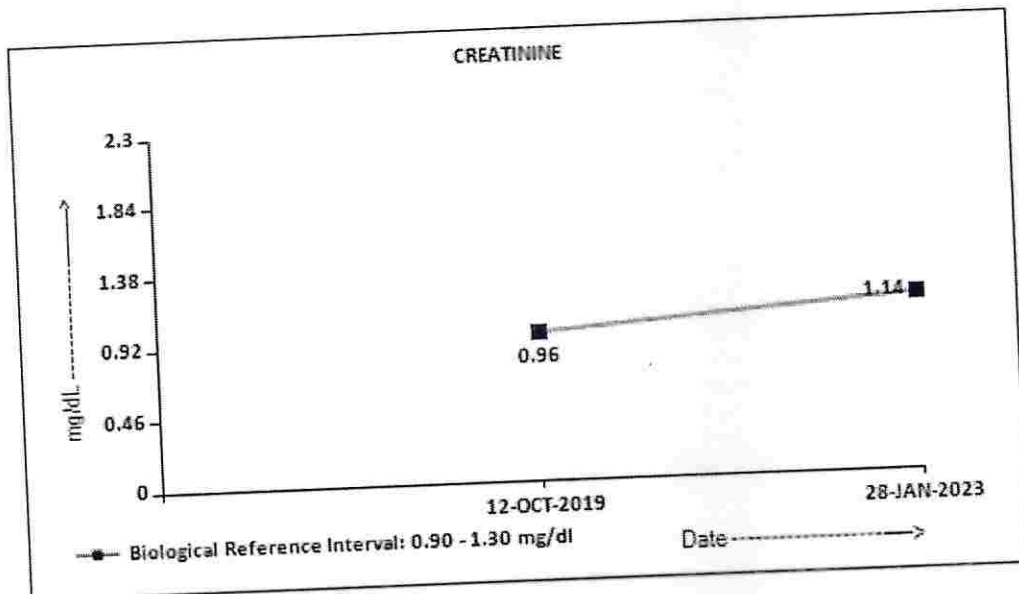
PATIENT NAME : MR.AKSHAY RAO PATIENT ID : **FH.4609601**
 ACCESSION NO : **0022WA005471** AGE : 33 Years SEX : Male ABHA NO :
 DRAWN : 28/01/2023 08:44:00 RECEIVED : 28/01/2023 08:44:05 REPORTED : 28/01/2023 13:56:16
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Test Report Status	Final	Results	Biological Reference Interval	Units
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BUN/CREAT RATIO	9.65	5.00 - 15.00	
BUN/CREAT RATIO METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM	4.6	3.5 - 7.2	mg/dL
URIC ACID METHOD : URICASE UV			
TOTAL PROTEIN, SERUM	7.5	6.4 - 8.2	g/dL
TOTAL PROTEIN METHOD : BIURET			
ALBUMIN, SERUM	4.2	3.4 - 5.0	g/dL
ALBUMIN METHOD : BCP DYE BINDING			
GLOBULIN	3.3	2.0 - 4.1	g/dL
GLOBULIN			



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CLINICAL INFORMATION :
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 CORP-OPD
 BILLNO-150123OPCR005439
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Test Report Status	Final	Results	Biological Reference Interval	Units
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		137	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		5.04	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM		101	98 - 107	mmol/L
METHOD : ISE INDIRECT				
Interpretation(s)				
PHYSICAL EXAMINATION, URINE				
COLOR		PALE YELLOW		
METHOD : PHYSICAL				
APPEARANCE		CLEAR		
METHOD : VISUAL				
CHEMICAL EXAMINATION, URINE				
PH		6.5	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD				
SPECIFIC GRAVITY		<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)				
PROTEIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE				
GLUCOSE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD				
KETONES		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE				
BLOOD		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN				
BILIRUBIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT				
UROBILINOGEN		NORMAL	NORMAL	



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 CIN - U74899PB1995PLC045956
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PATIENT NAME : MR.AKSHAY RAO

ACCESSION NO : 0022WA005471 **AGE :** 33 Years **SEX :** Male

ABHA NO :

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 CORP-OPD
 BILLNO-150123OPCR005439
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Test Report Status	Final	Results	Biological Reference Interval	Units
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)		NOT DETECTED	NOT DETECTED	
NITRITE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE		NOT DETECTED	NOT DETECTED	
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY		NOT DETECTED	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION		1-2	0-5	/HPF
PUS CELL (WBC'S)		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
EPITHELIAL CELLS		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
CASTS		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
CRYSTALS		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION		NOT DETECTED	NOT DETECTED	
REMARKS		NOTE :- URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT		

Interpretation(s)

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 EGFR- EPI-GFR- Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.



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

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

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

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

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

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

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

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 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.

ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood s protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.



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 MAHARASHTRA INDIA

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

PATIENT NAME : MR.AKSHAY RAO
PATIENT ID : FH.4609601
ABHA NO :
AGE : 33 Years **SEX :** Male
ACCESSION NO : 0022WA005471
REPORTED : 28/01/2023 13:56:16
DRAWN : 28/01/2023 08:44:00 **RECEIVED :** 28/01/2023 08:44:05
CLIENT PATIENT ID : UID:4609601
REFERRING DOCTOR : SELF

CLINICAL INFORMATION :
 UID:4609601 REQNO-1363889
 CORP-OPD
 BILLNO-150123OPCR005439
 BILLNO-150123OPCR005439

Test Report Status	Final	Results	Biological Reference Interval	Units
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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.5	13.0 - 17.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	5.36	4.5 - 5.5	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	6.35	4.0 - 10.0	thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	180	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	46.4	40 - 50	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	86.5	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.0	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	33.5	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.7	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	16.1		
MEAN PLATELET VOLUME (MPV)	10.8	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	51	40 - 80	%
METHOD : FLOWCYTOMETRY			
LYMPHOCYTES	36	20 - 40	%
METHOD : FLOWCYTOMETRY			



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 MAHARASHTRA INDIA

SRL Ltd
 HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 1C
 NAVI MUMBAI, 400703
 MAHARASHTRA, INDIA
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ACCESSION NO : 0022WA005471 AGE : 33 Years SEX : Male

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MONOCYTES		8	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		5	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		3.24	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.29	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.51	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.32	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.4		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC			PREDOMINANTLY NORMOCYTIC NORMOCHROMIC	
METHOD : MICROSCOPIC EXAMINATION				
WBC			NORMAL MORPHOLOGY	
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS			ADEQUATE	
METHOD : MICROSCOPIC EXAMINATION				

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



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 MAHARASHTRA INDIA

SRL Ltd
 HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10
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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) 10650
 This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R 03 0 - 14 mm at 1 hr
 METHOD : WESTERGREN METHOD

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-
 Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.
 ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
 Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
 In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm/hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O
 METHOD : TUBE AGGLUTINATION
 RH TYPE POSITIVE
 METHOD : TUBE AGGLUTINATION



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MUMBAI 440001
MAHARASHTRA INDIA

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10
NAVI MUMBAI, 400703
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Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-
Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.75	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.15	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.60	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.2	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.3	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.3	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	33	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	42	< 45.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	61	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	30	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			



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MAHARASHTRA INDIA

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD, SECTOR 10
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ABHA NO :

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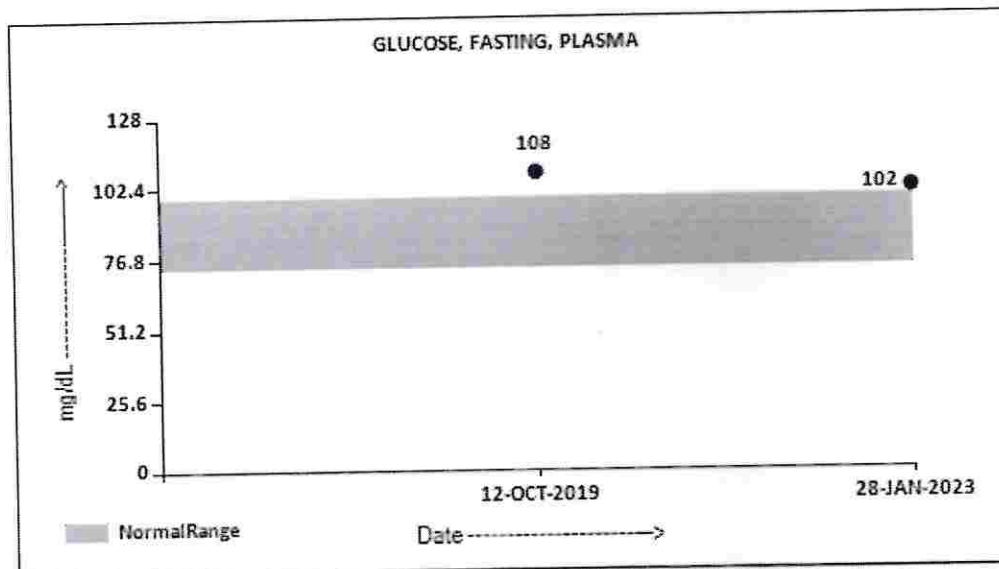
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Test Report Status	Final	Results	Biological Reference Interval	Units
LACTATE DEHYDROGENASE		227	High 100 - 190	U/L
METHOD : LACTATE -PYRUVATE				
GLUCOSE FASTING,FLUORIDE PLASMA				
FBS (FASTING BLOOD SUGAR)		102	High 74 - 99	mg/dL
METHOD : HEXOKINASE				



GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.5	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)	111.2	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			



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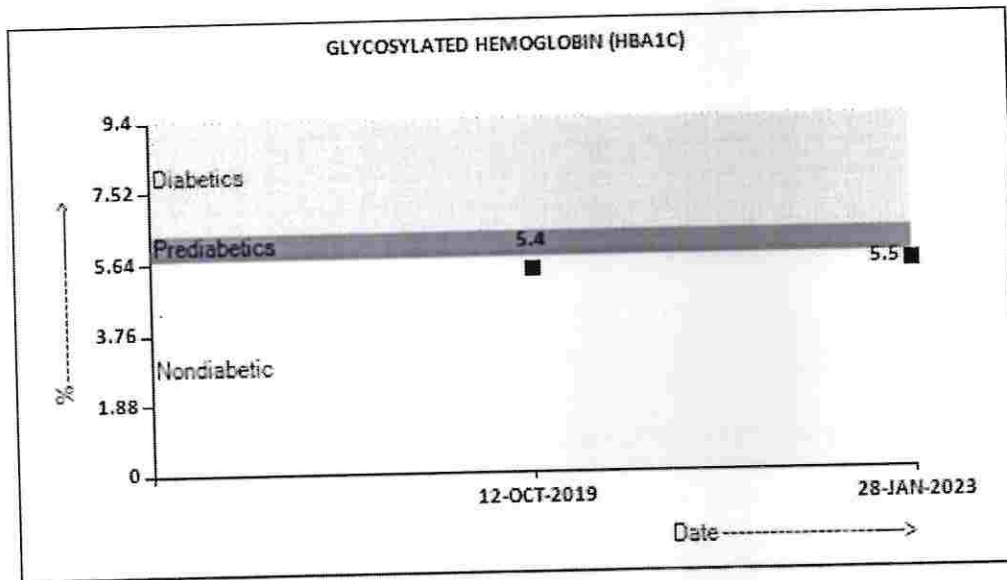
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Interpretation(s)

LIVER FUNCTION PROFILE, SERUM-LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels are seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered



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source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. 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, Nephro syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

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 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. The glycosylated hemoglobin (HbA1c) levels are favored to monitor glycaemic 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:

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 - Diagnosing diabetes.
 - 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.
- eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 - eAG gives an evaluation of blood glucose levels for the last couple of months.
 - eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- Vitamin C & E are reported to falsely lower test results (possibly by inhibiting glycation of hemoglobin).
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiate addition are reported to interfere with some assay methods, falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in
 - Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
 - Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
 - 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

BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	182	< 200 Desirable 200 - 239 Borderline High ≥/ = 240 High	mg/dL
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METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE



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BILLNO-150123OPCR005439

Test Report Status	Final	Results	Biological Reference Interval	Units
TRIGLYCERIDES		62	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY				
HDL CHOLESTEROL		45	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG				
LDL CHOLESTEROL, DIRECT		120	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High >/= 190 Very High	mg/dL
METHOD : DIRECT MEASURE WITHOUT SAMPLE PRETREATMENT				
NON HDL CHOLESTEROL		137	High Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
METHOD : CALCULATED PARAMETER				
VERY LOW DENSITY LIPOPROTEIN		12.4	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER				
CHOL/HDL RATIO		4.0	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER				
LDL/HDL RATIO		2.7	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER				



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LABORATORY REPORT



CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

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

Cert. No. MC-2275

PATIENT NAME : MR.AKSHAY RAO

PATIENT ID : FH.4609601

ACCESSION NO : 0022WA005471 AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 28/01/2023 08:44:00

RECEIVED : 28/01/2023 08:44:05

REPORTED : 28/01/2023 13:56:16

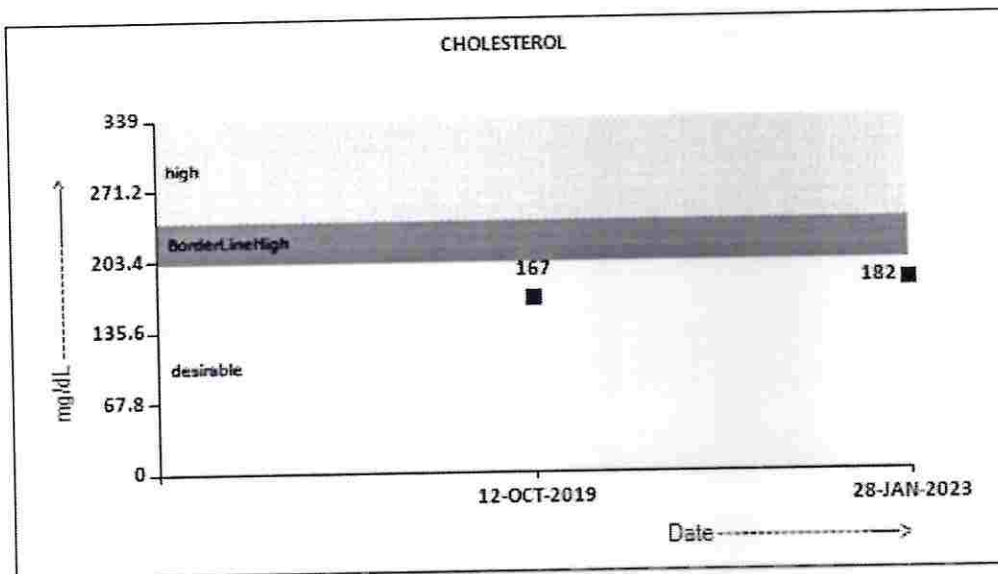
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CLIENT PATIENT ID : UID:4609601

CLINICAL INFORMATION :

UID:4609601 REQNO-1363889
CORP-OPD
BILLNO-150123OPCR005439
BILLNO-150123OPCR005439

Test Report Status	Final	Results	Biological Reference Interval	Units
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LABORATORY REPORT



CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
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FORTIS HOSPITAL # VASHI,

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MAHARASHTRA INDIA

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

PATIENT ID : **FH.4609601**

PATIENT NAME : **MR.AKSHAY RAO**

ACCESSION NO : **0022WA005471** AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 28/01/2023 08:44:00

RECEIVED : 28/01/2023 08:44:05

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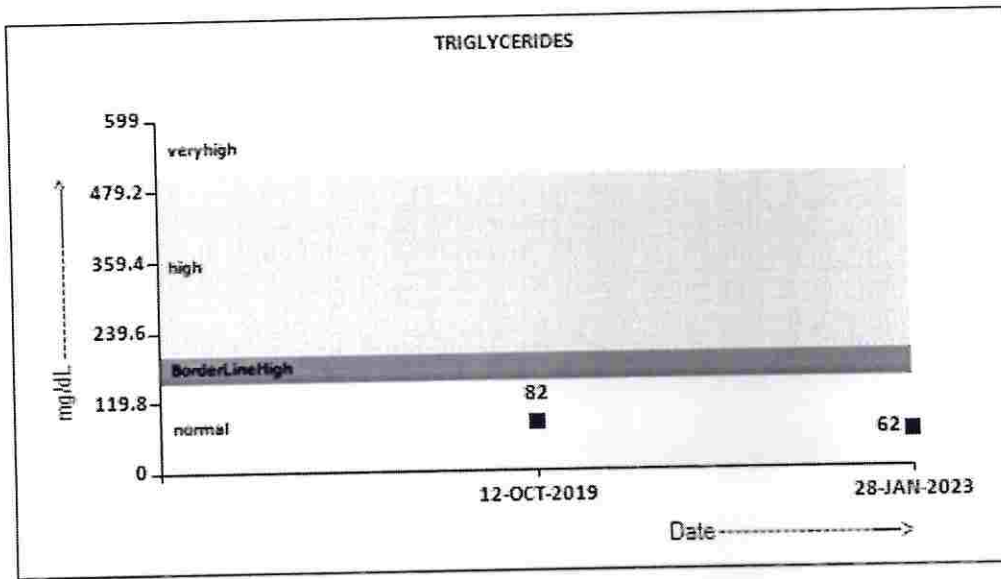
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CLIENT PATIENT ID : UID:4609601

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CORP-OPD
BILLNO-150123OPCR005439
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Test Report Status	Final	Results	Biological Reference Interval	Units
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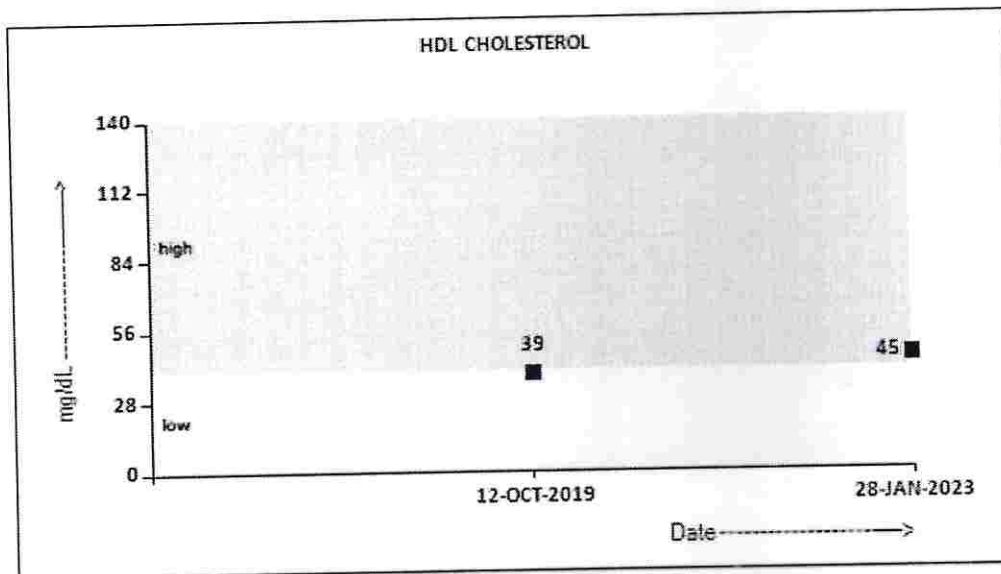
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CLIENT PATIENT ID : UID:4609601

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CORP-OPD
BILLNO-150123OPCR005439
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Test Report Status	Final	Results	Biological Reference Interval	Units
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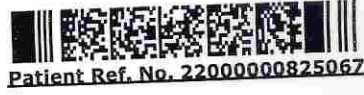


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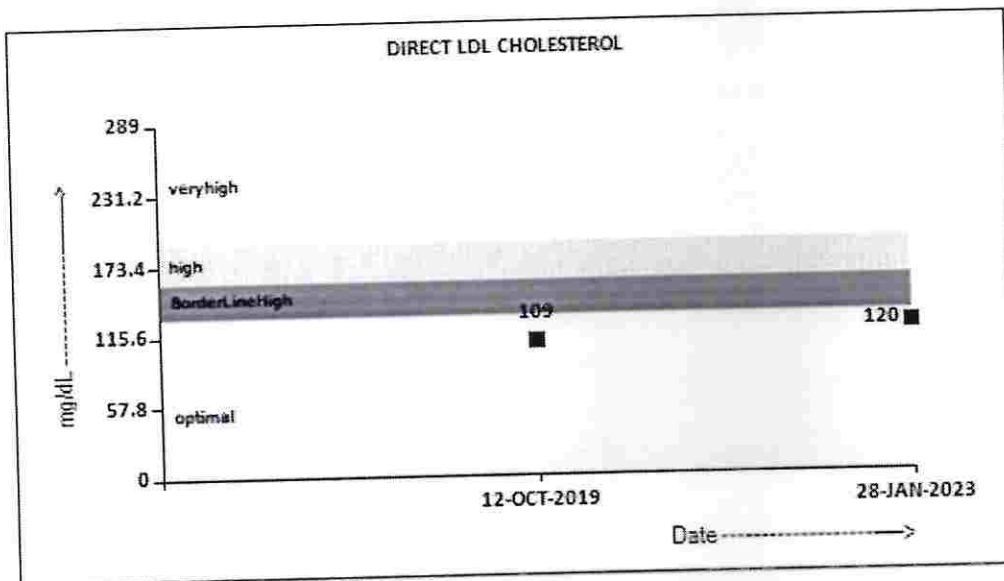
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Interpretation(s)

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr. Akta Dubey
Consultant Pathologist

Dr. Rekha Nair, MD
Microbiologist



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LABORATORY REPORT



CLIENT CODE : C000045507

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FORTIS VASHI-CHC -SPLZD
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Tel : 022-39199222,022-49723322,
CIN - U74899PB1995PLC045956
Email : -

Cert. No. MC-2275

PATIENT NAME : MR.AKSHAY RAO

PATIENT ID : FH.4609601

ACCESSION NO : 0022WA005565 AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 28/01/2023 11:32:00

RECEIVED : 28/01/2023 11:37:13

REPORTED : 28/01/2023 13:03:05

REFERRING DOCTOR :

CLIENT PATIENT ID : UID:4609601

CLINICAL INFORMATION :

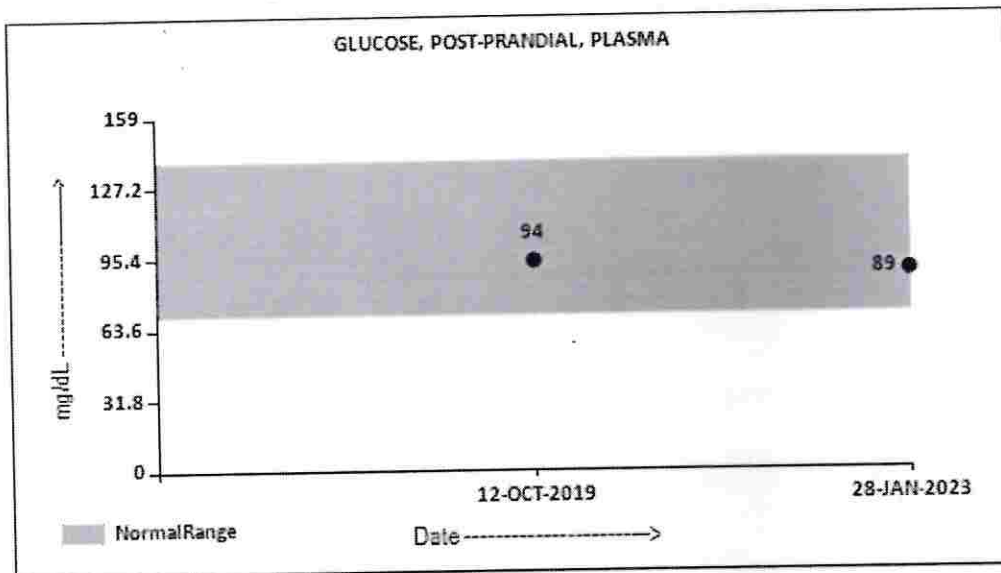
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CORP-OPD
BILLNO-150123OPCR005439
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Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 89 70 - 139 mg/dL
METHOD : HEXOKINASE



Comments

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

Interpretation(s)

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

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession



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LABORATORY REPORT



Patient Ref. No. 22000000825161



Cert. No. MC-2275

CLIENT CODE : C000045507

CLIENT'S NAME AND ADDRESS :
FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,

MUMBAI 440001
MAHARASHTRA INDIA

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

PATIENT NAME : MR.AKSHAY RAO

PATIENT ID : FH.4609601

ACCESSION NO : 0022WA005565 AGE : 33 Years SEX : Male

ABHA NO :

DRAWN : 28/01/2023 11:32:00

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CORP-OPD
BILLNO-150123OPCR005439
BILLNO-150123OPCR005439

Test Report Status	Final	Results	Biological Reference Interval	Units
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Dr.Akta Dubey
Counsultant Pathologist



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4609601
33 Years

AKSHAY KAU
Male

Rate 63 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Borderline prolonged PR interval.....PR >202, V-rate 50- 90
 . Probable left atrial enlargement.....P >50ms, <-0.10mV V1
 . Consider right ventricular hypertrophy.....large R or R' V1/V2
 . ST elev, probable normal early repol pattern.....ST elevation, age<55

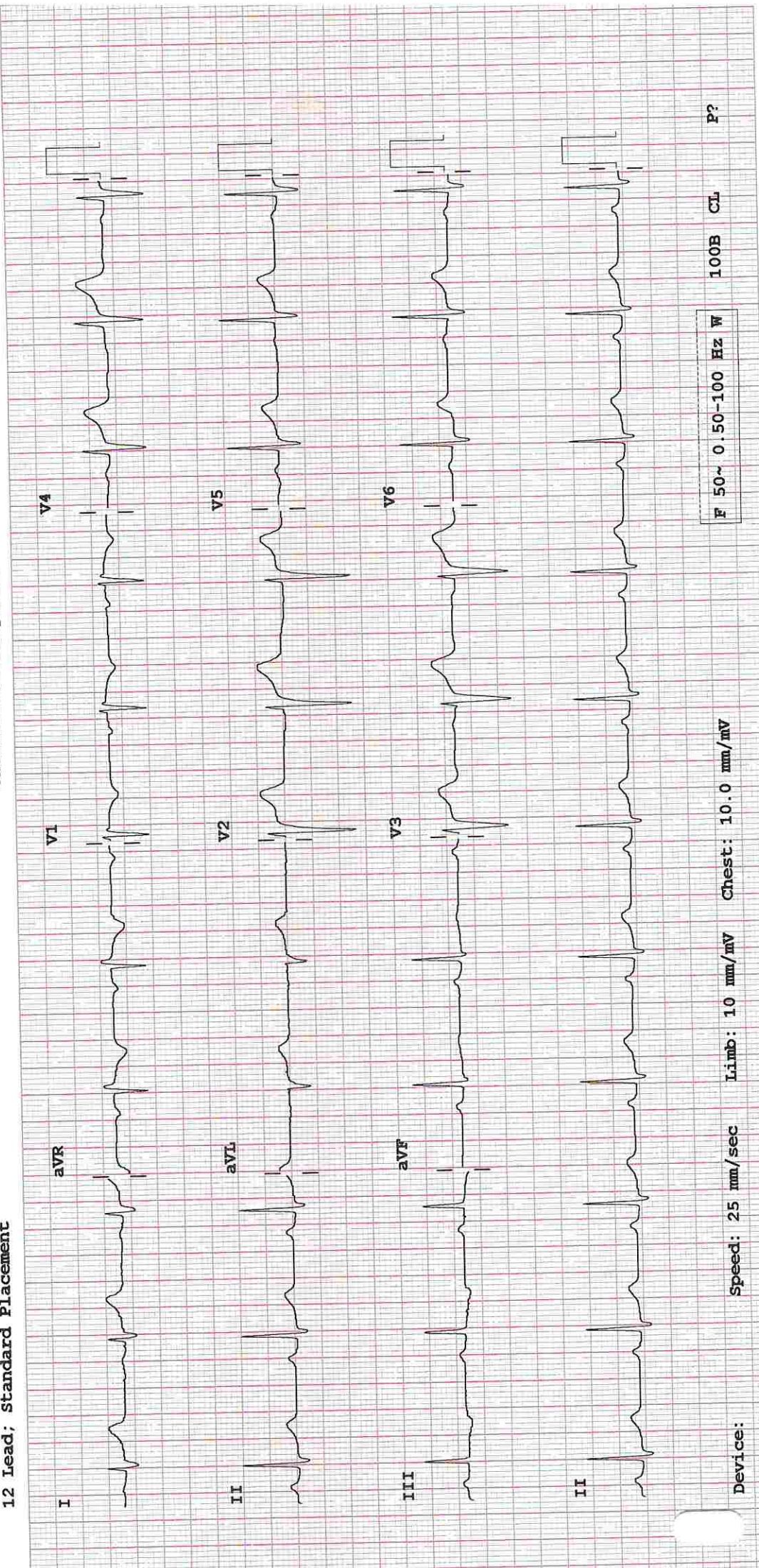
negative M/S

Normal
P

--AXIS--
 P 75
 QRS 92
 T 7
 12 Lead; Standard Placement

- ABNORMAL ECG -

Unconfirmed Diagnosis



F 50~ 0.50-100 Hz W

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

100B CL P?

Device:



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 28/Jan/2023

Name: Mr. Akshay Rao
Age | Sex: 33 YEAR(S) | Male
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 4609601 | 5562/23/1501
Order No | Order Date: 1501/PN/OP/2301/11372 | 28-Jan-2023
Admitted On | Reporting Date : 28-Jan-2023 11:11:57
Order Doctor Name : Dr.SELF.

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

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

M-MODE MEASUREMENTS:

LA	31	mm
AO Root	30	mm
AO CUSP SEP	17	mm
LVID (s)	28	mm
LVID (d)	49	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	21	mm
RA	28	mm
LVEF	60	%