

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
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Emergency: 022 - 39199100 | Ambulance: 1255
For Appointment: 022 - 39199222 | Health Checkup: 022 - 39199300
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CIN : U85100MH2005PTC154823
GST IN: 27AABC15894D1ZG | PAN NO: AABCH5894D



Hiranandani
HOSPITAL

Fortis Healthcare

UHID	5635380	Date	28/01/2023		
Name	Mrs. Shrikant Repale	Sex	Male	Age	34
OPD	Dental 12				

Drug allergy:
Sys illness:

Worn out bridges $\overline{765/567}$

stains & calculus &

Treatment

Adv new bridge $\overline{765/567}$

Adv oral prophylaxis.

Dr Diksha Kher

LABORATORY REPORT



REF. DOCTOR : SELF

PATIENT NAME : MR.SHRIKANT P REPALE

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

ACCESSION NO : 0022WA005482
PATIENT ID : FH.5635380
CLIENT PATIENT ID: UID:5635380
ABHA NO :

AGE/SEX : 34 Years Male
DRAWN : 28/01/2023 09:09:00
RECEIVED : 28/01/2023 09:12:22
REPORTED : 28/01/2023 13:36:47

CLINICAL INFORMATION :

UID:5635380 REQNO-1364028
 CORP-OPD
 BILLNO-150123OPCR005458
 BILLNO-150123OPCR005458

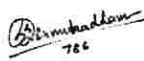
Test Report Status	Results	Biological Reference Interval	Units
Final			

SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

Test Name	Result	Biological Reference Interval	Units
T3 METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	120.50	80 - 200	ng/dL
T4 METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	6.82	5.1 - 14.1	µg/dL
TSH (ULTRASENSITIVE) METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY	1.860	0.270 - 4.200	µIU/mL

Interpretation(s)


Dr. Swapnil Sirmukaddam
 Consultant Pathologist



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[View I](#)

PERFORMED AT :

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



Patient Ref. No. 2200000082507

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SPECIALISED CHEMISTRY - TUMOR MARKER

PROSTATE SPECIFIC ANTIGEN, SERUM	0.220	< 1.4	ng/mL
PROSTATE SPECIFIC ANTIGEN			
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

PROSTATE SPECIFIC ANTIGEN, SERUM-- PSA is detected in the male patients with normal, benign hyperplastic and malignant prostate tissue and in patients with prostatitis.
 - PSA is not detected (or detected at very low levels) in the patients without prostate tissue (because of radical prostatectomy or cystoprostatectomy) and also in the female patient.
 - It a suitable marker for monitoring of patients with Prostate Cancer and it is better to be used in conjunction with other diagnostic procedures.
 - Serial PSA levels can help determine the success of prostatectomy and the need for further treatment, such as radiation, endocrine or chemotherapy and useful in detecting residual disease and early recurrence of tumor.
 - Elevated levels of PSA can be also observed in the patients with non-malignant diseases like Prostatitis and Benign Prostatic Hyperplasia.
 - Specimens for total PSA assay should be obtained before biopsy, prostatectomy or prostatic massage, since manipulation of the prostate gland may lead to elevated PSA (false positive) levels persisting up to 3 weeks.
 - As per American urological guidelines, PSA screening is recommended for early detection of Prostate cancer above the age of 40 years. Following Age specific reference range can be used as a guide 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 chemistry, 4th edition) 2.Wallach's Interpretation of Diagnostic Tests

****End Of Report****

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

Dr. Swapnil Sirmukaddam
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Dr. Swapnil Sirmukaddam
Consultant Pathologist



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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

Parameter	Result	Reference Interval	Units
BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN (HB) METHOD : SPECTROPHOTOMETRY	13.1	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : ELECTRICAL IMPEDANCE	5.86 High	4.5 - 5.5	mil/μL
WHITE BLOOD CELL (WBC) COUNT METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY	6.11	4.0 - 10.0	thou/μL
PLATELET COUNT METHOD : ELECTRICAL IMPEDANCE	283	150 - 410	thou/μL
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV) METHOD : CALCULATED PARAMETER	42.1	40 - 50	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	71.9 Low	83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	22.4 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	31.2 Low	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.9	11.6 - 14.0	%
MENTZER INDEX	12.3		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	8.7	6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT			
NEUTROPHILS METHOD : FLOWCYTOMETRY	59	40 - 80	%
LYMPHOCYTES METHOD : FLOWCYTOMETRY	32	20 - 40	%

Dr. Akta Dubey
 Consultant Pathologist



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MONOCYTES		7	2 - 10	%
METHOD : FLOWCYTOMETRY				
EOSINOPHILS		2	1 - 6	%
METHOD : FLOWCYTOMETRY				
BASOPHILS		0	0 - 2	%
METHOD : FLOWCYTOMETRY				
ABSOLUTE NEUTROPHIL COUNT		3.60	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.96	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.43	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.12	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)		1.8		
METHOD : CALCULATED PARAMETER				
MORPHOLOGY				
RBC			PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, MILD MICROCYTOSIS	
METHOD : MICROSCOPIC EXAMINATION				
WBC			NORMAL MORPHOLOGY	
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS			ADEQUATE	
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)
 RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.

Dr. Akta Dubey
 Counsultant Pathologist



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Results

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WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD	Results	Biological Reference Interval	Units
E.S.R	04	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 for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

Dr.Akta Dubey
 Consultant Pathologist



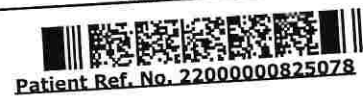
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Results

Biological Reference Interval Units

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP

METHOD : TUBE AGGLUTINATION

RH TYPE

METHOD : TUBE AGGLUTINATION

TYPE A


POSITIVE

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.


Dr. Akta Dubey
Counsultant Pathologist




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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	0.58	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.10	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.48	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.4	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.0	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.4	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.2	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	14 Low	15 - 37	U/L
METHOD : UV WITH PSP			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	22	< 45.0	U/L
METHOD : UV WITH PSP			
ALKALINE PHOSPHATASE	63	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	21	15 - 85	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	107	100 - 190	U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	99	74 - 99	mg/dL
METHOD : HEXOKINASE			

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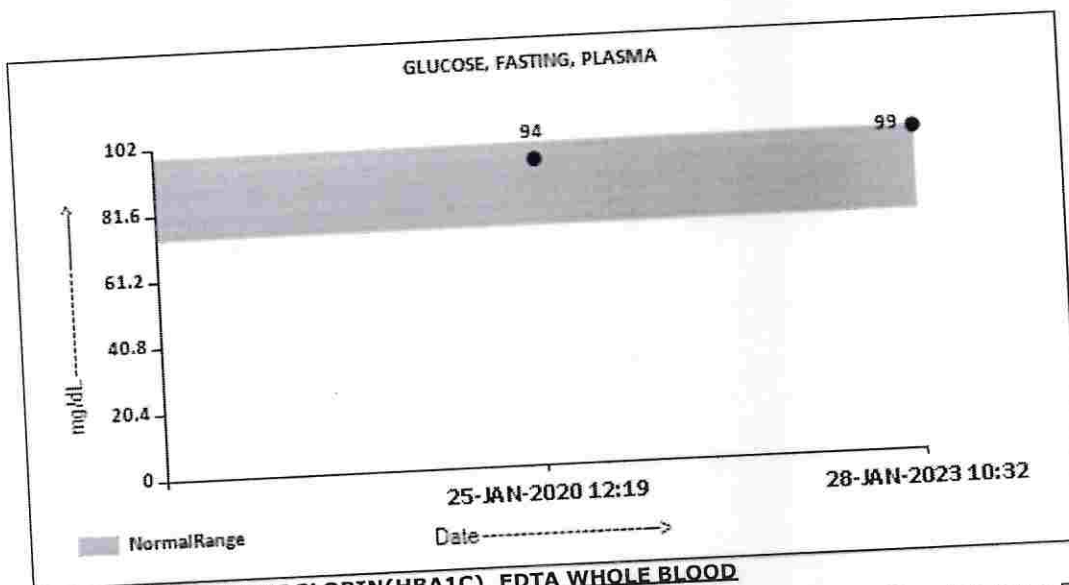
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GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C

5.9 High

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)

METHOD : CALCULATED PARAMETER

122.6 High

< 116.0

mg/dL

Akta Dubey
Dr.Akta Dubey
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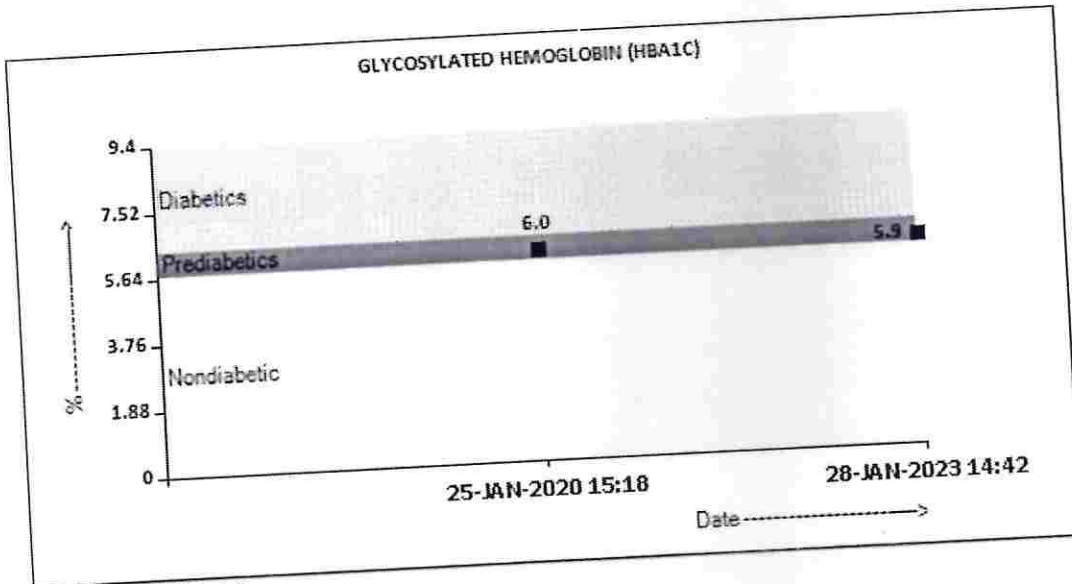
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN

METHOD : UREASE - UV

10

6 - 20

mg/dL

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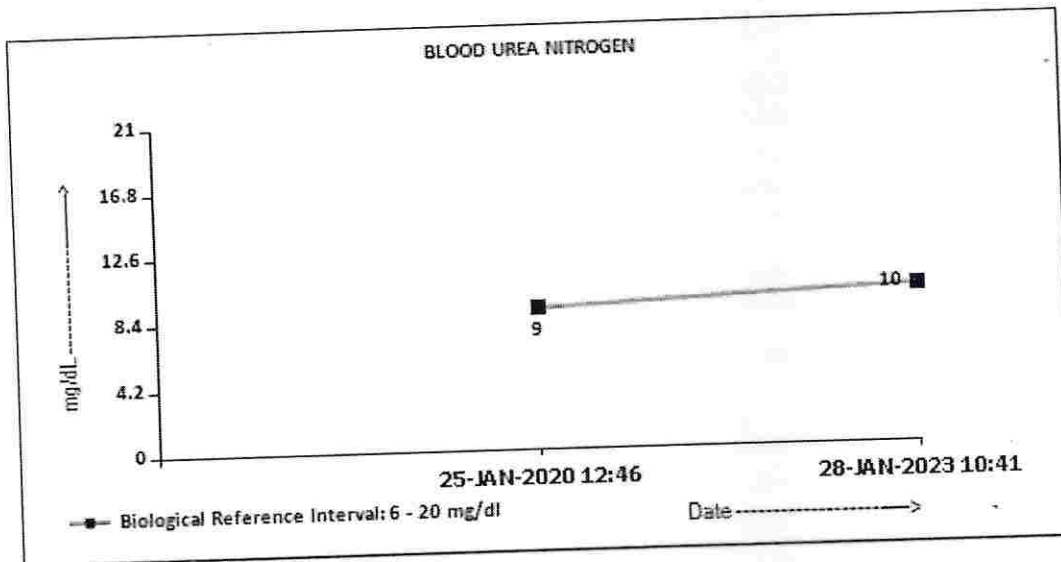
ACCESSION NO : 0022WA005482
PATIENT ID : FH.5635380
CLIENT PATIENT ID: UID:5635380
ABHA NO :

AGE/SEX : 34 Years Male
DRAWN : 28/01/2023 09:09:00
RECEIVED : 28/01/2023 09:12:22
REPORTED : 28/01/2023 15:34:54

CLINICAL INFORMATION :

UID:5635380 REQNO-1364028
 CORP-OPD
 BILLNO-150123OPCR005458
 BILLNO-150123OPCR005458

Test Report Status	Results	Biological Reference Interval	Units
Final			



CREATININE EGFR- EPI

CREATININE	0.81 Low	0.90 - 1.30	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	34		years
GLOMERULAR FILTRATION RATE (MALE)	118.65	Refer Interpretation Below	mL/min/1.73m ²
METHOD : CALCULATED PARAMETER			

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Patient Ref. No. 22000000825078

LABORATORY REPORT



PATIENT NAME : MR.SHRIKANT P REPALE

REF. DOCTOR : SELF

CODE/NAME & ADDRESS : C000045507 - FORTIS
 FORTIS VASHI-CHC -SPLZD
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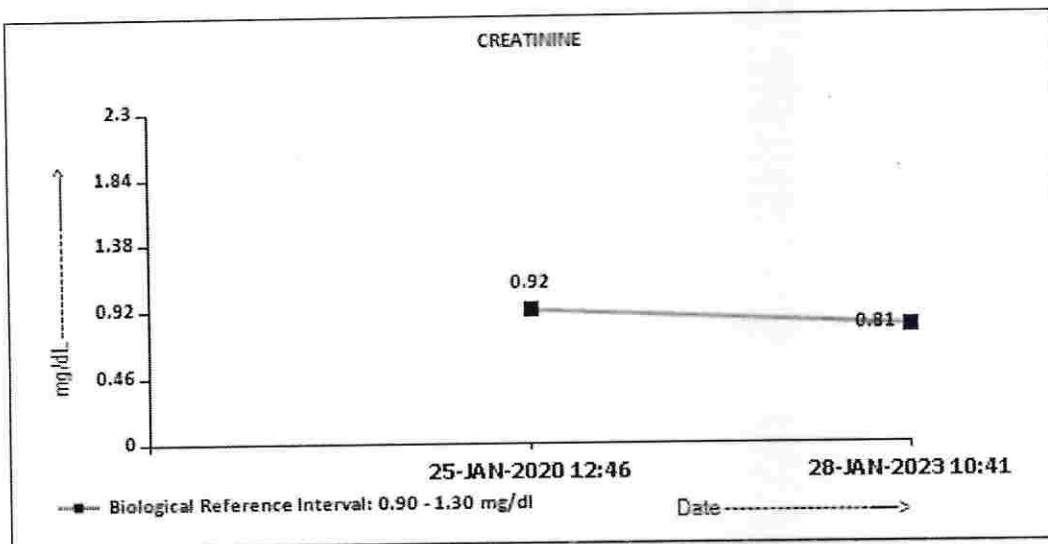
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BUN/CREAT RATIO

BUN/CREAT RATIO 12.35 5.00 - 15.00
 METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID 4.4 3.5 - 7.2 mg/dL
 METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN 7.4 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN 4.0 3.4 - 5.0 g/dL
 METHOD : BCP DYE BINDING

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GLOBULIN		3.4	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		138	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		4.72	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT				
CHLORIDE, SERUM		102	98 - 107	mmol/L
METHOD : ISE INDIRECT				

Interpretation(s)

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 the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. 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

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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 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; sulfonureas, 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
- BLOOD UREA NITROGEN (BUN), SERUM-** Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
- Causes of decreased level include Liver disease, SIADH.
- CREATININE EGFR- EPI-GFR-** Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
- A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.
- Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.
- The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.
- The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.
- URIC ACID, SERUM-** Causes of Increased levels:- Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic



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Patient Ref. No. 2200000825078

LABORATORY REPORT



PATIENT NAME : MR.SHRIKANT P REPALE **REF. DOCTOR : SELF**

CODE/NAME & ADDRESS : C000045507 - FORTIS FORTIS VASHI-CHC -SPLZD FORTIS HOSPITAL # VASHI, MUMBAI 440001	ACCESSION NO : 0022WA005482	AGE/SEX : 34 Years Male
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 CORP-OPD
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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 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.
ALBUMIN, SERUM-Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	172	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	83	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	49	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	111	< 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	123	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	16.6	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.5	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	2.3	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			

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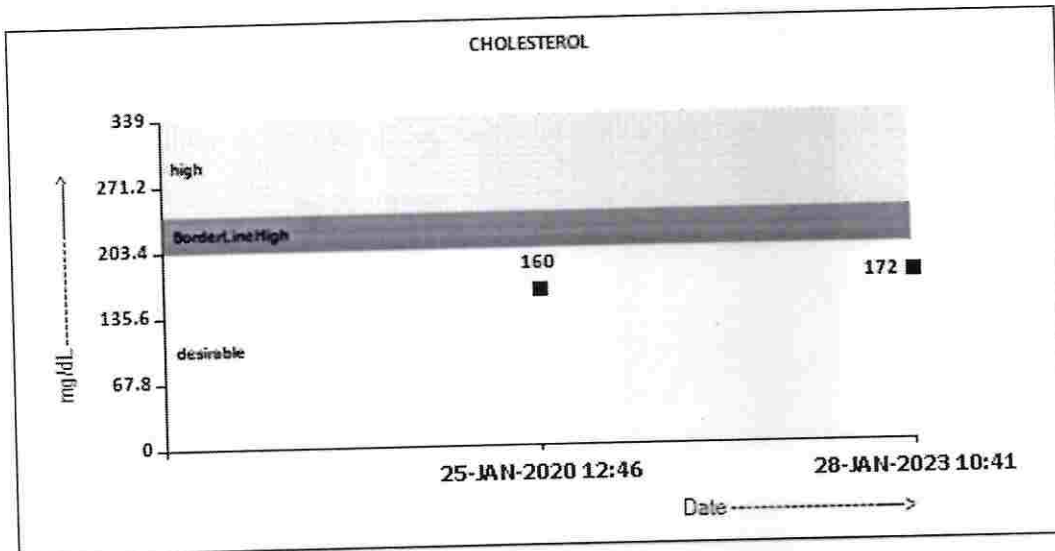
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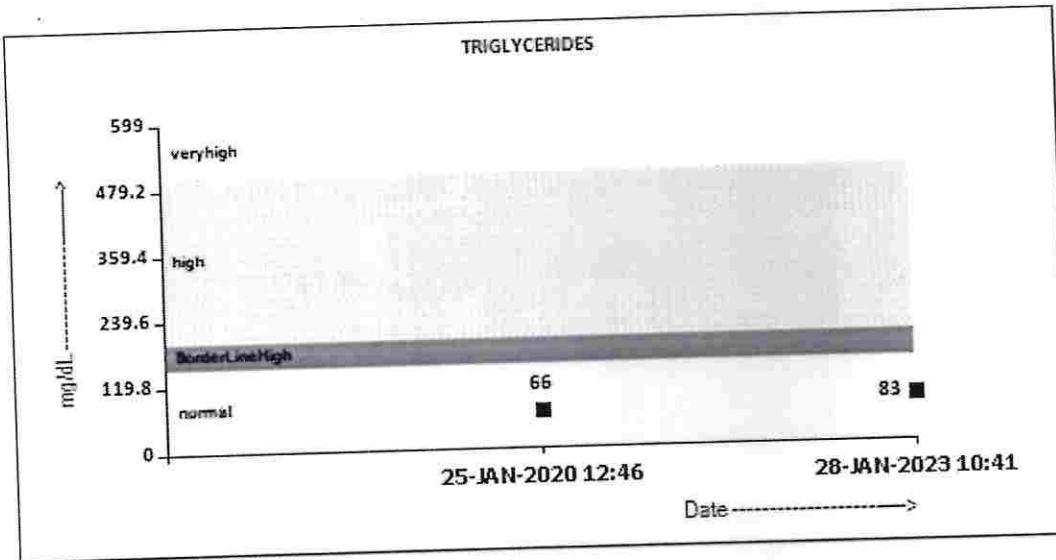
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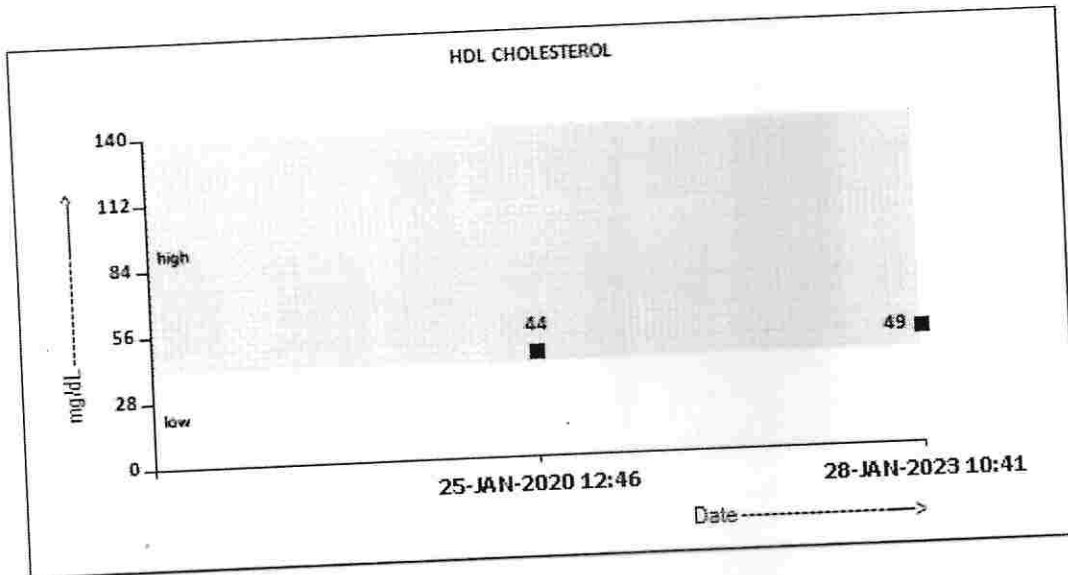
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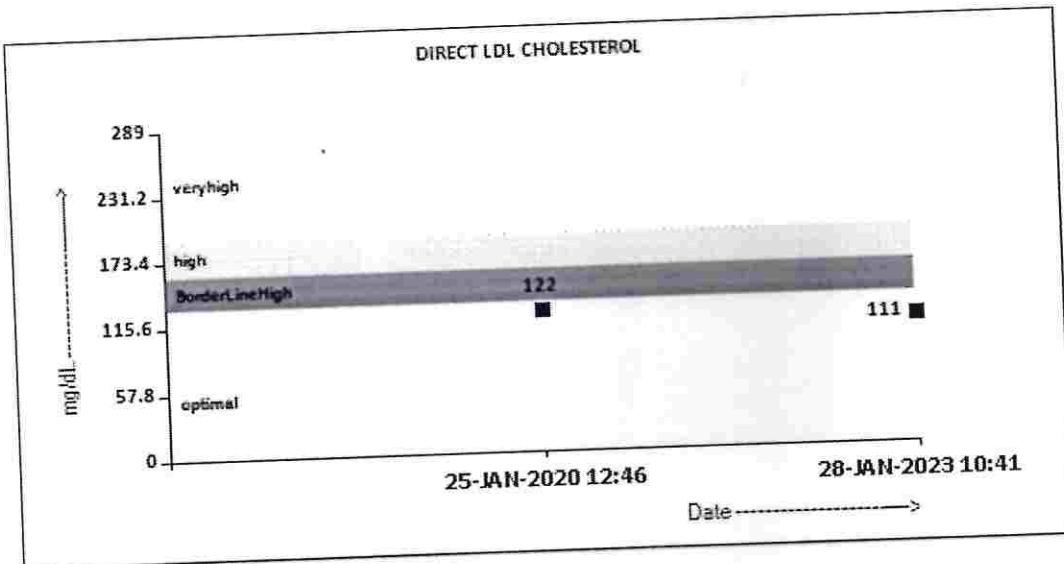
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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR PALE YELLOW
 METHOD : PHYSICAL
APPEARANCE CLEAR
 METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH	6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD			
SPECIFIC GRAVITY	1.020	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
PROTEIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE			
BLOOD	DETECTED (TRACE) IN URINE		
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE			
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY			
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	0 - 1	NOT DETECTED	/HPF

Akta Dubey
Dr. Akta Dubey
 Consultant Pathologist

Rekha Nair
Dr. Rekha Nair, MD
 Microbiologist



View Details



View Re

PERFORMED AT :

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

Patient Ref. No. 2200000825078

LABORATORY REPORT



REF. DOCTOR : SELF

PATIENT NAME : MR.SHRIKANT P REPALE

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

ACCESSION NO : 0022WA005482
PATIENT ID : FH.5635380
CLIENT PATIENT ID: UID:5635380
ABHA NO :

AGE/SEX : 34 Years Male
DRAWN : 28/01/2023 09:09:00
RECEIVED : 28/01/2023 09:12:22
REPORTED : 28/01/2023 15:34:54

CLINICAL INFORMATION :

UID:5635380 REQNO-1364028
 CORP-OPD
 BILLNO-150123OPCR005458
 BILLNO-150123OPCR005458

Test Report Status	Final	Results	Biological Reference Interval	Units
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
BACTERIA		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
YEAST		NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION				
REMARKS		NOTE :-URINARY MICROSCOPIC EXAMINATION DONE FROM URINARY CENTRIFUGED SEDIMENTATION.		

Interpretation(s)

****End Of Report****

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

Akta Dubey
Dr.Akta Dubey
 Counsultant Pathologist

Rekha N
Dr. Rekha Nair, MD
 Microbiologist



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



Patient Ref. No. 22000000825078

LABORATORY REPORT



PATIENT NAME : MR.SHRIKANT P REPALE

REF. DOCTOR :

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

ACCESSION NO : 0022WA005628
PATIENT ID : FH.5635380
CLIENT PATIENT ID: UID:5635380
ABHA NO :

AGE/SEX : 34 Years Male
DRAWN : 28/01/2023 14:22:00
RECEIVED : 28/01/2023 14:21:53
REPORTED : 28/01/2023 16:03:41

CLINICAL INFORMATION :

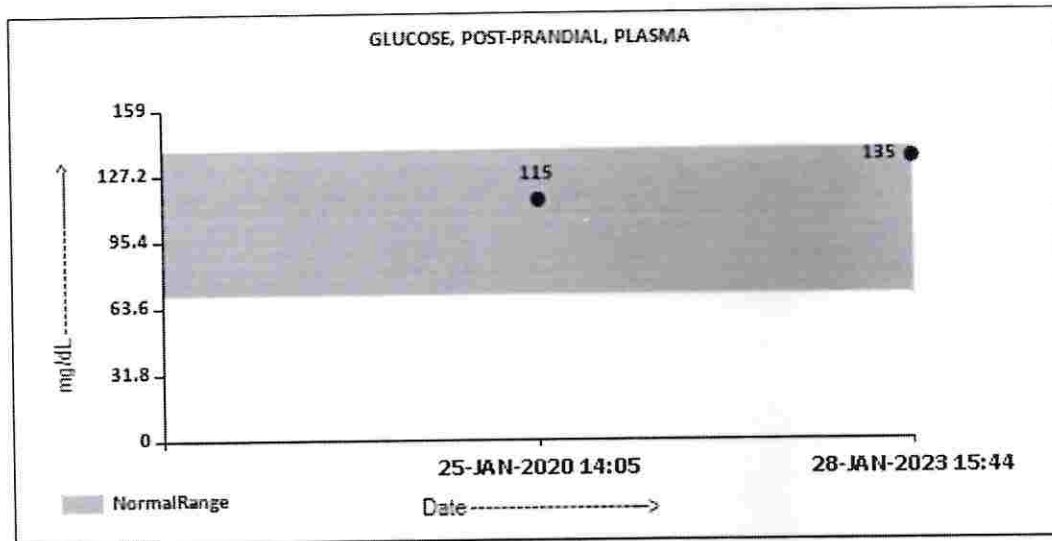
UID:5635380 REQNO-1364028
 CORP-OPD
 BILLNO-150123OPCR005458
 BTLLNO-150123OPCR005458

Test Report Status	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR) 135 70 - 139 mg/dL
 METHOD : HEXOKINASE



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

Dubey

Dr.Akta Dubey
 Consultant Pathologist



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 Email : -



Patient Ref. No. 2200000825224

34 Years

Male

Hc,

sinus bradycardia
normal
D

Rate 76 . Sinus rhythm.....normal P axis, V-rate 50- 99
Baseline wander in lead(s) V1, V2

PR 141

QRSD 81

QT 357

QTc 402

--AXIS--

P 68

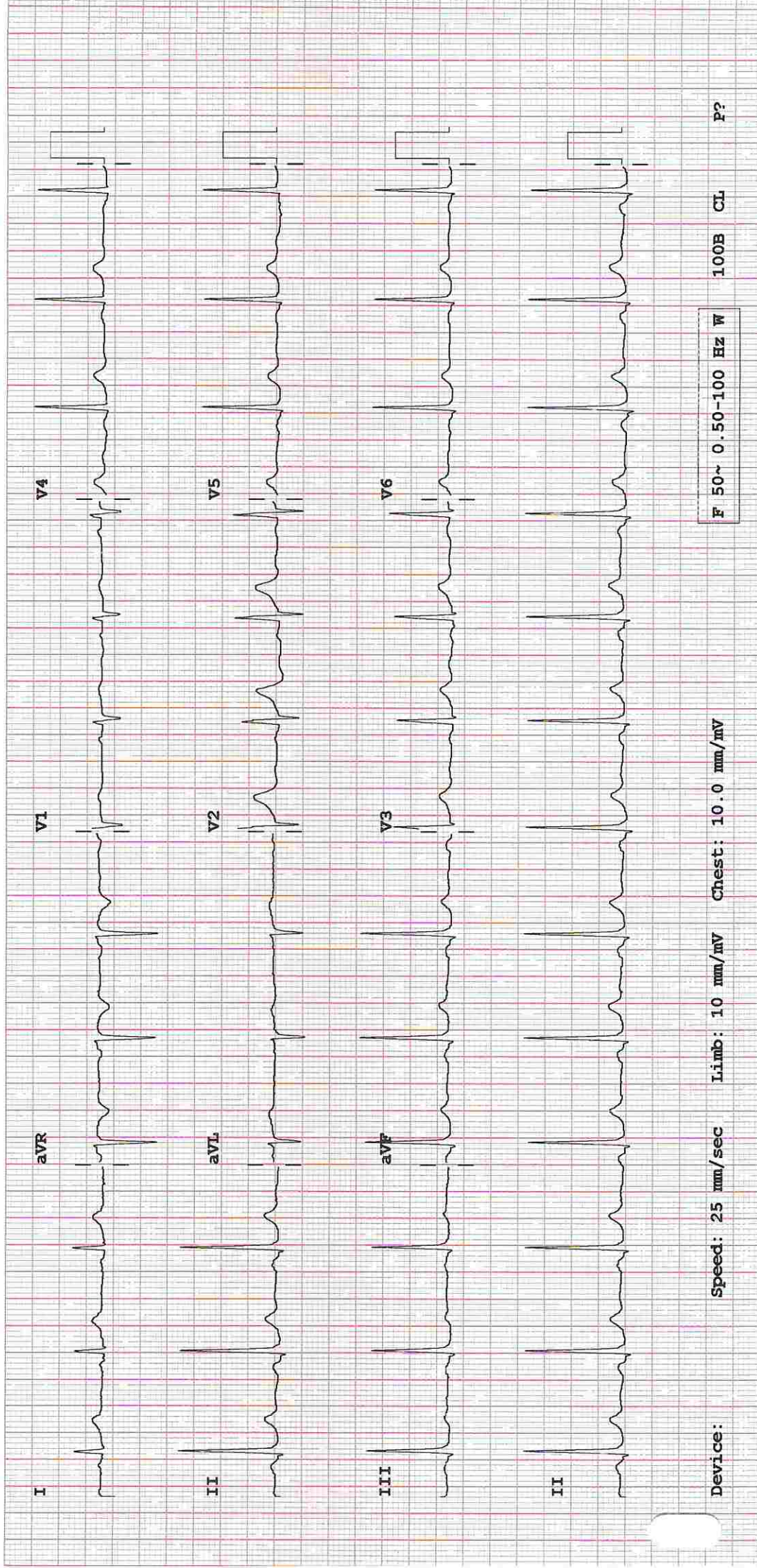
QRS 74

T 40

12 Lead; Standard Placement

- NORMAL ECG -

Unconfirmed Diagnosis



Hiranandani Healthcare Pvt. Ltd.

Mini Sea Shore Road, Sector 10-A, Vashi, Navi Mumbai - 400703.

Board Line: 022 - 39199222 | Fax: 022 - 39133220

Emergency: 022 - 39199100 | Ambulance: 1255

For Appointment: 022 - 39199200 | Health Checkup: 022 - 39199300

www.fortishealthcare.com | vashi@fortishealthcare.com

CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D

Hiranandani
HOSPITAL
(A FortisNetwork Hospital)**(For Billing/Reports & Discharge Summary only)**

Date: 30/Jan/2023

DEPARTMENT OF NIC

Name: Mr. Shrikant P Repale

Age | Sex: 34 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5635380 | 5582/23/1501

Order No | Order Date: 1501/PN/OP/2301/11411 | 28-Jan-2023

Admitted On | Reporting Date : 30-Jan-2023 12:08:29

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 e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension.
PASP = 25 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	30	mm
AO Root	26	mm
AO CUSP SEP	19	mm
LVID (s)	25	mm
LVID (d)	45	mm
IVS (d)	10	mm
LVPW (d)	10	mm
RVID (d)	21	mm
RA	30	mm
LVEF	60	%

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

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HOSPITAL
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DEPARTMENT OF NIC

Date: 30/Jan/2023

Name: Mr. Shrikant P Repale

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Admitted On | Reporting Date : 30-Jan-2023 12:08:29

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.5 m/sec.

A WAVE VELOCITY: 0.6 m/sec

E/A RATIO: 1.5, E/E' = 6

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	08			Nil
TRICUSPID VALVE	25			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- No LV diastolic dysfunction.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

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



DEPARTMENT OF RADIOLOGY

Date: 28/Jan/2023

Name: Mr. Shrikant P Repale

UHID | Episode No : 5635380 | 5582/23/1501

Age | Sex: 34 YEAR(S) | Male

Order No | Order Date: 1501/PN/OP/2301/11411 | 28-Jan-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 28-Jan-2023 17:49:46

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. VIVEK MANE

MBBS., DMRE. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 28/Jan/2023

Name: Mr. Shrikant P Repale

Age | Sex: 34 YEAR(S) | Male

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5635380 | 5582/23/1501

Order No | Order Date: 1501/PN/OP/2301/11411 | 28-Jan-2023

Admitted On | Reporting Date : 28-Jan-2023 14:36:04

Order Doctor Name : Dr.SELF.

USG-WHOLE ABDOMEN

LIVER is normal in size (12.5 cm) and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is partially distended. No evidence of pericholecystic collection. **CBD** appears normal in caliber.

SPLEEN is normal in size (11.0 cm) and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis. Right kidney measures 10.0 x 4.7 cm. Left kidney measures 10.9 x 4.8 cm.

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

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

PROSTATE is normal in size & echogenicity. It measures ~ 12 cc in volume.

No evidence of ascites.

IMPRESSION:

- No significant abnormality is detected.


DR. VIVEK MANE
MBBS., DMRE. (Radiologist)