**Patient Name** : **Mr. Dushyant Khatri**
**Age / Gender** : 33 Y / Male
**Referred By** : Dr. Gail Chaudhari
**SID No.** : **40013103**

**Reg.Date / Time** : 03/02/2024 / 09:57:12
**Report Date / Time** : 03/02/2024 / 20:14:38
**MR No.** : **0849067**



**Partial Test Report**

| Specimen | Test Name / Method | Result | Units | Biological Reference Interval |
|---|---|---|---|---|
| **HAEMATOLOGY** | | | | |
| **CBC-Haemogram & ESR, blood** | | | | |
| **EDTA WHOLE BLOOD** | | | | |
| | **HAEMOGLOBIN, RED CELL COUNT & INDICES** | | | |
| | HAEMOGLOBIN (Spectrophotometry) | **12.8** | gm% | 13-17 |
| | PCV (Electrical Impedance) | **36.5** | % | 40 - 50 |
| | MCV (Calculated) | 89.8 | fL | 83-101 |
| | MCH (Calculated) | 31.4 | pg | 27.0 - 32.0 |
| | MCHC (Calculated) | **35.0** | g/dl | 31.5-34.5 |
| | RDW-CV (Calculated) | 14 | % | 11.6-14.0 |
| | RDW-SD (Calculated) | **53** | fL | 36 - 46 |
| | TOTAL RBC COUNT (Electrical Impedance) | **4.06** | Million/cmm | 4.5-5.5 |
| | TOTAL WBC COUNT (Electrical Impedance) | 8440 | /cumm | 4000-10000 |
| | **DIFFERENTIAL WBC COUNT** | | | |
| | NEUTROPHILS (Flow cell) | 56.0 | % | 40-80 |
| | LYMPHOCYTES (Flow cell) | 35.0 | % | 20-40 |
| | EOSINOPHILS (Flow cell) | 1.4 | % | 1-6 |
| | MONOCYTES (Flow cell) | 6.6 | % | 2-10 |
| | BASOPHILS (Flow cell) | 1.0 | % | 1-2 |
| | **ABSOLUTE WBC COUNT** | | | |
| | ABSOLUTE NEUTROPHIL COUNT (Calculated) | 4710 | /cumm | 2000-7000 |
| | ABSOLUTE LYMPHOCYTE COUNT (Calculated) | 2950 | /cumm | 1000-3000 |

Contd ...

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|---|---|---|---|---|
| **HAEMATOLOGY** | | | | |
| | **ABSOLUTE WBC COUNT** | | | |
| | ABSOLUTE EOSINOPHIL COUNT (Calculated) | **120** | /cumm | 200-500 |
| | ABSOLUTE MONOCYTE COUNT (Calculated) | 560 | /cumm | 200-1000 |
| | ABSOLUTE BASOPHIL COUNT (Calculated) | 80 | /cumm | 0-220 |
| | PLATELET COUNT (Electrical Impedance) | 288000 | /cumm | 150000-410000 |
| | MPV (Calculated) | 10.4 | fL | 6.78-13.46 |
| | PDW (Calculated) | 16.5 | % | 11-18 |
| | PCT (Calculated) | 0.300 | % | 0.15-0.50 |
| | **PERIPHERAL BLOOD SMEAR** | | | |
| | COMMENTS (Microscopic) | Normocytic Normochromic RBCs | | |

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**Sample Collected on** : 03 Feb 2024 10:39
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**Barcode** :

**Dr.Rahul Jain**
**MD,PATHOLOGY**
**Consultant Pathologist**

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**Partial Test Report**

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|---|---|---|---|---|
| **HAEMATOLOGY** | | | | |
| **EDTA Blood** | **ABO BLOOD GROUP** | | | |
| | BLOOD GROUP (Erythrocyte-Magnetized Technology) | O | | |
| | Rh TYPE (Erythrocyte-Magnetized Technology) | POSITIVE | | |

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**Partial Test Report**

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|---|---|---|---|---|
| **HAEMATOLOGY** | | | | |
| **CBC-Haemogram & ESR, blood** | | | | |
| **EDTA WHOLE BLOOD** | | | | |
| | ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary) | 3 | mm / 1 hr | 0-15 |

**Notes :** The given result is measured at the end of first hour.

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**Partial Test Report**

| Specimen | Test Name / Method | Result | Units | Biological Reference Interval |
|---|---|---|---|---|
| **BIOCHEMISTRY** | | | | |
| **BLOOD GLUCOSE (F) + URINE SUGAR** | | | | |
| **FLOURIDE PLASMA** | | | | |
| | BLOOD GLUCOSE FASTING<br>(Hexokinase) | 88 | mg/dl | 70 - 110 |

**Notes :** An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.
References:
http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf, Understanding Diabetes.

| | | | |
|---|---|---|---|
| URINE GLUCOSE FASTING<br>(Urodip) | ABSENT | | |

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|---|---|---|---|---|
| **BIOCHEMISTRY** | | | | |
| **COMPREHENSIVE LIVER PROFILE** | | | | |
| **SERUM** | | | | |
| | BILIRUBIN TOTAL (Diazotization) | 0.51 | mg/dl | 0.2 - 1.3 |
| | BILIRUBIN DIRECT (Diazotization) | **0.09** | mg/dl | 0.1-0.4 |
| | BILIRUBIN INDIRECT (Calculation) | 0.42 | mg/dl | 0.2 - 0.7 |
| | ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC) | 40 | U/L | <40 |
| | ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase) | **55** | U/L | <41 |
| | ALKALINE PHOSPHATASE (Colorimetric IFCC) | 51 | U/L | 40-129 |
| | GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC) | 35 | U/L | <70 |
| | TOTAL PROTEIN (Colorimetric) | 7.20 | gm/dl | 6.6-8.7 |
| | ALBUMIN (Bromocresol Green) | 4.60 | gm/dl | 3.5 - 5.2 |
| | GLOBULIN (Calculation) | 2.60 | gm/dl | 2.0-3.5 |
| | A/G RATIO (Calculation) | 1.8 | | 1-2 |

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|---|---|---|---|---|
| **BIOCHEMISTRY** | | | | |
| **COMPREHENSIVE RENAL PROFILE** | | | | |
| **SERUM** | | | | |
| | CREATININE (Jaffe Method) | 0.8 | mg/dl | 0.6 - 1.3 |
| | BLOOD UREA NITROGEN (BUN) (Kinetic with Urease) | 9.0 | mg/dl | 6 - 20 |
| | BUN/CREATININE RATIO (Calculation) | 11.2 | | 10 - 20 |
| | URIC ACID (Uricase Enzyme) | 4.5 | mg/dl | 3.7 - 7.7 |
| | CALCIUM (Bapta Method) | **10.1** | mg/dl | 8.6-10 |
| | PHOSPHORUS (Phosphomolybdate) | 3.3 | mg/dl | 2.5-4.5 |

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|---|---|---|---|---|
| **BIOCHEMISTRY** | | | | |
| **LIPID PROFILE** | | | | |
| SERUM | TOTAL CHOLESTEROL<br>(Enzymatic colorimetric (PHOD)) | **229** | mg/dl | Desirable : < 200<br>Borderline: 200-239<br>High : > 239 |
| **Notes :** | Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.<br>Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.<br>Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665. | | | |
| SERUM | TRIGLYCERIDES<br>(Enzymatic Colorimetric GPO) | 108 | mg/dl | Normal : <150<br>Borderline : 150-199<br>High : 200-499<br>Very High : >499 |
| SERUM | CHOLESTEROL HDL - DIRECT<br>(Homogenize Enzymatic Colorimetry) | 46 | mg/dl | Low:<40<br>High:>60 |
| SERUM | LDL CHOLESTEROL<br>(Calculation) | **161** | mg/dl | Optimal : <100<br>Near Optimal/ Above optimal :100-129<br>Borderline High: 130-159<br>High : 160-189<br>Very High : >= 190 |
| SERUM | VLDL<br>(Calculation) | 22 | mg/dl | 15-40 |
| SERUM | CHOL / HDL RATIO | 5.0 | | 3-5 |
| SERUM | LDL /HDL RATIO<br>(Calculation) | 3.5 | | 0 - 3.5 |

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|---|---|---|---|---|
| **BIOCHEMISTRY** | | | | |
| **EDTA WHOLE BLOOD** | **GLYCOSYLATED HAEMOGLOBIN (HbA1C)** | | | |
| | HbA1C<br>(High Performance Liquid Chromatography) | 6.0 | %(NGSP) | Non Diabetic Range: <= 5.6<br>Prediabetes :5.7-6.4<br>Diabetes: >= 6.5 |
| | ESTIMATED AVERAGE BLOOD GLUCOSE<br>(Calculated) | 125 | mg/dl | |

**Notes :** HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.
HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.
HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.
References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

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|---|---|---|---|---|
| **IMMUNOLOGY** | | | | |
| **THYROID PROFILE - TOTAL** | | | | |
| **SERUM** | | | | |
| | TOTAL TRIIODOTHYRONINE (T3)<br>(ECLIA) | 1.37 | ng/ml | 0.7-2.04 |
| | TOTAL THYROXINE (T4)<br>(ECLIA) | 9.20 | ug/dl | 4.6 - 10.5 |
| | THYROID STIMULATING HORMONE (TSH)<br>(ECLIA) | 2.005 | uIU/ml | 0.27 - 4.20 |

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**IMMUNOLOGY**

**Notes :** TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level.The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)
-Low TSH, Low FT4 - Central hypothyroidism.
-Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
-Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter,Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
-Normal TSH,Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism,Medications.
-Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbumineic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
-High TSH, Low FT4- Primary hypothyroidism.
-High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
-High TSH, High FT4- TSH mediated hyperthyroidism

Note:
1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:
1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

Contd ...

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|---|---|---|---|---|
| **CLINICAL PATHOLOGY** | | | | |
| **Urine** | **URINE ANALYSIS** | | | |
| | **PHYSICAL EXAMINATION** | | | |
| | VOLUME<br>(Volumetric) | 30 | | |
| | COLOR<br>(Visual Examination) | PALE YELLOW | | |
| | APPEARANCE<br>(Visual Examination) | CLEAR | | |
| | **CHEMICAL EXAMINATION** | | | |
| | SP.GRAVITY<br>(Indicator System) | 1.005 | | 1.005 - 1.030 |
| | REACTION(pH)<br>(Double indicator) | ACIDIC | | |
| | PROTEIN<br>(Protein-error-of-Indicators) | ABSENT | | |
| | GLUCOSE<br>(GOD-POD) | ABSENT | | Absent |
| | KETONES<br>(Legal's Test) | ABSENT | | Absent |
| | OCCULT BLOOD<br>(Peroxidase activity) | ABSENT | | Absent |
| | BILIRUBIN<br>(Fouchets Test) | ABSENT | | Absent |
| | UROBILINOGEN<br>(Ehrlich Reaction) | NORMAL | | |
| | NITRITE<br>(Griess Test) | ABSENT | | |
| | **MICROSCOPIC EXAMINATION** | | | |
| | ERYTHROCYTES<br>(Microscopy) | ABSENT | /hpf | 0-2 |
| | PUS CELLS<br>(Microscopy) | 1-2 | /hpf | 0-5 |
| | EPITHELIAL CELLS<br>(Microscopy) | 1-2 | /hpf | 0-5 |
| | CASTS<br>(Microscopy) | ABSENT | | |
| | CRYSTALS<br>(Microscopy) | ABSENT | | |
| | ANY OTHER FINDINGS | NIL | | |

Contd ...

**MEDICAL REPORT**

**Lab Address:**
Udyog Bhavan, Unit No. 15, Ground Floor,
Wadala (Dadar), Mumbai - 400031.
**86528 86529**

**Patient Name** : **Mr. Dushyant Khatri**
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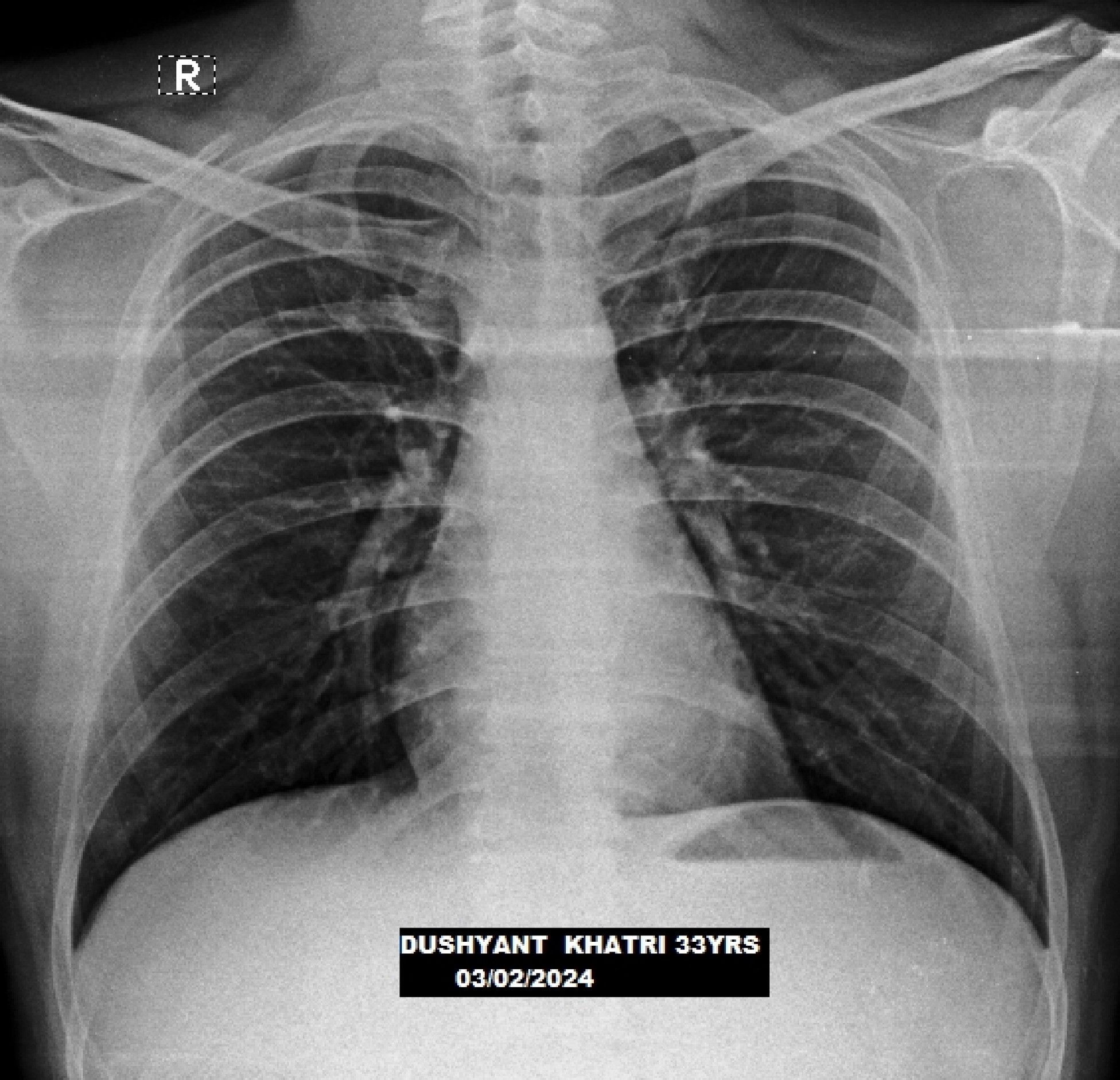
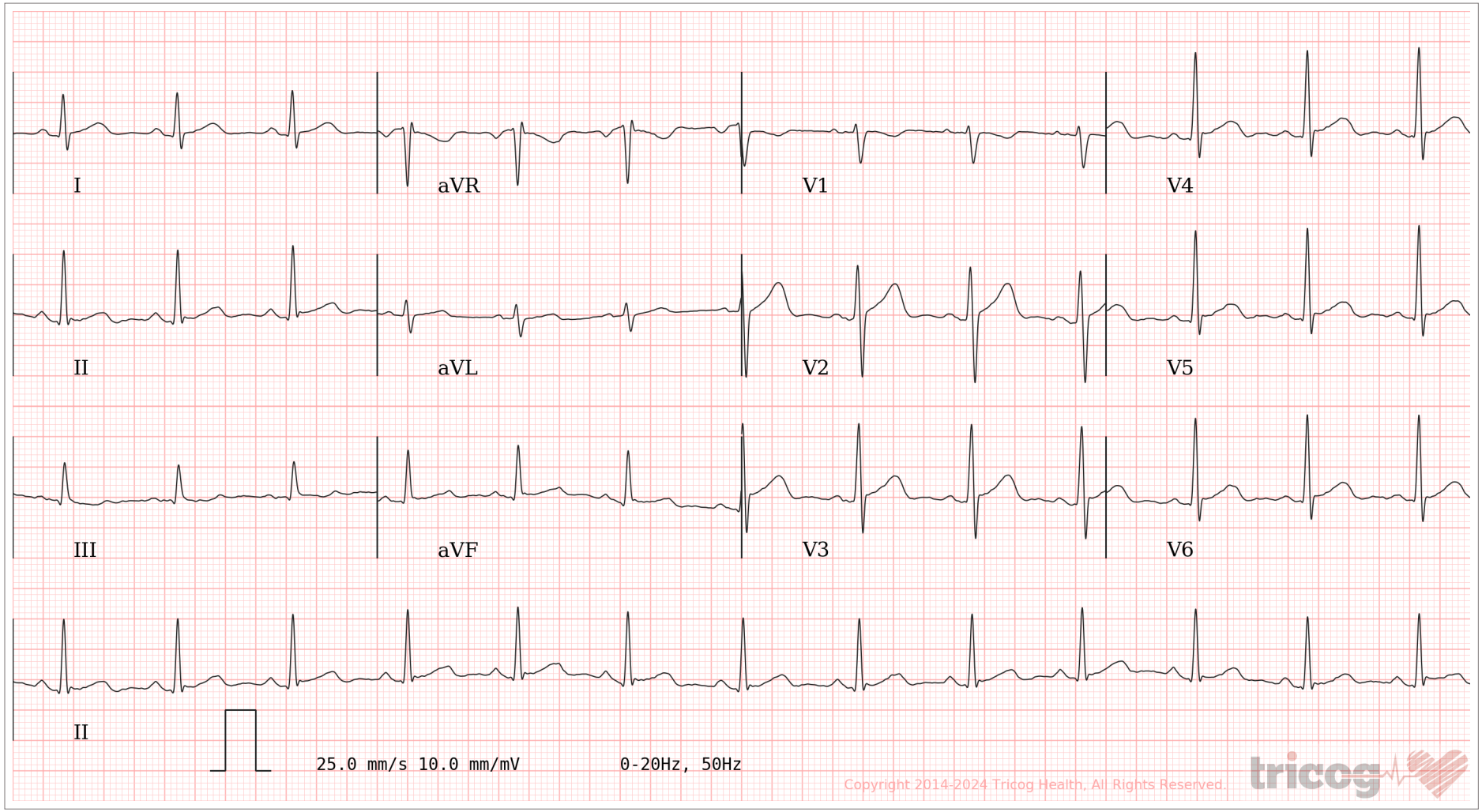

R
DUSHYANT KHATRI 33YRS
03/02/2024

HEALTHSPRING
FAMILY HEALTH EXPERTS

# Healthspring Andheri West

Age / Gender: 33/Male
Patient ID: 0849067
Patient Name: Dushyant Khatri

Date and Time: 3rd Feb 24 9:46 AM






AR: 81bpm VR: 80bpm QRSD: 94ms QT: 370ms QTcB: 426ms PRI: 146ms P-R-T: 40° NA 39°

ECG Within Normal Limits: Sinus Rhythm. Please correlate clinically.

AUTHORIZED BY

Dr. Charit
MD, DM: Cardiology

63382

REPORTED BY

Dr. Soumya Rao

HEALTHSPRING
FAMILY HEALTH EXPERTS

PATIENT'S NAME - Dushyant Khatri
AGE/GENDER - 33yr/M
DOCTOR'S NAME - Dr Gauri

DATE - 3/2/2024

## VISION SCREENING

| | RE | RE | LE | LE |
|---|---|---|---|---|
| | Glasses | UNAIDED | Glasses | UNAIDED |
| DISTANT | | 6/6 | | lazy eye. |
| NEAR | | N6 | | |
| COLOUR | normal | | | |
| Recommendations | | | | |

## VITALS

| | | |
|---|---|---|
| Pulse - 78 | B.P- 120/80 | SpO2 98 |
| Height 174 | Weight - 73.60 | BMI- |
| Waist - 90 | Hip - 102 | Waist/Hip Ratio- |
| Chest - 98 | Inspiration- | Expiration- |

CENTRE NAME - Oshiwara

SIGN & STAMP-

WELLSPRING HEALTHCARE LTD ANDHERI (W)

Date :- 03/02/24

Dear Sir / Madam,

Due to some urgency today, I had to leave.

I'll be doing the TMT test coming Sat.

Along with post breakfast blood test

+ Stool sample

Thanks

Dushyant

8209643088

Dushyant

भारत सरकार
Government of India

आधार

दुष्यंत खत्री
Dushyant Khatri
जन्म तिथि/DOB: 04/10/1990
पुरुष/ MALE

Download Date: 14/08/2020

Issue Date: 06/08/2020

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मेरा आधार, मेरी पहचान

भारतीय विशिष्ट पहचान प्राधिकरण
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AADHAAR

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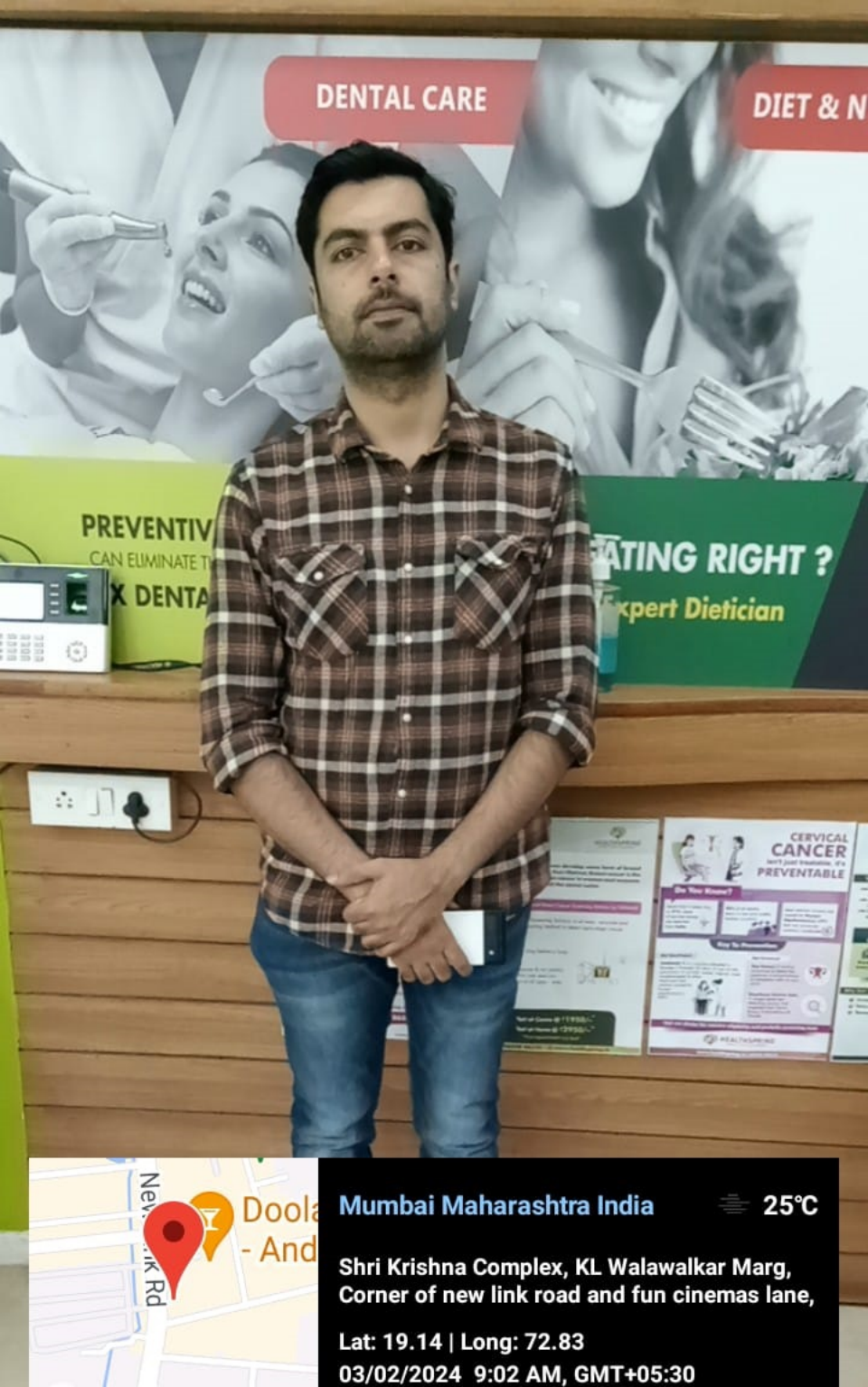


Mumbai Maharashtra India 25℃

Shri Krishna Complex, KL Walawalkar Marg, Corner of new link road and fun cinemas lane,

Lat: 19.14 | Long: 72.83
03/02/2024 9:02 AM, GMT+05:30

HEALTHSPRING
FAMILY HEALTH EXPERTS

| | |
|---|---|
| **Name : DUSHYANT KHATRI** | **Age : 33YRS** |
| **Gender : MALE** | **Date : 03/02/2024** |

# X-RAY CHEST PA VIEW

X-ray of the chest in P.A. projection reveals that the bony thorax is normal.

Lung fields and pleural spaces are clear on both sides.

The silhouettes of the heart and aorta are normal in size and configuration.

Both domes of the diaphragm are normal in position, contour and outline.

**IMPRESSION: NO EVIDENCE OF ANY DISEASE IS SEEN IN THE CHEST.**

Dr. Nitish Kotwal
MBBS, DMRD (Bom)
**Consultant Radiologist And Sonologist..**
**Online reporting done hence no signature**