

ms. Shippi haldar
Age - 35y/f

BP - 110/80
P - 96/mt
H - 167
wt - 70



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EXAMINATION OF EYES :- (BY OPHTHALMOLOGIST)

Patient Name Miss. Shilpa

Date 7/10/23

Sex/Age 35/F

MR No

Employee Id

EXTERNAL EXAMINATION				
SQUINT	<u>- No</u>			
NYSTAGMUS	<u>- No</u>			
COLOUR VISION	<u>- Normal</u>			
FUNDUS:(RE):-	<u>clear (LE):-</u>		<u>clear</u>	
INDIVIDUAL COLOUR IDENTIFICATION				
DISTANT VISION:(RE):-	<u>6/6</u>	(LE):-	<u>6/6</u>	
NEAR VISION:(RE):-	<u>M/6</u>	(LE):-	<u>M/6</u>	
NIGHT BLINDNESS				
	SPH	CYL	AXIS	ADD
RIGHT				
LEFT				
REMARKS :- <u>fundus - clear</u> <u>Vn < 6/6</u> <u>6/6</u>				



Dr. Vikas Mishra
MBBS, MS(Ophthalmologist)
Reg. No. CGMC 621/2006

Patient Name : Mrs SHILPI HALDER
UHID/ MR No : 7144
Visit Date : 09/10/2023
Sample Collected On : 09/10/2023 02:23PM
Ref. Doctor : SELF
Sponsor Name :

Age/Gender : 35 Y Female
OP Visit No : OPD-UNIT-II-2
Reported On : 10/10/2023 11:35AM

HAEMATOTOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
HEMOGRAM			
Haemoglobin(HB) Method: CELL COUNTER	12.7	gm/dl	12 - 16
Erythrocyte (RBC) Count Method: CELL COUNTER	4.73	mill/cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	38.10	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	80.5	fL	76.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	26.8	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	14.1	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	7.88	cells/cumm	3.50 - 11.00
Neutrophils Method: CELL COUNTER	67	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	27	%	15.0 - 45.0
Eosinophils Method: CELL COUNTER	01	%	1-6%
Monocytes	05	%	4.0 - 12.0
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report
Results are to be correlated clinically

Lab Technician / Technologist
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Dhananjay
DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

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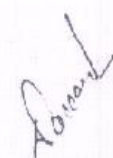
HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count Method: CELL COUNTER	337	lacs/cu.mm	150-400
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	25	mm /HR	0 - 20
Blood Group (ABO Typing)			
Blood Group (ABO Typing)	O		
RhD factor (Rh Typing)	POSITIVE		

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
Glucose Random Method: REAGENT GRADE WATER	105.0	mg/dl	70.0-140.0
KFT - RENAL PROFILE - SERUM			
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	08	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	0.83	mg/dl	0.6-1.4
Uric Acid Method: Spectrophotometric	3.9	mg/dL	2.6 - 7.2

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Age/Gender : 35 Y. Female
OP Visit No : OPD-UNIT-II-1
Reported On : 10/10/2023 11:35AM

BIO CHEMISTRY


Investigation	Observed Value	Unit	Biological Reference Interval
HbA1c (Glycosalated Haemoglobin)	5.6	%	Non-diabetic: ≤5.6, Pre-Diabetic 5.7-6.4, Diabetic: ≥6.5

- HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
 - HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
 - Trends in HbA1c are a better indicator of diabetic control than a solitary test.
 - Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammation.
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 - HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
 - Trends in HbA1c are a better indicator of diabetic control than a solitary test.
 - Low glycated haemoglobin (below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
 - To estimate the eAG from the HbA1C value, the following equation is used: $eAG(mg/dl) = 28.7 * A1c - 46.7$
 - Interference of Haemoglobinopathies in HbA1c estimation.
 - For HbF > 25%, an alternate platform (Fructosamine) is recommended for monitoring diabetic status.
 - Homozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status.
 - Heterozygous state dete

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	145.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	93.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotometric HDL Cholesterol	45.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotometric LDL Cholesterol	81.40	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very HiOptimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=1
Method: Spectrophotometric VLDL Cholesterol	18.60	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	3.22		3.5 - 5
Method: Spectrophotometric			

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	0.6	mg/dl	0.1-1.2
Bilirubin - Direct Method: Spectrophotometric	0.3	mg/dl	0.05-0.3
Bilirubin (Indirect) Method: Calculated	0.30	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	18	U/L	0 - 32
SGPT (ALT) Method: Spectrophotometric	23	U/L	0 - 33
ALKALINE PHOSPHATASE	56	U/L	25-147
Total Proteins Method: Spectrophotometric	6.7	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.3	mg/dl	3.4 - 5.0
Globulin Method: Calculated	2.4	g/dl	1.8 - 3.6
A/G Ratio Method: Calculated	1.79	%	1.1 - 2.2

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IMMUNO ASSAY


Investigation	Observed Value	Unit	Biological Reference Interval
T3, T4, TSH			
T3 (Total) by CLIA,serum	1.25	ng/mL	0.87-1.78
Clinical Use · Diagnose and monitor treatment of Hyperthyroidism Increased Levels: Pregnancy, Graves disease, T3 thyrotoxicosis, TSH dependent Hyperthyroidism, Increased TBG Decreased Levels: Nonthyroidal illness, Hypothyroidism, Nutritional deficiency, Systemic illness, Decreased TBG			
T4(Total) by CLIA,serum	8.90	mcg/dl	6.09-12.23
Clinical Use · Diagnose Hypothyroidism and Hyperthyroidism when overt and / or due to pituitary or hypothalamic disease. Increased Levels: Hyperthyroidism, Increased TBG, Familial dysalbuminemic hyperthyroxinemia, Increased Transthyretin, Estrogen therapy, Pregnancy Decreased Levels: Primary hypothyroidism, Pituitary TSH deficiency, Hypothalamic TRH deficiency, Non thyroidal illness, Decreased TBG.			
TSH (Ultrasensitive) CLIA Serum	5.64	mIU/ml	0.34- 6.0
Initial test of thyroid function in patients with suspected thyroid dysfunction · Assess thyroid status in patients with abnormal total T4 concentrations · Distinguish Euthyroid hyperthyroxinemias from hypothyroidism. Increased Levels: Thyroid hormone resistance, Hyperthyroidism Decreased Levels: Primary hypothyroidism, Secondary hypothyroidism Clinical Use · Initial test of thyroid function in patients with suspected thyroid dysfunction			

Note: Total T3 & T4 levels measure the hormone which is in the bound form and is not available to most tissues. In addition severe systemic illness which affects the thyroid binding proteins can falsely alter Total T4 levels in the absence of a primary thyroid disease. Hence Free T3 & T4 levels are recommended for accurate assessment of thyroid dysfunction.

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