Hiranandani
HOSPITAL
(A Fortis Network Hospital)

Hiranandani Fortis Hospital
Mini Seashore Road,
Sector 10 - A, Vashi,
Navi Mumbai - 400 703.
Tel. : +91-22-3919 9222
Fax : +91-22-3919 9220/21
Email : vashi@vashihospital.com

BMI CHART

Date: 24/9/____

Name: _____ Age: ____ yrs Sex: M / F

BP: 150/80 mm/Hg Height (cms): 158 cm Weight(kgs): 71.5 Kg BMI: _____

WEIGHT lbs	100	105	100	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215
kgs	45.5	47.7	50.50	52.3	54.5	56.8	59.1	61.4	63.6	65.9	68.2	70.5	72.7	75.0	77.3	79.5	81.8	84.1	86.4	88.6	90.9	93.2	95.5	97.7
HEIGHT in/cm	Underweight					Healthy					Overweight					Obese					Extremely Obese			
5'0" - 152.4	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
5'1" - 154.9	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	36	37	38	39	40
5'2" - 157.4	18	19	20	21	22	22	23	24	25	26	27	28	29	30	31	32	33	33	34	35	36	37	38	39
5'3" - 160.0	17	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	32	32	33	34	35	36	37	38
5'4" - 162.5	17	18	18	19	20	21	22	23	24	24	25	26	27	28	29	30	31	31	32	33	34	35	36	37
5'5" - 165.1	16	17	18	19	20	20	21	22	23	24	25	25	26	27	28	29	30	30	31	32	33	34	35	35
5'6" - 167.6	16	17	17	18	19	20	21	21	22	23	24	25	25	26	27	28	29	29	30	31	32	33	34	34
5'7" - 170.1	15	16	17	18	18	19	20	21	22	22	23	24	25	25	26	27	28	29	29	30	31	32	33	33
5'8" - 172.7	15	16	16	17	18	19	19	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	32	32
5'9" - 176.2	14	15	16	17	17	18	19	20	20	21	22	22	23	24	25	25	26	27	28	28	29	30	31	31
5'10" - 177.8	14	15	15	16	17	18	18	19	20	20	21	22	23	23	24	25	25	26	27	28	28	29	30	30
5'11" - 180.3	14	14	15	16	16	17	18	18	19	20	21	21	22	23	23	24	25	25	26	27	28	28	29	30
6'0" - 182.8	13	14	14	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28	29
6'1" - 185.4	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27	28
6'2" - 187.9	12	13	14	14	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	25	25	26	27	27
6'3" - 190.5	12	13	13	14	15	15	16	16	17	18	18	19	20	20	21	21	22	23	23	24	25	25	26	26
6'4" - 193.0	12	12	13	14	14	15	15	16	17	17	18	18	19	20	20	21	22	22	23	23	24	25	25	26

Doctors Notes:

_____

_____

_____

_____

_____

_____

_____
Signature

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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
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D

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UHID	**4609607**	**Date**	**24/09/2022**		
Name	**Mrs.Mangal Chandrakant Patil**	**Sex**	~~Fe~~**Male**	**Age**	**41**
OPD	**Pap Smear**	**Health Check-up**			

Drug allergy:
Sys illness:

Allgs | P2L2.

LMP: 14.9.22.

PMC: 3|30d, RMP.

Psp - exp (H) pap ug

- Breast exam (N)
- SBE explained.

Adv

- F/u c reports

Noha

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		Date	24/09/2022		
UHID	4609607	Sex	FeMale	Age	41
Name	Mrs.Mangal Chandrakant Patil	Health Check-up			
OPD	Opthal 14				

Drug allergy:
Sys illness:

RG. Plano 6/6.
LE Plano 6/6.
Add +1.00 → N6, N6

Ant seg (normal)

IOP → 14.5, 15.2

Fundus normal

(signature)

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(A Fortis Network Hospital)

UHID	**4609607**	**Date**	**24/09/2022**		
Name	**Mrs.Mangal Chandrakant Patil**	**Sex**	~~Fe~~**Male**	**Age**	**41**
OPD	**Dental 12**	**Health Check-up**			

Drug allergy:
Sys illness:

Caries $\frac{7\,6\,2 \mid 6\,7}{7 \mid 3\,4\,7}$

missing $\frac{\quad \mid \quad}{6 \mid 6}$

Staining ++

Calculus ++

Treatment:

Adv. filling $\frac{7\,6\,2 \mid 6\,7}{7 \mid 3\,4\,7}$

Adv. replacement $\frac{\quad \mid \quad}{6 \mid 6}$

Adv. Oral prophylaxis

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID :	**FH.4609607**	CLIENT PATIENT ID :			
ACCESSION NO :	**0022VI005164**	AGE : 41 Years	SEX : Female	DATE OF BIRTH :	01/08/1981
DRAWN :	24/09/2022 12:50	RECEIVED : 24/09/2022 12:55		REPORTED :	24/09/2022 15:15
CLIENT NAME :	**FORTIS VASHI-CHC -SPLZD**	**REFERRING DOCTOR :** SELF			

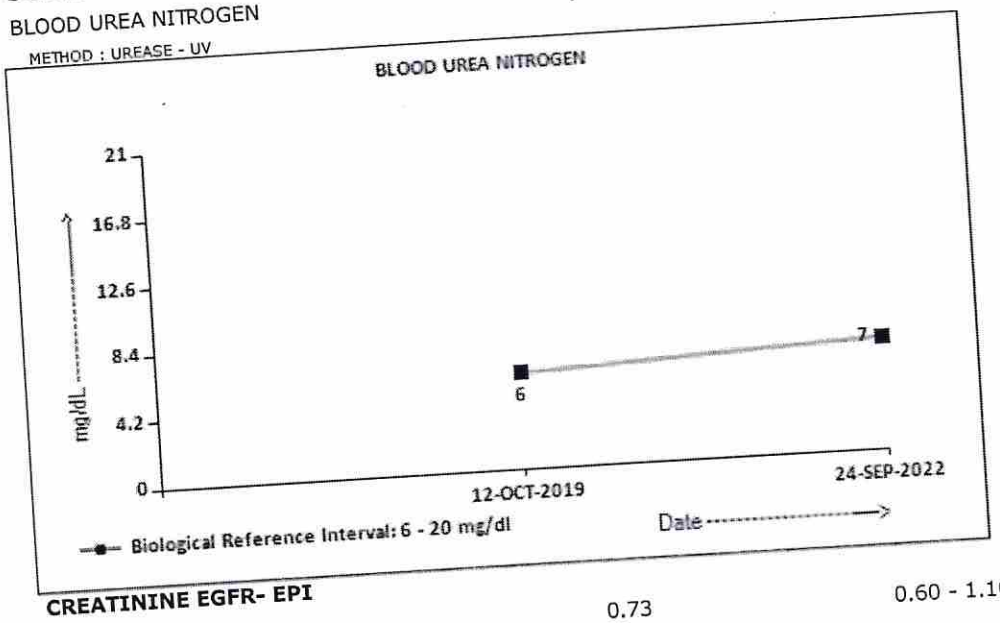
Test Report Status **Final**	Results	Biological Reference Interval	Units

KIDNEY PANEL - 1

SERUM BLOOD UREA NITROGEN

BLOOD UREA NITROGEN — 7 — 6 - 20 — mg/dL

METHOD : UREASE - UV



CREATININE EGFR- EPI

CREATININE — 0.73 — 0.60 - 1.10 — mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE — 41 — years

GLOMERULAR FILTRATION RATE (FEMALE) — 105.89 — Refer Interpretation Below — mL/min/1.73m

METHOD : CALCULATED PARAMETER

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Patient Ref. No. 2200000079

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

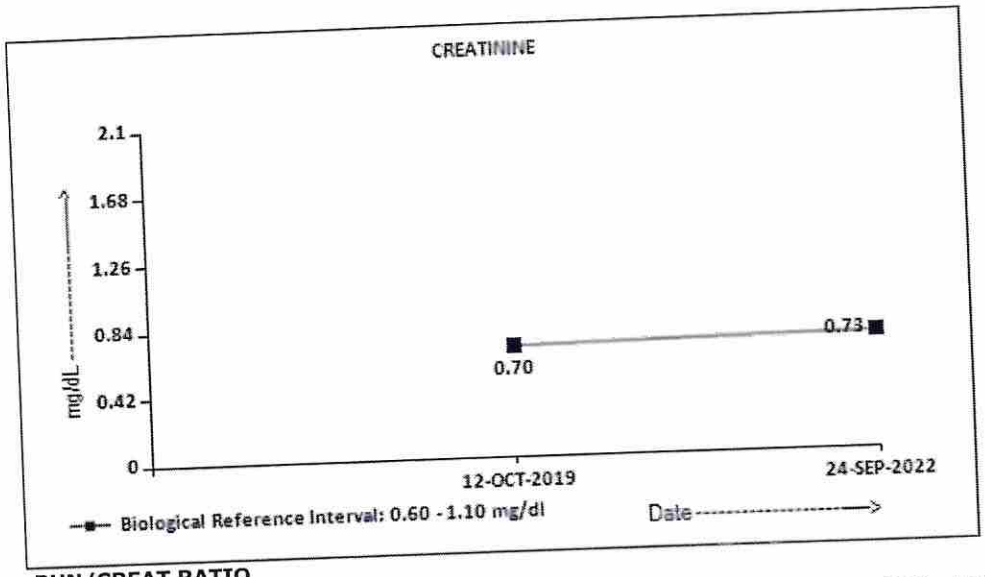
PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval	Units



BUN/CREAT RATIO			
BUN/CREAT RATIO	9.59	5.00 - 15.00	
METHOD : CALCULATED PARAMETER			
URIC ACID, SERUM			
URIC ACID	3.4	2.6 - 6.0	mg/dL
METHOD : URICASE UV			
TOTAL PROTEIN, SERUM			
TOTAL PROTEIN	8.2	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN, SERUM			
ALBUMIN	3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN			
GLOBULIN	**4.4**	**High** 2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ELECTROLYTES (NA/K/CL), SERUM			
SODIUM	140	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM	4.44	3.50 - 5.10	mmol/L
METHOD : ISE INDIRECT			
CHLORIDE	105	98 - 107	mmol/L
METHOD : ISE INDIRECT			
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		

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Patient Ref. No. 2200000079749

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval	Units
METHOD : PHYSICAL APPEARANCE	CLEAR		
METHOD : VISUAL SPECIFIC GRAVITY	<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)			
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD 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	
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			
PUS CELL (WBC'S)	2-3	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION EPITHELIAL CELLS	0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION ERYTHROCYTES (RBC'S)	NOT DETECTED	NOT DETECTED	/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	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

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Patient Ref. No. 220000007974

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval

Interpretation(s)

SERUM BLOOD UREA NITROGEN-

Causes of Increased levels

Pre renal

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
- Renal Failure

Post Renal

- Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- 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 syndrome.

Causes of decreased levels

- Low Zinc Intake
- OCP's
- Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluids
- Limit animal proteins
- High Fibre foods
- Vit C Intake
- Antioxidant rich foods

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.

ELECTROLYTES (NA/K/CL), SERUM-

Sodium levels are Increased in dehydration, cushing's syndrome, aldosteronism & decreased in Addison's disease, hypopituitarism,liver disease. Hypokalemia (low K) is common in vomiting, diarrhea, alcoholism, folic acid deficiency and primary aldosteronism. Hyperkalemia may be seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid K infusion.Chloride is increased in dehydration, renal tubular acidosis (hyperchloremia metabolic acidosis), acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction, salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt.Chloride is decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting,

MICROSCOPIC EXAMINATION, URINE-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous

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PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

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Test Report Status **Final**	Results	Biological Reference Interval

exercise.
Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.
Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.
Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

HAEMATOLOGY

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD			
HEMOGLOBIN	**10.4**	**Low** 12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL COUNT	3.91	3.8 - 4.8	mil/µL
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL COUNT	7.20	4.0 - 10.0	thou/µL
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	340	150 - 410	thou/µL
METHOD : ELECTRICAL IMPEDANCE			
RBC AND PLATELET INDICES			
HEMATOCRIT	**30.2**	**Low** 36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME	**77.2**	**Low** 83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN	**26.5**	**Low** 27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	34.3	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	19.7		
RED CELL DISTRIBUTION WIDTH	**15.5**	**High** 11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME	10.3	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT - NLR			
NEUTROPHILS	52	40 - 80	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT	3.74	2.0 - 7.0	thou/µL
METHOD : CALCULATED PARAMETER			
LYMPHOCYTES	35	20 - 40	%
METHOD : FLOW CYTOMETRY			

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PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

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Test Report Status **Final**	Results	Biological Reference Interval	
ABSOLUTE LYMPHOCYTE COUNT	2.52	1.0 - 3.0	thou/µL
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.5		
METHOD : CALCULATED PARAMETER			
EOSINOPHILS	4	1 - 6	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE EOSINOPHIL COUNT	0.29	0.02 - 0.50	thou/µL
METHOD : CALCULATED PARAMETER			
MONOCYTES	9	2 - 10	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE MONOCYTE COUNT	0.65	0.2 - 1.0	thou/µL
METHOD : CALCULATED PARAMETER			
BASOPHILS	00	0 - 2	%
METHOD : FLOW CYTOMETRY			
ABSOLUTE BASOPHIL COUNT	**0**	**Low** 0.02 - 0.10	thou/µL
METHOD : CALCULATED PARAMETER			
DIFFERENTIAL COUNT PERFORMED ON:	EDTA SMEAR		
MORPHOLOGY			
RBC	MILD HYPOCHROMASIA, MILD MICROCYTOSIS, MILD ANISOCYTOSIS		
METHOD : MICROSCOPIC EXAMINATION			
WBC	NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS	ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION			
ERYTHRO SEDIMENTATION RATE, BLOOD			
SEDIMENTATION RATE (ESR)	**34**	**High** 0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

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.
WBC DIFFERENTIAL COUNT - NLR-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.
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non - specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants. The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced b age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

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"

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Patient Ref. No. 22000000797

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

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

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.

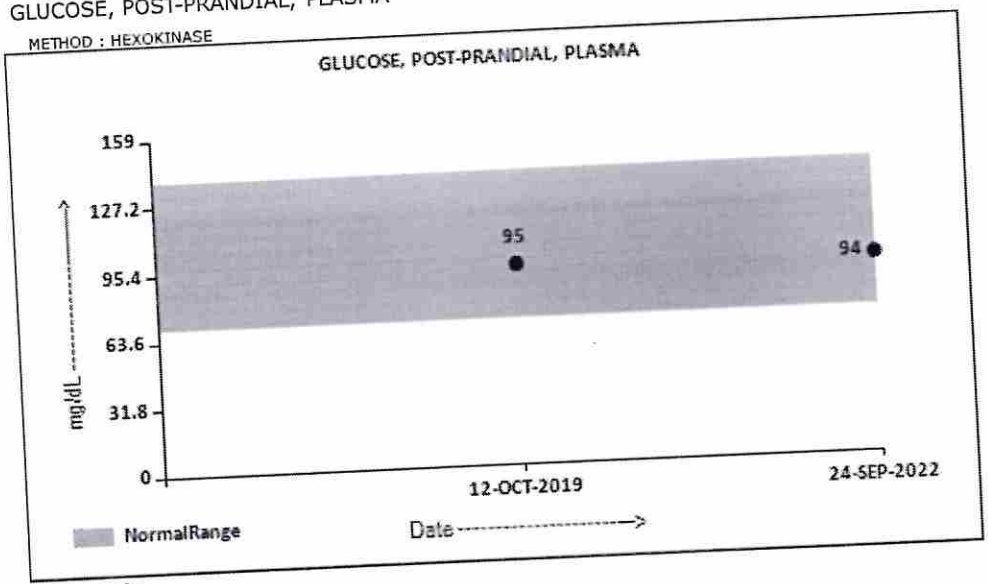
Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

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

BIO CHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA	94	70 - 139	mg/dL
METHOD : HEXOKINASE			



Comments

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

GLUCOSE, FASTING, PLASMA

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Patient Ref. No. 2200000079

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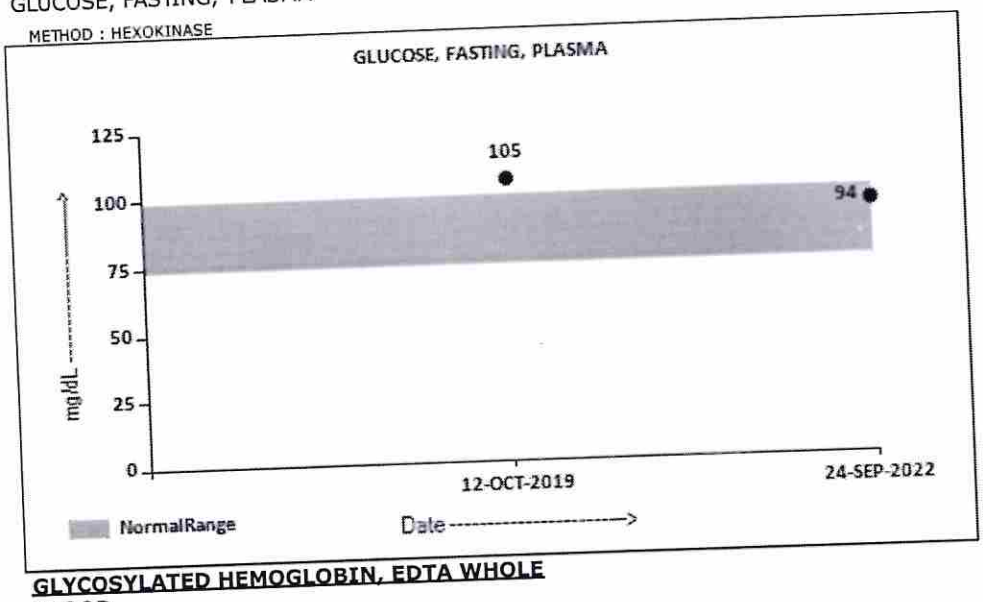
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval	
GLUCOSE, FASTING, PLASMA	94	74 - 99	mg/dL

METHOD : HEXOKINASE



GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD

GLYCOSYLATED HEMOGLOBIN (HBA1C)	5.3	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 ADA Target: 7.0 Action suggested: > 8.0	%
METHOD : HB VARIANT (HPLC)			
MEAN PLASMA GLUCOSE	105.4	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER			

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Patient Ref. No. 2200000079749

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

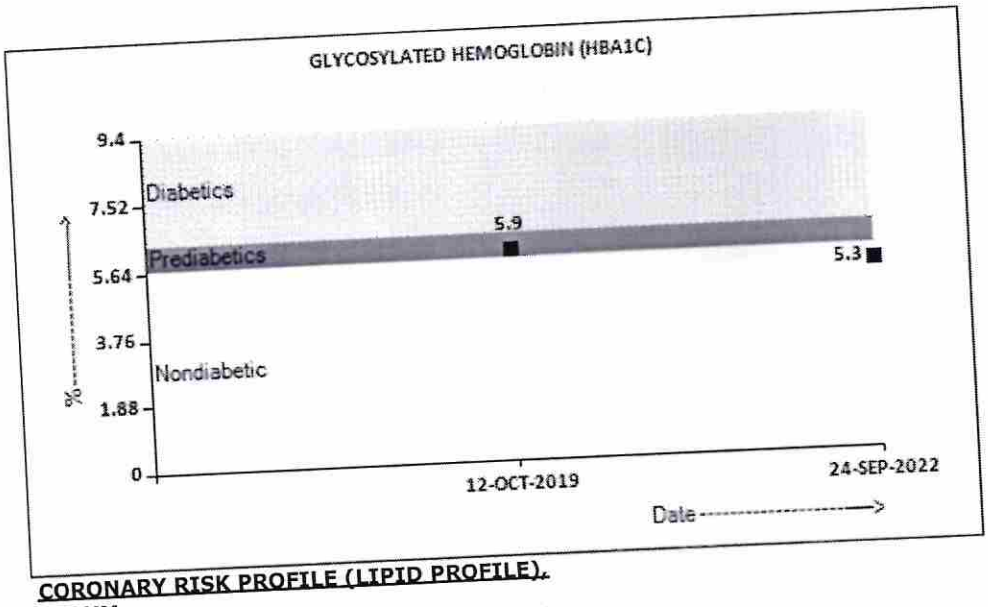
PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval



CORONARY RISK PROFILE (LIPID PROFILE),
SERUM

CHOLESTEROL	126		< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE TRIGLYCERIDES	61		< 150 Normal 150 - 199 Borderline High 200 - 499 High >/=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY HDL CHOLESTEROL	**36**	**Low**	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG DIRECT LDL CHOLESTEROL	78		< 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	90		Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	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	

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Patient Ref. No. 22000000797

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

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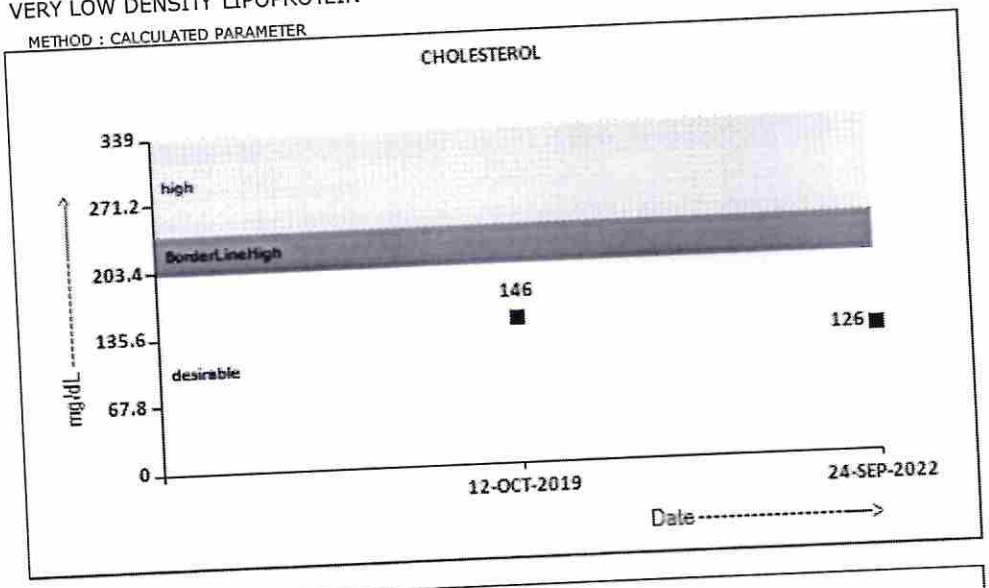
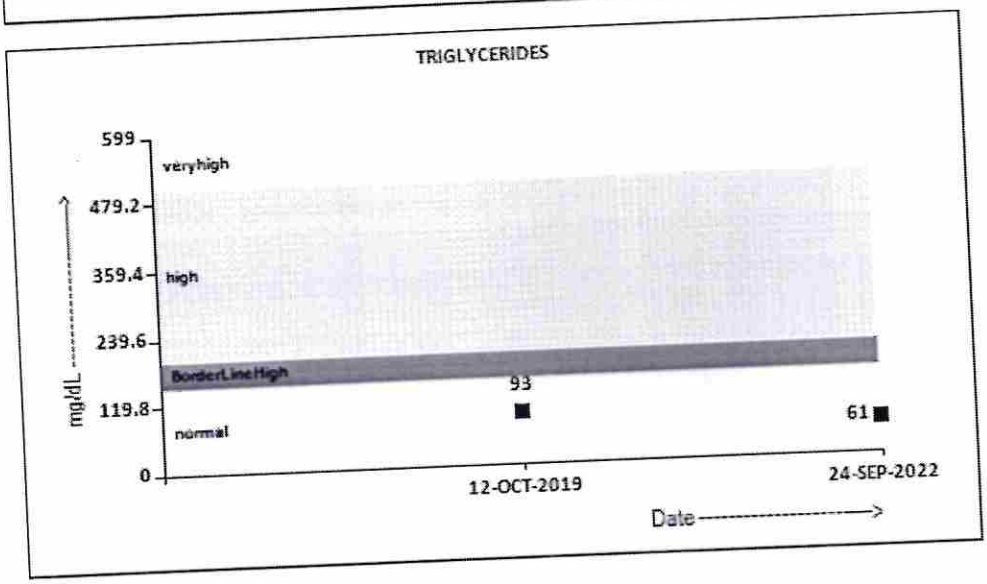
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval	
		> 11.0 High Risk	
METHOD : CALCULATED PARAMETER LDL/HDL RATIO	2.2	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER VERY LOW DENSITY LIPOPROTEIN	12.2	</= 30.0	mg/dL

METHOD : CALCULATED PARAMETER





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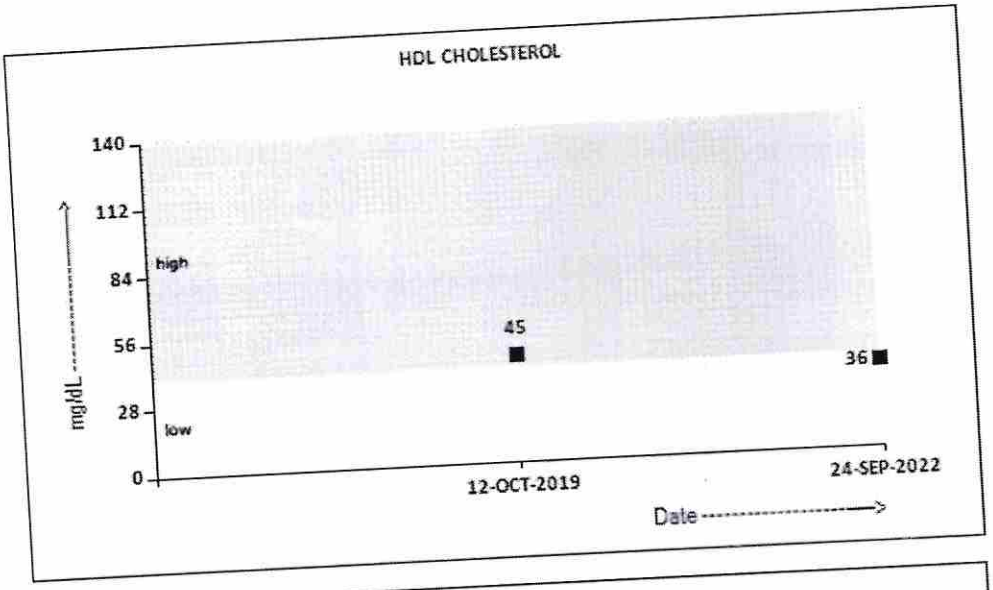
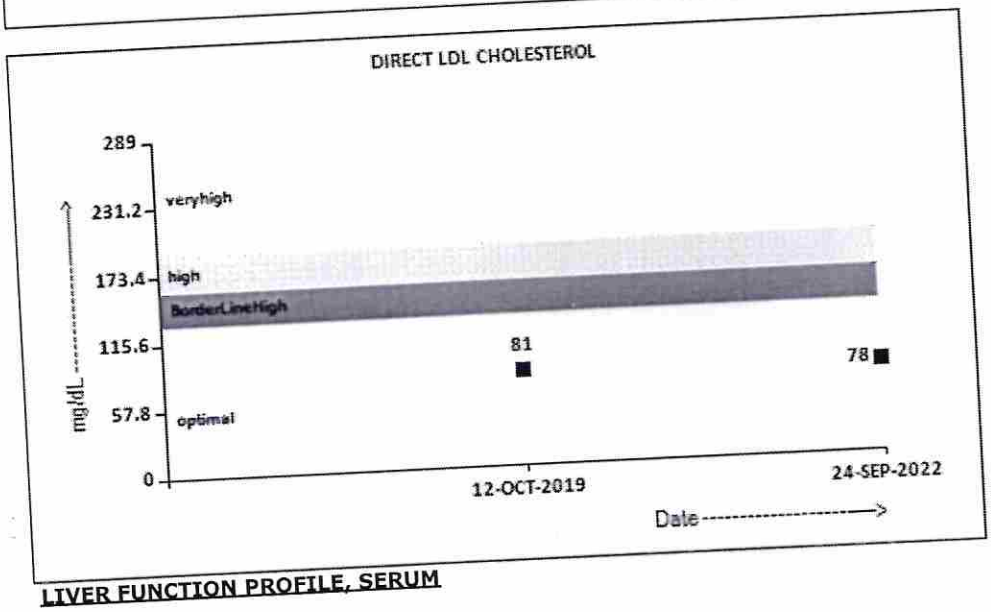
Test Report Status **Final**	Results	Biological Reference Interval





LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL	**0.18**	**Low**	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	0.08		0.1 - 1.0	mg/dL

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Patient Ref. No. 2200000079

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

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CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval	
METHOD : CALCULATED PARAMETER TOTAL PROTEIN	8.2	6.4 - 8.2	g/dL
METHOD : BIURET ALBUMIN	3.8	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING GLOBULIN	**4.4**	**High** 2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER ALBUMIN/GLOBULIN RATIO	**0.9**	**Low** 1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER ASPARTATE AMINOTRANSFERASE (AST/SGOT)	**14**	**Low** 15 - 37	U/L
METHOD : UV WITH P5P ALANINE AMINOTRANSFERASE (ALT/SGPT)	15	< 34.0	U/L
METHOD : UV WITH P5P ALKALINE PHOSPHATASE	94	30 - 120	U/L
METHOD : PNPP-ANP GAMMA GLUTAMYL TRANSFERASE (GGT)	19	5 - 55	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE LACTATE DEHYDROGENASE	138	100 - 190	U/L
METHOD : LACTATE -PYRUVATE			

Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-ADA Guidelines for 2hr post prandial glucose levels is only after ingestion of 75grams of glucose in 300 ml water,over a period of 5 minutes.

GLUCOSE, FASTING, PLASMA-

ADA 2021 guidelines for adults, after 8 hrs fasting is as follows:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: > or = 126 mg/dL

GLYCOSYLATED HEMOGLOBIN, EDTA WHOLE BLOOD-

Glycosylated hemoglobin (GHb) has been firmly established as an index of long-term blood glucose concentrations and as a measure of the risk for the development of complications in patients with diabetes mellitus. Formation of GHb is essentially irreversible, and the concentration in the blood depends on both the life span of the red blood cell (average 120 days) and the blood glucose concentration. Because the rate of formation of GHb is directly proportional to the concentration of glucose in the blood the GHb concentration represents the integrated values for glucose over the preceding 6-8 weeks.

Any condition that alters the life span of the red blood cells has the potential to alter the GHb level. Samples from patients with hemolytic anemias will exhibit decreased glycated hemoglobin values due to the shortened life span of the red cells. This effect will depend upon the severity of the anemia. Samples from patients with polycythem or post-splenectomy may exhibit increased glycated hemoglobin values due to a somewhat longer life span of the red cells.

Glycosylated hemoglobins results from patients with HbSS, HbCC, and HbSC and HbD must be interpreted with caution, given the pathological processes, including anemia increased red cell turnover, transfusion requirements, that adversely impact HbA1c as a marker of long-term glycemic control. In these conditions, alternative forms of testing such as glycated serum protein (fructosamine) should be considered.

"Targets should be individualized; More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations."

References

1. Tietz Textbook of Clinical Chemistry and Molecular Diagnostics, edited by Carl A Burtis, Edward R.Ashwood, David E Bruns, 4th Edition, Elsevier publication, 2006, 879-884.
2. Forsham PH. Diabetes Mellitus:A rational plan for management. Postgrad Med 1982, 71,139-154.
3. Mayer TK, Freedman ZR: Protein glycosylation in Diabetes Mellitus: A review of laboratory measurements and their clinical utility. Clin Chim Acta 1983, 127, 147-184.

CORONARY RISK PROFILE (LIPID PROFILE), SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This te can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don""t cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for hear disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn""t need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or ha diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, othe diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determinatio provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open an

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Patient Ref. No. 220000007

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005164** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : 24/09/2022 12:50 RECEIVED : 24/09/2022 12:55 REPORTED : 24/09/2022 15:15

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	Results	Biological Reference Interval

blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
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 results 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 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 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

****End Of Report****

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Rekha. N

Dr. Rekha Nair, MD
Microbiologist

Dr.Akta Dubey
Counsultant Pathologist

LABORATORY REPORT

Cert. No. MC-2275

Fortis

SRL Diagnostics

PATIENT NAME : MRS. MANGAL CHANDRAKANT PATIL

PATIENT ID : **FH.4609607** CLIENT PATIENT ID :

ACCESSION NO : **0022VI005212** AGE : 41 Years SEX : Female DATE OF BIRTH : 01/08/1981

DRAWN : RECEIVED : 24/09/2022 14:26 REPORTED : 26/09/2022 10:36

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** **REFERRING DOCTOR :** SELF

Test Report Status **Final**	**Units**

CYTOLOGY

PAPANICOLAOU SMEAR

PAPANICOLAOU SMEAR

TEST METHOD	CONVENTIONAL GYNEC CYTOLOGY
SPECIMEN TYPE	TWO UNSTAINED CERVICAL SMEARS RECEIVED
REPORTING SYSTEM	2014 BETHESDA SYSTEM FOR REPORTING CERVICAL CYTOLOGY
SPECIMEN ADEQUACY	SMEARS STUDIED SHOW SUPERFICIAL SQUAMOUS CELLS, INTERMEDIATE SQUAMOUS CELLS, OCCASIONAL SQUAMOUS METAPLASTIC CELLS, OCCASIONAL CLUSTERS OF ENDOCERVICAL CELLS IN THE BACKGROUND OF FEW POLYMORPHS.

METHOD : MICROSCOPIC EXAMINATION

MICROSCOPY	SAMPLE NOT RECEIVED

Comments

PLEASE NOTE PAPANICOLAU SMEAR STUDY IS A SCREENING PROCEDURE FOR CERVICAL CANCER WITH INHERENT FALSE NEGATIVE RESULTS, HENCE SHOULD BE INTERPRETED WITH CAUTION.

NO CYTOLOGICAL EVIDENCE OF HPV INFECTION IN THE SMEARS STUDIED.

****End Of Report****

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Dr.Akta Dubey

Counsultant Pathologist

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Patient Ref. No. 22000000797539

4609607
41 Years

MAGAL CHANDRAKANT PATIL
Female

9/24/2022 12:26:32 PM
FORTIS HIRANANDANIHOSPITAL VASHI

Rate 77 . Sinus rhythm.....normal P axis, V-rate 50- 99

PR 150
QRSD 91
QT 367
QTc 416

--AXIS--
P 41
QRS 55
T 33

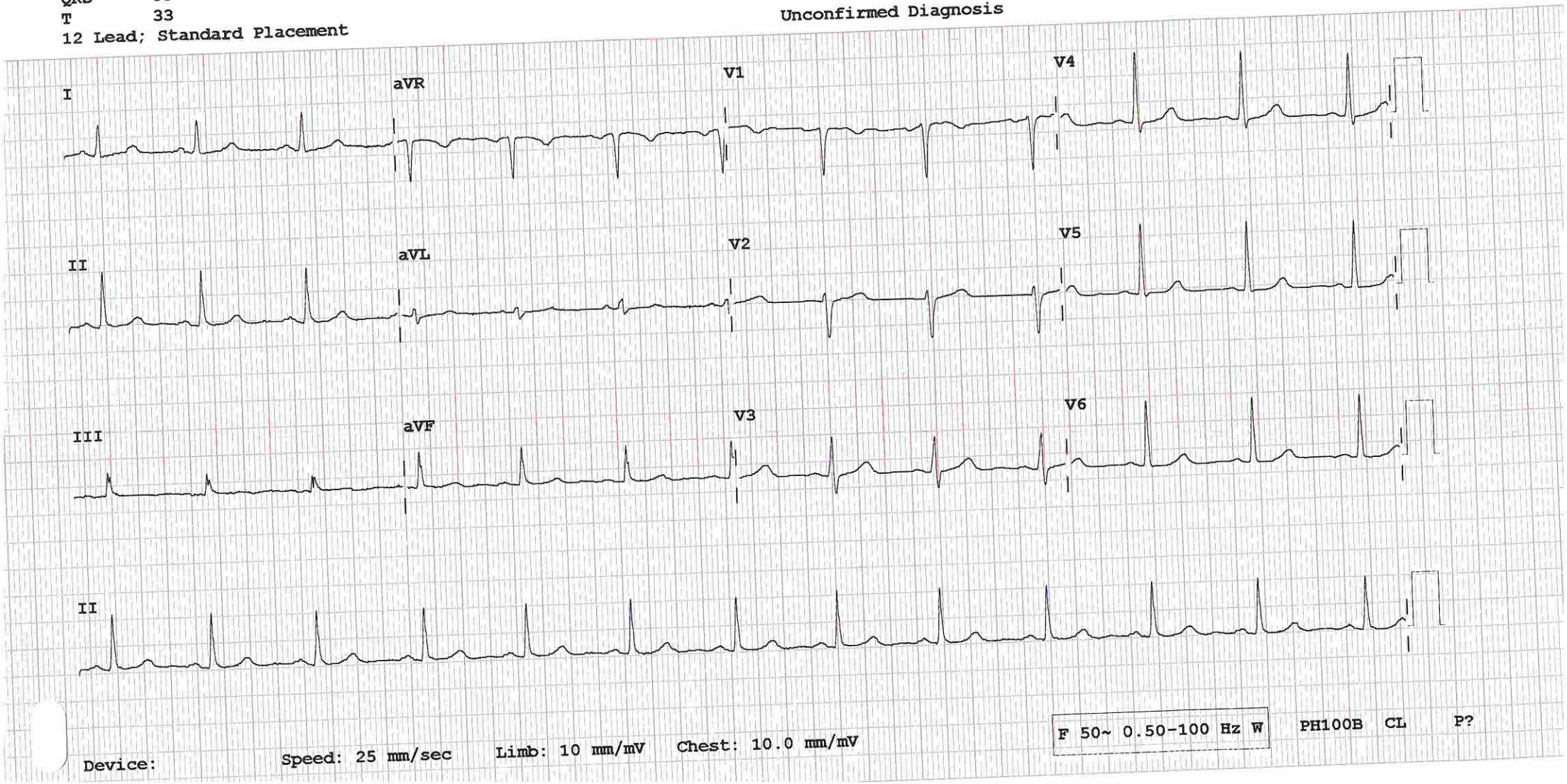
12 Lead; Standard Placement

HC

NSR

- NORMAL ECG -

Unconfirmed Diagnosis



Device:

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

F 50~ 0.50-100 Hz W PH100B CL P?

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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

Date : 24/09/2022
UHID : 4607607

Mangal Patil
41 Years / Female

X-RAY CHEST (PA VIEW)

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 is unremarkable.

DR. YOGESH PATHADE
(MD Radio-diagnosis)

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GST IN : 27AABCH5894D1ZG
PAN NO : AABCH5894D

Hiranandani HOSPITAL
(A Fortis Network Hospital)

Mangal Patil
41 Years / Female

Date : 24/09/2022
UHID : 4607607

USG – WHOLE ABDOMEN

LIVER is normal in size (14.3 cm) and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

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 (10.0 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 8.3 x 4.7 cm.
Left kidney measures 9.6 x 4.3 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.

UTERUS is normal in size and echotexture.
Endometrium measures 4.3 mm in thickness.

Both ovaries are normal.

No evidence of ascites.

IMPRESSION:

- **No significant abnormality is detected.**

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Age: 41 yrs/Female

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BILATERAL DIGITAL X-RAY MAMMOGRAPHY

Findings:

Bilateral film screen mammography was performed in cranio-caudal and medio-lateral oblique views.

Both breasts show scattered areas of fibroglandular density.

Benign calcification is seen in both the breasts.

No evidence of any dominant mass, clusters of microcalcifications, nipple retraction, skin thickening or abnormal vascularity is seen in either breast.

No evidence of axillary lymphadenopathy.

IMPRESSION:

- **Benign calcification in both the breasts. (BI-RADS category II).**
- **No obvious mass lesion in the breasts.**

Normal-interval follow-up is recommended.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)