

BMI CHART

Date: ___/___/___

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

BP: 110/80 mmHg Height (cms): 153 cm Weight(kgs): 64.9 kg BMI: _____
Pulse 82 bpm
SpO2 100%

WEIGHT lbs 100 105 110 115 120 125 130 135 140 145 150 155 160 165 170 175 180 185 190 195 200 205 210 215
kgs 45.5 47.7 50.0 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



UHID	5652365	Date	09/12/2023		
Name	Mrs.Navjeet Kaur	Sex	Female	Age	33
OPD	Ophthal 14	Health Check Up			

Ch. No

Uu No

Drug allergy: -> Not Known

Sys illness: -> NO

Habit: -> NO

UuV → Rg 6/9P
 → Ce 6/9+3

Ph → Pa Phos / -0.75 x 180° 6/6
 → S Phos / -0.50 x 180° 6/6
 MR → Ra NG
 → Ce NG

FOP → Rg → 14.8
 → Ce 14.4

[Handwritten signature]



UHID	5652365	Date	09/12/2023		
Name	Mrs. Navjeet Kaur (7387752812)	Sex	Female	Age	33
OPD	Dental 12	Health Check Up			

Drug allergy:
 Sys illness:

M/H → NRH.

O/E → stains ++, calculus ++

→ clinically missing $\frac{1}{3}$

→ crowded lower anterior

→ Buccally placed $\frac{1}{8}$ (cheek bite)

Ex → Adv. Scaling.

→ Adv. extraction $\frac{1}{8}$ after OPG.

(To pay for:

Scaling (Grade I)

↳ ₹2420)

(Signature)

Diksha Kelam
 MDS (Perio)

4-39457

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



Hiranandani
HOSPITAL

(A Fortis Network Hospital)

UHID	5652365	Date	09/12/2023		
Name	Mrs.Navjeet Kaur	Sex	Female	Age	33
OPD	Pap	Health Check Up			

Drug allergy:
Sys illness:

PATIENT NAME : MRS.NAVJEET KAUR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022WL001403

PATIENT ID : FH.5652365
CLIENT PATIENT ID: UID:5652365
ABHA NO :

AGE/SEX : 33 Years Female
DRAWN : 09/12/2023 08:59:00
RECEIVED : 09/12/2023 09:00:00
REPORTED : 09/12/2023 18:22:35

CLINICAL INFORMATION :

UID:5652365 REQNO-1635229
CORP-OPD
BILLNO-150123OPCR069275
BILLNO-150123OPCR069275

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

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS METHOD	12.7	12.0 - 15.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	4.75	3.8 - 4.8	mil/ μ L
WHITE BLOOD CELL (WBC) COUNT METHOD : FLUORESCENCE FLOW CYTOMETRY	5.03	4.0 - 10.0	thou/ μ L
PLATELET COUNT METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION	199	150 - 410	thou/ μ L

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD	39.0	36.0 - 46.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	82.1 Low	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	26.7 Low	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	32.6	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	12.9	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	17.3		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	11.8 High	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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Consultant Pathologist



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NEUTROPHILS		51	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
LYMPHOCYTES		37	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
MONOCYTES		6	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
EOSINOPHILS		6	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		2.57	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		1.86	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.30	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.30	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.4		
METHOD : CALCULATED				

MORPHOLOGY

RBC

METHOD : MICROSCOPIC EXAMINATION

PREDOMINANTLY NORMOCYTIC NORMOCHROMIC

WBC

METHOD : MICROSCOPIC EXAMINATION

NORMAL MORPHOLOGY

PLATELETS

METHOD : MICROSCOPIC EXAMINATION

ADEQUATE



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CODE/NAME & ADDRESS : C000045507		ACCESSION NO : 0022WL001403	
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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-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), EDTA BLOOD

E.S.R	19	0 - 20	mm at 1 hr
METHOD : WESTERGREN METHOD			

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	5.2	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)	%
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ESTIMATED AVERAGE GLUCOSE(EAG)	102.5	< 116.0	mg/dL
METHOD : HB VARIANT (HPLC)			
METHOD : CALCULATED PARAMETER			

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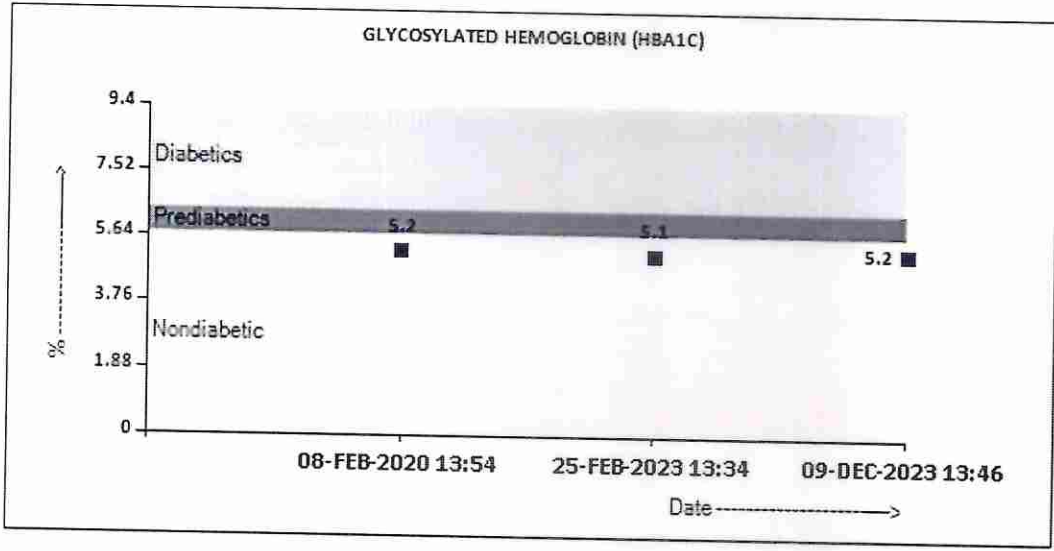
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Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA 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(52 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 :

- Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;
- Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;
- The reference for

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the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.
 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 md/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 :

1. 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.
2. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin).
3. 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.
4. 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

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IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP	TYPE B
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.

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BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : JENDRASSIK AND GROFF	1.49 High	0.2 - 1.0	mg/dL
BILIRUBIN, DIRECT METHOD : JENDRASSIK AND GROFF	0.32 High	0.0 - 0.2	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	1.17 High	0.1 - 1.0	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.6	6.4 - 8.2	g/dL
ALBUMIN METHOD : BCP DYE BINDING	3.9	3.4 - 5.0	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	3.7	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.1	1.0 - 2.1	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT) METHOD : UV WITH P5P	29	15 - 37	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITH P5P	37 High	< 34.0	U/L
ALKALINE PHOSPHATASE METHOD : PNPP-ANP	119	30 - 120	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	17	5 - 55	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE	161	81 - 234	U/L

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	96	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >/=126	mg/dL
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(Reg.no. MMC 2019/09/6377)
Consultant Pathologist



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Maharashtra, India
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CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000889323

PATIENT NAME : MRS.NAVJEET KAUR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022WL001403

PATIENT ID : FH.5652365

CLIENT PATIENT ID: UID:5652365

ABHA NO :

AGE/SEX :33 Years Female

DRAWN :09/12/2023 08:59:00

RECEIVED :09/12/2023 09:00:00

REPORTED :09/12/2023 18:22:35

CLINICAL INFORMATION :

UID:5652365 REQNO-1635229

CORP-OPD

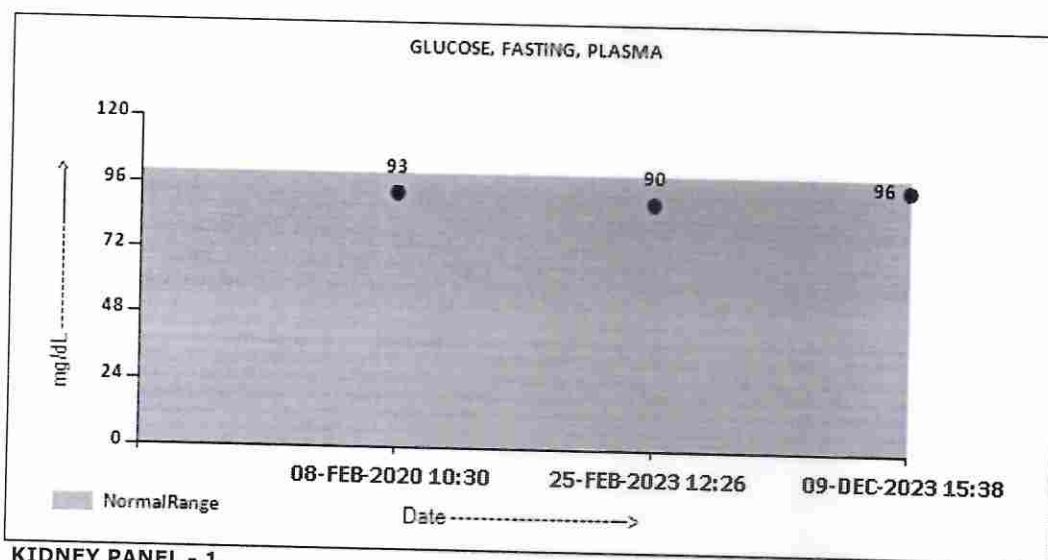
BILLNO-150123OPCR069275

BILLNO-150123OPCR069275

Test Report Status Final

Results

Biological Reference Interval Units



KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN

8

6 - 20

mg/dL

METHOD : UREASE - UV

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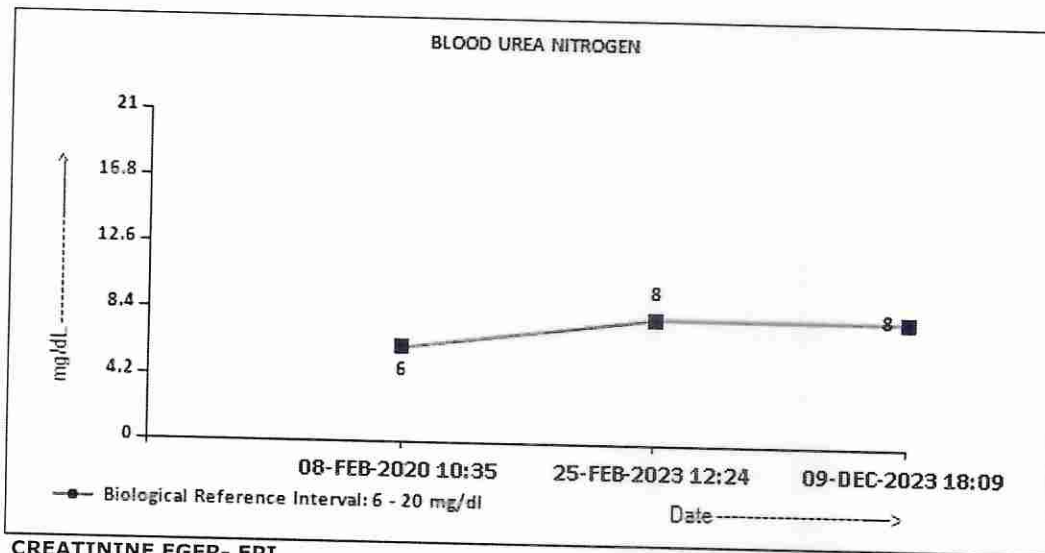
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CREATININE EGFR- EPI

CREATININE	0.74	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES			
AGE	33		years
GLOMERULAR FILTRATION RATE (FEMALE)	115.48	Refer Interpretation Below	mL/min/1.73m ²
METHOD : CALCULATED PARAMETER			

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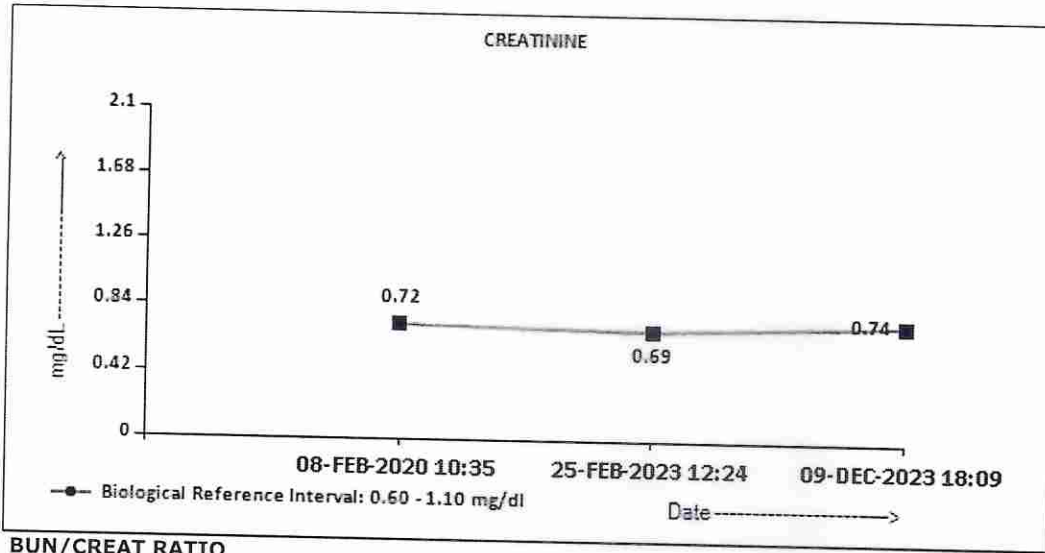
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BUN/CREAT RATIO

BUN/CREAT RATIO 10.81 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 7.6 6.4 - 8.2 g/dL
 METHOD : BIURET

ALBUMIN, SERUM

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ALBUMIN		3.9	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN		3.7	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				
ELECTROLYTES (NA/K/CL), SERUM				
SODIUM, SERUM		139	136 - 145	mmol/L
METHOD : ISE INDIRECT				
POTASSIUM, SERUM		4.03	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-

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, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons 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

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liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
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, Waldenström'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 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, sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. 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.

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-- Kidney disease outcomes quality initiative (KDOQI) guidelines state that estimation of GFR is the best overall indices of the Kidney function.

- It gives a rough measure of number of functioning nephrons .Reduction in GFR implies progression of underlying disease.

- The GFR is a calculation based on serum creatinine test.

- Creatinine is mainly derived from the metabolism of creatine in muscle, and its generation is proportional to the total muscle mass. As a result, mean creatinine generation is higher in men than in women, in younger than in older individuals, and in blacks than in whites.

- Creatinine is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate.

- When kidney function is compromised, excretion of creatinine decreases with a consequent increase in blood creatinine levels. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

- This equation takes into account several factors that impact creatinine production, including age, gender, and race.

- CKD EPI (Chronic kidney disease epidemiology collaboration) equation performed better than MDRD equation especially when GFR is high (>60 ml/min per 1.73m2).. This formula has less bias and greater accuracy which helps in early diagnosis and also reduces the rate of false positive diagnosis of CKD.

References:

National Kidney Foundation (NKF) and the American Society of Nephrology (ASN).
Estimated GFR Calculated Using the CKD-EPI equation-<https://testguide.labmed.uw.edu/guideline/egfr>

Ghuman JK, et al. Impact of Removing Race Variable on CKD Classification Using the Creatinine-Based 2021 CKD-EPI Equation. Kidney Med 2022, 4:100471. 35756325

Harrison's Principle of Internal Medicine, 21st ed. pg 62 and 334

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

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

TOTAL PROTEIN, SERUM-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, Waldenström'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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CORP-OPD
BILLNO-150123OPCR069275
BILLNO-150123OPCR069275

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY - LIPID

LIPID PROFILE, SERUM

CHOLESTEROL, TOTAL	171	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC,CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	56	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	60	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	96	< 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	111	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	11.2	</= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	2.9 Low	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			

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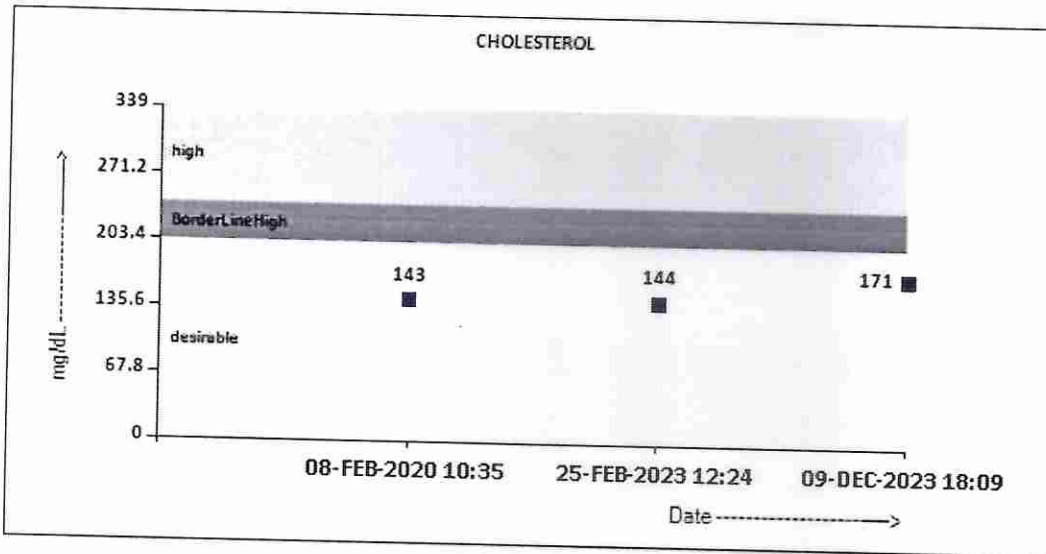
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LDL/HDL RATIO	1.6	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk
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METHOD : CALCULATED PARAMETER



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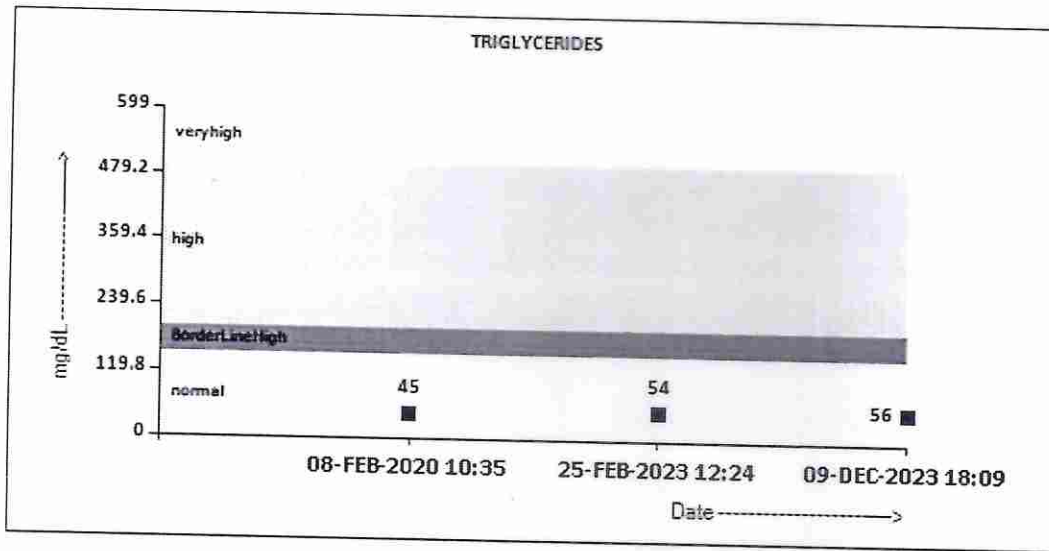
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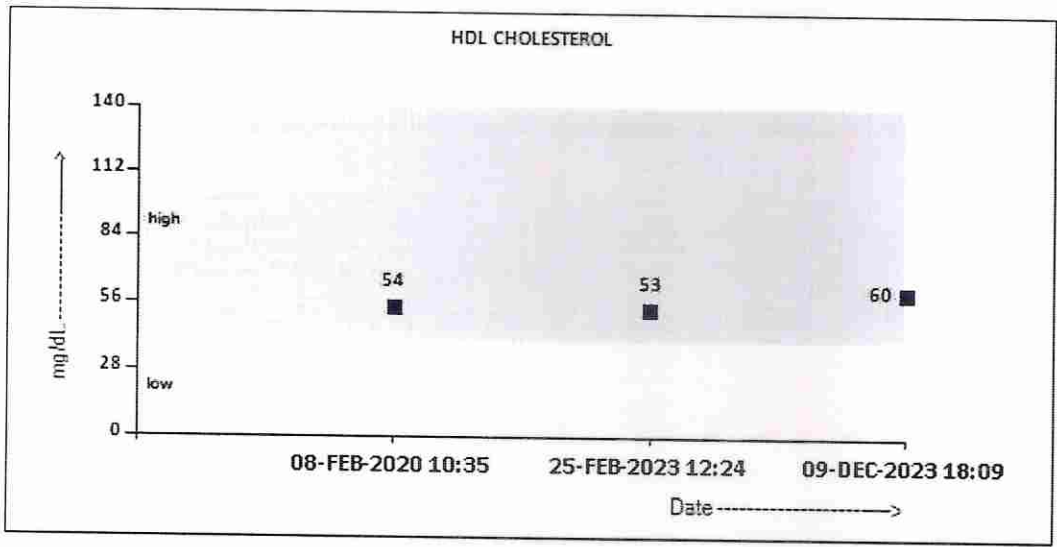


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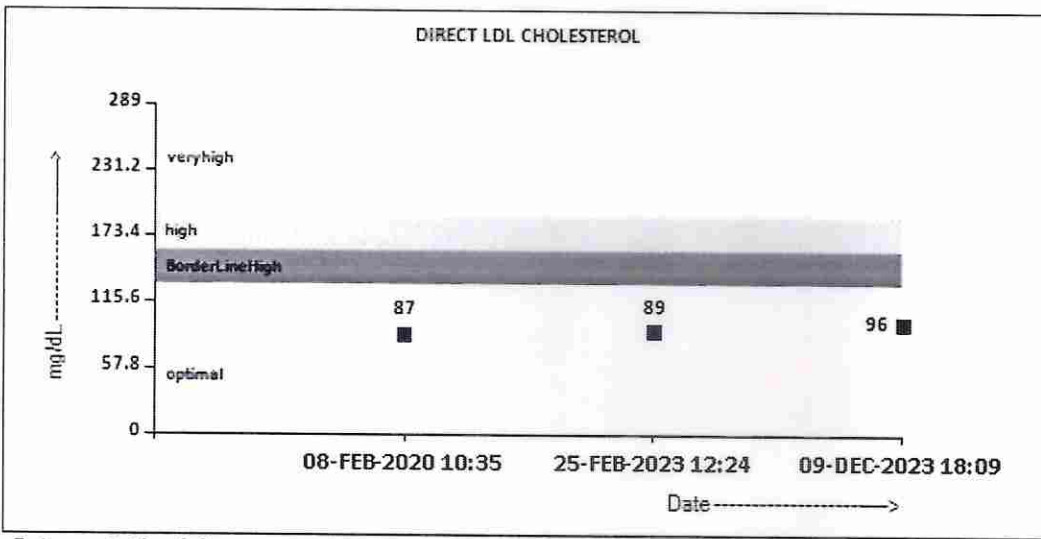
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Test Report Status **Final**

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CLINICAL PATH - URINALYSIS

KIDNEY PANEL - 1

PHYSICAL EXAMINATION, URINE

COLOR

PALE YELLOW

METHOD : PHYSICAL

APPEARANCE

SLIGHTLY HAZY

METHOD : VISUAL

CHEMICAL EXAMINATION, URINE

PH

6.5

4.7 - 7.5

METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD

SPECIFIC GRAVITY

<=1.005

1.003 - 1.035

METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)

PROTEIN

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE

GLUCOSE

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD

KETONES

NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE

BLOOD

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

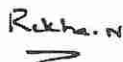
NOT DETECTED

NOT DETECTED

METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY



Dr. Akshay Dhotre, MD
(Reg.no. MMC 2019/09/6377)
Consultant Pathologist



Dr. Rekha Nair, MD
(Reg No. MMC 2001/06/2354)
Microbiologist

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Agilus Diagnostics 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. 2200000889323

PATIENT NAME : MRS.NAVJEET KAUR

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

FORTIS VASHI-CHC -SPLZD
FORTIS HOSPITAL # VASHI,
MUMBAI 440001

ACCESSION NO : 0022WL001403

PATIENT ID : FH.5652365

CLIENT PATIENT ID: UID:5652365

ABHA NO :

AGE/SEX : 33 Years Female

DRAWN : 09/12/2023 08:59:00

RECEIVED : 09/12/2023 09:00:00

REPORTED : 09/12/2023 18:22:35

CLINICAL INFORMATION :

UID:5652365 REQNO-1635229
CORP-OPD
BILLNO-150123OPCR069275
BILLNO-150123OPCR069275

Test Report Status	Final	Results	Biological Reference Interval	Units
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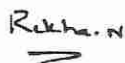
MICROSCOPIC EXAMINATION, URINE

RED BLOOD CELLS	DETECTED (OCCASIONAL)	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
PUS CELL (WBC'S)	3-5	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION			
EPITHELIAL CELLS	5-7	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	URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.		

Interpretation(s)



Dr. Akshay Dhotre, MD
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Consultant Pathologist



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Patient Ref. No. 22000000889323

PATIENT NAME : MRS.NAVJEET KAUR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507		ACCESSION NO : 0022WL001403	
FORTIS VASHI-CHC -SPLZD		PATIENT ID : FH.5652365	AGE/SEX :33 Years Female
FORTIS HOSPITAL # VASHI,		CLIENT PATIENT ID: UID:5652365	DRAWN :09/12/2023 08:59:00
MUMBAI 440001		ABHA NO :	RECEIVED :09/12/2023 09:00:00
			REPORTED :09/12/2023 18:22:35

CLINICAL INFORMATION :
 UID:5652365 REQNO-1635229
 CORP-OPD
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Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	107.3	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
T4	10.19	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
METHOD : ELECTROCHEMILUMINESCENCE IMMUNOASSAY, COMPETITIVE PRINCIPLE			
TSH (ULTRASENSITIVE)	2.320	Non Pregnant Women 0.27 - 4.20 Pregnant Women (As per American Thyroid Association) 1st Trimester 0.100 - 2.500 2nd Trimester 0.200 - 3.000 3rd Trimester 0.300 - 3.000	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

****End Of Report****
 Please visit www.agilusdiagnostics.com for related Test Information for this accession

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Patient Ref. No. 22000000889323

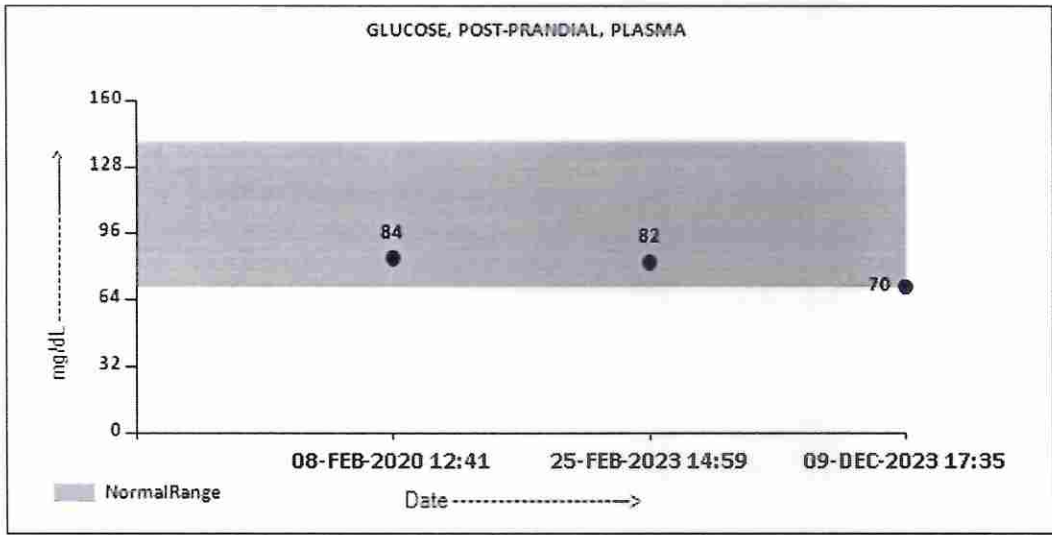
PATIENT NAME : MRS.NAVJEET KAUR		REF. DOCTOR :	
CODE/NAME & ADDRESS : C000045507		ACCESSION NO : 0022WL001479	
FORTIS VASHI-CHC -SPLZD		AGE/SEX : 33 Years Female	
FORTIS HOSPITAL # VASHI,		DRAWN : 09/12/2023 11:42:00	
MUMBAI 440001		RECEIVED : 09/12/2023 11:46:15	
		REPORTED : 09/12/2023 17:44:47	
		PATIENT ID : FH.5652365	
		CLIENT PATIENT ID: UID:5652365	
		ABHA NO :	

CLINICAL INFORMATION :
 UID:5652365 REQNO-1635229
 CORP-OPD
 BILLNO-150123OPCR069275
 BILLNO-150123OPCR069275

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA				
PPBS(POST PRANDIAL BLOOD SUGAR)	70	70 - 140	mg/dL	
METHOD : HEXOKINASE				



Comments

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

Interpretation(s)

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

****End Of Report****

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Patient Ref. No. 22000000889399

Rate 80 . Sinus rhythm.
 PR 166 . Borderline T abnormalities, anterior leads
 QRSD 75 . Baseline wander in lead(s) V2, V5
 QT 369
 QTc 426

--AXIS--

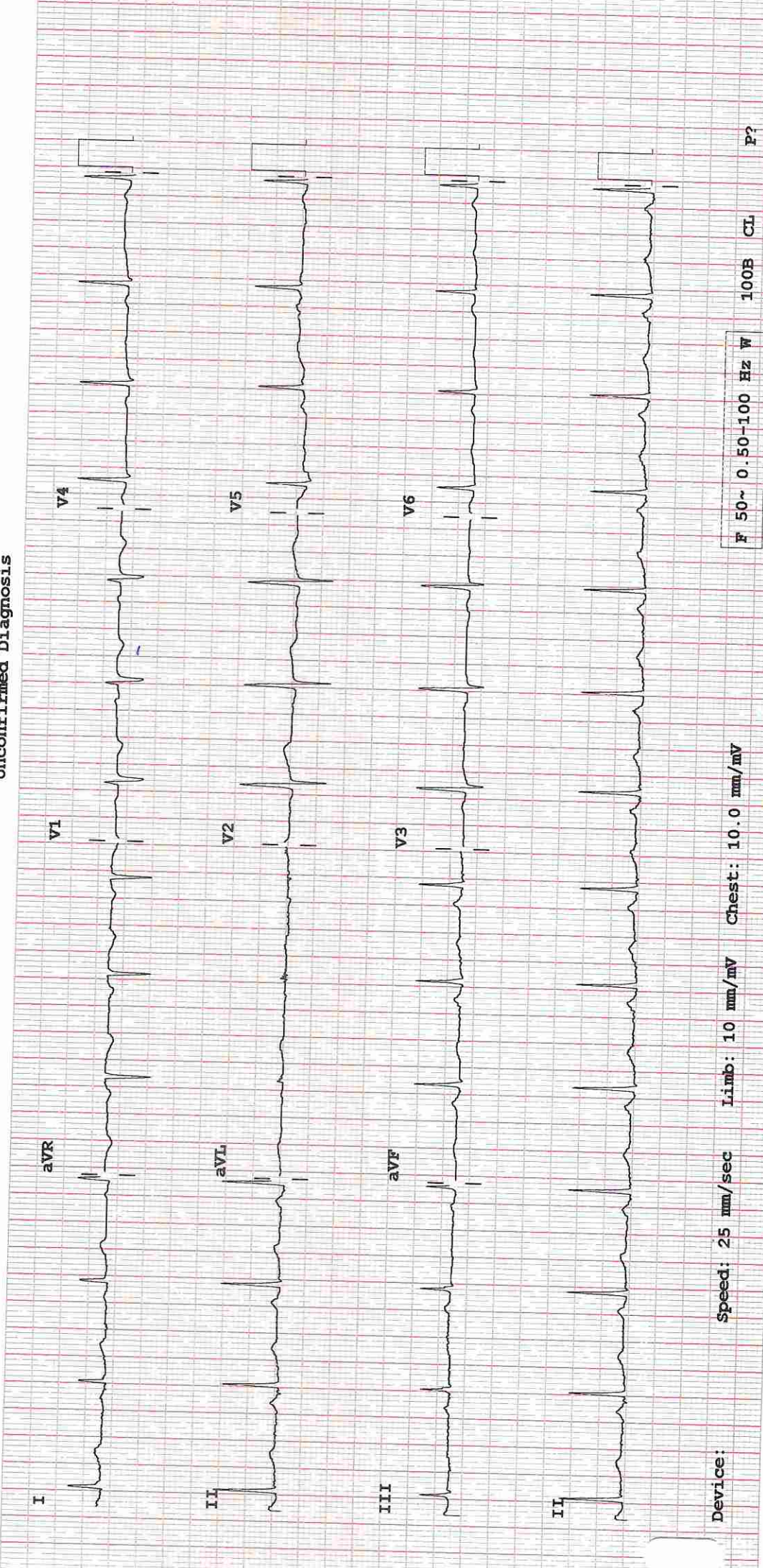
P 63
 QRS 58
 T 30

12 Lead; Standard Placement

-- BORDERLINE ECG --

Unconfirmed Diagnosis

HC
Sinus brhythm
No significant abnormalities
Amig



Device: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV
 F 50~ 0.50-100 Hz W 100B CL P?



DEPARTMENT OF NIC

Date: 11/Dec/2023

Name: Mrs. Navjeet Kaur

Age | Sex: 33 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5652365 | 70508/23/1501

Order No | Order Date: 1501/PN/OP/2312/146340 | 09-Dec-2023

Admitted On | Reporting Date : 11-Dec-2023 11:18:37

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.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	39	mm
AO Root	24	mm
AO CUSP SEP	18	mm
LVID (s)	27	mm
LVID (d)	40	mm
IVS (d)	10	mm
LVPW (d)	11	mm
RVID (d)	26	mm
RA	28	mm
LVEF	60	%



DEPARTMENT OF NIC

Date: 11/Dec/2023

Name: Mrs. Navjeet Kaur

Age | Sex: 33 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5652365 | 70508/23/1501

Order No | Order Date: 1501/PN/OP/2312/146340 | 09-Dec-2023

Admitted On | Reporting Date : 11-Dec-2023 11:18:37

Order Doctor Name : Dr.SELF.

DOPPLER STUDY:

E WAVE VELOCITY: 1.2 m/sec.

A WAVE VELOCITY: 0.7 m/sec

E/A RATIO: 1.7

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	26			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

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

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

DR. AMIT SINGH,
MD(MED), DM(CARD)

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



DEPARTMENT OF RADIOLOGY

Date: 09/Dec/2023

Name: Mrs. Navjeet Kaur

Age | Sex: 33 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 5652365 | 70508/23/1501

Order No | Order Date: 1501/PN/OP/2312/146340 | 09-Dec-2023

Admitted On | Reporting Date : 09-Dec-2023 15:42:47

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 is unremarkable.

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



Patient Name	: Navjeet Kaur	Patient ID	: 5652365
Sex / Age	: F / 33Y 2M 23D	Accession No.	: PHC.7074244
Modality	: US	Scan DateTime	: 09-12-2023 11:19:56
IPID No	: 70508/23/1501	ReportDatetime	: 09-12-2023 11:30:05

USG – WHOLE ABDOMEN

LIVER is normal in size 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 and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis.

Right kidney measures 11.1 x 3.9 cm.

Left kidney measures 10.7 x 4.4 cm.

PANCREAS: Head and body of pancreas is visualised and appears normal. Rest of the pancreas is obscured.

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

UTERUS is normal in size, measuring 8.3 x 6.1 x 3.4 cm.

Endometrium measures 7.2 mm in thickness.

Right ovary measures 3.1 x 1.8 cm and shows dominant follicle within.

Left ovary measures 3.3 x 1.7 cm.

No evidence of ascites.

Impression:

- No significant abnormality is detected.


DR. KUNAL NIGAM
M.D. (Radiologist)