

Hiranandani Healthcare Pvt. Ltd.
Mini Sea Shore Road, Sector 10 -A, Vashi, Navi Mumbai - 400703
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Emergency: 022 - 39199100 | Ambulance: 1255
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CIN : U85100MH2005PTC154823
GST IN: 27AABCH5894D1ZG | PAN NO: AABCH5894D



Hiranandani
HOSPITAL
(A Fortis Network Hospital)

UHID	12643560	Date	12/08/2023		
Name	Mrs.Swati	Sex	Female	Age	34
OPD	Pap	Health Check Up			

Drug allergy:
Sys illness:

PATIENT NAME : MS.SWATI .

REF. DOCTOR :

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

ACCESSION NO : 0022WH002909
 PATIENT ID : FH.12643560
 CLIENT PATIENT ID: UID:12643560
 ABHA NO :

AGE/SEX : 34 Years Female
 DRAWN : 12/08/2023 10:22:00
 RECEIVED : 12/08/2023 10:24:57
 REPORTED : 12/08/2023 14:41:06

CLINICAL INFORMATION :

UID:12643560 REQNO-1559011
 CORP-OPD
 BILLNO-150123OPCR045685
 BILLNO-150123OPCR045685

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)	12.2	12.0 - 15.0	g/dL
METHOD : SLS METHOD			
RED BLOOD CELL (RBC) COUNT	4.22	3.8 - 4.8	mil/ μ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	6.75	4.0 - 10.0	thou/ μ L
METHOD : FLUORESCENCE FLOW CYTOMETRY			
PLATELET COUNT	243	150 - 410	thou/ μ L
METHOD : HYDRODYNAMIC FOCUSING BY DC DETECTION			
RBC AND PLATELET INDICES			
HEMATOCRIT (PCV)	37.6	36.0 - 46.0	%
METHOD : CUMULATIVE PULSE HEIGHT DETECTION METHOD			
MEAN CORPUSCULAR VOLUME (MCV)	89.1	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.9	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	32.4	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.2	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	21.1		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	11.5 High	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			
WBC DIFFERENTIAL COUNT			
NEUTROPHILS	47	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
LYMPHOCYTES	40	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			
MONOCYTES	7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING			



Dr. Akshay Dhotre
 Consultant Pathologist

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EOSINOPHILS		6	1 - 6	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY WITH LIGHT SCATTERING				
ABSOLUTE NEUTROPHIL COUNT		3.17	2.0 - 7.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.70	1.0 - 3.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.47	0.2 - 1.0	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		0.41	0.02 - 0.50	thou/ μ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE BASOPHIL COUNT		0.00 Low	0.02 - 0.10	thou/ μ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.2		
METHOD : CALCULATED				
MORPHOLOGY				
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC		
METHOD : MICROSCOPIC EXAMINATION				
WBC		NORMAL MORPHOLOGY		
METHOD : MICROSCOPIC EXAMINATION				
PLATELETS		ADEQUATE		
METHOD : MICROSCOPIC EXAMINATION				

Interpretation(s)

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
 WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
 (Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
 This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	09	0 - 20	mm at 1 hr
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METHOD : WESTERGRENN METHOD

Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR (>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemia, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI In first trimester is 0-40 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 :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACCC 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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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.



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BIOCHEMISTRY**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.61	0.2 - 1.0	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, DIRECT	0.11	0.0 - 0.2	mg/dL
METHOD : JENDRASSIK AND GROFF			
BILIRUBIN, INDIRECT	0.50	0.1 - 1.0	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.7	6.4 - 8.2	g/dL
METHOD : BIURET			
ALBUMIN	4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING			
GLOBULIN	3.6	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.1	1.0 - 2.1	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	15	15 - 37	U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)	27	< 34.0	U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE	116	30 - 120	U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)	15	5 - 55	U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	147	81 - 234	U/L
METHOD : LACTATE -PYRUVATE			

GLUCOSE FASTING, FLUORIDE PLASMA

FBS (FASTING BLOOD SUGAR)	91	Normal : < 100 Pre-diabetes: 100-125 Diabetes: >=126	mg/dL
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METHOD : HEXOKINASE

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD


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HBA1C		5.0	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
METHOD : HB VARIANT (HPLC)				
ESTIMATED AVERAGE GLUCOSE(EAG)		96.8	< 116.0	mg/dL
METHOD : CALCULATED PARAMETER				
KIDNEY PANEL - 1				
BLOOD UREA NITROGEN (BUN), SERUM				
BLOOD UREA NITROGEN		6	6 - 20	mg/dL
METHOD : UREASE - UV				
CREATININE EGFR- EPI				
CREATININE		0.54 Low	0.60 - 1.10	mg/dL
METHOD : ALKALINE PICRATE KINETIC JAFFES				
AGE		34		years
GLOMERULAR FILTRATION RATE (FEMALE)		123.82	Refer Interpretation Below	mL/min/1.73m2
METHOD : CALCULATED PARAMETER				
BUN/CREAT RATIO				
BUN/CREAT RATIO		11.11	5.00 - 15.00	
METHOD : CALCULATED PARAMETER				
URIC ACID, SERUM				
URIC ACID		4.9	2.6 - 6.0	mg/dL
METHOD : URICASE UV				
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN		7.7	6.4 - 8.2	g/dL
METHOD : BIURET				
ALBUMIN, SERUM				
ALBUMIN		4.1	3.4 - 5.0	g/dL
METHOD : BCP DYE BINDING				
GLOBULIN				
GLOBULIN		3.6	2.0 - 4.1	g/dL
METHOD : CALCULATED PARAMETER				



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ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM	137	136 - 145	mmol/L
METHOD : ISE INDIRECT			
POTASSIUM, SERUM	4.16	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 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, Waldenstroms 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.

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High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic Index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-Used For:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
 2. Diagnosing diabetes.
 3. Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
 2. eAG gives an evaluation of blood glucose levels for the last couple of months.
 3. eAG is calculated as $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

HbA1c Estimation can get affected due to :

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

BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-GFR- Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test.

Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

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



Dr. Akshay Dhotre
Consultant Pathologist

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Maharashtra, India
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CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 2200000864361

PATIENT NAME : MS.SWATI .**REF. DOCTOR :**

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

ACCESSION NO : 0022WH002909
PATIENT ID : FH.12643560
CLIENT PATIENT ID: UID:12643560
ABHA NO :

AGE/SEX : 34 Years Female
DRAWN : 12/08/2023 10:22:00
RECEIVED : 12/08/2023 10:24:57
REPORTED : 12/08/2023 14:41:06

CLINICAL INFORMATION :

UID:12643560 REQNO-1559011
 CORP-OPD
 BILLNO-150123OPCR045685
 BILLNO-150123OPCR045685

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY - LIPID**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	168	< 200 Desirable 200 - 239 Borderline High >= 240 High	mg/dL
METHOD : ENZYMATIC/COLORIMETRIC, CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE			
TRIGLYCERIDES	87	< 150 Normal 150 - 199 Borderline High 200 - 499 High >=500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	51	< 40 Low >=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	106	< 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	117	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	17.4	<= 30.0	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	3.3	3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
METHOD : CALCULATED PARAMETER			
LDL/HDL RATIO	2.1	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk Risk >6.0 High Risk	
METHOD : CALCULATED PARAMETER			



Dr.Akshay Dhotre
 Consultant Pathologist

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Interpretation(s)


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Consultant Pathologist

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CLINICAL PATH - URINALYSIS

URINALYSIS

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 1.010 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 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

RED BLOOD CELLS NOT DETECTED NOT DETECTED /HPF

METHOD : MICROSCOPIC EXAMINATION

PUS CELL (WBC'S) 2-3 0-5 /HPF

METHOD : MICROSCOPIC EXAMINATION

Dr. Akta Dubey
 Counsultant Pathologist

Dr. Rekha Nair, MD
 Microbiologist



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Patient Ref. No. 22000000864361

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 CORP-OPD
 BILLNO-150123OPCR045685
 BILLNO-150123OPCR045685

Test Report Status	Final	Results	Biological Reference Interval	Units
EPITHELIAL CELLS		10-15	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. Akta Dubey
 Counsultant Pathologist

Dr. Rekha Nair, MD
 Microbiologist



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Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	125.7	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	8.60	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)	2.070	Non Pregnant Women 0.27 - 4.20 Pregnant Women 1st Trimester: 0.33 - 4.59 2nd Trimester: 0.35 - 4.10 3rd Trimester: 0.21 - 3.15	µIU/mL
METHOD : ELECTROCHEMILUMINESCENCE,SANDWICH IMMUNOASSAY			

Interpretation(s)

****End Of Report****

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Dr.Akta Dubey
 Counsultant Pathologist



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Patient Ref. No. 22000000864361

PATIENT NAME : MS.SWATI .

REF. DOCTOR :

CODE/NAME & ADDRESS : C000045507

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

ACCESSION NO : 0022WH002981

PATIENT ID : FH.12643560

CLIENT PATIENT ID: UID:12643560

ABHA NO :

AGE/SEX : 34 Years Female

DRAWN : 12/08/2023 13:10:00

RECEIVED : 12/08/2023 13:11:24

REPORTED : 12/08/2023 15:02:56

CLINICAL INFORMATION :

UID:12643560 REQNO-1559011

CORP-OPD

BILLNO-150123OPCR045685

BILLNO-150123OPCR045685

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)

90

70 - 140

mg/dL

METHOD : HEXOKINASE

Interpretation(s)

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

End Of Report

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Dr.Akshay Dhotre
Consultant Pathologist

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CIN - U74899PB1995PLC045956
Email : -



Patient Ref. No. 22000000864433

HC

8/12/2023 12:34:12 PM

MRS SWATI
Female

12643560
34 Years

gino rhythm
B

Rate 76 . Sinus rhythm.....normal P axis, V-rate 50- 99

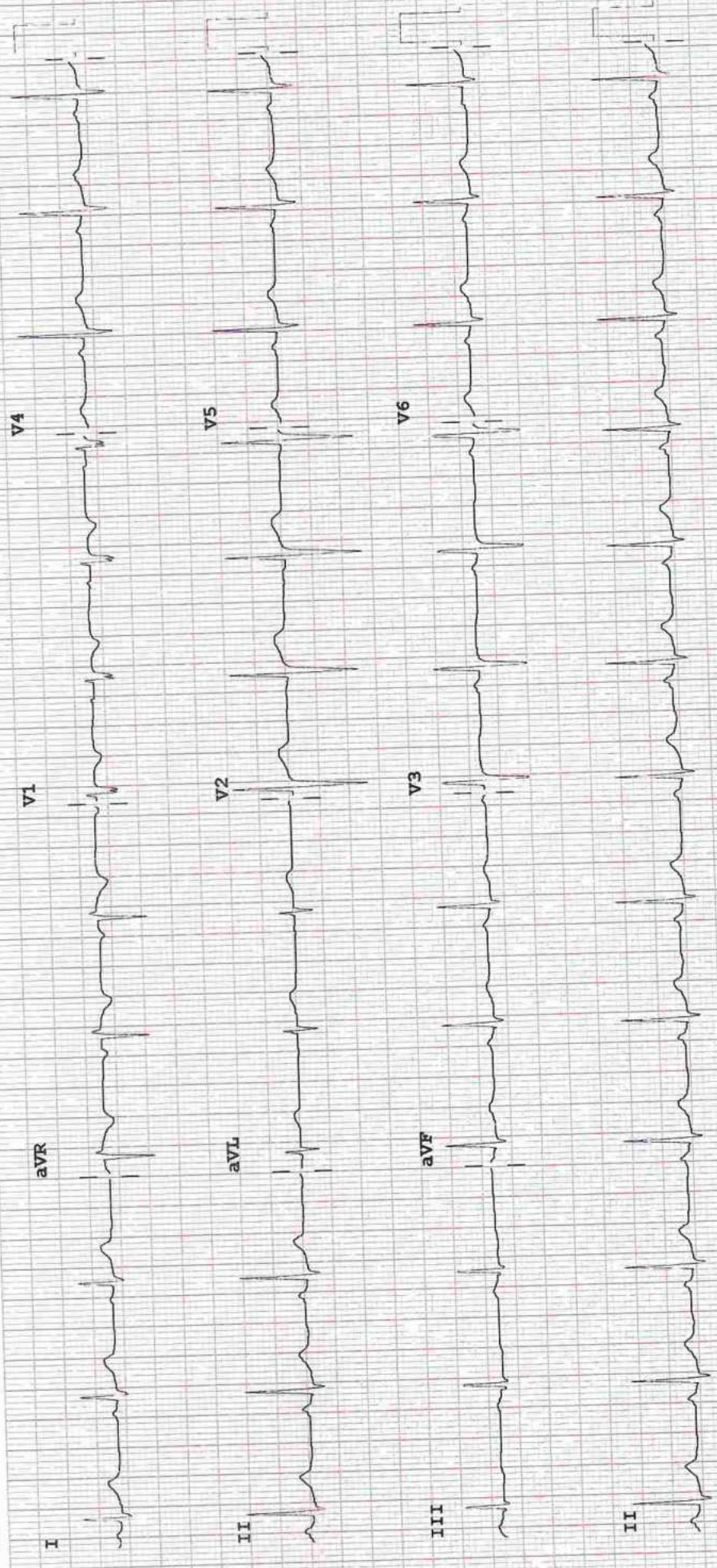
PR 151
QRSD 84
QT 353
QTc 397

--AXIS--
P 57
QRS 56
T 16

- NORMAL ECG -

Unconfirmed Diagnosis

12 Lead; Standard Placement



F 50~ 0.50-100 Hz W

100B CL P?

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

Device:



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 12/Aug/2023

Name: Ms. Swati .

UHID | Episode No : 12643560 | 46346/23/1501

Age | Sex: 34 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2308/96560 | 12-Aug-2023

Order Station : FO-OPD

Admitted On | Reporting Date : 12-Aug-2023 17:11:18

Bed Name :

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 left ventricle hypertrophy. No left ventricle dilatation.
- Structurally normal valves.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- No tricuspid regurgitation. No pulmonary hypertension.
- Intact IAS and IVS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimensions.
- Normal left atrium and left ventricle dimension.
- Normal right ventricle systolic function. No hepatic congestion.

M-MODE MEASUREMENTS:

LA	36	mm
AO Root	27	mm
AO CUSP SEP	19	mm
LVID (s)	29	mm
LVID (d)	41	mm
IVS (d)	09	mm
LVPW (d)	10	mm
RVID (d)	29	mm
RA	31	mm
LVEF	60	%

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 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



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Order Station : FO-OPD

Admitted On | Reporting Date : 12-Aug-2023 17:11:18

Bed Name :

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.9 m/sec.

A WAVE VELOCITY: 0.5 m/sec

E/A RATIO: 1.4

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

Final Impression :

Normal 2 Dimensional and colour doppler echocardiography study.

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

Hiranandani Healthcare Pvt. Ltd.

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Date: 12/Aug/2023

DEPARTMENT OF RADIOLOGY

Name: Ms. Swati .

Age | Sex: 34 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12643560 | 46346/23/1501
Order No | Order Date: 1501/PN/OP/2308/96560 | 12-Aug-2023

Admitted On | Reporting Date : 12-Aug-2023 16:51:35
Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Mild flattening of left dome of diaphragm.

Prominent bronchovascular markings is seen, predominantly in right lung - could be seen in lower respiratory tract infection.
Rest of the 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.

HRCT chest would be worthwhile for further evaluation.

DR. ABHIJEET BHAMBURE
DMRD, DNB (Radiologist)

Hiranandani Healthcare Pvt. Ltd.

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CIN: U85100MH2005PTC 154823

GST IN : 27AABCH5894D1ZG

PAN NO : AABCH5894D



Date: 12/Aug/2023

DEPARTMENT OF RADIOLOGY

Name: Ms. Swati .

Age | Sex: 34 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 12643560 | 46346/23/1501

Order No | Order Date: 1501/PN/OP/2308/96560 | 12-Aug-2023

Admitted On | Reporting Date : 12-Aug-2023 12:45:02

Order Doctor Name : Dr.SELF .

US-WHOLE ABDOMEN

LIVER is normal in size and shows mildly raised echogenicity. Intrahepatic portal and biliary systems are normal. No focal lesion is seen in liver. Portal vein is normal.

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 9.5 x 3.5 cm. Left kidney measures 10.9 x 4.2 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 mass/calculi.

UTERUS is normal in size, measuring 9.7 x 5.3 x 2.7 cm. Endometrium measures 10 mm in thickness.


Both ovaries are normal.

Right ovary measures 3.1 x 1.7 cm. Left ovary measures 2.6 x 1.6 cm.

No evidence of ascites.

IMPRESSION:

- Grade I fatty infiltration of liver.


DR. CHETAN KHADKE
M.D. (Radiologist)