







CLIENT CODE: CA00010147
CLIENT'S NAME AND ADDRESS: MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 DELHI INDIA 8800465156

DDRC SRL DIAGNOSTICS ASTER SQUARE BUILDING, ULLOOR, MEDICAL COLLEGE P.O TRIVANDRUM, 695011 KERALA, INDIA

Tel: 93334 93334, Fax: CIN - U85190MH2006PTC161480

Email: customercare.ddrc@srl.in

PATIENT NAME: MR ANEESH T ANIL PATIENT ID: MRANM291186418

AGE: 36 Years ACCESSION NO: 4182VK012748 SEX: Male

RECEIVED: 29/11/2022 08:57 30/11/2022 14:59 DRAWN: REPORTED:

REFERRING DOCTOR: SELF CLIENT PATIENT ID:

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

MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

OPTHAL

OPTHAL REPORT ATTACHED

* TREADMILL TEST

TREADMILL TEST REPORT ATTACHED

* PHYSICAL EXAMINATION

PHYSICAL EXAMINATION REPORT ATTACHED



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MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

* BUN/CREAT RATIO

BUN/CREAT RATIO 7.4

CREATININE, SERUM

CREATININE 1.35 18 - 60 yrs : 0.9 - 1.3 mg/dL

* GLUCOSE, POST-PRANDIAL, PLASMA

GLUCOSE, POST-PRANDIAL, PLASMA 61 (Rechecked) Diabetes Mellitus : > or = 200. mg/dL

Impaired Glucose tolerance/ Prediabetes: 140 - 199. Hypoglycemia: < 55.

GLUCOSE, FASTING, PLASMA

GLUCOSE, FASTING, PLASMA 101 Diabetes Mellitus: > or = 126. mg/dL

> Impaired fasting Glucose/ Prediabetes: 101 - 125. Hypoglycemia : < 55.

* GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE **BLOOD**

GLYCOSYLATED HEMOGLOBIN (HBA1C) 5.1 Normal : 4.0 - 5.6%.%

Non-diabetic level : < 5.7%. Diabetic : >6.5%

Glycemic control goal

More stringent goal : < 6.5 %. General goal : < 7%. Less stringent goal : < 8%.

Glycemic targets in CKD :-If eGFR > 60 : < 7%. If eGFR < 60: 7 - 8.5%.

MEAN PLASMA GLUCOSE 99.7 mg/dL

* LIPID PROFILE, SERUM

CHOLESTEROL 264 High Desirable: < 200 mg/dL

Borderline: 200-239

High : >or= 240 **TRIGLYCERIDES** Normal 83 : < 150 mg/dL

: 150-199 Hiah

Hypertriglyceridemia: 200-499

Very High : > 499

HDL CHOLESTEROL 54 General range: 40-60 mg/dL











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DIRECT LDL CHOLESTEROL	197	High	Optimum : < 100 Above Optimum : 100-139 Borderline High : 130-159 High : 160-189 Very High : >or= 190	mg/dL
NON HDL CHOLESTEROL	210	High	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
CHOL/HDL RATIO	4.9	High	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO	3.7	High	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate >6.0 High Risk	Risk
VERY LOW DENSITY LIPOPROTEIN	16.6		Desirable value : 10 - 35	mg/dL
* LIVER FUNCTION TEST WITH GGT				
BILIRUBIN, TOTAL	0.84		General Range : < 1.1	mg/dL
BILIRUBIN, DIRECT	0.26		General Range : < 0.2	mg/dL
BILIRUBIN, INDIRECT	0.58		0.00 - 0.60	mg/dL
TOTAL PROTEIN	6.4		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
ALBUMIN	4.4		20-60yrs : 3.5 - 5.2	g/dL
GLOBULIN	2.0		2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO	2.2		General Range : 1.1 - 2.5	RATIO
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	22		Adults: < 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	39		Adults: < 45	U/L
ALKALINE PHOSPHATASE	62		Adult(<60yrs): 40 -130	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	22		Adult (Male): < 60	U/L
TOTAL PROTEIN, SERUM				
TOTAL PROTEIN	6.4		Ambulatory: 6.4 - 8.3 Recumbant: 6 - 7.8	g/dL
URIC ACID, SERUM				
URIC ACID	6.8		Adults: 3.4-7	mg/dL
APO CROUR & BU TYPE EDTA WHOLE BLOOD				

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD



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ADO CDOUD	TVDE D			
ABO GROUP RH TYPE	TYPE B POSITIVE			
	POSITIVE			
BLOOD COUNTS,EDTA WHOLE BLOOD	14 5		12.0 17.0	~ / -/ !
HEMOGLOBIN	14.5		13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	4.61		4.5 - 5.5	mil/µL
WHITE BLOOD CELL COUNT	4.49		4.0 - 10.0	thou/µL
PLATELET COUNT	160		150 - 410	thou/μL
RBC AND PLATELET INDICES	42.0		40 50	0.4
HEMATOCRIT	43.0		40 - 50	%
MEAN CORPUSCULAR VOL	93.4		83 - 101	fL
MEAN CORPUSCULAR HGB.	31.4		27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.6		31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	14.3		12.0 - 18.0	%
MENTZER INDEX	20.3			
MEAN PLATELET VOLUME	7.9		6.8 - 10.9	fL
WBC DIFFERENTIAL COUNT				
SEGMENTED NEUTROPHILS	44		40 - 80	%
LYMPHOCYTES	42	High	20 - 40	%
MONOCYTES	8		2 - 10	%
EOSINOPHILS	6		1 - 6	%
BASOPHILS	0		0 - 2	%
ABSOLUTE NEUTROPHIL COUNT	1.98	Low	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT	1.89		1 - 3	thou/µL
ABSOLUTE MONOCYTE COUNT	0.36		0.20 - 1.00	thou/µL
ABSOLUTE EOSINOPHIL COUNT	0.27		0.02 - 0.50	thou/µL
ABSOLUTE BASOPHIL COUNT	0.00	Low	0.02 - 0.10	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR)	1.0			
ERYTHROCYTE SEDIMENTATION RATE (ES BLOOD	R),WHOLE			
SEDIMENTATION RATE (ESR)	2		0 - 14	mm at 1 hr
STOOL: OVA & PARASITE	RESULT PENDIN	G		
* SUGAR URINE - POST PRANDIAL				
SUGAR URINE - POST PRANDIAL	NOT DETECTED		NOT DETECTED	
* TUVDOTO DANIEL CEDIM				

* THYROID PANEL, SERUM



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Т3	87.12	80 - 200	ng/dL
T4	9.54	5.1 - 14.1	μg/dl
TSH 3RD GENERATION	1.080	21-50 yrs : 0.4 - 4.2	μIU/mL
PHYSICAL EXAMINATION, URINE			
COLOR	PALE YELLOW		
APPEARANCE	CLEAR		
CHEMICAL EXAMINATION, URINE			
PH	6.0	4.7 - 7.5	
SPECIFIC GRAVITY	1.016	1.003 - 1.035	
PROTEIN	NEGATIVE	NOT DETECTED	
GLUCOSE	NEGATIVE	NOT DETECTED	
KETONES	NEGATIVE	NOT DETECTED	
BLOOD	NEGATIVE	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NEGATIVE	NOT DETECTED	
MICROSCOPIC EXAMINATION, URINE			
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
WBC	0-1	0-5	/HPF
EPITHELIAL CELLS	0-1	0-5	/HPF
CASTS	NEGATIVE		
CRYSTALS	NEGATIVE		
REMARKS	NIL		
* SERUM BLOOD UREA NITROGEN			
BLOOD UREA NITROGEN	10	Adult(<60 yrs): 6 to 20	mg/dL
* SUGAR URINE - FASTING			
SUGAR URINE - FASTING	NOT DETECTED	NOT DETECTED	

Interpretation(s)

- CREATININE, SERUM-Higher than normal level may be due to:

 Blockage in the urinary tract

 Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:



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• Myasthenia Gravis

Muscular dystrophy

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 2012 guidelines for adults as follows: Pre-diabetics: 100 - 125 mg/dL Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)

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 patients 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 :I.Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic

II. Vitamin C & E are reported to falsely lower test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.

III. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin.

III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods, falsely increasing results.

IV. 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 paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test 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 heart 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 diabetes with elevels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination 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 and 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 trialycerides and may be best used in patients for whom fasting is difficult.
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



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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. 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
- · Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels

- Drink plenty of fluidsLimit animal proteins
- High Fibre foodsVit C Intake
- Antioxidant rich foods 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.

BLOOD COUNTS, EDTA WHOLE BLOOD-

The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology. 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 COUNTThe 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.

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, Vasculities, 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(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum. Decreased in: Polycythermia vera, Sickle cell anemia

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,



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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. SUGAR URINE - POST PRANDIAL-METHOD: DIPSTICK/BENEDICT"S TEST

THYROID PANEL, SERUMTriiodothyronine T3 , is a thyroid hormone. It affects almost every physiological process in the body, including growth, development, metabolism, body temperature, and heart rate. Production of T3 and its prohormone thyroxine (T4) is activated by thyroid-stimulating hormone (TSH), which is released from the pituitary gland. Elevated

concentrations of T3, and T4 in the blood inhibit the production of TSH.
Thyroxine T4, Thyroxine's principal function is to stimulate the metabolism of all cells and tissues in the body. Excessive secretion of thyroxine in the body is hyperthyroidism, and deficient secretion is called hypothyroidism. Most of the thyroid hormone in blood is bound to transport proteins. Only a very small fraction of the In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low. Below mentioned are the guidelines for Pregnancy related reference ranges for Total T4, TSH & Total T3

Levels in TOTAL T4 TSH3G TOTAL T3

Pregnancy (µg/dL) (µIU/mL) (ng/dL) 0.1 - 2.5 0.2 - 3.0 0.3 - 3.0 First Trimester 6.6 - 12.4 81 - 190 6.6 - 15.5 6.6 - 15.5 100 - 260 100 - 260 2nd Trimester 3rd Trimester

Below mentioned are the guidelines for age related reference ranges for T3 and T4. Т3

(µg/dL) 1-3 day: 8.2 - 19.9 (ng/dL) New Born: 75 - 260

1 Week: 6.0 - 15.9

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.

Kindly note: Method specific reference ranges are appearing on the report under biological reference range.

Reference:

- Burtis C.A., Ashwood E. R. Bruns D.E. Teitz textbook of Clinical Chemistry and Molecular Diagnostics, 4th Edition.
 Gowenlock A.H. Varley's Practical Clinical Biochemistry, 6th Edition.
 Behrman R.E. Kilegman R.M., Jenson H. B. Nelson Text Book of Pediatrics, 17th Edition

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.

SUGAR URINE - FASTING-METHOD: DIPSTICK/BENEDICT'S TEST



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CLIENT'S NAME AND ADDRESS: MEDIWHEEL ARCOFEMI HEALTHCARE LIMITED F701A, LADO SARAI, NEW DELHI, SOUTH DELHI, DELHI, SOUTH DELHI 110030 **DELHI INDIA** 8800465156

ACCESSION NO: 4182VK012748

DDRC SRL DIAGNOSTICS ASTER SQUARE BUILDING, ULLOOR, MEDICAL COLLEGE P.O TRIVANDRUM, 695011 KERALA, INDIA

Tel: 93334 93334, Fax: CIN - U85190MH2006PTC161480

PATIENT ID:

Email: customercare.ddrc@srl.in

PATIENT NAME: MR ANEESH T ANIL

RECEIVED: 29/11/2022 08:57 30/11/2022 14:59 DRAWN: REPORTED:

REFERRING DOCTOR: SELF CLIENT PATIENT ID:

AGE: 36 Years

Test Report Status Results Units

SEX: Male

MEDIWHEEL HEALTH CHEKUP BELOW 40(M)TMT

* ECG WITH REPORT

RFPORT

REPORT GIVEN

* USG ABDOMEN AND PELVIS

REPORT

REPORT GIVEN

* CHEST X-RAY WITH REPORT

REPORT

REPORT GIVEN

End Of Report

Please visit www.srlworld.com for related Test Information for this accession TEST MARKED WITH '*' ARE OUTSIDE THE NABL ACCREDITED SCOPE OF THE LABORATORY.

BABU K MATHEW HOD-BIOCHEMISTRY

DR.VAISHALI RAJAN **HOD - HAEMATOLOGY** PADMANABHAN NAIR **HOD - HORMONES**

DR. SRI SRUTHY CONSULTANT **MICROBIOLOGIST**







Scan to View Report



MEDICAL EXAMINATION REPORT (MER)

Name of the c Mark of Ident Age/Date of I Photo ID Che	examinee : Mr./ cification : (Mo	Mrs./Ms.	Anees y other (specify ction Card/PAN (h T. Arm location)): Gender:	J '	me and the	
HYSICAL DETA		55.0	0.0	TERRET FORMS	ZE KANGN	NO	11512
a. Height/8	(cms) b. We	ight		c. Girth of Systolic		90. (cms astolic)
d. Pulse Rate	(/Min) e. Bio	od Pressu	1" Reading	/30		Sp.	System.
			2 ^{sd} Reading	190		MARIE AND SHORT	
AMILY HISTOR	v.			Transmitted	esergen des	HARD MINES AT	
Relation	Age if Living	Healt	h Status	If deceased,	age at the	time and cause	
Father							
Mother	Glo	pal Dia	gnostics Ne	etwork			
Brother(s)							
Sister(s)		18/smo	dec 5501 1334	b.4	26-12-11	street and see	N. OLI
	ost knySomvices		Sedative	HOTHERA Wide set the	iteda e d	Alcohol	10 to
from any ment If No, please a	rORY attly in good health and en al or Physical impairment tach details. ergone/been advised any sergone/been advised a	surgical	nity. exam	g the last 5 yea ined, received a ted to any hosp you lost or gain	iny advice	or treatment or	YIN

DDRC SRL Diagnostics Private Limited

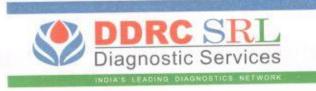
Corp. Office: DDRC SRL Tower, G- 131, Panampilly Nagar, Ernakulam - 682 036 Ph No. 0484-2318223, 2318222, e-mail: info@ddrcsrl.com, web: www.ddrcsrl.com

	0.8		
Any disorders of Urinary System?	YIN	 Any disorder of the Eyes, Ears Nose, Throat or Mouth & Skin 	Y/N
FOR FEMALE CANDIDATES ONLY			-
a. Is there any history of diseases of breast/genital organs?	Y/N	d. Do you have any history of miscarriage/ abortion or MTP	Y/N
b. Is there any history of abnormal PAP— Smear/Mammogram/USG of Pelvis or any other tests? (If yes attach reports)	r Y/N	 e. For Parous Women, were there any complication during pregnancy such as gestational diabetes, hypertension etc 	on Y/N
c. Do you suspect any disease of Uterus, Cervix or Ovaries?	Y/N	f. Are you now pregnant? If yes, how many month	hs? Y/N
CONFIDENTAIL COMMENTS FROM MEDIC	AL EXA	MINER	
➤ Was the examinee co-operative?		Owner o	XX
Is there anything about the examine's health, life his/her job?	estyle tha	t might affect him/her in the near future with regard	d to Y/N
> Are there any points on which you suggest furth	er inforr	nation be obtained?	YIN
> Based on your clinical impression, please provide	le your si	aggestions and recommendations below;	/
Chade	9	fatty duri	
Do you think ha/sha is MEDICALLY FIT or UN	JEIT for	nloyment	
Do you think he/she is MEDICALLY FIT or UN	VF11 101	e ipioyment.	
MEDICAL EXAMINER'S DECLARATION			
I hereby confirm that I have examined the above andi above are true and correct to the best of my knowledge		ter verification of his/her identity and the findings s	tated
	and A	Dr. SERIN LOPEZ. MBBS	
Name & Signature of the Medical Examiner :	9	DDRC SRL Diagnostics Ltd. Aster Square, Medical College PO	
Seal of Medical Examiner :		GRL Diagno	
Name & Seal of DDRC SRL Branch :		MEDICALCOLLEGE) 51	

Date & Time

29/4/2000

HR PR PR ORS OT	ID: 012748 Male 36Years
69 bpm Pire Bruse 84. 7 Hmll. 123 ms 190 ms 83 ms 347/374 ms 66/35/67 o 1.894/0.831 mV Report Confirmed by	kg mm!
MEDICAL OFFICER AMB: Square, Medical College P.O., TVM Reg. No. 77556	The state of the s
Standard	V3
	V4



NAME: MR ANEESH T ANIL AGE:36/M DATE:29/11/2022

CHEST X-RAY REPORT

CHEST X-RAY PA VIEW

: Trachea central

No cardiomegaly

Normal vascularity

No parenchymal lesion.

Costophrenic and cardiophrenic angles clear

> IMPRESSION

: Normal Chest Xray

ELECTRO CARDIOGRAM

NSR:69/minute

No evidence of ischaemia.

> IMPRESSION

: Normal Ecg.

Dr. SERIN LOPEZ. MBBS
MEDICAL OFFICER
DDRC SRL Diagnostics Ltd.
Aster Square, Medical College P.O., TVM

RPB No 77656

DR SERIN LOPEZ MBBS

Reg No 77656

DDRC SRL DIAGNOSTICS LTD





Acc no:4182VK012748

Name: Mr. Aneesh T Anil

Age: 36 y

Sex: Male

Date: 29.11.22

US SCAN WHOLE ABDOMEN

LIVER is enlarged in size (15.5 cm). Margins are regular. Hepatic parenchyma shows increased echogenicity. No focal lesions seen. No dilatation of intrahepatic biliary radicles. CBD is not dilated. Portal vein is normal in caliber (11.9 mm).

GALL BLADDER is partially distended and grossly normal. No pericholecystic fluid seen.

SPLEEN is normal in size (9.7 cm) and parenchymal echotexture. No focal lesion seen.

PANCREAS Head and body visualized, appears normal in size and parenchymal echotexture. Pancreatic duct is not dilated.

RIGHT KIDNEY is normal in size (10.1 x 3.9 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

LEFT KIDNEY is normal in size (9.3 x 4.2 cm) and shows normal parenchymal echotexture. Cortico medullary differentiation is maintained. Parenchymal thickness is normal. No echogenic focus with shadowing suggestive of renal calculi seen. No dilatation of pelvicalyceal system seen. Ureter is not dilated. Perinephric spaces are normal.

PARAAORTIC AREA No retroperitoneal lymphadenopathy or mass seen.

URINARY BLADDER is distended, normal in wall thickness, lumen clear.

PROSTATE is normal in size (vol - 12.2 cc) and shows normal echotexture. No focal lesion seen. No ascites or pleural effusion.

CONCLUSION:-

Grade II fatty liver - Suggest LFT correlation.

Dr. Nisha Unni MD , DNB (RD) Consultant radiologist.

Thanks, your feedback will be appreciated.
(Please bring relevant investigation reports during all visits).
Because of technical and technological limitations complete accuracy cannot be assured on imaging.
Suggested correlation with clinical findings and other relevant investigations consultations, and if required repeat imaging recommended in the event of controversities. AR















DDRC SRL

Patient Details Date: 29-Nov-22 Time: 10:11:39 AM

Name: ANEESH T ANIL ID: 4182VK012748

Age: 36 y Sex: M Height: 184 cms Weight: 87 Kgs

Clinical History: NIL

Medications: NIL

Test Details

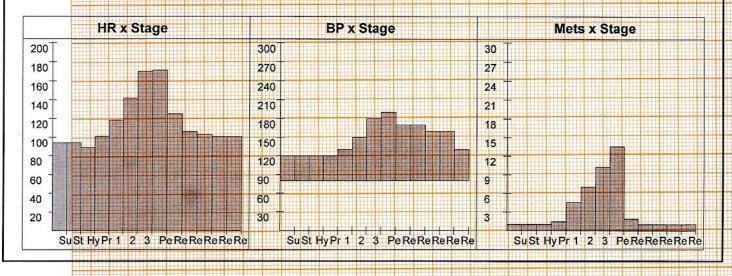
Protocol: Bruce Pr.MHR: 184 bpm THR: 165 (90 % of Pr.MHR) bpm

Total Exec. Time: 9 m 10 s Max. HR: 171 (93% of Pr.MHR)bpm Max. Mets: 13.50

Test Termination Criteria: THR ATTAINED

Protocol Details

Stage Name	Stage Time	Mets	Speed	Grade	Heart	Max. BP	Max. ST	Max. ST
	(min : sec)		(mph)	(%)	Rate	(mm/Hg)	Level	Slope
					(bpm)		(mm)	(mV/s)
Supine	0:17	1.0	0	0	94	120 / 80	-1.27 aVR	3.54 V5
Standing	0:1	1.0	0	0	94	120 / 80	-1.27 aVR	3.54 V5
Hyperventilation	0:20	1.0	0 .	0	89	120 / 80	-1.27 aVR	3.54 V5
1	3:0	4.6	1.7	10	118	130 / 80	-1.49 aVR	5.66 V4
2	3:0	7.0	2.5	12	142	150 / 80	-1.91 aVR	5.66 II
3	3:0	10.2	3.4	14	170	180 / 80	-2.55 aVR	5.66 II
Peak Ex	0:10	13.5	4.2	16	171	190 / 80	-2.76 aVR	5.66 II
Recovery(1)	1:0	1.8	1	0	125	170 / 80	-3.82 aVR	5.66 II
Recovery(2)	1:0	1.0	0	0	106	170 / 80	-3.61 aVR	5.66 II
Recovery(3)	1:0	1.0	0	0	103	160 / 80	-2.12 aVR	5.66 II
Recovery(4)	1:0	1.0	0	0	101	160 / 80	-1.27 aVR	5.66 V2
Recovery(5)	0:27	1.0	0	0	101	130 / 80	-1.27 aVR	4.95 V4



DDRC SRL

Patient Details Date: 29-Nov-22 Time: 10:11:39 AM

Name: ANEESH T ANIL ID: 4182VK012748

Age: 36 y Sex: M Height: 184 cms Weight: 87 Kgs

Interpretation

The patient exercised according to the Bruce protocol for 9 m 10 s achieving a work level of Max. METS: 13.50. Resting heart rate initially 94 bpm, rose to a max. heart rate of 171 (93% of Pr.MHR) bpm. Resting blood Pressure 120 / 80 mmHg, rose to a maximum blood pressure of 190 / 80 mmHg. NO ANGINA/ARRHYTHMIAS/SOB

GOOD EFFORT TOLERANCE

NO SIGNIFICANT ST CHANGES

TEST IS NEGATIVE FOR INDUCIBLE ISCHEMIA

Ref. Doctor: MEDIWHEEL

(Summary Report edited by user)



Doctor: DR.J.PRABAKARAN

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