

**PATIENT NAME : MANISH KUMAR MITTAL**

**REF. DOCTOR : DR. ARCOFEMI HEALTHCARE LTD (MEDIWHEEL)**

**CODE/NAME & ADDRESS :** C000138364  
 ARCOFEMI HEALTHCARE LTD (MEDIWHEEL  
 F-703, LADO SARAI, MEHRAULISOUTH WEST  
 DELHI  
 NEW DELHI 110030  
 8800465156

**ACCESSION NO :** **0321XC002246**  
**PATIENT ID :** MANIM040682321  
**CLIENT PATIENT ID:**  
**ABITA NO :**

**AGE/SEX :** 41 Years Male  
**DRAWN :** 29/03/2024 00:00:00  
**RECEIVED :** 29/03/2024 09:19:01  
**REPORTED :** 30/03/2024 12:41:24

Test Report Status	<b>Preliminary</b>	Results	Biological Reference Interval	Units
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<b>MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE</b>	RESULT PENDING
<b>XRAY-CHEST</b>	RESULT PENDING
<b>ECG</b>	RESULT PENDING
<b>MEDICAL HISTORY</b>	RESULT PENDING
<b>ANTHROPOMETRIC DATA &amp; BMI</b>	RESULT PENDING
<b>GENERAL EXAMINATION</b>	RESULT PENDING
<b>CARDIOVASCULAR SYSTEM</b>	RESULT PENDING
<b>RESPIRATORY SYSTEM</b>	RESULT PENDING
<b>PER ABDOMEN</b>	RESULT PENDING
<b>CENTRAL NERVOUS SYSTEM</b>	RESULT PENDING
<b>MUSCULOSKELETAL SYSTEM</b>	RESULT PENDING
<b>BASIC EYE EXAMINATION</b>	RESULT PENDING
<b>BASIC ENT EXAMINATION</b>	RESULT PENDING
<b>BASIC DENTAL EXAMINATION</b>	RESULT PENDING
<b>SUMMARY</b>	RESULT PENDING
<b>FITNESS STATUS</b>	RESULT PENDING



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**ULR No.775000006986587-0321**

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**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**ULTRASOUND ABDOMEN**

**ULTRASOUND ABDOMEN**

MILD FATTY LIVER.

**TMT OR ECHO**

RESULT PENDING

**Dr.Sahil .N.Shah**  
**Consultant Radiologist**



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## HAEMATOLOGY - CBC

## MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

## BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	<b>11.5 Low</b>	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT	4.87	4.5 - 5.5	mil/ $\mu$ L
WHITE BLOOD CELL (WBC) COUNT	4.92	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	236	150 - 410	thou/ $\mu$ L

## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	<b>37.3 Low</b>	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV)	<b>76.5 Low</b>	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	<b>23.6 Low</b>	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION (MCHC)	<b>30.8 Low</b>	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW)	<b>27.6 High</b>	11.6 - 14.0	%
MENTZER INDEX	15.7		
MEAN PLATELET VOLUME (MPV)	7.6	6.8 - 10.9	fL

## WBC DIFFERENTIAL COUNT

NEUTROPHILS	64	40 - 80	%
LYMPHOCYTES	24	20 - 40	%
MONOCYTES	10	2.0 - 10.0	%
EOSINOPHILS	2	1.0 - 6.0	%
BASOPHILS	0	0 - 1	%
ABSOLUTE NEUTROPHIL COUNT	3.15	2.0 - 7.0	thou/ $\mu$ L
ABSOLUTE LYMPHOCYTE COUNT	1.18	1.0 - 3.0	thou/ $\mu$ L
ABSOLUTE MONOCYTE COUNT	0.49	0.2 - 1.0	thou/ $\mu$ L
ABSOLUTE EOSINOPHIL COUNT	0.10	0.02 - 0.50	thou/ $\mu$ L
ABSOLUTE BASOPHIL COUNT	<b>0.00 Low</b>	0.02 - 0.10	thou/ $\mu$ L



Dr. Miral Gajera  
Consultant Pathologist

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NEUTROPHIL LYMPHOCYTE RATIO (NLR) 2.7

**MORPHOLOGY**

RBC	MILD MICROCYTIC HYPOCHROMIC, ANISOCYTOSIS PRESENT(+).
WBC	NORMAL MORPHOLOGY
PLATELETS	ADEQUATE
REMARKS	NO PREMATURE CELLS ARE SEEN. MALARIAL PARASITE NOT DETECTED.

**Interpretation(s)**

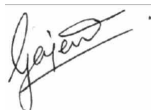
BLOOD COUNTS,EDTA WHOLE BLOOD-The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

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 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

## MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

## ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD

E.S.R	13	0 - 14	mm at 1 hr
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## GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.7	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)	88.2	< 116.0	mg/dL
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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 (Paraproteinemia, 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: 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)

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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.  
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



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## IMMUNOHAEMATOLOGY

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE****ABO GROUP & RH TYPE, EDTA WHOLE BLOOD**

ABO GROUP	TYPE O
RH TYPE	POSITIVE

**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**

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**GLUCOSE FASTING,FLUORIDE PLASMA**

FBS (FASTING BLOOD SUGAR) 89 74 - 99 mg/dL

**GLUCOSE, POST-PRANDIAL, PLASMA**

PPBS(POST PRANDIAL BLOOD SUGAR) 91 70 - 140 mg/dL

**LIPID PROFILE WITH CALCULATED LDL, SERUM**

CHOLESTEROL, TOTAL 86 Desirable: < 200 mg/dL  
 BorderlineHigh: 200 - 239  
 High: > or = 240

TRIGLYCERIDES 77 Desirable: < 150 mg/dL  
 BorderlineHigh: 150 - 199  
 High: 200 - 499  
 Very High: > or = 500

HDL CHOLESTEROL **33 Low** < 40 Low mg/dL  
 > or = 60 High

CHOLESTEROL LDL 38 Adult levels: mg/dL  
 Optimal < 100  
 Near optimal/above optimal:  
 100-129  
 Borderline high : 130-159  
 High : 160-189  
 Very high : = 190

NON HDL CHOLESTEROL 53 Desirable: Less than 130 mg/dL  
 Above Desirable: 130 - 159  
 Borderline High: 160 - 189  
 High: 190 - 219  
 Very high: > or = 220

VERY LOW DENSITY LIPOPROTEIN 15.4 < or = 30 mg/dL  
 CHOL/HDL RATIO **2.6 Low** 3.3 - 4.4

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LDL/HDL RATIO	1.2	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk		
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**LIVER FUNCTION PROFILE, SERUM**

BILIRUBIN, TOTAL	0.18	Upto 1.2	mg/dL
BILIRUBIN, DIRECT	0.12	Upto 0.2	mg/dL
BILIRUBIN, INDIRECT	0.06	0.00 - 1.00	mg/dL
TOTAL PROTEIN	7.1	6.4 - 8.3	g/dL
ALBUMIN	4.6	3.5 - 5.2	g/dL
GLOBULIN	2.5	2.0 - 4.1	g/dL
ALBUMIN/GLOBULIN RATIO	1.8	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	19	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	14	0 - 41	U/L
ALKALINE PHOSPHATASE	115	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT)	8	8 - 61	U/L
LACTATE DEHYDROGENASE	196	135 - 225	U/L

**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN	7	6 - 20	mg/dL
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**CREATININE, SERUM**

CREATININE	0.73 Low	0.90 - 1.30	mg/dL
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**BUN/CREAT RATIO**

BUN/CREAT RATIO	9.59	5.0 - 15.0	
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**URIC ACID, SERUM**

URIC ACID	4.2	3.4 - 7.0	mg/dL
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**TOTAL PROTEIN, SERUM**

TOTAL PROTEIN	7.1	6.4 - 8.3	g/dL
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**ALBUMIN, SERUM**

ALBUMIN	4.6	3.5 - 5.2	g/dL
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**GLOBULIN**

GLOBULIN	2.5	2.0 - 4.1	g/dL
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**ELECTROLYTES (NA/K/CL), SERUM**

SODIUM, SERUM	139.2	136 - 145	mmol/L
POTASSIUM, SERUM	4.86	3.3 - 5.1	mmol/L
CHLORIDE, SERUM	106.0	98 - 106	mmol/L

**Interpretation(s)****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.



**Dr. Miral Gajera**  
Consultant Pathologist

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ULR No. 775000006986587-0321

**PATIENT NAME : MANISH KUMAR MITTAL**

**REF. DOCTOR : DR. ARCOFEMI HEALTHCARE LTD (MEDIWHEEL)**

<b>CODE/NAME &amp; ADDRESS : C000138364</b> ARCOFEMI HEALTHCARE LTD (MEDIWHEEL) F-703, LADO SARAI, MEHRAULISOUTH WEST DELHI NEW DELHI 110030 8800465156	<b>ACCESSION NO : 0321XC002246</b>	<b>AGE/SEX : 41 Years Male</b>
	<b>PATIENT ID : MANIM040682321</b>	<b>DRAWN : 29/03/2024 00:00:00</b>
	<b>CLIENT PATIENT ID: ABHTA NO</b>	<b>RECEIVED : 29/03/2024 09:19:01</b>
		<b>REPORTED : 30/03/2024 12:41:24</b>

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**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. 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 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

**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, 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:** • Myasthenia Gravis, Muscuophy 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. Miral Gajera**  
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**PATIENT NAME : MANISH KUMAR MITTAL**

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**CLINICAL PATH - URINALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**PHYSICAL EXAMINATION, URINE**

COLOR	Yellow
APPEARANCE	Clear

**CHEMICAL EXAMINATION, URINE**

PH	5.5	4.7 - 7.5
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035
PROTEIN	NOT DETECTED	NOT DETECTED
GLUCOSE	NOT DETECTED	NEGATIVE
KETONES	NOT DETECTED	NOT DETECTED
BLOOD	NOT DETECTED	NEGATIVE
BILIRUBIN	NOT DETECTED	NOT DETECTED
UROBILINOGEN	NORMAL	NORMAL
NITRITE	NOT DETECTED	NOT DETECTED
LEUKOCYTE ESTERASE	NOT DETECTED	NOT DETECTED

**MICROSCOPIC EXAMINATION, URINE**

RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)	NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS	2-3	0-5	/HPF
CASTS	NOT DETECTED		
CRYSTALS	NOT DETECTED		
BACTERIA	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	
REMARKS	MICROSCOPIC EXAMINATION OF URINE IS CARRIED OUT ON CENTRIFUGED URINARY SEDIMENT.		

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**CLINICAL PATH - STOOL ANALYSIS**

**MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE**

**PHYSICAL EXAMINATION,STOOL**

COLOUR	BROWN	
CONSISTENCY	WELL FORMED	
MUCUS	ABSENT	NOT DETECTED
VISIBLE BLOOD	ABSENT	ABSENT
ADULT PARASITE	NOT DETECTED	

**CHEMICAL EXAMINATION,STOOL**

STOOL PH	NEGATIVE	
OCCULT BLOOD	NOT DETECTED	NOT DETECTED

**MICROSCOPIC EXAMINATION,STOOL**

PUS CELLS	NOT DETECTED		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CYSTS	NOT DETECTED	NOT DETECTED	
OVA	NOT DETECTED		
LARVAE	NOT DETECTED	NOT DETECTED	
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
FAT	ABSENT		
VEGETABLE CELLS	ABSENT		
CHARCOT LEYDEN CRYSTALS	ABSENT		

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8800465156

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## SPECIALISED CHEMISTRY - HORMONE

## MEDI WHEEL FULL BODY HEALTH CHECK UP ABOVE 40 MALE

## THYROID PANEL, SERUM

T3	107.60	80.0 - 200.0	ng/dL
T4	8.55	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE)	2.370	0.270 - 4.200	µIU/mL

\*\*End Of Report\*\*

Please visit [www.agilusdiagnostics.com](http://www.agilusdiagnostics.com) for related Test Information for this accession

## CONDITIONS OF LABORATORY TESTING &amp; REPORTING

1. It is presumed that the test sample belongs to the patient named or identified in the test requisition form.
2. All tests are performed and reported as per the turnaround time stated in the AGILUS Directory of Services.
3. Result delays could occur due to unforeseen circumstances such as non-availability of kits / equipment breakdown / natural calamities / technical downtime or any other unforeseen event.
4. A requested test might not be performed if:
  - i. Specimen received is insufficient or inappropriate
  - ii. Specimen quality is unsatisfactory
  - iii. Incorrect specimen type
  - iv. Discrepancy between identification on specimen container label and test requisition form
5. AGILUS Diagnostics confirms that all tests have been performed or assayed with highest quality standards, clinical safety & technical integrity.
6. Laboratory results should not be interpreted in isolation; it must be correlated with clinical information and be interpreted by registered medical practitioners only to determine final diagnosis.
7. Test results may vary based on time of collection, physiological condition of the patient, current medication or nutritional and dietary changes. Please consult your doctor or call us for any clarification.
8. Test results cannot be used for Medico legal purposes.
9. In case of queries please call customer care (91115 91115) within 48 hours of the report.

## Agilus Diagnostics Ltd

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