| | | | |
|---|---|---|---|
| Patient NAME | : Mrs.SEEMA YADAV | Barcode NO | : 20010241 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 04:34PM |
| LabNo | : DPL21514 | Sample Collected Date | : 09/Mar/2024 04:34PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 08:55PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

## DEPARTMENT OF CYTOPATHOLOGY

### LIQUID BASED CYTOLOGY - PAP SMEAR

| | |
|---|---|
| CASE NO: | LBC – 53/2024 |
| SPECIMEN: | LBC fluid. Received 12.0 ml of fluid with brush. Single smear prepared from the cyto centrifuged sediment and stained with pap's stain. |
| MICROSCOPIC EXAMINATION: | Satisfactory for Evaluation<br>Transformation zone: Absent<br>Squamous cellularity: Adequate<br>Inflammatory change: Mild<br>Negative for intraepithelial lesion or malignancy (NILM) |
| DIAGNOSIS: | Negative for intraepithelial lesion or malignancy (NILM) |
| ADVICE: | Follow up. |

The PAP Smear is not a diagnostic procedure and should not be used as the sole means to evaluate cervical cancer. It is a screening procedure to aid in detection of cervical cancer and its precursors.

The foundation of Liquid Based Cytology (LBC) is that it produces uniform, thin layer slides and minimizes obscuring artefacts as, blood and mucus. On balance, LBC provides consistent improvement compared with conventional PAP testing in specimen adequacy and detection of LSIL and HSIL categories.

Cervico - vaginal cytology is screened & reported as per the Bethesda 2014.

References :


1. Johnson J and Patnick J. 2000. Achievable standards, benchmarks for reporting, and criteria for evaluating cervical cytopathology. Revised 2nd Edition. NHSCSP Publications NHS Cancer Screening Programmes.
2. Bankhead C, Austoker J, Davey C. 2003. Cervical Screening Results Explained a guide for primary care. NHS Cancer Screening Programme.
3. Gibb RK, Martens MG. The Impact of Liquid Based Cytology in decreasing the incidence of cervical cancer. Rev Obstet Gynecol 2011; 4(Suppl 1):S2-S11
4. The Bathesda system for reporting cervical cytology, 2014, 3rd Edition.


*** End Of Report ***

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

| | | |
|---|---|---|
| Patient First Name: SEEMA | Patient Last Name: YADAV | Patient Mobile Number: 9991710732 |
| Patient E-mail ID: yseema1007@gmail.com | Date of Birth: 01-02-1989 | Gender: female |
| Client: **ARCOFEMI HEALTHCARE LIMITED** | Agreement Name: (1) ARCOFEMI MEDIWHEEL FEMALE AHC CREDIT PAN INDIA OP AGREEMENT | |
| Package Name: (1) ARCOFEMI - MEDIWHEEL - FULL BODY HC STARTER FEMALE - PAN INDIA - FY2324 | Visit Type: in-clinic | |
| Visit Status: Show | Report Status: Order partially completed | City |
| Clinic: SOHNA ROAD | Order Date: 08-03-2024 | Appointment Date: 09-03-2024 |
| Net Amount: 1500 | Appointment ID: 386939 | Ref_Appointment ID: UBOIE4111 |

Slot Time: 08:30-08:45

Visit ID

DRIVING LICENCE

FORM 7
Rule16(2)

OLA ::HR-34License No::HR-3420120039484Dated 19/03/2012

Name : SEEMA YADAV

D/o : SURAT SINGH YADAV

Date of Birth : 10/07/1988 Blood Group AB+

Address : HO.NO. 181 NEAR LUXMI HOTEL MAHENDERGARH HARYANA 123029

Non-Tr Valid Upto: 18/03/2032

Tr. Valid upto

is licenced to drive througout India vehicle of the following descriptions :

M.C with Gear, LMV-NT-Car Only

Signature of Holder

Endorsements

Licencing Authority

SUB DIVISIONAL OFFICER(CIVIL) MAHENDERGARH

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Sohna Road

DATE- 09/03/24

NAME - Seema Yadav
PHONE - 9991710732

AGE/GENDER - 35- Female
ADDRESS - G73A, 2nd Floor, South City 2, G Block, Ggn

EMAIL - yseema1007@gmail.com
CORPORATE NAME - Union Bank of India

1. **Past medical history & medications**:-

N/A

2. **Any existing disease: -**

N/A

3. **Current medications :-**

N/A

4. **VITALS** - (To be filled by medical personnel)

- BLOOD PRESSURE - 115/67 mm/hg
- PULSE RATE - 69 bpm
- TEMPERATURE – 97.3°F
- SPO2 – 99%
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 172.6 cm.
- WEIGHT – 74 Kg
- BMI – 25.0

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5. **FINDINGS: -**

LAB INVESTIGATION: - Hb - 12.70 (Borderline low)
Rest investigation - Normal.

CARDIOLOGY INVESTIGATIONS: - ECG - Normal

RADIOLOGY INVESTIGATIONS: - USG - Normal

6. **DOCTOR REMARKS: –** None.

Mowi

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# CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Seema Yadav on 11/3/24

After reviewing the medical history and on clinical examination it has been found that he/she is

| | Tick |
|---|---|
| • Medically Fit | ✓ |
| • Fit with restrictions/recommendations<br><br>Though following restrictions have been revealed, in my opinion, these are not impediments to the job.<br><br>1.....<br><br>2.....<br><br>3.....<br><br>However the employee should follow the advice/medication that has been communicated to him/her.<br><br>Review after_____ | |
| • Currently Unfit.<br>Review after_____ _____recommended | |
| • Unfit | |

Dr. _____
**Medical Officer**
**The Apollo Clinic, (Location)**

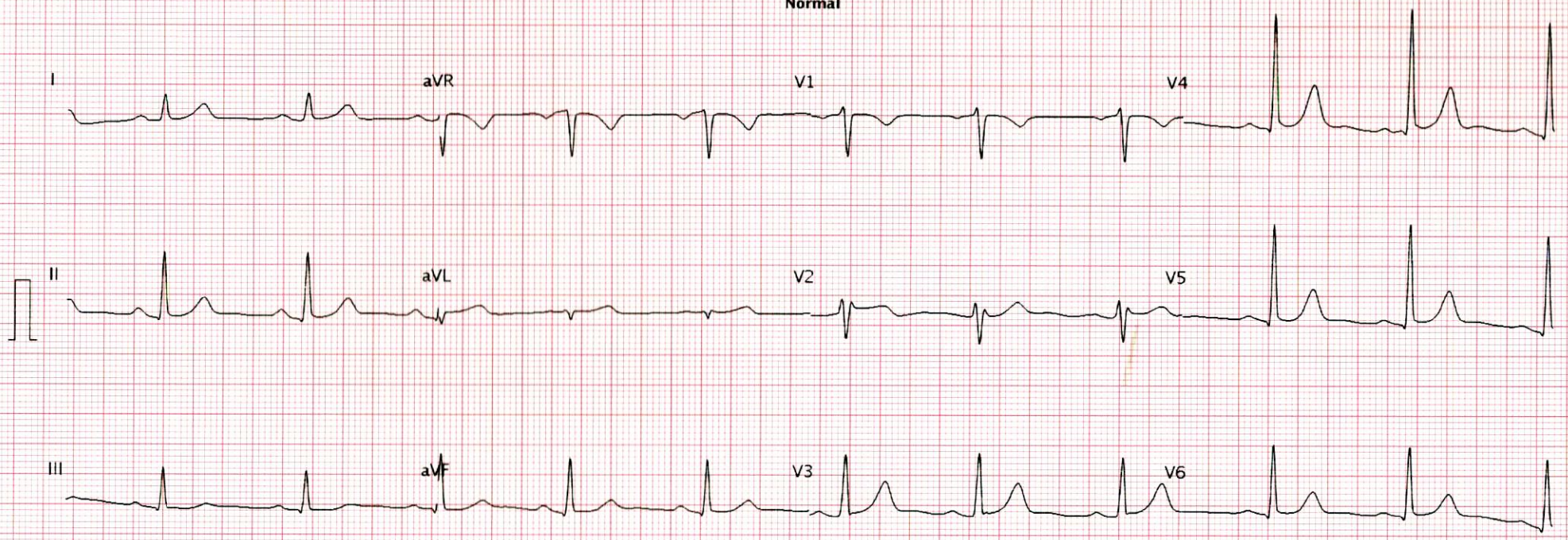
*This certificate is not meant for medico-legal purposes*

| | | | |
|---|---|---|---|
| Name | **Seema yadav Emergency** | **09.03.2024 10:21:21** | |
| Patient ID | **7026a689-c914-4df0-9b27-8e9aa4bde45b** | **Standard 12-Lead** | |

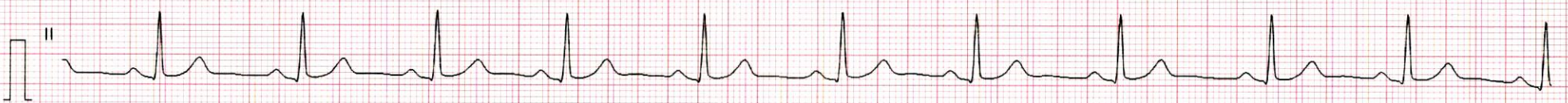
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Date of birth** | 10.07.1988 | **Visit ID** | **HR** | **65 bpm** | **RR** | 928 ms | Sinus rhythm |
| **Gender** | Female | **Room** | | | **P** | 104 ms | Normal electrical axis |
| **Height** | | **Medication** | | | **PR** | 172 ms | Normal ECG |
| **Weight** | | **Order ID** | **P axis** | 46 ° | **QRS** | 77 ms | |
| **Ethnicity** | Undefined | **Ord. prov.** | **QRS axis** | 62 ° | **QT** | 407 ms | **Unconfirmed report** |
| **Pacemaker** | Unknown | **Ord. prot.** | **T axis** | 35 ° | **QTcB** | 422 ms | |

**Indication**
**Remark**

**Normal**




25 mm/s, 10 mm/mV — Sequential — LP 25Hz, AC 60Hz




25 mm/s, 10 mm/mV — LP 25Hz, AC 60Hz

**DR. BINDU BISHT**
B.D.S, MIDA, MISDT
(General Dentist)

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NAME:- Seema Yadav AGE/SEX: /F DATE: 9/March/24.

C/C Through health checkup

O/E → Maintain good oral hygiene

9A-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

TO BOOK AN APPOINTMENT
08079 838383

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| | |
|---|---|
| **Patient's name:- MS SEEMA YADAV** | **Date:- 09-03-2024** |
| **Referred by:- HEALTH CHECK UP** | **Age/Sex:- 35Y/F** |

## ULTRASOUND WHOLE ABDOMEN

*CLINICAL PROFILE – General check up*

The movements of both the domes of diaphragm are normal.

The liver is normal in size, outline and parenchymal echotexture. No focal lesion is seen. The portal vein is normal in calibre and course.

The gall bladder shows normal contents. The intra hepatic biliary radicals and CBD are normal.

The pancreas and spleen are normal.

Both the kidneys are normal in size, outline and parenchymal echopattern. No calculus, hydronephrosis or any other abnormality is seen on either side.

No free fluid is seen in the peritoneal cavity.

No lymphadenopathy is seen.

The urinary bladder is normal in outline.

The uterus is retroverted, measures 78x67x60mm. The myometrium shows homogenous echoes. The endometrial lining is central, 6.7mm. The myo-endometrial interface is preserved.

Both ovaries appear normal.

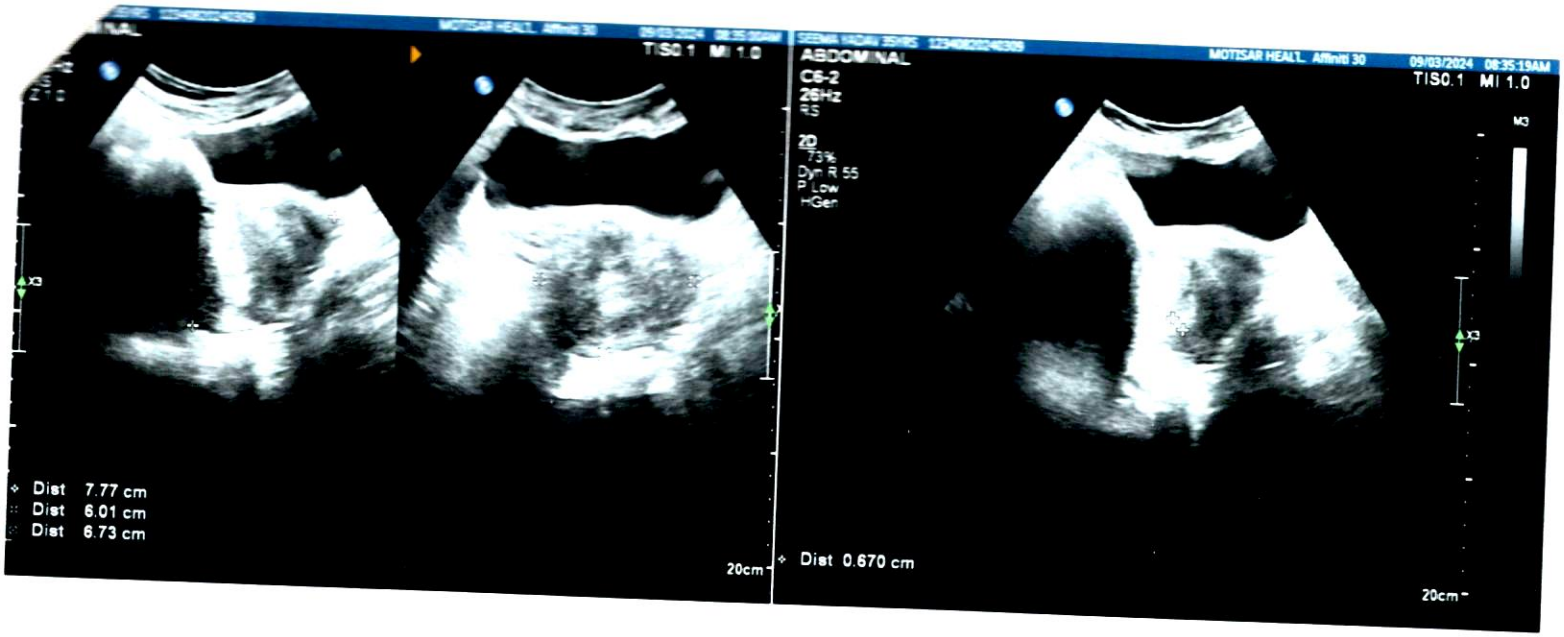
The pouch of douglas does not show any free fluid.

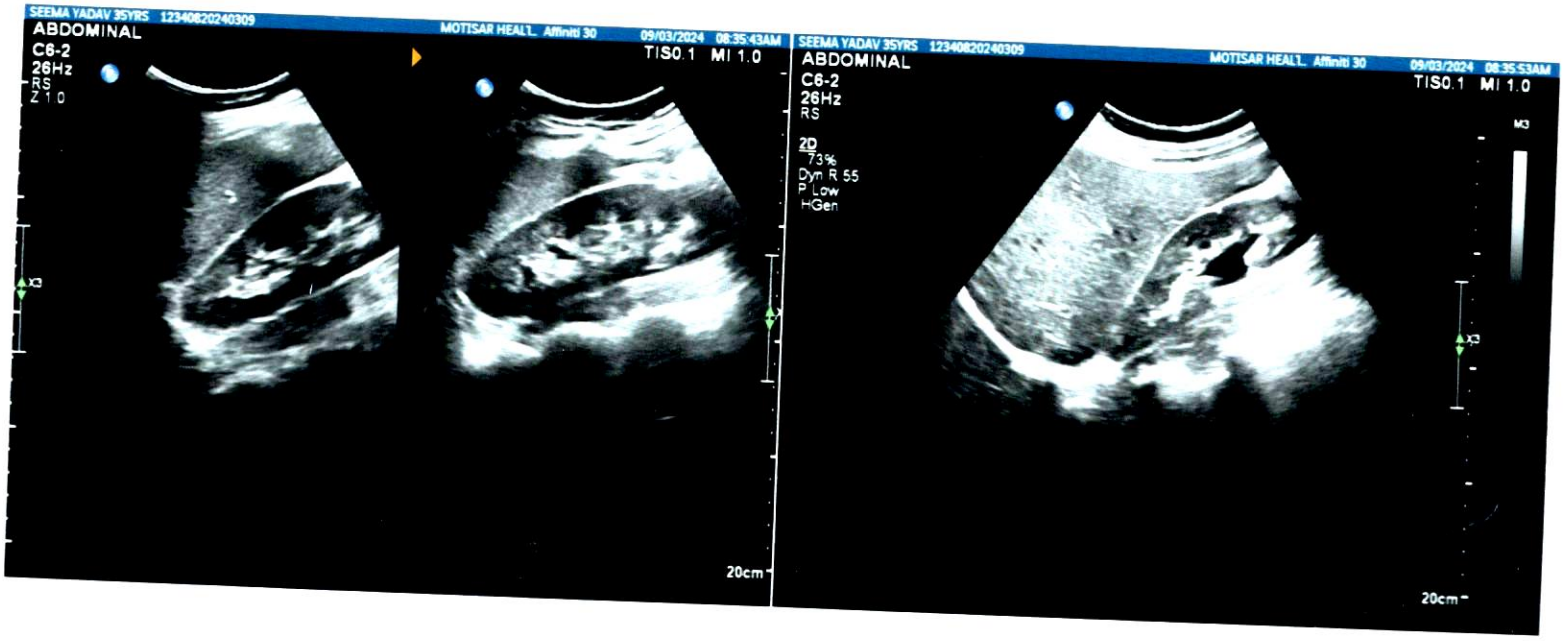
**IMPRESSION:**

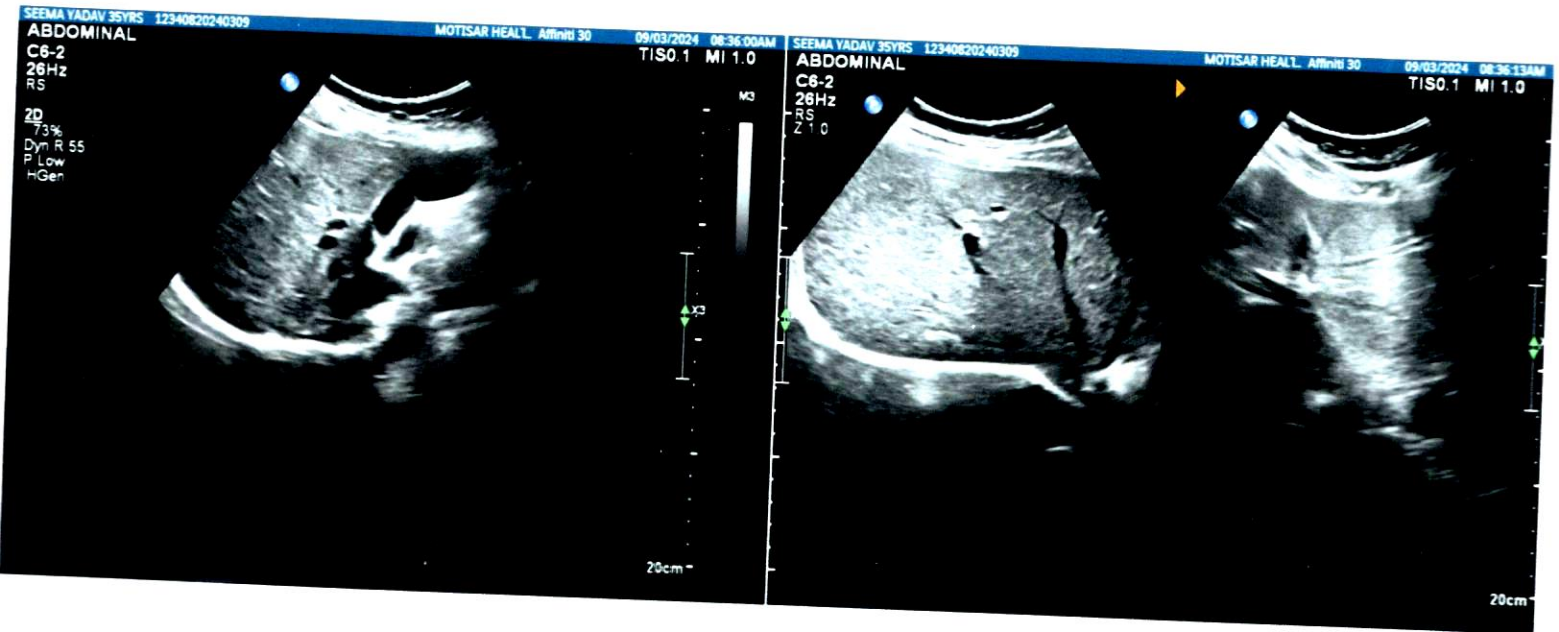
NO OBVIOUS ABNORMALITY IS SEEN IN THE STDY

*CLINICAL CORRELATION /TVS EXAMINATION MAY BE NECESSARY.*

**DR. RAJNISH JUNEJA**
**MBBS, DNB RADIODIAGNOSIS**


ABDOMINAL
C6-2
26Hz
RS
2D
73%
Dyn R 55
P Low
HGen
TIS0.1 MI 1.0
Dist 7.77 cm
Dist 6.01 cm
Dist 6.73 cm
Dist 0.670 cm
20cm


SEEMA YADAV 35YRS 12340820240309
ABDOMINAL
C6-2
26Hz
RS
2D
73%
Dyn R 55
P Low
HGen
TIS0.1 MI 1.0
20cm


SEEMA YADAV 35YRS 12340820240309
ABDOMINAL
C6-2
26Hz
RS
2D
73%
Dyn R 55
P Low
HGen
TIS0.1 MI 1.0
20cm

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| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 05:50PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| COMPLETE BLOOD COUNT | | | | |
| Sample Type : WHOLE BLOOD EDTA | | | | |
| HAEMOGLOBIN (HB) | 12.70 | gm/dL | 13.5 - 18.0 | Cynmeth Photometric Measurement |
| RBC COUNT(RED BLOOD CELL COUNT) | 4.4 | mil/cu.mm | 4.7 - 6.0 | Electrical Impedence |
| PCV/HAEMATOCRIT | 39.8 | % | 42-52 | Calculated |
| MCV | 90.50 | fL | 78-100 | Electrical Impedence |
| MCH | 28.9 | pg | 27-31 | Calculated |
| MCHC | 31.9 | gm/dL | 32-36 | Calculated |
| RDW-SD | 13.1 | fL | 39-46 | Calculated |
| TOTAL LEUCOCYTE COUNT (TLC) | 6430 | cell/cmm | 4000-10000 | Electrical Impedence |
| NEUTROPHIL | 59 | % | 40-80 | VCSn Technology |
| LYMPHOCYTE | 34 | % | 20-40 | VCSn Technology |
| MONOCYTE | 05 | % | 2-10 | VCSn Technology |
| EOSINOPHIL | 02 | % | 1-6 | VCSn Technology |
| BASOPHIL | 00 | % | 0-2 | VCSn Technology |
| PLATELET COUNT | 247 | 10^3/ul | 150 - 450 | Electrical Impedence |
| MPV | 11.5 | fL | 7.2 - 11.7 | Electrical Impedence |
| PCT | 0.3 | % | 0.2 - 0.5 | Calculated |
| PDW | 13.3 | % | 9.0 - 17.0 | Calculated |
| ABSOLUTE NEUTROPHIL COUNT | 3.79 | x10^3 Cells/uL | 1.5-7.8 | Automated Calculated |
| ABSOLUTE LYMPHOCYTE COUNT | 2.19 | x10^3 Cells/uL | 2.0-3.9 | Automated Calculated |
| ABSOLUTE MONOCYTE COUNT | 0.32 | x10^3 Cells/uL | 0.2-0.95 | Automated Calculated |
| ABSOLUTE EOSINOPHIL COUNT | 0.13 | x10^3 Cells/uL | 0.2-0.5 | Automated Calculated |

Tests done on Automated Three Part Cell Counter. (WBC, RBC,Platelet count by impedance method, colorimetric method for Hemoglobin, WBC differential by flow cytometry using laser technology other parameters are calculated). All Abnormal Haemograms are reviewed confirmed microscopically.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 05:50PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| ERYTHROCYTE SEDIMENTATION RATE | | | | |
| Sample Type : WHOLE BLOOD EDTA | | | | |
| ERYTHROCYTE SEDIMENTATION RATE | 12 | mm/hr | <20 | EDTA Whole blood, modified westerngren |

**Note:**

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

| | | | | |
|---|---|---|---|---|
| BLOOD GROUP ABO & RH | | | | |
| Sample Type : WHOLE BLOOD EDTA | | | | |
| ABO | AB | | | Gel Columns agglutination |
| Rh Typing | POSITIVE | | | Gel agglutination |

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings.

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 04:50PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| **LIVER FUNCTION TEST** | | | | |
| Sample Type : SERUM | | | | |
| TOTAL BILIRUBIN | 0.90 | mg/dL | 0.1-1.2 | Jendrassik Grof |
| CONJUGATED ( D. Bilirubin) | 0.30 | mg/dL | Adults and Children: < 0.3 | Diazotization |
| UNCONJUGATED ( I.D. Bilirubin) | 0.60 | mg/dL | 0.1 - 1.0 | Calculated |
| SGPT | 13.80 | U/L | < 45 | UV with P5P, IFCC 37 Degree |
| SGOT | 24.30 | U/L | < 50 | UV with P5P, IFCC 37 degree |
| SGOT/SGPT | 1.76 | Ratio | 0.7 - 1.4 | |
| GGT | 21 | U/L | < 55 | G-glutamyl-carboxy-nitoanilide |
| ALKALINE PHOSPHATASE | 73.00 | U/L | 56-119 | PNPP, AMP Buffer, IFCC 37 degree |
| TOTAL PROTEINS | 7.20 | g/dL | 6.6-8.3 | Biuret, reagent blank end point |
| ALBUMIN | 4.40 | g/dL | Adults: 3.5 - 5.2 | Bromcresol purple |
| GLOBULIN | 2.8 | g/dL | 1.8 - 3.6 | Calculated |
| A/G RATIO | 1.57 | Ratio | 1.2 - 2.2 | Calculated |

**Note:**

**Bilirubin Total**

Clinical Significance :"Total Bilirubin is one of the most commonly used tests to assess liver function. A number of inherited and acquired diseases affect bilirubin production, metabolism, storage and excretion and causes hyperbilirubinemia resulting in jaundice.Hyperbilirubinemia may be due to increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Unconjugated hyperbilirubinemia is seen in newborn andd known as physiological jaundice. Elevated unconjugated bilirubin in the neonatal period may result in brain damage (kernicterus).Crigler-Najjar syndromes type I and type II are also associated with elevated levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatitis and space-occupying lesions of the liver; and obstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

**Bilirubin Direct**

Clinical Significance :"Direct bilirubin is a measurement of conjugated bilirubin.Jaundice can occur as a result of increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Inherited disorders in which direct bilirubin levels are increased are seen in Dubin-Johnson syndrome and Rotor syndrome,idiopathic neonatal hepatitis and biliary atresia. The most commonly occurring form of jaundice of the newborn called physiological jaundiceis due to increase in levels of indirect bilirubin.Both conjugated and unconjugated bilirubin are increased in hepatocellular diseases such as hepatitis and space-occupying lesions of the liver, bstructive lesions such as carcinoma of the head of the pancreas, common bile duct, or ampulla of Vater."

**SGOT / AST**

Clinical Significance :"Elevated aspartate aminotransferase (AST) values are seen most commonly in parenchymal liver diseases. Values can be elevated from 10 to 100 times the normal range, though commonly 20 to 50 times elevations are seen. AST levels are raised in infectious hepatitis and other inflammatory conditions

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 04:50PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|

affecting the liver along with ALT, though ALT levels are higher. The ALT:AST ratio which is normally 1. AST levels are usually raised before clinical signs and symptoms of disease appear. AST and ALT also rise in primary or metastatic carcinoma of the liver, with AST usually being higher than ALT.Elevated AST values may also be seen in disorders affecting the heart, skeletal muscle and kidney, such as myocardial infarction, muscular dystrophy, dermatomyositis, acute pancreatitis and crushed muscle injuries."

**SGPT / ALT**

Clinical Significance :Elevated alanine aminotransferase (ALT) values are seen in parenchymal liver diseases characterized by a destruction of hepatocytes. Values are at least 10 times higher the normal range and may reach up to 100 times the upper reference limit. Commonly, values are seen to be 20 - 50 times higher than normal. In infectious hepatitis and other inflammatory conditions affecting the liver, ALT levels rise more than aspartate aminotransferase (AST), and the ALT/AST ratio, which is normally 1. ALT levels usually rise before clinical signs and symptoms of disease appear.

**Alkaline Phosphatase (ALP)**

Clinical Significance :Alkaline Phosphatase levels can be elevated in both liver related as well as bone related conditions. ALP levels are raised (more than 3 fold) in extrahepatic biliary obstruction (eg, by stone or by cancer of the head of the pancreas) than in intrahepatic obstruction, and isdirectly proportional to the level of obstruction. Levels may rise up to 10 to 12 times the upper limit of normal range and returns to normal on surgical removal of the obstruction. ALP levels rise together with GGT levels and If both GGT and ALP are elevated, a liver source of the ALP is likely. Among bone diseases, ALP levels rise in Paget disease (up to 25 fold),osteomalacia,rickets,primary and secondary hyperparathyroidism and osteogenic bone cancer. Elevated ALP is seen in children following accelerated bone growth. Also, a 2 to 3fold elevation may be observed in women in the third trimester of pregnancy, although the interval is very wide and levels may not exceed the upper limit of the reference interval in some cases.

**Total Protein**

Clinical Significance :High levels of Serum Total Protein is seen in increased acute phase reactants in inflammation, late-stage liver disease, infections,multiple myeloma and other malignant paraproteinemias.n. Hypoproteinemia is seen in hypogammaglobulinemia, nephrotic syndrome and protein-losing enteropathy.

**Albumin**

Clinical Significance :"Hypoalbuminemia can be caused by impaired synthesis due to liver disease (primary) or due to diminished protein intake (secondary), increased catabolism due to tissue damage and inflammation; malabsorption of amino acids; and increased renal excretion (eg, nephrotic syndrome).Hyperalbuminemia is seen in dehydration."

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| | | | |
|---|---|---|---|
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| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 04:48PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| **LIPID PROFILE** | | | | |
| TOTAL CHOLESTEROL | 160.00 | mg/dL | Desirable: <= 200<br>Borderline High: 201-239<br>High:>239<br>Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report. | Serum, Cholesterol oxidase esterase, peroxidase |
| TRIGLYCERIDES | 67.30 | mg/dL | Normal: < 150<br>Borderline High: 150-199<br>High: 200-499<br>Very High: >= 500 | Serum, Enzymatic, endpoint |
| H D L CHOLESTEROL | 58.20 | mg/dL | Normal: > 40<br>Major Heart Risk: < 40 | Serum, Direct measure-PEG |
| L D L CHOLESTEROL | 88.34 | mg/dL | Optimal: < 100<br>Near optimal/above optimal: 100-129<br>Borderline high: 130-159<br>High: 160-189<br>Very High: >= 190 | Serum |
| NON HDL CHOLESTEROL | 101.8 | mg/dL | Desirable: < 130 mg/dL<br>Borderline High: 130-159mg/dL<br>High: 160-189 mg/dL<br>Very High: > or = 190 mg/dL | Calculated |
| VLDL | 13.46 | mg/dL | 6 - 38 | Calculated |
| T. CHOLESTEROL/ HDL RATIO | 2.75 | Ratio | 3.5 - 5.0 | Calculated |
| LDL / HDL RATIO | 1.52 | Ratio | Desirable / low risk - 0.5 -3.0<br>Low/ Moderate risk - 3.0- 6.0<br>Elevated / High risk - >6.0<br>Desirable / low risk - 0.5 -3.0<br>Low/ Moderate risk - 3.0- 6.0<br>Elevated / High risk - > 6.0 | Calculated |
| HDL/LDL RATIO | 0.66 | Ratio | Desirable / low risk - 0.5 -3.0<br>Low/ Moderate risk - 3.0- 6.0<br>Elevated / High risk - > 6.0<br>Desirable / low risk - 0.5 -3.0<br>Low/ Moderate risk - 3.0- 6.0<br>Elevated / High risk - > 6.0 | Calculated |

Prasad

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
| Referred BY | : SELF | Report Generated Date | : 09/Mar/2024 04:48PM |
| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|

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MBBS, DNB Pathology
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| | | | |
|---|---|---|---|
| Patient NAME | : MRS.SEEMA YADAV | Barcode NO | : 20010206 |
| Age/Gender | : 35 Y 0 M 0 D /F | Registration Date | : 09/Mar/2024 03:03PM |
| LabNo | : DPL21479 | Sample Collected Date | : 09/Mar/2024 03:03PM |
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| Refer Lab/Hosp | : APOLLO CLINIC | | |

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| HBA1C | | | | |
| Sample Type : WHOLE BLOOD EDTA | | | | |
| HBA1c | 5.3 | % | Non-Diabetic: <=6.0<br>Pre Diabetic:6.1 - 7.0<br>Diabetic: >=7.0 | EDTA Whole blood,HPLC |
| ESTIMATED AVG. GLUCOSE | 105.41 | mg/dL | | |

**Interpretations**

1. HbA1C has been endorsed by clinical groups and American Diabetes Association guidelines 2017 for diagnosing diabetes using a cut off point of 6.5%
2. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
3. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

- Excellent control-6-7 %
- Fair to Good control – 7-8 %
- Unsatisfactory control – 8 to 10 %
- Poor Control – More than 10 %

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| GLUCOSE - FASTING | | | | |
| Sample Type : FLOURIDE PLASMA | | | | |
| Plasma Glucose Fasting | 87.1 | mg/dL | Normal: 70-100<br>Impaired Fasting Glucose (IFG): 100-125<br>Diabetes Mellitus: >= 126<br>(On more than one occasion) | Plasma, Hexokinase |

**Note:**

As per American Diabetic Association,(ADA) 2018 Guidelines:

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on Two separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

**Fasting is defined as no caloric intake for at least 8 hours**

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| KIDNEY FUNCTION TEST | | | | |
| Sample Type : SERUM | | | | |
| SERUM UREA | 19.70 | mg/dL | 17- 43 | Urease GLDH |
| Blood Urea Nitrogen (BUN) | 9.21 | mg/dL | 7 - 18 | Urease |
| SERUM URIC ACID | 4.40 | mg/dL | 3.5 - 7.2 | Uricase/POD |
| SERUM CREATININE | 0.80 | mg/dL | 0.67 - 1.17 | Jaffe IDMS |
| SERUM TOTAL CALCIUM | 8.70 | mg/dL | 8.8 - 10.6 | Arsenazo III |
| SERUM SODIUM | 137.1 | mmol/L | 136 - 146 | ISE |
| SERUM POTASSIUM | 4.20 | mmol/L | 3.5 - 5.1 | ISE |
| SERUM CHLORIDE | 103.9 | mmol/L | 101 - 109 | ISE |

**Note:**

**Blood Urea Nitrogen (BUN)**

Clinical Significance : Increased blood urea nitrogen (BUN) may be due to prerenal causes (cardiac decompensation, water depletion due to decreased intake and excessive loss, increased protein catabolism, and high protein diet), renal causes (acute glomerulonephritis, chronic nephritis, polycystic kidney disease, nephrosclerosis, and tubular necrosis) and postrenal causes (eg, all types of obstruction of the urinary tract, such as stones, enlarged prostate gland, tumors).

**Creatinine**

Clinical Significance : Serum creatinine is inversely correlated with glomerular filtration rate (GFR). Increased levels of Serum Creatinine is associated with renal dysfunction.

**Calcium**

Serum Calcium levels are used to monitor and diagnose a wide range of diseases of bone, kidney, parathyroid gland, or gastrointestinal tract. Calcium levels may also reflect abnormal vitamin D or protein levels. Hypocalcemia or low serum calcium levels is associated with absent or decreased function of the parathyroid glands, impaired vitamin-D synthesis, low dietary intake and chronic renal failure. Hypercalcemia is due to increased mobilization of calcium from the skeletal system or increased intestinal absorption.It is usually seen in case of primary hyperparathyroidism (pHPT) or bone metastasis of carcinoma of the breast, prostate, thyroid gland, or lung.

**Sodium**

Clinical Significance : Serum Sodium estimation is performed to assess acid-base balance, water balance, water intoxication, and dehydration.

**Potassium**

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|

Clinical Significance : Potassium (K+) is the major intracellular cation. It regulates neuromuscular excitability, heart contractility, intracellular fluid volume, and hydrogen ion concentration. High levels of serum Potassium is seen in acute renal disease and end-stage renal failure due to decreased excretion.Levels are also high during the diuretic phase of acute tubular necrosis, during administration of non-potassium sparing diuretic therapy, and during states of excess mineralocorticoid or glucocorticoid.

**Chloride**

Clinical Significance : Chloride (Cl) is the major extracellular anion and it has an important role in maintaining proper body water distribution, osmotic pressure, and normalanion-cation balance in the extracellular fluid compartment. Chloride is increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis associated with prolonged diarrhea and loss of sodium bicarbonate, diabetes insipidus, adrenocortical hyperfuction,salicylate intoxication and with excessive infusion of isotonic saline or extremely high dietary intake of salt. Hyperchloremia acidosis may be a sign of severe renal tubular pathology. Chloride is decreased inoverhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis, congestive heart failure, Addisonian crisis, certain types of metabolic acidosis, persistent gastric secretion and prolonged vomiting, aldosteronism, bromide intoxication, syndrome of inappropriate antidiuretic hormone secretion,and conditions associated with expansion of extracellular fluid volume."

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| THYROID PROFILE (T3,T4,TSH) | | | | |
| Sample Type : SERUM | | | | |
| T3 | 1.13 | ng/mL | 0.79 - 1.58 | CLIA |
| T4 | 8.93 | µg/dl | 4.9 - 11.00 | CLIA |
| TSH | 1.80 | µIU/m | 0.38 - 4.31 | FIA |

**Interpretation**

It is recommended to interpret serum TSH levels with thyroid hormone levels (especially T4 levels) taking into consideration the clinical status of patient. Pitfalls in the interpretation of the serum TSH alone are in patients with recent treatment for thyrotoxicosis, non-thyroidal illness(acute severe illness or chronic illness), central hypothyroidism, confounding medications.

| Condition | TSH | T4 | T3 |
|---|---|---|---|
| Primary Hypothyroidism | Increased | Low | Normal /Low |
| Subclinical Hypothyroidism | Increased | Normal | Normal |
| Primary Hyperthyroidism | Decreased | Increased | Increased |
| T3 Toxicosis | Decreased | Normal | Increased |
| Subclinical Hyperthyroidism | Decreased | Normal | Normal |
| Central Hyperthyroidism/ Thyroid Hormone Resistance | Increased /Normal | Increased | Increased |
| Central Hypothyroidism / Non Thyroidal Illness | Decreased /Normal | Decreased | Decreased |

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)

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DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 23

| Test Name | Result | Unit | Bio. Ref. Range | Method |
|---|---|---|---|---|
| URINE ROUTINE EXAMINATION | | | | |
| VOLUME | 15 | ml | - | |
| COLOUR | PALE YELLOW | | PALE YELLOW | |
| TRANSPARENCY | CLEAR | | Clear | |
| REACTION (PH) | 6.50 | | 4.5 - 7.0 | |
| SPECIFIC GRAVITY | 1.030 | | 1.010 - 1.030 | |
| CHEMICAL EXAMINATION | | | | |
| URINE SUGAR. | ABSENT | | Nill | |
| Urine Protein | ABSENT | | Nil | |
| Urine Ketones | ABSENT | | Nil | |
| BLOOD | ABSENT | | Absent | |
| Leukocyte esterase | ABSENT | | Negative | |
| Bile pigments | ABSENT | | Absent | |
| NITRITE | ABSENT | | Negative | |
| UROBILINOGEN | ABSENT | | Normal | |
| MICROSCOPIC EXAMINATION | | | | |
| PUS CELLS | 3-4 | /hpf | 0 - 5 | |
| EPITHELIAL CELLS | 2-3 | /hpf | 0 - 5 | |
| RBCs | ABSENT | /hpf | Absent | |
| CRYSTALS | ABSENT | | Absent | |
| CASTS | ABSENT | | Absent | |
| OTHER | ABSENT | | | |

*** End Of Report ***

Dr. Sarita Prasad
MBBS, DNB Pathology
Sr. Consultant (HMC.9669)