UNITED HOSPITAL
Care Par Excellence

ilac-MRA

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. NITIN BHAWSAR	Order No	: 1000080320
UHID	: UHJA23021474	Registered On	: 28/03/2024 08:37:31 AM
Age/Sex	: 46/Years Male	Collected On	: 28/03/2024 09:33:00 AM
Ward / Bed No	:	Reported On	: 28/03/2024 04:47:12 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230026583
Station	: At Hospital	Mobile No	: 8696905556
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	112	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	96.79	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.76	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.72	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.88	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	220	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	199	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	137.3	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	39.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.11		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.19		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	177	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	1.10	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	11.8		12˜20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.97	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.81	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.72	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.98	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.58		2:1
SERUM SGOT (Method:IFCC without P5P)	27	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	32	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	84	U/L	50-116
GGT (Method:IFCC)	48	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.77	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	28.1	mg/dL	17-43

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.48	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.4	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5330	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	52.29	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.99	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.30	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.01	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.41	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.10	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	89.1	fL	78-100
MCH (Method: Calculated)	30.4	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	13.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.81	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.58	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	B		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

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Payer Name	: Mediwheel	Report Status	: Final Report

CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.020		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NA		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Rashmita

---End of Report---

Dr. Shobha Emmanuel
MBBS, M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC:66136

*NABL renewal under process.

28-Mar-2024 AM10:11:16

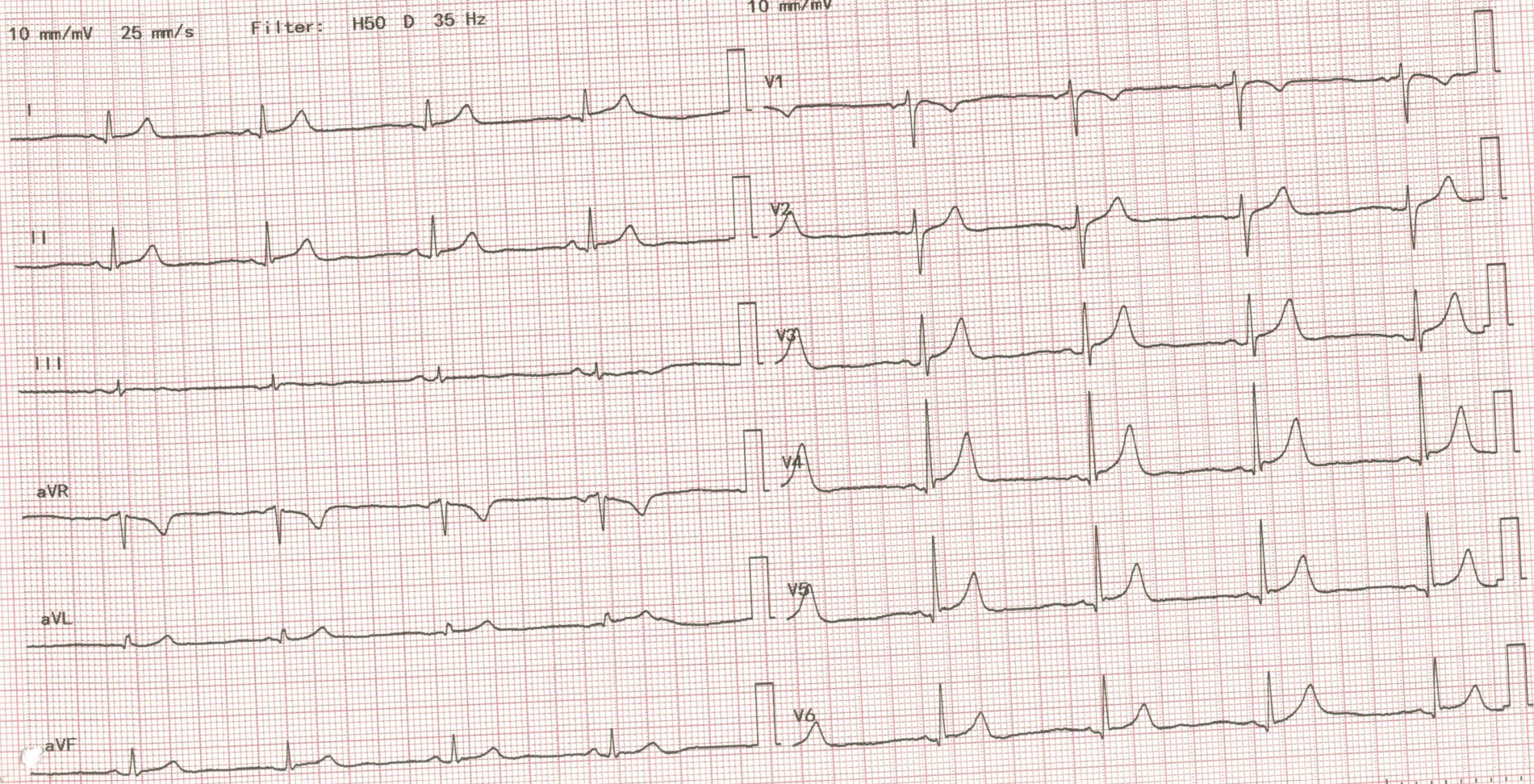
ID:21474
Name:MR NITIN
ex:M Birth date: 46 years
cm kg / mmHg
edication:
ymptoms:
istory:

ent. rate	55	bpm
R int	130	ms
RS dur	80	ms
T/QTc(E) int	400/ 388	ms
/QRS/T axis	66/ 54/ 33	°
V5/SV1 amp	1.41/ 0.82	mV
V5+SV1 amp	2.23	mV

1100 Sinus rhythm
40302 ST elevation, probably early repolarization [ST elevation (I, II, V3, V4, V5)]
9130 ** borderline ECG **

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz



Exam:UNITED HOSPITAL

DEPARTMENT OF RADIODIAGNOSIS

Name	Nitin Bhawsar	**Date**	28/03/24
Age	46 years	**Hospital ID**	UHJA23021474
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in caliber. **CBD** is not dilated.

Gall bladder is contracted. No obvious calculi are seen in the visualized portion of theh lumen. Suggested review scan if any gallbladder pathology is suspected.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (10.0 x 3.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (9.7 x 3.8 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 11.3 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH NABL No.1

HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.NITIN BHAWSAR	UHID	: UHJA23021474
Age / Sex	: 46 Years / Male	OP NO/Reg Dt	: 28-03-2024 08:37 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

nil systemic

VA (glass) 6/6, 6/6

Investigations:

AS: OU Normal

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CD ratio 0.3:1 FR (+)

Follow Up Advice :

Ref. Error

Continue same glasses

Signature of the Doctor

28/3/24

United Hospital
No.110 (30), Madhavan Park Circle, 10th Main Rd,
Jayanagar, Bangalore - 560 011
T: 080 4566 6666
E: appointments@unitedhospital.in
W: www.unitedhospitals.com

DEPARTMENT OF RADIODIAGNOSIS

Name	Nitin Bhawsar	**Date**	28/03/24
Age	46 years	**Hospital ID**	UHJA23021474
Sex	Male	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

Patient name :	Mr. NITIN BHAWSAR	Date :	28/03/24
Age :	46 years GENDER: MALE	Patient ID :	21474
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 2.6 (2.5-3.7)	LVIDD : 4.4 (3.5-5.5)	MV EV : 1.12	AV : 56.8	MR : NORMAL
LA : 3.2 (1.9-4.0)	LVIDS : 2.6 (2.4-4.2)	AV : 1.28		AR : NORMAL
RA : 2.3 (<4.4)	IVSD : 1.0 (0.6-1.1)	PV : 0.60		PR : NORMAL
RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.9 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis	: NO RWMA
Mitral Valve	: NORMAL
Aortic Valve	: NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL AND COLLAPSING

IMPRESSION:

NORMAL CHAMBER DIMENSIONS
NORMAL VALVES
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

Out Patient Record

Patient Name	**: Mr.NITIN BHAWSAR**	**UHID**	**: UHJA23021474**
Age / Sex	: 46 Years / Male	OP NO/Reg Dt	: 28-03-2024 08:37 AM
Spouse / Father Name	: .	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

Wt - 65
HT - 170 cm
Bp - 110/70
SpO2 - 98
PR - 58b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

28-Mar-2024 AM10:11:16

ID:21474
Name:MR NITIN
ex:M Birth date: 46 years
cm kg / mmHg
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Reviewed by:

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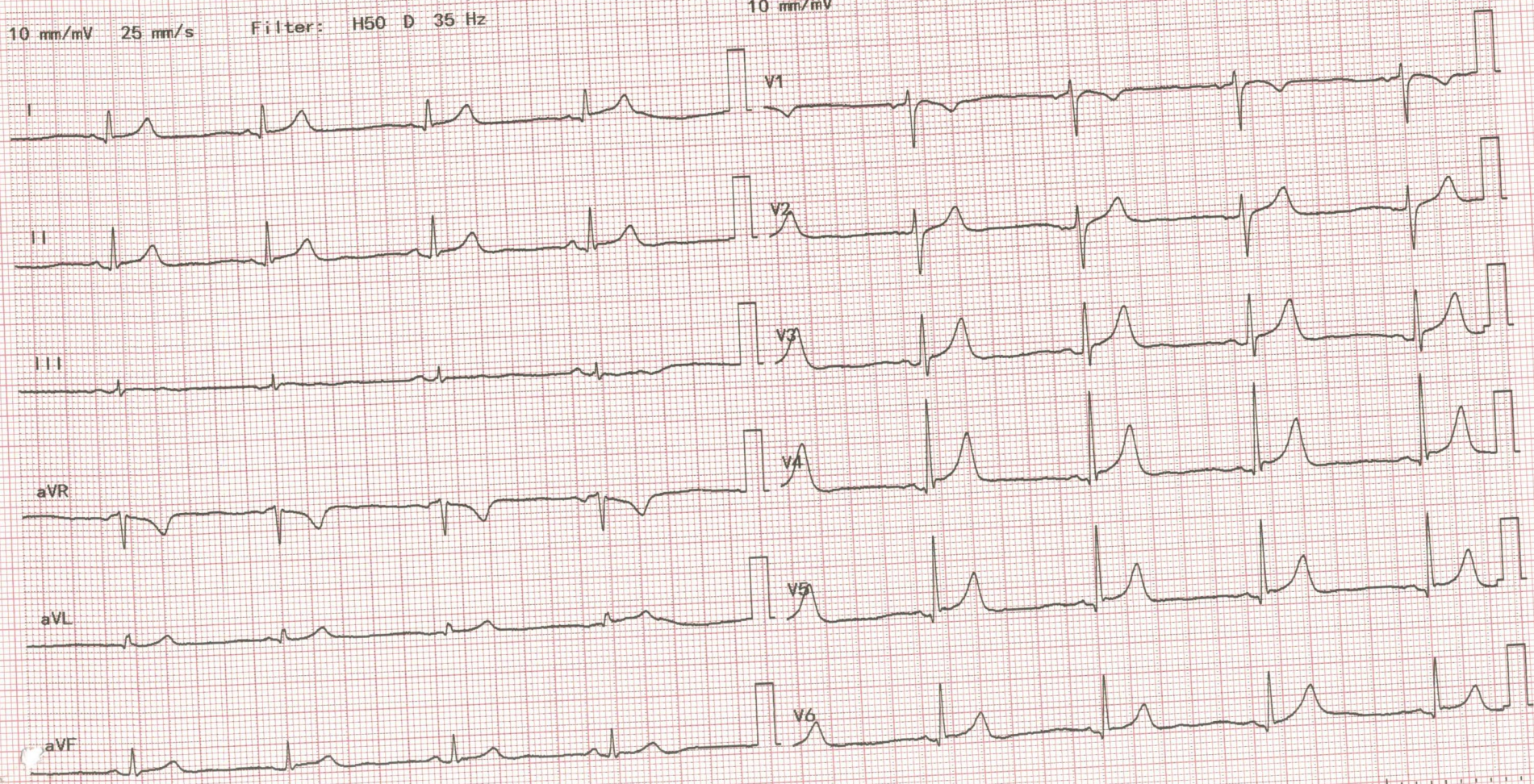

Exam:UNITED HOSPITAL

DEPARTMENT OF RADIODIAGNOSIS

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Age	46 years	**Hospital ID**	UHJA23021474
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

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Gall bladder is contracted. No obvious calculi are seen in the visualized portion of theh lumen. Suggested review scan if any gallbladder pathology is suspected.

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Address	: ., , Bengaluru Urban, Karnataka, INDIA,	Refered By	:
		Consultant	: Dr.Preventive Health Check Up
		KMC No.	:

Complaints / Findings / Observations :

VA (glass) 6/6, 6/6

nil systemic

Investigations:

AS: OU Normal

Treatment / Care of Plan / Provisional Diagnosis :

Fundus (undilated) OU CD rt 0.3:1 FR (+)

Follow Up Advice :

Ref: Rf, Exa

Continue same glasses

Signature of the Doctor

28/3/24

DEPARTMENT OF RADIODIAGNOSIS

Name	Nitin Bhawsar	**Date**	28/03/24
Age	46 years	**Hospital ID**	UHJA23021474
Sex	Male	**Ref.**	Health check

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Dr. Elluru Santosh Kumar
Consultant Radiologist

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Age :	46 years GENDER: MALE	Patient ID :	21474
Ref by :	DR. CMO	OP/ IP :	HEALTH CHECKUP

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LA : 3.2 (1.9-4.0)	LVIDS : 2.6 (2.4-4.2)	AV : 1.28		AR : NORMAL
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RV : 2.0 (<3.5)	IVSS : 1.2 (0.9-1.2)	TV EV : ----	AV : ----	TR : NORMAL
TAPSE: 1.9 (>1.6)	LVPWD : 1.0 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

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NORMAL VALVES
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
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NO REGIONAL WALL MOTION ABNORMALITIES
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HT - 170 cm
Bp - 110/70
SpO2 - 98
PR - 58b/m

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

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Care Par Excellence

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DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. NITIN BHAWSAR	Order No	: 1000080320
UHID	: UHJA23021474	Registered On	: 28/03/2024 08:37:31 AM
Age/Sex	: 46/Years Male	Collected On	: 28/03/2024 09:33:00 AM
Ward / Bed No	:	Reported On	: 28/03/2024 04:47:12 PM
Reference	: Dr. Preventive Health Check Up	Bill No	: OPBJA230026583
Station	: At Hospital	Mobile No	: 8696905556
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	90	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	112	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	96.79	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	0.76	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	10.72	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.88	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	220	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	199	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	43.0	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method:ENZYMATIC METHOD)	137.3	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	39.79	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	5.11		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	3.19		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	177	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	5.4	mg/dL	3.5-7.2
BUN/CREATININE RATIO			Sample: Serum
BLOOD UREA NITROGEN(BUN) (Method:Urease GLDH - Kinetic)	13	mg/dL	7.93-20.07
CREATININE (Method:Modified Jaffe, Kinetic)	1.10	mg/dL	0.9-1.3
BUN/CRE-RATIO (Method: Calculated)	11.8		12˜20 : 1
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.97	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.16	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.81	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.7	g/dL	6.6-8.3

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Test Name	Result	Unit	Bio. Ref. Interval
ALBUMIN (Method:BCG)	4.72	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.98	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.58		2:1
SERUM SGOT (Method:IFCC without P5P)	27	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	32	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	84	U/L	50-116
GGT (Method:IFCC)	48	U/L	< 55
PROSTATE SPECIFIC ANTIGEN (PSA) (Method:CLIA)	0.77	ng/mL	< 4.0

Interpretation Notes

Serum PSA concentrations should not be interpreted as absolute evidence for the presence or absence of malignant disease nor should serum PSA be used alone as a screening test for malignant disease. For diagnostic purposes, the results obtained by immunometric assay should always be used in combination with the clinical examinations, patient medical history and other findings. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

UREA (Method:Urease GLDH - Kinetic)	28.1	mg/dL	17-43

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC)

Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	15.48	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	45.4	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	5330	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	52.29	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	33.99	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	5.30	%	0-6
MONOCYTES (Method:Optical/Impedance)	8.01	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.41	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.10	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	89.1	fL	78-100
MCH (Method: Calculated)	30.4	pg	27-31
MCHC (Method: Calculated)	34.1	g/dL	31-37
RDW - CV (Method: Calculated)	13.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.81	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.58	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	15.9	fl	9-19
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	10	mm/hour	1-15

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Gel Method)	B		
Rh Factor (Method:Agglutination Gel Method)	Positive		

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			Sample: Urine
PHYSICAL EXAMINATION			
VOLUME	20	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.020		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	NA		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Rashmita

---End of Report---

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*NABL renewal under process.