

Patient Name : Mr. SANDIP NARAYAN SAHOO
UHID/ MR No : 20243410014
Visit Date : 03/04/2024
Sample Collected On : 03/04/2024 02:34PM
Ref. Doctor : SELF
Sponsor Name :

Age/Gender : 36 Y. Male
OP Visit No : G/7094
Reported On : 03/04/2024 06:19PM

HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
CBC - COMPLETE BLOOD COUNT			
Haemoglobin(HB) Method: CELL COUNTER	14.5	gm/dl	12 - 17
Erythrocyte (RBC) Count Method: CELL COUNTER	5.23	mill/cu.mm.	4.20 - 6.00
PCV (Packed Cell Volume) Method: CELL COUNTER	43.50	%	39 - 52
MCV (Mean Corpuscular Volume) Method: CELL COUNTER	83.2	fL	76.00 - 100
MCH (Mean Corpuscular Haemoglobin) Method: CELL COUNTER	27.7	pg	26 - 34
MCHC (Mean Corpuscular Hb Concn.) Method: CELL COUNTER	33.3	g/dl	32 - 35
RDW (Red Cell Distribution Width) Method: CELL COUNTER	13.6	%	11- 16
Total Leucocytes (WBC) Count Method: CELL COUNTER	7.80	cells/cumm	3.50 - 10.00
Neutrophils Method: CELL COUNTER	63	%	40.0 - 73.0
Lymphocytes Method: CELL COUNTER	29	%	15.0 - 45.0
Monocytes	05	%	4.0 - 12.0
Eosinophils Method: CELL COUNTER	03	%	1-6%
Basophils Method: CELL COUNTER	00	%	0.0 - 2.0

End of Report
Results are to be correlated clinically

Lab Technician / Technologist
path



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CLINICAL PATHOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
URINE ROUTINE EXAMINATION			
Physical Examination			
Volum of urine	30ML		
Appearance	Clear		Clear
Colour	Pale Yellow		Colourless
Specific Gravity	1.020		1.001 - 1.030
Reaction (pH)	6.0		
Chemical Examination			
Protein(Albumin) Urine	Absent		Absent
Glucose(Sugar) Urine	Absent		Absent
Blood	Absent		Absent
Leukocytes	Absent		Absent
Ketone Urine	Absent		Absent
Bilirubin Urine	Absent		Absent
Urobilinogen	Absent		Absent
Nitrite (Urine)	Absent		Absent
Microscopic Examination			
RBC (Urine)	NIL	/hpf	0 - 2
Pus cells	Occasional	/hpf	0 - 5
Epithelial Cell	Occasional	/hpf	0 - 5
Crystals	Not Seen	/hpf	Not Seen
Bacteria	Not Seen	/hpf	Not Seen
Budding yeast	Not Seen	/hpf	Not Seen

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HAEMATOLOGY

Investigation	Observed Value	Unit	Biological Reference Interval
Platelet Count	195	lacs/cu.mm	150-400
Method: CELL COUNTER			

1. As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.
2. Test conducted on EDTA whole blood.

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DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

Apollo Clinic

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 **0771 4033341/42**

PatientName	:Mr.SANDIP NARAYAN SAHOO	Collected	:01/Apr/2024 04:06PM
Age/Gender	:36Y0M0D/M	Received	:01/Apr/2024 06:37PM
UHID/MRNo	:DSUS.0000007062	Reported	:01/Apr/2024 07:43PM
VisitID	: DSUSOPV8222	Status	:FinalReport
RefDoctor	:APOLLOCLINIC	ClientName	:PUPAPOLLOCLINICSAMRIDDHIAR
IP/OPNO	:	Patientlocation	:Raipur,Raipur

DEPARTMENTOFBIOCHEMISTRY

TestName	Result	Unit	Bio.Ref.Range	Method
HBA1C(GLYCATEDHEMOGLOBIN),WHOLEBLOODEDTA				
HBA1C, GLYCATEDHEMOGLOBIN	6.2	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	131	mg/dL		Calculated


Comment:

ReferenceRangesperAmericanDiabetesAssociation(ADA)2023Guidelines:

REFERENCEGROUP	HBA1C%
NONDIABETIC	<5.7
PREDIABETES	5.7-6.4
DIABETES	≥6.5
DIABETICS	
EXCELLENTCONTROL	6-7
FAIRTOGOODCONTROL	7-8
UNSATISFACTORYCONTROL	8-10
POORCONTROL	>10

Note:Dietarypreparationorfastingisnotrequired.

- HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
- Trends in HbA1C values is a better indicator of Glycemic control than a single test.
- Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
- Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte lifespan or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
- In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control:
 - A: HbF >25%
 - B: Homozygous Hemoglobinopathy.
 (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)


Apollo Clinic
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LICENSED AS AMBULANCE AROGYAM PVT. LTD.
M.B.B.S, M.D (Pathology)
Apollo Clinic (Raipur) Pat. Registrar

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PatientName	:Mr.SANDIP NARAYAN SAHOO	Collected	:01/Apr/2024 04:06PM
Age/Gender	:36Y0M0D/M	Received	:01/Apr/2024 04:40PM
UHID/MRNo	:DSUS.0000007062	Reported	:01/Apr/2024 06:11PM
VisitID	: DSUSOPV8222	Status	:FinalReport
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IP/OPNO	:	Patientlocation	:Raipur,Raipur

DEPARTMENTOFIMMUNOLOGY

TestName	Result	Unit	Bio.Ref.Range	Method
THYROIDPROFILETOTAL(T3,T4,TSH),SERUM				
TRI-iodothyronine(T3,TOTAL)	1.43	ng/mL	0.6-1.81	CLIA
THYROXINE(T4,TOTAL)	11.6	µg/dL	3.2-12.6	CLIA
THYROID STIMULATING HORMONE (TSH)	6.540	µIU/mL	0.35-5.5	CLIA

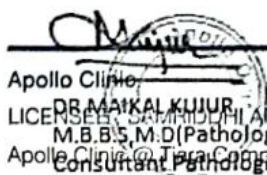
Kindly correlate with Free T3-T4 and clinically.

Comment:

For pregnant females	BioRefRange for TSH in IU/ml (As per American Thyroid Association)
First trimester	0.1-2.5
Second trimester	0.2-3.0
Third trimester	0.3-3.0

1. TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
2. TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
3. Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
4. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Nonthyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma



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DEPARTMENTOFIMMUNOLOGY

*****EndOfReport*****



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Investigation	Observed Value	Unit	Biological Reference Interval
ESR- Erythrocyte Sedimentation Rate Method: Westergren's Method	10	mm /HR	0 - 10

1. It indicates presence and intensity of an inflammatory process, never diagnostic of a specific disease. Changes are more significant than a single abnormal test.
2. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, bacterial endocarditis, acute rheumatic fever, rheumatoid arthritis, SLE, Hodgkins disease, temporal arteritis, polymyalgia rheumatica.
3. Also increased in pregnancy, multiple myeloma, menstruation & hypothyroidism

Blood Group (ABO Typing)

Blood Group (ABO Typing) : B
RhD factor (Rh Typing) : POSITIVE

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
BUN-Blood Urea Nitrogen METHOD: Spectrophotometric	10	mg/dl	7 - 20
Creatinine METHOD: Spectrophotometric	0.99	mg/dl	0.6-1.4

COMMENTS: 1. Creatinine is a waste product formed in the muscle from the high energy storage compound, creatine phosphate.
 2. The amount of creatinine produced is fairly constant (unlike Urea), and is primarily a function of muscle mass.
 3. It is not greatly affected by diet, age, sex or exercise.
 4. Creatinine is removed from plasma by glomerular filtration and then excreted in urine without any appreciable resorption by the tubules; thus it is used to assess the renal function. However, serum creatinine levels do not start to rise until renal function has decreased by atleast 50%.

Uric Acid

Uric Acid Method: Spectrophotometric	4.62	mg/dL	2.6 - 7.2
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GLUCOSE - (POST PRANDIAL)

Glucose -Post prandial Method: REAGENT GRADE WATER	140.0	mg/dl	70-140
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GLUCOSE (FASTING)

Glucose- Fasting SUGAR REAGENT GRADE WATER	98.0	mg/dl	70 - 120
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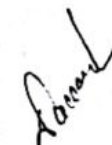
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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIPID PROFILE TEST (PACKAGE)			
Cholesterol - Total	162.0	mg/dl	Desirable: < 200 Borderline High: 200-239 High: >= 240
Triglycerides level	96.0	mg/dl	Normal : < 150 Borderline High : 150-199 Very High : >=500
Method: Spectrophotometric			
HDL Cholesterol	40.0	mg/dl	Major risk factor for heart disease: < 40 Negative risk factor for heart disease :>60
Method: Spectrophotometric			
LDL Cholesterol	102.80	mg/dl	Optimal:< 100 Near Optimal :100 – 129 Borderline High : 130-159 High : 160-189 Very High : >=190
Method: Spectrophotometric			
VLDL Cholesterol	19.20	mg/dl	6 - 38
Total Cholesterol/HDL Ratio	4.05		3.5-5
Method: Spectrophotometric			

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DR DHANANJAY RAMCHANDRA PRASAD
M.D. PATHOLOGY

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BIO CHEMISTRY

Investigation	Observed Value	Unit	Biological Reference Interval
LIVER FUNCTION TEST			
Bilirubin - Total Method: Spectrophotometric	0.6	mg/dl	0.1- 1.2
Bilirubin - Direct Method: Spectrophotometric	0.1	mg/dl	0.05-0.3
Bilirubin (Indirect) Mathod: Calculated	0.50	mg/dl	0 - 1
SGOT (AST) Method: Spectrophotometric	22	U/L	0 - 40
SGPT (ALT) Method: Spectrophotometric	30	U/L	0 - 41
ALKALINE PHOSPHATASE	96	U/L	25-147
Total Proteins Method: Spectrophotometric	6.3	g/dl	6 - 8
Albumin Method: Spectrophotometric	4.0	mg/dl	3.4 - 5.0
Globulin Mathod: Calculated	2.3	g/dl	1.8 - 3.6
A/G Ratio Mathod: Calculated	1.73	%	1.1 - 2.2

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 path



MR. Sandip Narayan Saloo
Age - 36 y/m

BP - 130/80

P - 84/4

H - 166 G.M

WT - 74 Kg

BMI - 26.9



ID: 79
MR SANDIP NARAYAN SAHOO
Male 36Years

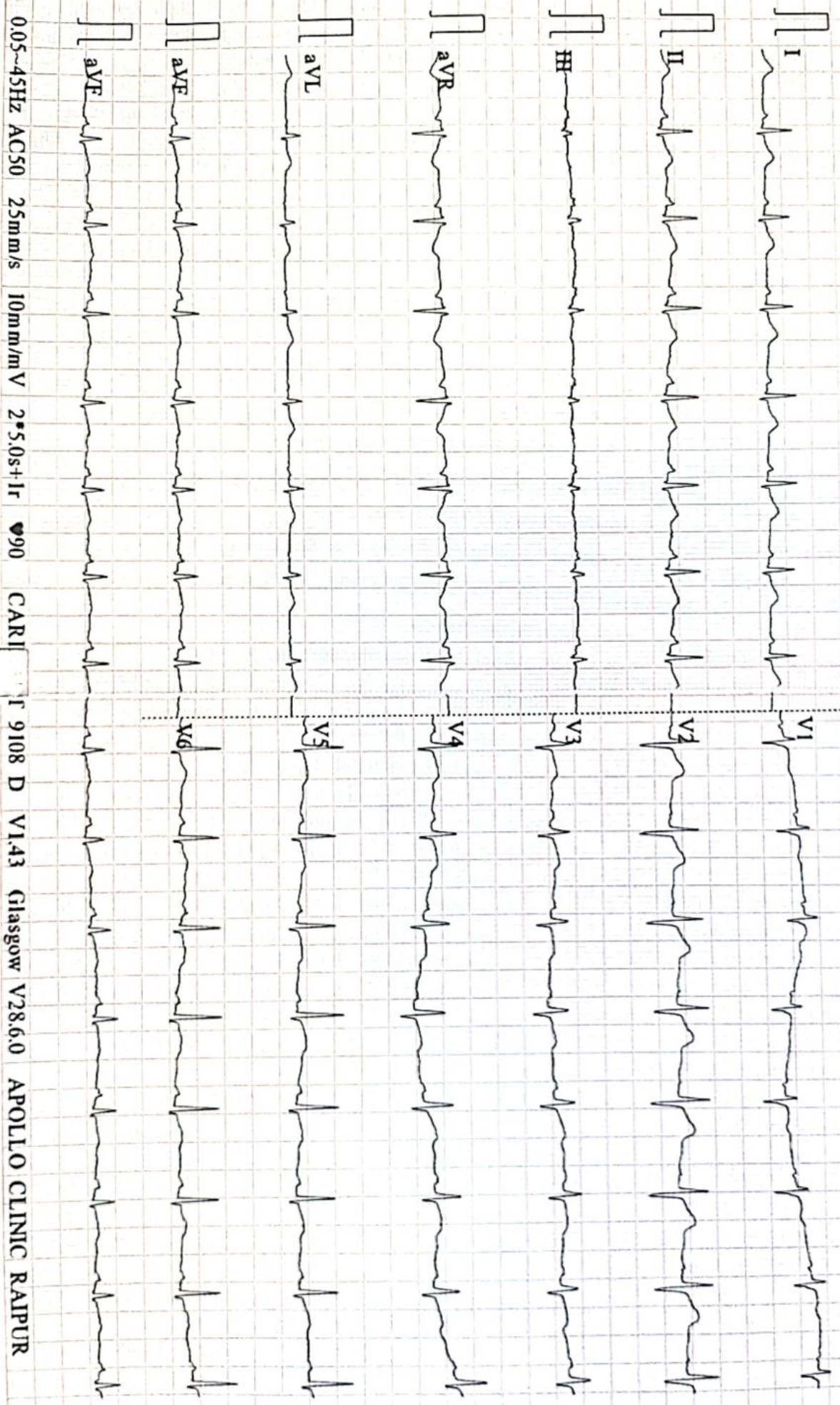
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HR : 90 bpm
P : 86 ms
PR : 136 ms
QRS : 76 ms
QT/QTc : 332/407 ms
P/QRS/T : 56/34/30 °
RV5/SV1 : 0.758/0.379 mV

Diagnosis Information:
Sinus rhythm
Normal ECG

Report Confirmed by:

Dr. Animesh Choudhary
MD Medicine
Reg. No. CGMC 3583/2017
Apollo Clinic, Raipur

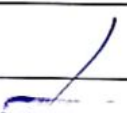


0.05~45Hz AC50 25mm/s 10mm/mV 2*5.0s+1r 90 CARL F 9108 D V1.43 Glasgow V28.6.0 APOLLO CLINIC RAIPUR

EXAMINATION OF EYES :- (BY OPHTHALMOLOGIST)

Patient Name Mr. Sandip Neerayan Sahoo Date 1.10.24
 Sex/Age M/36 year MR No Employee Id

EXTERNAL EXAMINATION				
SQUINT				
NO				
NYSTAGMUS				
COLOUR VISION				
NORMAL				
FUNDUS:(RE):-		(LE):-		
WNL		WNL		
INDIVIDUAL COLOUR IDENTIFICATION				
Good				
DISTANT VISION:(RE):-		(LE):-		
PC-5mtr-6/12		PC-6/12		
NEAR VISION:(RE):-		(LE):-		
NG		NG		
NIGHT BLINDNESS				
N/A				
	SPH	CYL	AXIS	ADD
RIGHT	-9.0	-2.0	10	
LEFT	-8.50	-2.0	160	
REMARKS :-				


Dr. Vikas Mishra
 (MBBS, MS (Ophthalmologist))
 Reg. No: EGMC 621/2006



NAME OF PATIENT; MR. SANDIP NARAYAN SAHOO

AGE: 36YRS/MALE

REFERRED BY: UNION BANK

DATE: 01/04/2024

CHEST X - RAY PA VIEW

FINDINGS:

- Both the domes of diaphragm and CP angles are normal.
- Both the hila and mediastinum are normal.
- Both the lung fields are clear. No e/o focal parenchymal lesion.
- Cardio-thoracic ratio is normal.
- Soft tissues and bony cage are unremarkable.

IMPRESSION:

- NO SIGNIFICANT ABNORMALITY SEEN.

Advised: Clinical correlation and further evaluation if clinically indicated.



Dr. Zeeshan Ateeb Dani
MBBS, MD
Consultant Radiologist
Reg. No. CGMC-2311
DR. ZEESHAN ATEEB DANI
(MD)
CONSULTANT RADIOLOGIST

This report is for perusal of the doctor only not the definitive diagnosis; findings have to be clinically correlated. This report is not for medico-legal purposes.