Neha Nidhi

From: Mediwheel <wellness@mediwheel.in>
Sent: 05 March 2024 18:10
To: Neha Nidhi
Cc: customercare@mediwheel.in
Subject: Health Check up Booking Confirmed Request(UBOIES3947),Package Code-PKG10000450, Beneficiary Code-309144

011-41195959

Dear **NEHA NIDHI**,

We are pleased to confirm your health checkup booking request with the following details.

Hospital Package Name	: Mediwheel Annual Health Checkup Female Starter
Patient Package Name	: Executive Health Checkup Female For Self And Spouse
Name of Diagnostic/Hospital	: Apollo Clinic - Sohna Road
Address of Diagnostic/Hospital-	: Apollo Clinic, 9A,9B,10A,10B &11, Ground Floor, Vipul Trade Center, Badshahpur Sohna Rd Hwy, Sector 48, Gurugram - 122048
City	: Gurgaon
State	:
Pincode	: 122048
Appointment Date	: 09-03-2024
Confirmation Status	: Booking Confirmed
Preferred Time	: 8:30am
Booking Status	: Booking Confirmed

Member Information		
Booked Member Name	Age	Gender
Vineet Kumar	39 year	Male
NEHA NIDHI	39 year	Female

Note - Please note to not pay any amount at the center.

Instructions to undergo Health Check:

- Please ensure you are on complete fasting for 10-To-12-Hours prior to check.
- During fasting time do not take any kind of medication, alcohol, cigarettes, tobacco or any other liquids (except Water) in the morning.
- Bring urine sample in a container if possible (containers are available at the Health Check centre).
- Please bring all your medical prescriptions and previous health medical records with you.
- Kindly inform the health check reception in case if you have a history of diabetes and cardiac problems.

For Women:

- Pregnant Women or those suspecting are advised not to undergo any X-Ray test.
- It is advisable not to undergo any Health Check during menstrual cycle.

Request you to reach half an hour before the scheduled time.

In case of further assistance, Please reach out to Team Mediwheel.

Thanks,
Mediwheel Team

Please Download Mediwheel App


यूनियन बैंक
ऑफ इंडिया
Union Bank
of India
नाम : नेहा निधि
Name : Neha Nidhi
कर्मचारी क्र./ Employee No.: 648417
जन्म तिथि / Birth Date : 26/08/1984
रक्त ग्रुप/ Blood Group : A+
हस्ताक्षर / Signature
जारी करने का स्थान : क्षेत्रीय कार्यालय गुरुग्राम
Place of Issue : Ro Gurugram
जारी करने की तारीख : २२ /जून/२०२३
Date of Issue : 22/06/2023
जारीकर्ता प्राधिकारी / Issuing Authority

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DATE- 09/3/2024

NAME - NEHA NIDHI PHONE - 9873753706

AGE/GENDER - 39/F ADDRESS - 760, Sec 22B, GURUGRAM

EMAIL - nehan@unionbankofindia.bank CORPORATE NAME - UBI

1. **Past medical history & medications**:- Cholestrol / No medicine

2. **Any existing disease: -** NO

3. **Current medications :-** NO

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

- BLOOD PRESSURE - 150/98 mm (High)
- PULSE RATE - 78/hr
- TEMPERATURE – 97.2 F
- SPO2 – 98%
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 159.6cm
- WEIGHT – 85.4 Kg.
- BMI – 33.4 (obesity)

Vision- LE } 6/12
RE }

Colour vision- Normal

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5. **FINDINGS**: -

LAB INVESTIGATION: - Hb (11.20).

PAP- smear- Normal

CARDIOLOGY INVESTIGATIONS: - ECG- Normal

RADIOLOGY INVESTIGATIONS: - USG- Grade I fatty liver.
CXR- Normal.

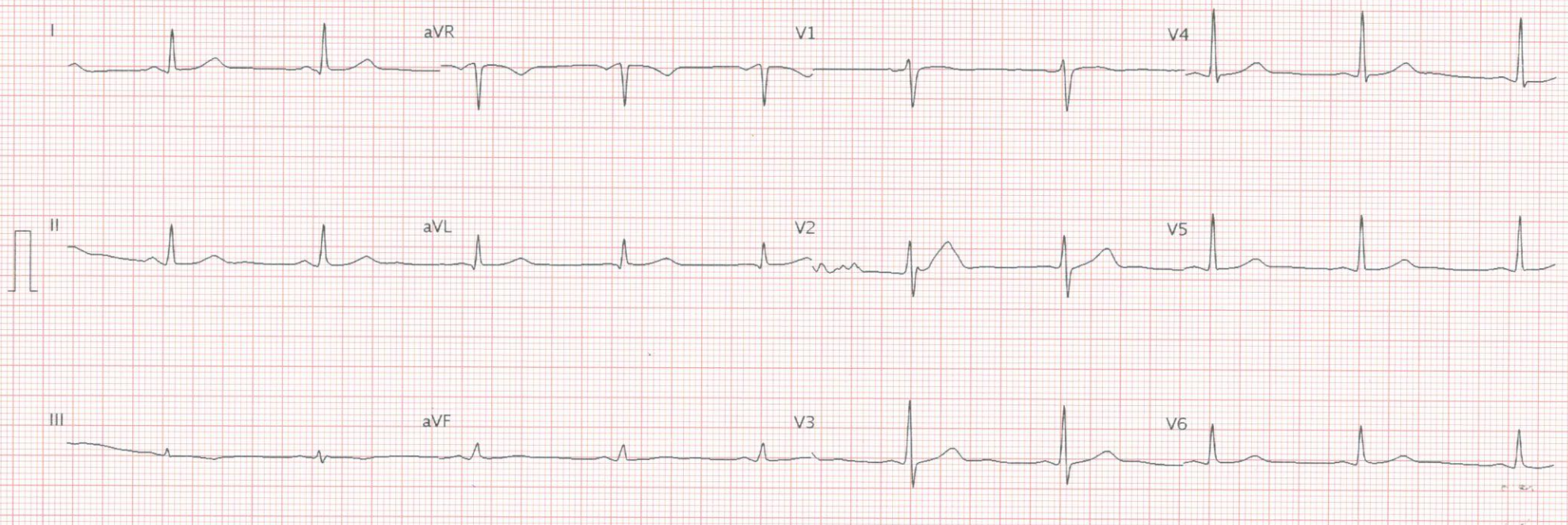
6. **DOCTOR REMARKS:** – 1020 HB., Obesity.
High BP

Name	**Ms.neha nidhi Emergency**	**09.03.2024 08:43:20**	
Patient ID	**73d8c9c3-e6f6-4c2d-8f63-ea2c0abb6126**	**Standard 12-Lead**	

Date of birth	26.08.1984	**Visit ID**	**HR**	**60 bpm**	**RR**	1003 ms	Sinus rhythm
Gender	Female	**Room**			**P**	108 ms	Normal electrical axis
Height		**Medication**			**PR**	141 ms	Normal ECG
Weight		**Order ID**	**P axis**	38 °	**QRS**	79 ms	
Ethnicity	Undefined	**Ord. prov.**	**QRS axis**	23 °	**QT**	409 ms	**Unconfirmed report**
Pacemaker	Unknown	**Ord. prot.**	**T axis**	14 °	**QTcB**	408 ms	

Indication
Remark

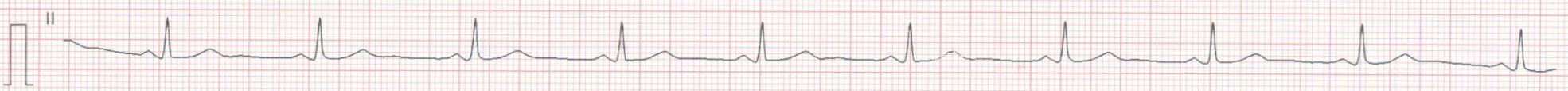
Normal



25 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



25 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

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Patient's Name:-	MS. NEHA NIDHI	Date	:- 09/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 38Y/F

Radiograph of Chest (PA View)

Visualized lungs fields appear normal.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardiac shadow appears normal..

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

Dr Arushi Gupta

MBBS, DNB (Radio – Diagnosis)

Radiologist

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Patient's name:- MS NEHA NIDHI	**Date:- 09-03-2024**
Referred by:- HEALTH CHECK UP	**Age/Sex:- 39Y/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 shows increase in 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 anteverted, measures normal in size and outline. The myometrium shows homogenous echoes. The endometrial lining is central, 3.9mm. The myo-endometrial interface is preserved.

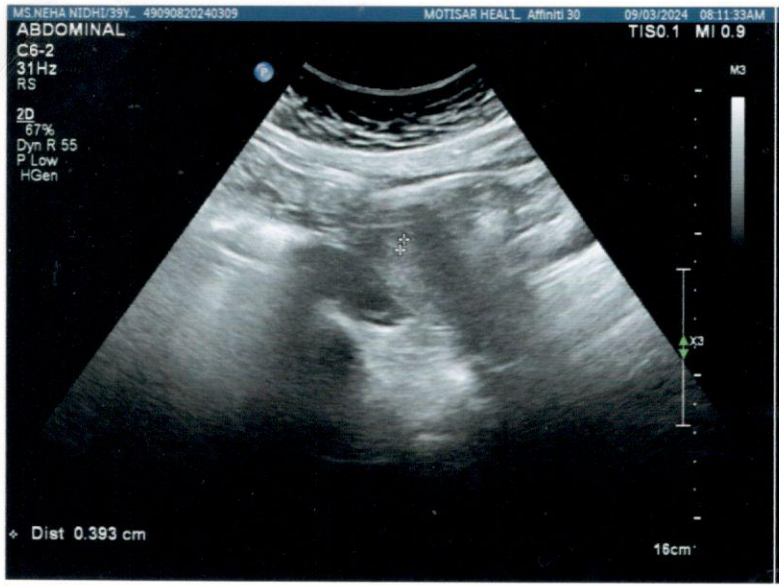
Both ovaries appear normal.

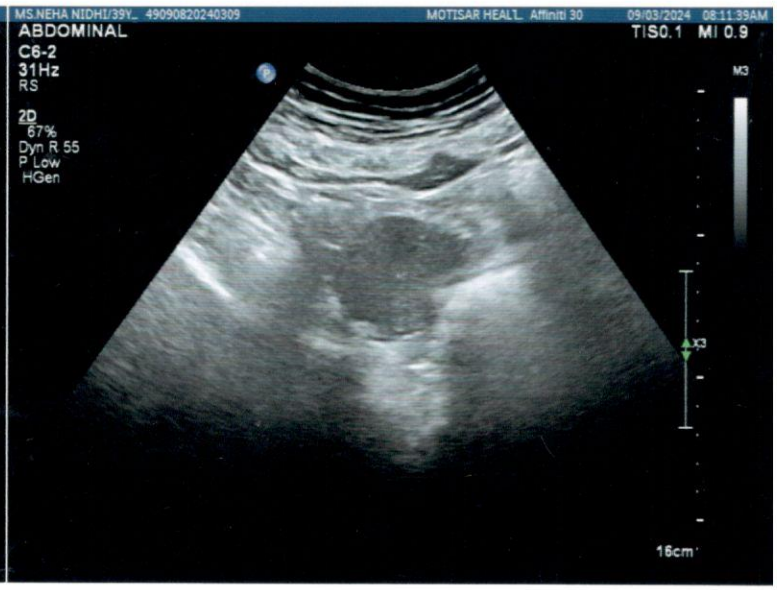
The pouch of douglas does not show any free fluid.

IMPRESSION:

GRADE I FATTY INFILTRATION OF LIVER
CLINICAL CORRELATION IS NECESSARY.

DR. RAJNISH JUNEJA
MBBS, DNB RADIODIAGNOSIS


MS.NEHA NIDHI/39Y_ 49090820240309
MOTISAR HEALT_ Affiniti 30
09/03/2024 08:11:33AM
ABDOMINAL
TIS0.1 MI 0.9
C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen
M3
X3
Dist 0.393 cm
16cm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MOTISAR HEALT_ Affiniti 30
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Dyn R 55
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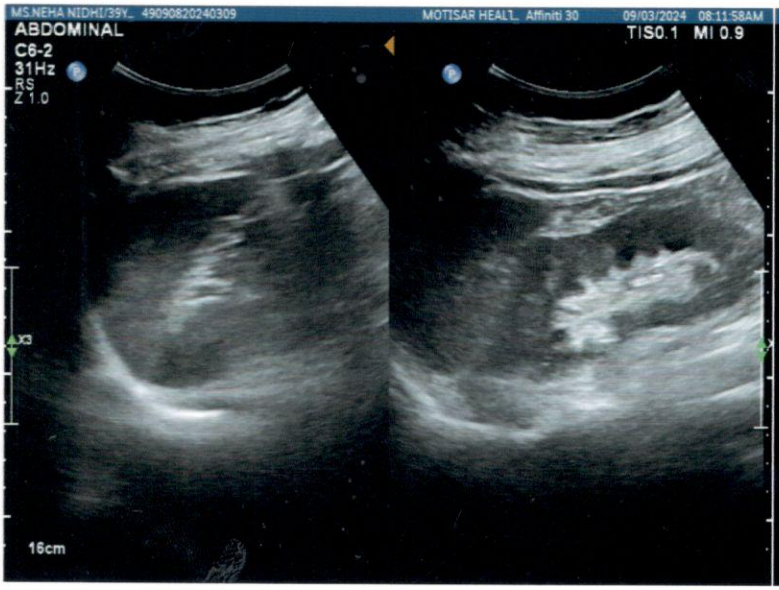
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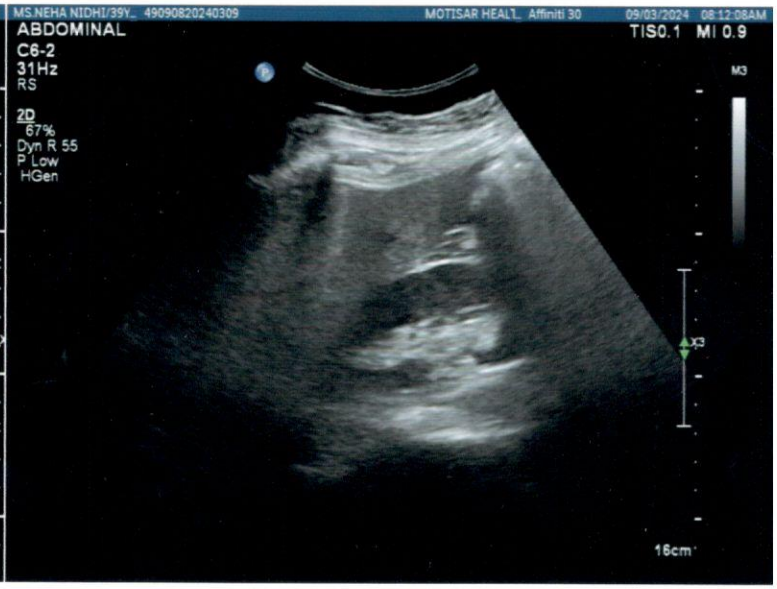
C6-2
31Hz
RS
Z 1.0
X3
16cm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2D
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P Low
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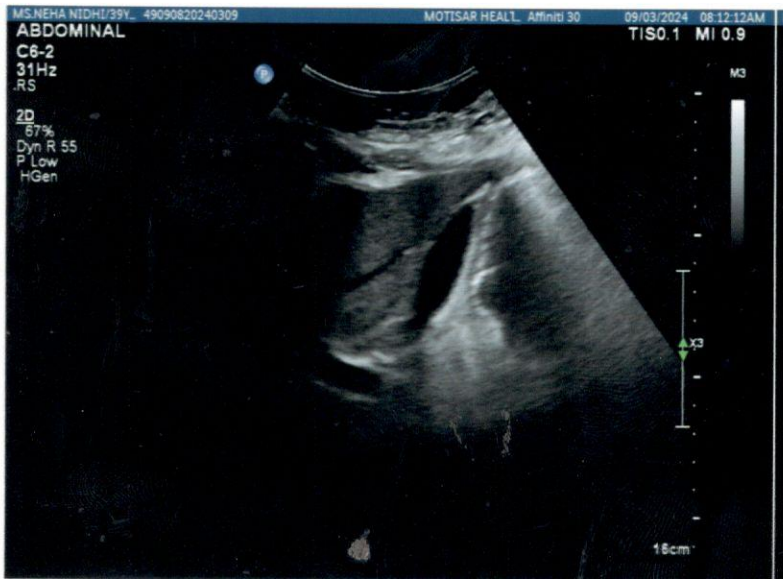
M3
X3
16cm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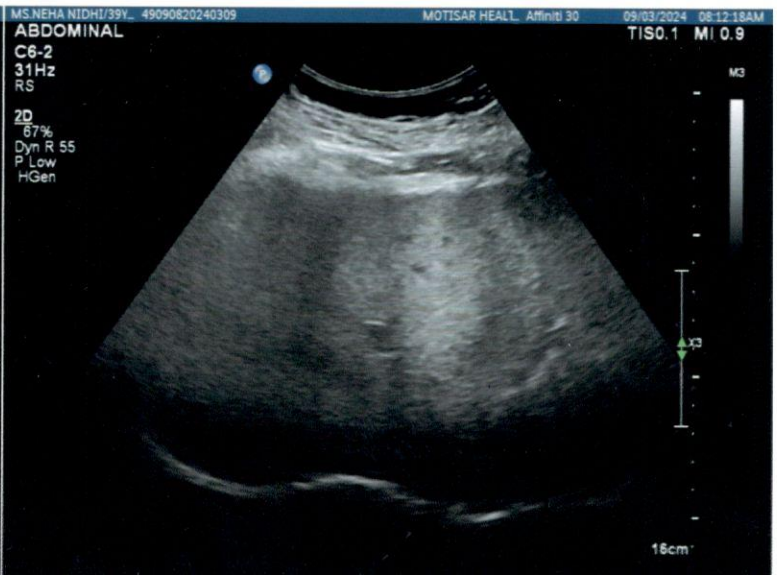
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ABDOMINAL
TIS0.1 MI 0.9
C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen
M3
X3
16cm

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

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NAME:- Neha mittal AGE/SEX: 39/F DATE: 9/March/24

Through health checkup.

O/E Dental caries. 7/7

Bindu Bisht

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

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Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:26PM
LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:47PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	11.20	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	4.6	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	36.4	%	42-52	Calculated
MCV	79.80	fL	78-100	Electrical Impedence
MCH	24.6	pg	27-31	Calculated
MCHC	30.8	gm/dL	32-36	Calculated
RDW-SD	13.4	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6830	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	60	%	40-80	VCSn Technology
LYMPHOCYTE	35	%	20-40	VCSn Technology
MONOCYTE	03	%	2-10	VCSn Technology
EOSINOPHIL	02	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	266	10^3/ul	150 - 450	Electrical Impedence
MPV	11.3	fL	7.2 - 11.7	Electrical Impedence
PCT	0.3	%	0.2 - 0.5	Calculated
PDW	14.1	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	4.1	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	2.39	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.2	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	0.14	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)

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DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	22	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	A		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.

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 06:11PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY
APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.40	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.18	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.22	mg/dL	0.1 - 1.0	Calculated
SGPT	29.52	U/L	< 45	UV with P5P, IFCC 37 Degree
SGOT	32.50	U/L	< 50	UV with P5P, IFCC 37 degree
SGOT/SGPT	1.10	Ratio	0.7 - 1.4	
GGT	13	U/L	< 55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	77.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.30	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	3.90	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.4	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.15	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

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Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

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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DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	162.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	98.20	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	43.50	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	98.86	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	118.5	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	19.64	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	3.72	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	2.27	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.44	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

Prasad

Dr. Sarita Prasad
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Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.8	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	119.76	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)

Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:26PM
LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:37PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	99.20	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (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

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Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:26PM
LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 07:28PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	41.30	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	19.30	mg/dL	7 - 18	Urease
SERUM URIC ACID	6.60	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.87	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	8.90	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	137.2	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.20	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	101.4	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
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Sr. Consultant (HMC.9669)

Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:26PM
LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 07:28PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 10

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
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Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 03:26PM
LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:41PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.28	ng/mL	0.79 - 1.58	CLIA
T4	8.65	µg/dl	4.9 - 11.00	CLIA
TSH	3.20	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

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Patient NAME	: MRS.NEHA NIDHI	Barcode NO	: 20010219
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LabNo	: DPL21492	Sample Collected Date	: 09/Mar/2024 03:26PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:37PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 10

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	25	ml	-	
COLOUR	PALE YELLOW		PALE YELLOW	
TRANSPARENCY	SLIGHTLY TURBID		Clear	
REACTION (PH)	6.50		4.5 - 7.0	
SPECIFIC GRAVITY	1.025		1.010 - 1.030	
CHEMICAL EXAMINATION				
URINE SUGAR.	ABSENT		Nill	
Urine Protein	ABSENT		Nil	
Urine Ketones	ABSENT		Nil	
BLOOD	TRACE		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	1-2	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

*** End Of Report ***

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

Patient NAME	: Mrs.NEHA NIDHI	Barcode NO	: 20010240
Age/Gender	: 39 Y 0 M 0 D /F	Registration Date	: 09/Mar/2024 04:33PM
LabNo	: DPL21513	Sample Collected Date	: 09/Mar/2024 04:33PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 08:53PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF CYTOPATHOLOGY

LIQUID BASED CYTOLOGY - PAP SMEAR

CASE NO:	LBC – 52/2024
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 Transformation zone: Absent Squamous cellularity: Adequate Inflammatory change: Mild 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)

Neha Nidhi

From: Mediwheel <wellness@mediwheel.in>
Sent: 05 March 2024 18:10
To: Neha Nidhi
Cc: customercare@mediwheel.in
Subject: Health Check up Booking Confirmed Request(UBOIES3947),Package Code-PKG10000450, Beneficiary Code-309144

011-41195959

Dear **NEHA NIDHI**,

We are pleased to confirm your health checkup booking request with the following details.

Hospital Package Name	:	Mediwheel Annual Health Checkup Female Starter
Patient Package Name	:	Executive Health Checkup Female For Self And Spouse
Name of Diagnostic/Hospital	:	Apollo Clinic - Sohna Road
Address of Diagnostic/Hospital-	:	Apollo Clinic, 9A,9B,10A,10B &11, Ground Floor, Vipul Trade Center, Badshahpur Sohna Rd Hwy, Sector 48, Gurugram - 122048
City	:	Gurgaon
State	:	
Pincode	:	122048
Appointment Date	:	09-03-2024
Confirmation Status	:	Booking Confirmed
Preferred Time	:	8:30am
Booking Status	:	Booking Confirmed

Member Information		
Booked Member Name	Age	Gender
Vineet Kumar	39 year	Male
NEHA NIDHI	39 year	Female

Note - Please note to not pay any amount at the center.

Instructions to undergo Health Check:

- Please ensure you are on complete fasting for 10-To-12-Hours prior to check.
- During fasting time do not take any kind of medication, alcohol, cigarettes, tobacco or any other liquids (except Water) in the morning.
- Bring urine sample in a container if possible (containers are available at the Health Check centre).
- Please bring all your medical prescriptions and previous health medical records with you.
- Kindly inform the health check reception in case if you have a history of diabetes and cardiac problems.

For Women:

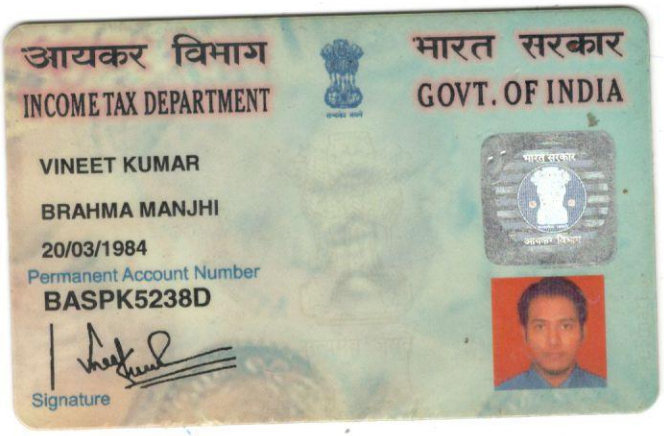
- Pregnant Women or those suspecting are advised not to undergo any X-Ray test.
- It is advisable not to undergo any Health Check during menstrual cycle.

Request you to reach half an hour before the scheduled time.

In case of further assistance, Please reach out to Team Mediwheel.

Thanks,
Mediwheel Team

Please Download Mediwheel App


आयकर विभाग
INCOME TAX DEPARTMENT
भारत सरकार
GOVT. OF INDIA
VINEET KUMAR
BRAHMA MANJHI
20/03/1984
Permanent Account Number
BASPK5238D
Signature

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Sohna Road

DATE- 09/03/1984.

NAME - Vineet Kumar | PHONE - 8447423713.

AGE/GENDER - 39 yrs / M | ADDRESS -

EMAIL - Vineet.k.007@gmail.com | CORPORATE NAME -

1. **Past medical history & medications**:-
   - High Blood pressure.
   - Cholestrol.

2. **Any existing disease: -**

3. **Current medications :-**
   - Amlodipine. - 5mg
   - Atorvastine - 20mg.

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

- BLOOD PRESSURE - 150/100 mm/hg (High)
- PULSE RATE - 82 b/m
- TEMPERATURE – 98.0°F
- SPO2 – 98%.
- BLOOD SUGAR (RANDOM) – .....
- HEIGHT – 168 cm
- WEIGHT – 70.3 Kg
- BMI – 24.9

Vision - RE - 6/12
LE - 6/6.

Colour vision - Normal

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5. **FINDINGS: -**

LAB INVESTIGATION: - All investigation- Normal

CARDIOLOGY INVESTIGATIONS: - ECG- Left Ventricular Hypertrophy.

RADIOLOGY INVESTIGATIONS: - USG-Normal

CXR- Normal

6. **DOCTOR REMARKS:** – High BP

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CERTIFICATE OF MEDICAL FITNESS

This is to certify that I have conducted the clinical examination

of Vineet Kumar 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 Though following restrictions have been revealed, in my opinion, these are not impediments to the job. 1..... 2..... 3..... However the employee should follow the advice/medication that has been communicated to him/her. Review after_____	
• Currently Unfit. Review after_____recommended	
• Unfit	

Dr. [signature]
Medical Officer
The Apollo Clinic, (Location)

This certificate is not meant for medico-legal purposes

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

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NAME:- Vheet Kumar AGE/SEX: 39/M DATE: 9 March 25

Through health checkup

O/E - chr. gen. gingivitis.

- missing — 6.

Advice - scaling & prophylaxis.

- Implant — 6.

94-11A, Ground Floor, Vipul Trade Centre,
Sector-48, Sohna Road, Gurgaon-122018 (Haryana)

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Patient's Name:-	MR.VINEET KUMAR	Date	:- 09/03/2024
Referred By :-	HEALTH CHEAKUP	Age/Sex	:- 39Y/M

Radiograph of Chest (PA View)

Visualized lungs fields appear normal.

Both hila appear normal

Both CP Angle are clear.

Domes are normally placed.

Cardia size is prominent with unfolding of aortic arch.

Trachea and mediastinum are normal.

Thoracic bony cage is normal.

Please correlate clinically

Dr Arushi Gupta

MBBS, DNB (Radio - Diagnosis)

Radiologist

e – –
nt ID **Vineet**

09.03.2024 11:13:36
Standard 12-Lead

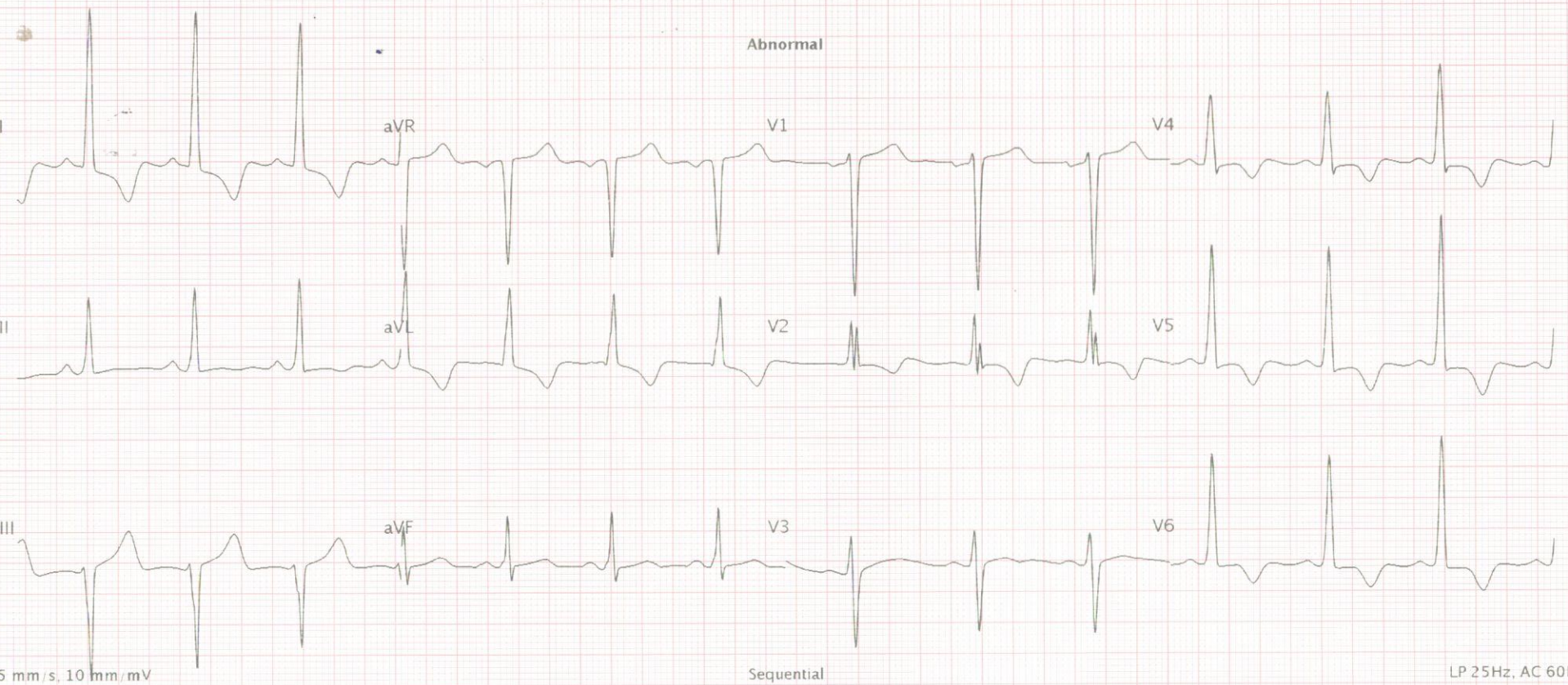
of birth	– –	Visit ID	
er	Male	Room	
nt		Medication	
nt		Order ID	
city	Undefined	Ord. prov.	
naker	Unknown	Ord. prot.	

ation
rk

HR	**83 bpm**	RR	727 ms	Sinus rhythm
		P	113 ms	Normal electrical axis
		PR	153 ms	R/S transition shift to right
P axis	36 °	QRS	88 ms	Left ventricular hypertrophy with repolarisation abnormality
QRS axis	9 °	QT	410 ms	Prolonged QT
T axis	157 °	QTcB	481 ms	Abnormal ECG

Unconfirmed report

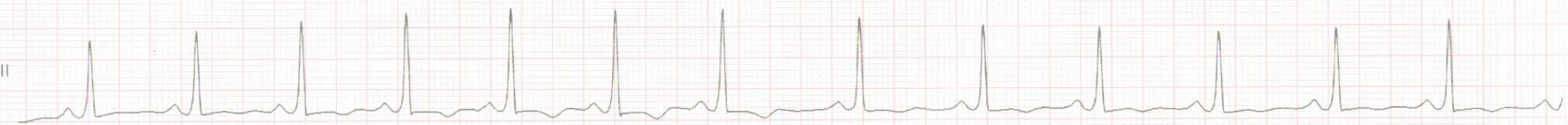
Abnormal



5 mm/s, 10 mm/mV

Sequential

LP 25Hz, AC 60Hz



5 mm/s, 10 mm/mV

LP 25Hz, AC 60Hz

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Patient's Name	MR VINEET KUMAR	Date	09-03-2024
Referred By	HEALTH CHECK UP	Age/Sex	39RS/M

ULTRASOUND OF ABDOMEN & PELVIS

Clinical profile: - General check up

Liver: , is normal in size, outline , and parenchymal echotexture . No focal lesion is seen. There is no evidence of intrahepatic biliary dilatation. The hepatic veins are normal. The portal vein shows normal flow and appears normal in calibre.

GALL BLADDER: is distended and shows normal contents. Visualized portion of CBD is normal in calibre.

PANCREAS: Normal in size, shape and echo pattern. Main pancreatic diameter is normal.

SPLEEN: Normal in size shape and echopattern. No focal lesion is seen.

KIDNEYS- Both kidneys are normal in size, shape, position, axis and echopattern.

The corticomedullary differentiation is well maintained.

Collecting system appears normal. No calculus or hydronephrosis is seen.

Both the adrenal regions have also been evaluated and no obvious abnormality is seen.

URINARY BLADDER: well distended. No wall thickening seen. No calculus/mass seen.

PROSTATE: Normal in shape and echotexture. It measures 36x34x34mm and weighs 20gms

No free fluid is seen in abdominal cavity.

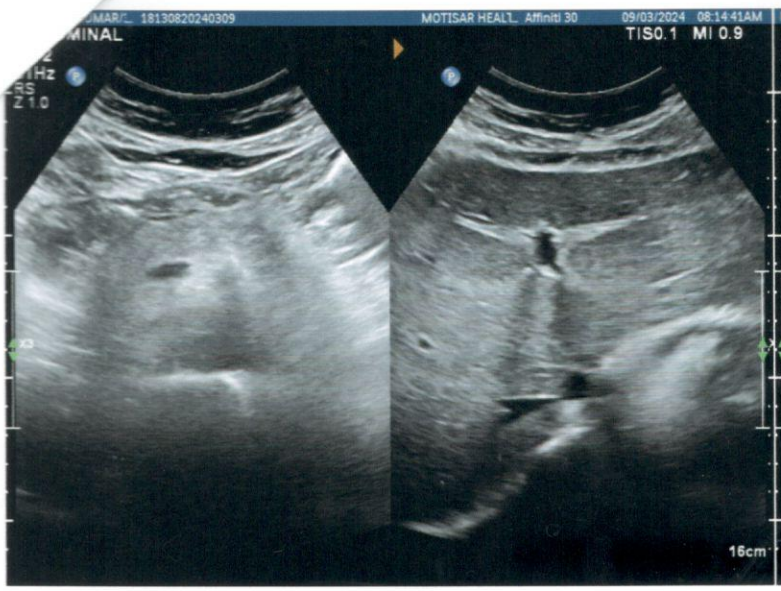
No e/o any lymphadenopathy.

IMPRESSION:

NO OBVIOUS SONOLOGICAL ABNORMALITY IS SEEN

CLINICAL CORRELATION IS NECESSARY

DR. RAJNISH JUNEJA
MBBS, DNB RADIODIAGNOSIS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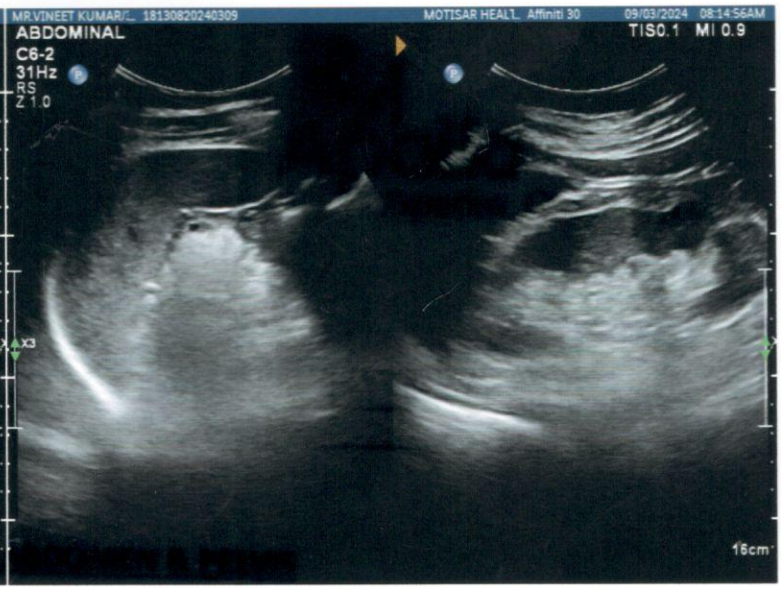
C6-2
31Hz
RS
Z 1.0
16cm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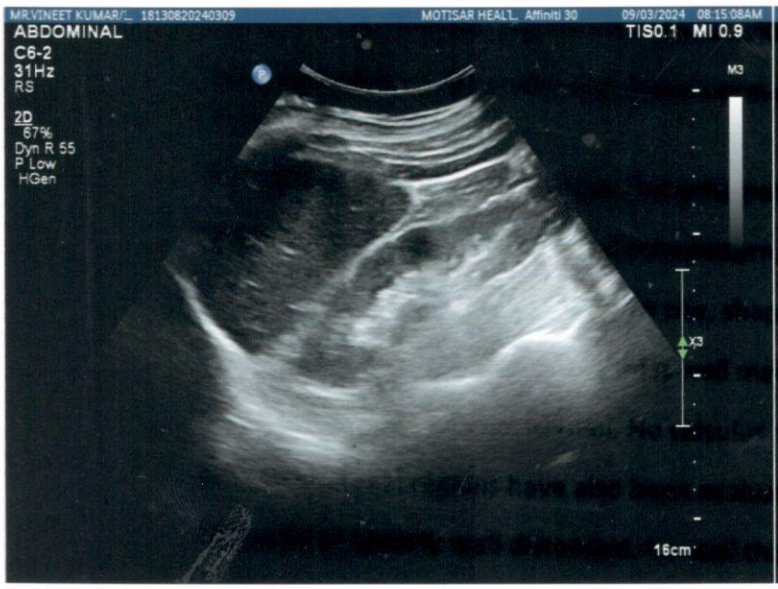
TIS0.1 MI 0.9
C6-2
31Hz
RS
Z 1.0
16cm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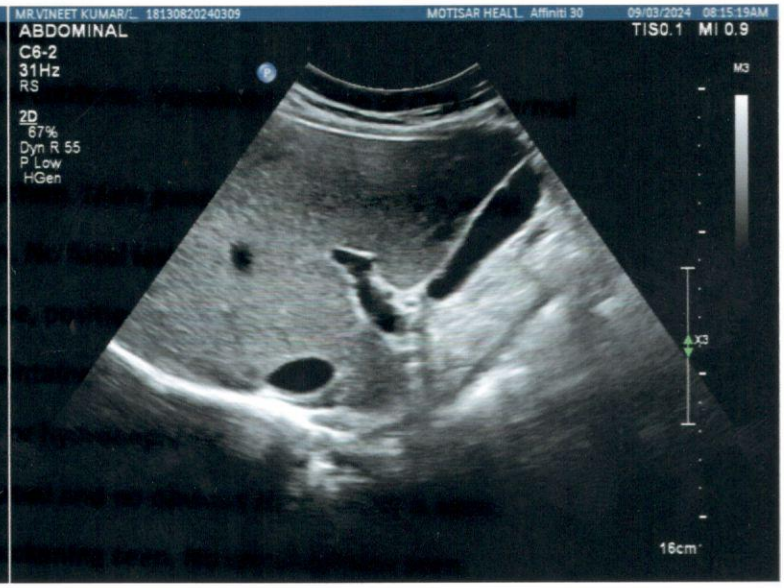
ABDOMINAL
TIS0.1 MI 0.9
C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen
16cm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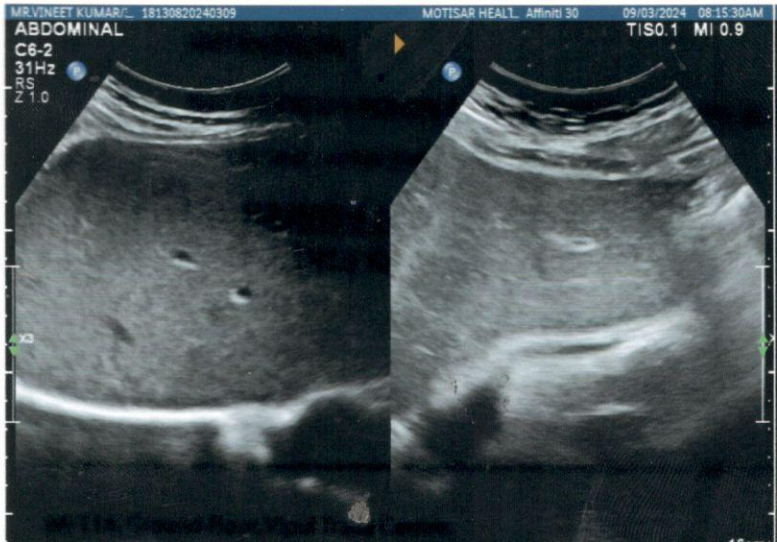
TIS0.1 MI 0.9
C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen
16cm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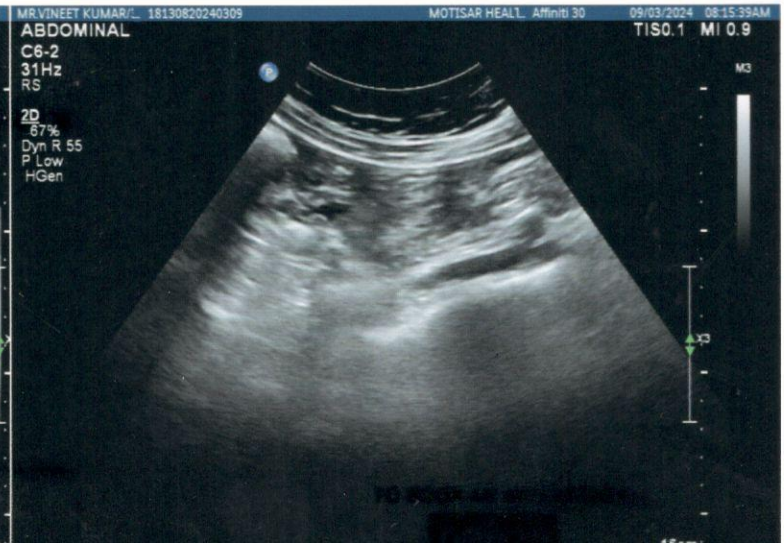
ABDOMINAL
TIS0.1 MI 0.9
C6-2
31Hz
RS
Z 1.0


MR.VINEET KUMAR/ 18130820240309
MOTISAR HEALTH Affiniti 30 09/03/2024 08:15:39AM
ABDOMINAL
TIS0.1 MI 0.9
C6-2
31Hz
RS
2D
67%
Dyn R 55
P Low
HGen

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Patient NAME	: MR.VINEET KUMAR	Barcode NO	: 20010237
Age/Gender	: 39 Y 0 M 0 D /M	Registration Date	: 09/Mar/2024 04:21PM
LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:46PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	14.60	gm/dL	13.5 - 18.0	Cynmeth Photometric Measurement
RBC COUNT(RED BLOOD CELL COUNT)	5.6	mil/cu.mm	4.7 - 6.0	Electrical Impedence
PCV/HAEMATOCRIT	46.6	%	42-52	Calculated
MCV	82.60	fL	78-100	Electrical Impedence
MCH	25.9	pg	27-31	Calculated
MCHC	31.3	gm/dL	32-36	Calculated
RDW-SD	14	fL	39-46	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	6230	cell/cmm	4000-10000	Electrical Impedence
NEUTROPHIL	66	%	40-80	VCSn Technology
LYMPHOCYTE	26	%	20-40	VCSn Technology
MONOCYTE	07	%	2-10	VCSn Technology
EOSINOPHIL	01	%	1-6	VCSn Technology
BASOPHIL	00	%	0-2	VCSn Technology
PLATELET COUNT	160	10^3/ul	150 - 450	Electrical Impedence
MPV	12.2	fL	7.2 - 11.7	Electrical Impedence
PCT	0.2	%	0.2 - 0.5	Calculated
PDW	16.3	%	9.0 - 17.0	Calculated
ABSOLUTE NEUTROPHIL COUNT	4.11	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	1.62	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.44	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	0.06	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.

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Patient NAME	: MR.VINEET KUMAR	Barcode NO	: 20010237
Age/Gender	: 39 Y 0 M 0 D /M	Registration Date	: 09/Mar/2024 04:21PM
LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:46PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HAEMATOLOGY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
ERYTHROCYTE SEDIMENTATION RATE				
Sample Type : WHOLE BLOOD EDTA				
ERYTHROCYTE SEDIMENTATION RATE	20	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	B		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.

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LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:37PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY
APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	0.60	mg/dL	0.1-1.2	Jendrassik Grof
CONJUGATED (D. Bilirubin)	0.20	mg/dL	Adults and Children: < 0.3	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.40	mg/dL	0.1 - 1.0	Calculated
SGPT	18.90	U/L	< 45	UV with P5P, IFCC 37 Degree
SGOT	25.10	U/L	< 50	UV with P5P, IFCC 37 degree
SGOT/SGPT	1.33	Ratio	0.7 - 1.4	
GGT	17	U/L	< 55	G-glutamyl-carboxy-nitoanilide
ALKALINE PHOSPHATASE	115.00	U/L	56-119	PNPP, AMP Buffer, IFCC 37 degree
TOTAL PROTEINS	7.60	g/dL	6.6-8.3	Biuret, reagent blank end point
ALBUMIN	4.40	g/dL	Adults: 3.5 - 5.2	Bromcresol purple
GLOBULIN	3.2	g/dL	1.8 - 3.6	Calculated
A/G RATIO	1.38	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

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Age/Gender	: 39 Y 0 M 0 D /M	Registration Date	: 09/Mar/2024 04:21PM
LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:37PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

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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LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:36PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY
APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID PROFILE				
TOTAL CHOLESTEROL	107.00	mg/dL	Desirable: <= 200 Borderline High: 201-239 High:>239 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.	Serum, Cholesterol oxidase esterase, peroxidase
TRIGLYCERIDES	76.50	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: >= 500	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	42.8	mg/dL	Normal: > 40 Major Heart Risk: < 40	Serum, Direct measure-PEG
L D L CHOLESTEROL	48.90	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: >= 190	Serum
NON HDL CHOLESTEROL	64.2	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL	Calculated
VLDL	15.3	mg/dL	6 - 38	Calculated
T. CHOLESTEROL/ HDL RATIO	2.5	Ratio	3.5 - 5.0	Calculated
LDL / HDL RATIO	1.14	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - >6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated
HDL/LDL RATIO	0.88	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0 Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0	Calculated

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:36PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method

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Patient NAME	: MR.VINEET KUMAR	Barcode NO	: 20010237
Age/Gender	: 39 Y 0 M 0 D /M	Registration Date	: 09/Mar/2024 04:21PM
LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 04:47PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.1	%	Non-Diabetic: <=6.0 Pre Diabetic:6.1 - 7.0 Diabetic: >=7.0	EDTA Whole blood,HPLC
ESTIMATED AVG. GLUCOSE	99.67	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 %

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Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE - FASTING				
Sample Type : FLOURIDE PLASMA				
Plasma Glucose Fasting	97.1	mg/dL	Normal: 70-100 Impaired Fasting Glucose (IFG): 100-125 Diabetes Mellitus: >= 126 (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

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:36PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	26.50	mg/dL	17- 43	Urease GLDH
Blood Urea Nitrogen (BUN)	12.38	mg/dL	7 - 18	Urease
SERUM URIC ACID	7.10	mg/dL	3.5 - 7.2	Uricase/POD
SERUM CREATININE	0.99	mg/dL	0.67 - 1.17	Jaffe IDMS
SERUM TOTAL CALCIUM	9.20	mg/dL	8.8 - 10.6	Arsenazo III
SERUM SODIUM	143.5	mmol/L	136 - 146	ISE
SERUM POTASSIUM	4.32	mmol/L	3.5 - 5.1	ISE
SERUM CHLORIDE	105.3	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

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:36PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF BIOCHEMISTRY

APOLLO PACKAGE 9

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."

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LabNo	: DPL21510	Sample Collected Date	: 09/Mar/2024 04:21PM
Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:24PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	1.36	ng/mL	0.79 - 1.58	CLIA
T4	8.97	µg/dl	4.9 - 11.00	CLIA
TSH	6.20	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

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:24PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF HORMONE ASSAYS

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL				
PROSTATE SPECIFIC ANTIGEN	0.40	ng/mL	0-4	CLIA

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.

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Referred BY	: SELF	Report Generated Date	: 09/Mar/2024 05:37PM
Refer Lab/Hosp	: APOLLO CLINIC		

DEPARTMENT OF CLINICAL PATHOLOGY

APOLLO PACKAGE 9

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
VOLUME	35	ml	-	
COLOUR	PALE YELLOW		PALE YELLOW	
TRANSPARENCY	CLEAR		Clear	
REACTION (PH)	6.00		4.5 - 7.0	
SPECIFIC GRAVITY	1.025		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	3-5	/hpf	0 - 5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	ABSENT	/hpf	Absent	
CRYSTALS	ABSENT		Absent	
CASTS	ABSENT		Absent	
OTHER	ABSENT			

*** End Of Report ***

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