

PATIENT NAME : RAM PARVESH

REF. DOCTOR : SELF

FORTIS MOHALI-CHC -SPLZD  
FORTIS HOSPITAL # MOHALI,  
MOHALI 160062  
7087030817

ACCESSION NO : **0006XC009322**  
PATIENT ID : FH.10500386  
CLIENT PATIENT ID: UID:10500386  
ABHA NO :

AGE/SEX : 35 Years Male  
DRAWN : 09/03/2024 10:44:00  
RECEIVED : 09/03/2024 15:24:09  
REPORTED : 14/03/2024 10:32:21

## CLINICAL INFORMATION :

UID:10500386 REQNO-1674257  
CORP-OPD  
BILLNO-1002124OPCS003970  
BILLNO-1002124OPCS003970

Test Report Status	Final	Results	Biological Reference Interval	Units
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## HAEMATOLOGY - CBC

## CBC-5, EDTA WHOLE BLOOD

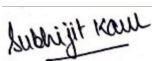
## BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	15.9	13.0 - 17.0	g/dL
METHOD : SLS- HEMOGLOBIN DETECTION METHOD			
RED BLOOD CELL (RBC) COUNT	5.41	4.5 - 5.5	mil/ $\mu$ L
METHOD : HYDRODYNAMIC FOCUSING			
WHITE BLOOD CELL (WBC) COUNT	7.70	4.0 - 10.0	thou/ $\mu$ L
METHOD : FLOWCYTOMETRY			
PLATELET COUNT	204	150 - 410	thou/ $\mu$ L
METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY			


## RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	<b>50.2 High</b>	40.0 - 50.0	%
METHOD : HYDRODYNAMIC FOCUSING			
MEAN CORPUSCULAR VOLUME (MCV)	92.8	83.0 - 101.0	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	29.4	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	31.7	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	13.5	11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	17.2		
METHOD : CALCULATED PARAMETER			
MEAN PLATELET VOLUME (MPV)	<b>13.4 High</b>	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

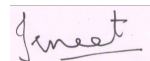
## WBC DIFFERENTIAL COUNT



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Senior Resident, 49300



Dr. Shafira Garg (MD, Pathology)  
Attending Consultant, 47150



Dr. Irneet Mundi (MD,DNB  
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Email : lab.mohali@fortishealthcare.com



Patient Ref. No. 6000003312621



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NEUTROPHILS		57	40.0 - 80.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
LYMPHOCYTES		28	20.0 - 40.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
MONOCYTES		7	2.0 - 10.0	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
EOSINOPHILS		<b>8 High</b>	1 - 6	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
BASOPHILS		0	0 - 2	%
METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY				
ABSOLUTE NEUTROPHIL COUNT		4.39	2.0 - 7.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE LYMPHOCYTE COUNT		2.16	1.0 - 3.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE MONOCYTE COUNT		0.54	0.2 - 1.0	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
ABSOLUTE EOSINOPHIL COUNT		<b>0.62 High</b>	0.02 - 0.50	thou/ $\mu$ L
METHOD : CALCULATED PARAMETER				
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		2.0		
METHOD : CALCULATED PARAMETER				

**Interpretation(s)**

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.  
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.  
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504  
This ratio element is a calculated parameter and out of NABL scope.

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## HAEMATOLOGY

**ERYTHROCYTE SEDIMENTATION RATE (ESR), EDTA BLOOD**

E.S.R	05	0 - 14	mm at 1 hr
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METHOD : WESTERGREN METHOD

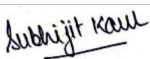
**GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD**

HBA1C	<b>10.9 High</b>	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%
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METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	<b>266.1 High</b>	< 116.0	mg/dL
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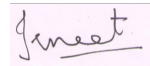
METHOD : CALCULATED PARAMETER



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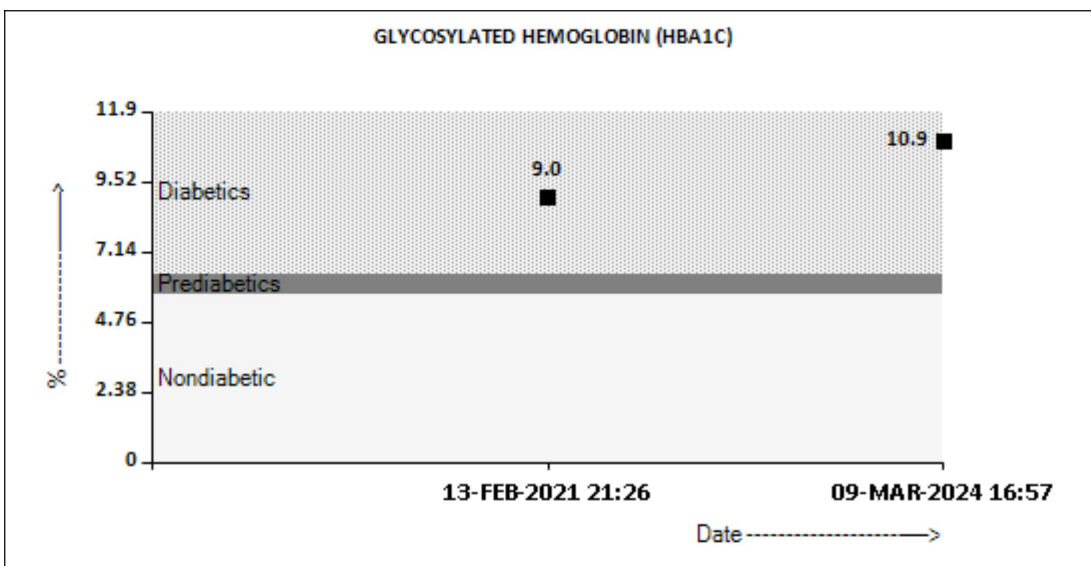
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**Interpretation(s)**

**ERYTHROCYTE SEDIMENTATION RATE (ESR),EDTA BLOOD-TEST DESCRIPTION :-**

Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

**TEST INTERPRETATION**

**Increase** in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

**Decreased** in: Polycythemia vera, Sickle cell anemia

**LIMITATIONS**

**False elevated** ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

**False Decreased** : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

**REFERENCE :**

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for

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the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.  
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For:**

- Evaluating the long-term control of blood glucose concentrations in diabetic patients.
  - Diagnosing diabetes.
  - Identifying patients at increased risk for diabetes (prediabetes).
- The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
- eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
  - eAG gives an evaluation of blood glucose levels for the last couple of months.
  - eAG is calculated as  $eAG (mg/dl) = 28.7 * HbA1c - 46.7$

**HbA1c Estimation can get affected due to :**

- Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
- Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
- Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods,falsely increasing results.
- Interference of hemoglobinopathies in HbA1c estimation is seen in

- Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
- Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
- HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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## BIOCHEMISTRY

## LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL METHOD : DIAZONIUM ION, BLANKED (ROCHE)	0.29	UPTO 1.2	mg/dL
BILIRUBIN, DIRECT METHOD : DIAZOTIZATION	0.11	0.00 - 0.30	mg/dL
BILIRUBIN, INDIRECT METHOD : CALCULATED PARAMETER	0.18	0.00 - 0.60	mg/dL
TOTAL PROTEIN METHOD : BIURET	7.5	6.6 - 8.7	g/dL
ALBUMIN METHOD : BROMOCRESOL GREEN	4.8	3.97 - 4.94	g/dL
GLOBULIN METHOD : CALCULATED PARAMETER	2.7	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
ALBUMIN/GLOBULIN RATIO METHOD : CALCULATED PARAMETER	1.8	1.0 - 2.0	RATIO
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	21	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT) METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE	32	0 - 41	U/L
ALKALINE PHOSPHATASE METHOD : PNPP - AMP BUFFER	<b>130 High</b>	40 - 129	U/L
GAMMA GLUTAMYL TRANSFERASE (GGT) METHOD : GAMMA GLUTAMYL CARBOXY 4NITROANILIDE	<b>82 High</b>	8 - 61	U/L
LACTATE DEHYDROGENASE METHOD : LACTATE -PYRUVATE UV	181	135 - 225	U/L

## GLUCOSE FASTING, FLUORIDE PLASMA

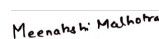
FBS (FASTING BLOOD SUGAR) METHOD : HEXOKINASE	<b>254 High</b>	74 - 106	mg/dL
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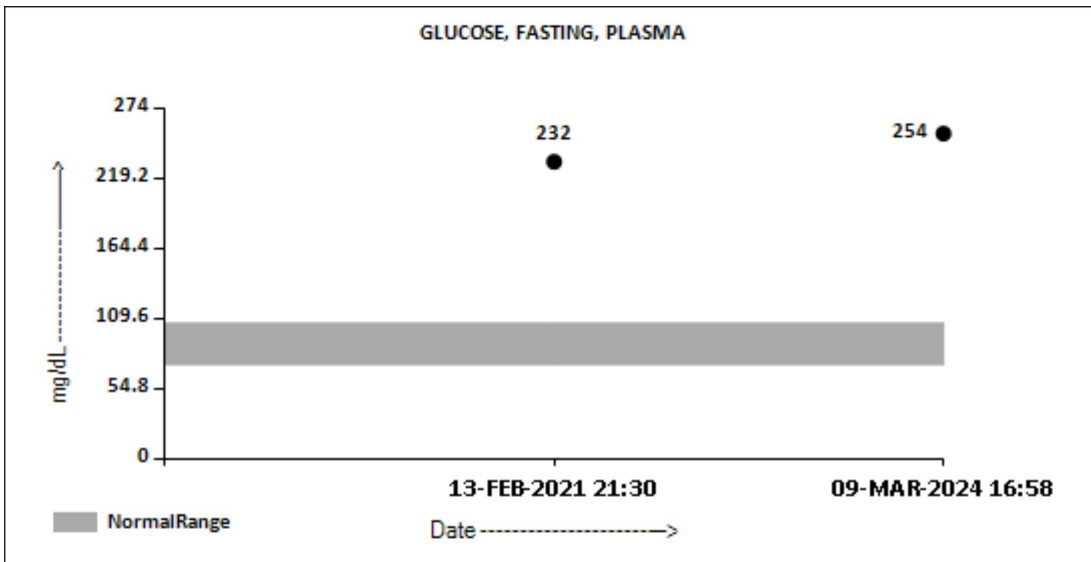
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**BLOOD UREA NITROGEN (BUN), SERUM**

BLOOD UREA NITROGEN 14 6 - 20 mg/dL  
METHOD : UREASE - UV

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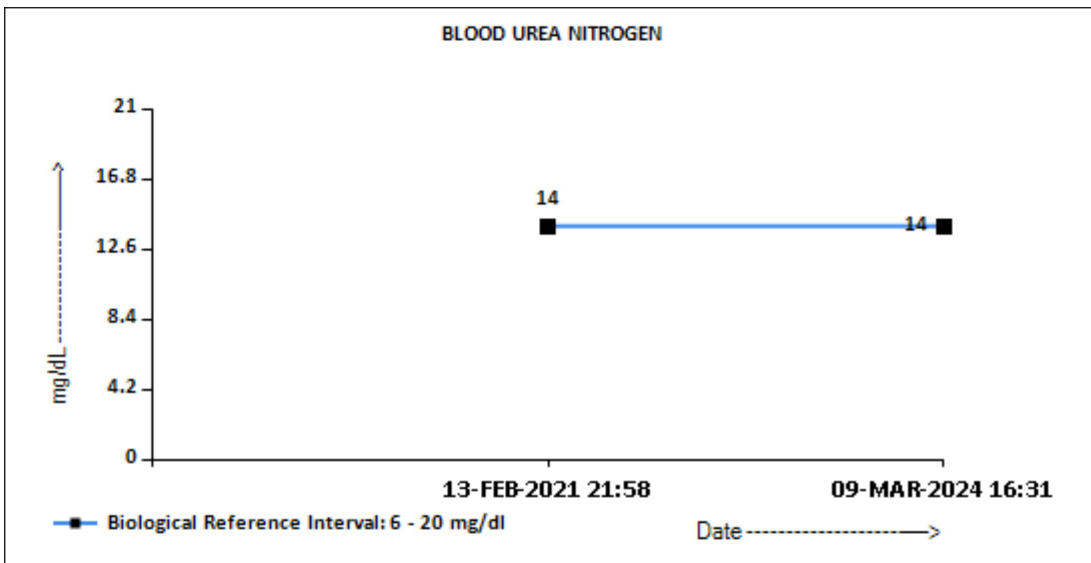
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**URIC ACID, SERUM**

URIC ACID	4.3	3.4 - 7.0	mg/dL
METHOD : URICASE, COLORIMETRIC			

**CREATININE EGFR**

CREATININE	<b>0.60 Low</b>	0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC			
AGE	35		years

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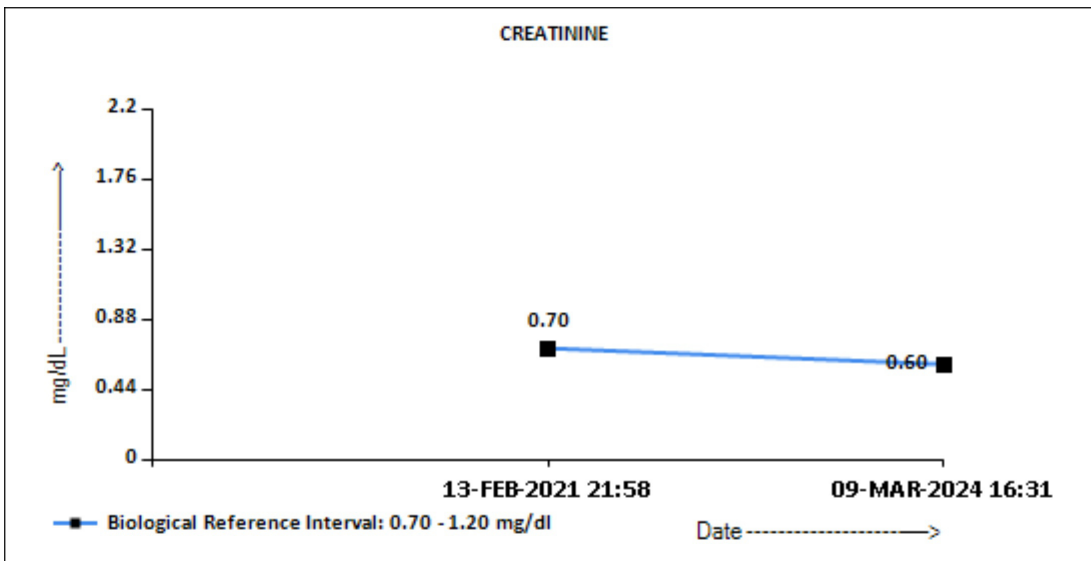
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REPORTED : 14/03/2024 10:32:21

**CLINICAL INFORMATION :**

UID:10500386 REQNO-1674257  
CORP-OPD  
BILLNO-1002124OPCS003970  
BILLNO-1002124OPCS003970

Test Report Status	Final	Results	Biological Reference Interval	Units
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GLOMERULAR FILTRATION RATE (MALE)	129	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)
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**Interpretation(s)**

**GLUCOSE POST-PRANDIAL, PLASMA**

*Ritu Pankaj*

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PDCC  
Additional Director, 30897**

*Hardeep Kaur*

**Ms. Hardeep Kaur, M.Sc.  
Biochemistry**

*Meenakshi Malhotra*

**Dr. Meenakshi Malhotra (MD,  
Pathology)  
Senior Consultant,48159**



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**PERFORMED AT :**

CLINICAL LABORATORY  
Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase VIII,  
Mohali, 160062  
Punjab, India  
Tel : 0172-469-2222 Extn. 6726, 6727), 0172-469-2221 - CIN -  
L85110DL1996PLC076704  
Email : lab.mohali@fortishealthcare.com



**Patient Ref. No. 6000003312621**



**PATIENT NAME : RAM PARVESH**

**REF. DOCTOR : SELF**

FORTIS MOHALI-CHC -SPLZD  
FORTIS HOSPITAL # MOHALI,  
MOHALI 160062  
7087030817

ACCESSION NO : **0006XC009322**  
PATIENT ID : FH.10500386  
CLIENT PATIENT ID: UID:10500386  
ABHA NO :

AGE/SEX : 35 Years Male  
DRAWN : 09/03/2024 10:44:00  
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PPBS(POST PRANDIAL BLOOD SUGAR)		TEST NOT PERFORMED	Non-Diabetes 70 - 140	mg/dL

METHOD : HEXOKINASE

**Interpretation(s)**

**LIVER FUNCTION PROFILE, SERUM-**

**Bilirubin** is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. **Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

**AST** is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

**ALP** is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilsons disease.

**GGT** is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc.

**Total Protein** also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstroms disease. Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc.

**Albumin** is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc

**GLUCOSE FASTING, FLUORIDE PLASMA- TEST DESCRIPTION**

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

**Increased in:** Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

**Decreased in :** Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g. galactosemia), Drugs- insulin, ethanol, propranolol; sulfonylureas, tolbutamide, and other oral hypoglycemic agents.

**NOTE:** While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

**BLOOD UREA NITROGEN (BUN), SERUM- Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)

**Causes of decreased** level include Liver disease, SIADH.

**URIC ACID, SERUM- Causes of Increased levels:** Dietary (High Protein Intake, Prolonged Fasting, Rapid weight loss), Gout, Lesch nyhan syndrome, Type 2 DM, Metabolic

*Ritu Pankaj*

*Hardeep Kaur*

*Meenakshi Malhotra*

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REF. DOCTOR : SELF

FORTIS MOHALI-CHC -SPLZD  
 FORTIS HOSPITAL # MOHALI,  
 MOHALI 160062  
 7087030817

ACCESSION NO : **0006XC009322**  
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syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis  
 GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

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Patient Ref. No. 600003312621



MC-2559

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**REF. DOCTOR : SELF**

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**BIOCHEMISTRY - LIPID**

**LIPID PROFILE, SERUM**

CHOLESTEROL, TOTAL	<b>208 High</b>	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	<b>198 High</b>	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	<b>30 Low</b>	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	<b>148 High</b>	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	<b>178 High</b>	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	<b>39.6 High</b>	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	<b>6.9 High</b>	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

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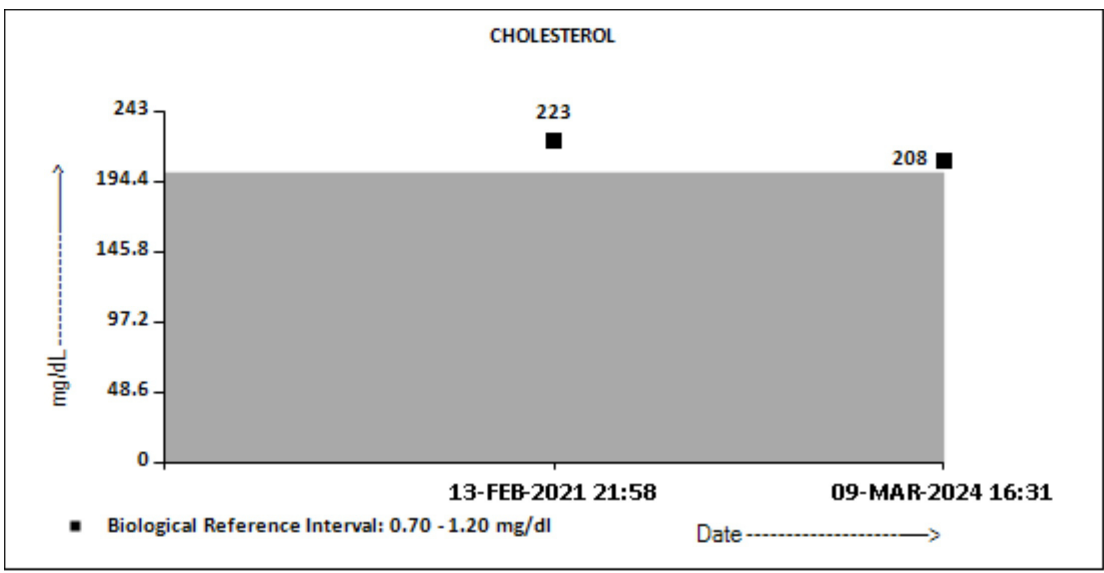


<b>PATIENT NAME : RAM PARVESH</b>	<b>REF. DOCTOR : SELF</b>	
FORTIS MOHALI-CHC -SPLZD FORTIS HOSPITAL # MOHALI, MOHALI 160062 7087030817	ACCESSION NO : <b>0006XC009322</b> PATIENT ID : FH.10500386 CLIENT PATIENT ID: UID:10500386 ABHA NO :	AGE/SEX : 35 Years Male DRAWN : 09/03/2024 10:44:00 RECEIVED : 09/03/2024 15:24:09 REPORTED : 14/03/2024 10:32:21

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LDL/HDL RATIO		<b>4.9 High</b>	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER



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**Ms. Hardeep Kaur, M.Sc.**  
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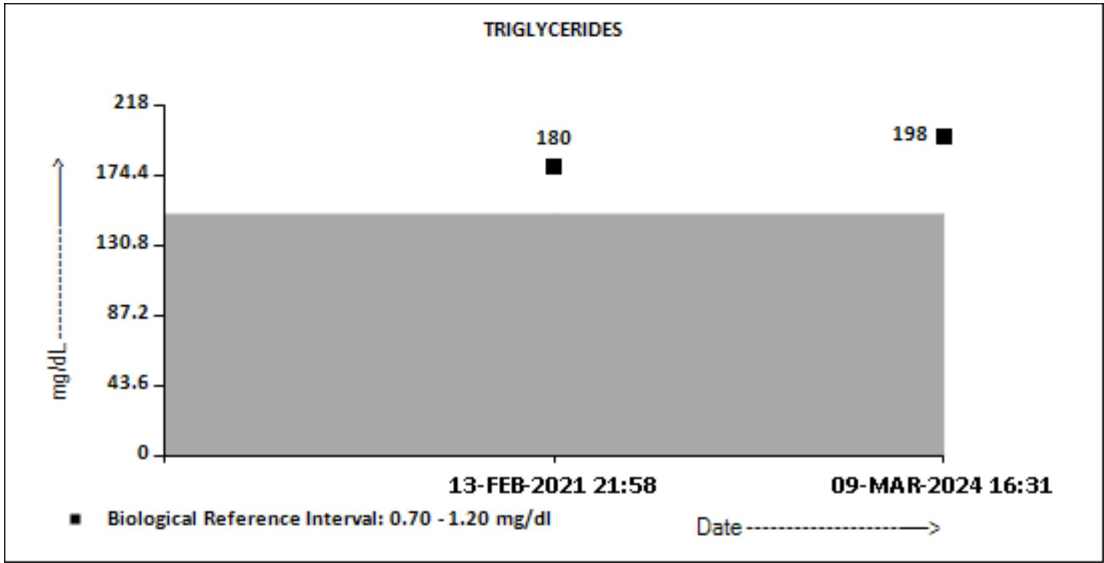




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*Hardeep Kaur*  
**Ms. Hardeep Kaur, M.Sc.**  
**Biochemistry**

*Meenakshi Malhotra*  
**Dr. Meenakshi Malhotra (MD,**  
**Pathology)**  
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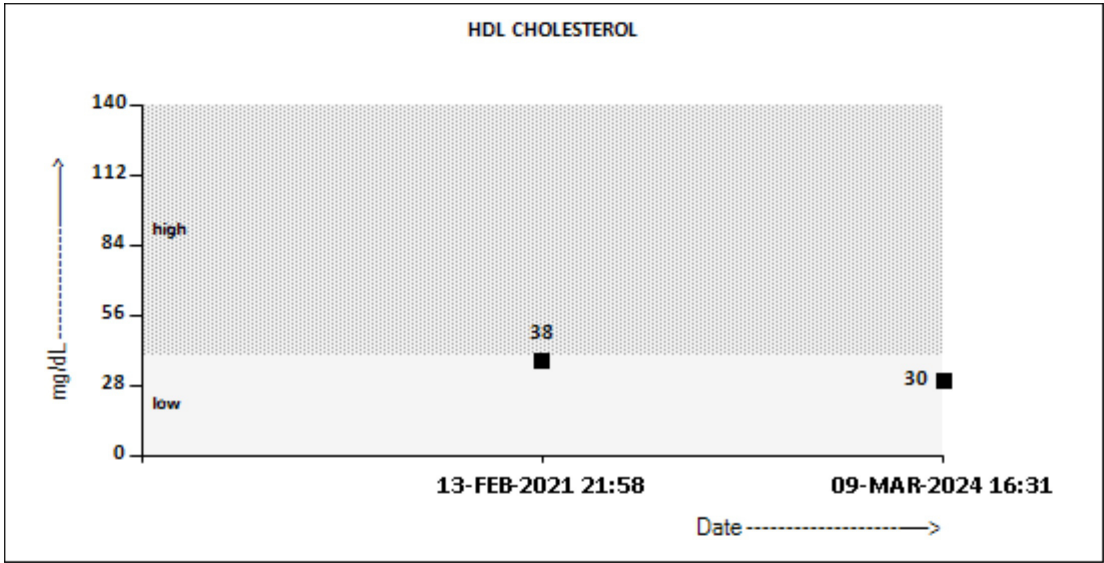
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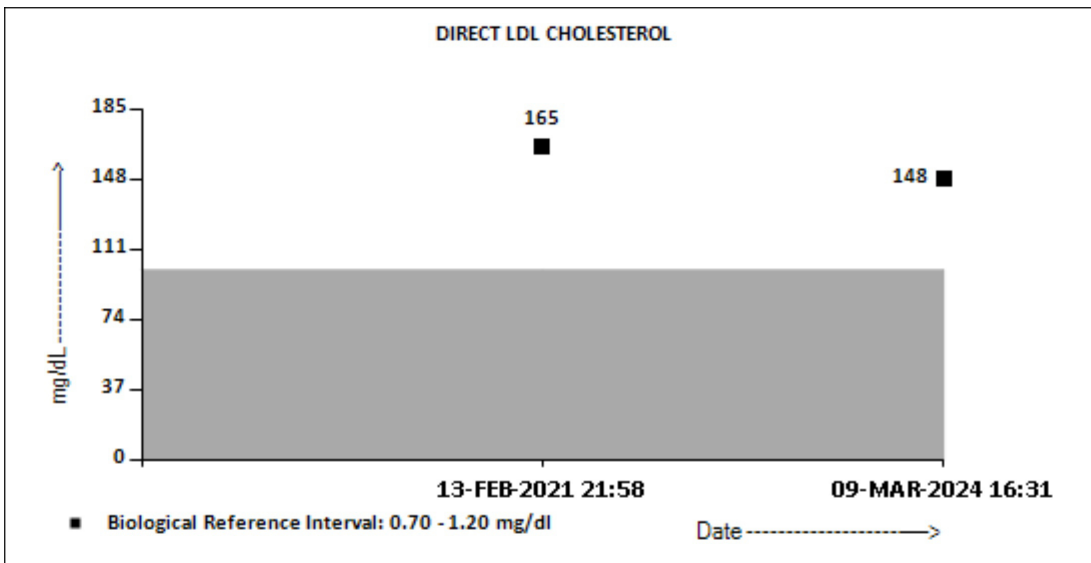
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**Interpretation(s)**

*Hardeep Kaur*  
**Ms. Hardeep Kaur, M.Sc.**  
Biochemistry

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MC-2559

**PATIENT NAME : RAM PARVESH**

**REF. DOCTOR : SELF**

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**CLINICAL PATH - URINALYSIS**

**URINALYSIS**

**PHYSICAL EXAMINATION, URINE**

COLOR	YELLOW
METHOD : MANUAL EXAMINATION	
APPEARANCE	SLIGHTLY HAZY
METHOD : MANUAL EXAMINATION	

**CHEMICAL EXAMINATION, URINE**

PH	6.0	4.7 - 7.5
METHOD : DOUBLE INDICATOR PRINCIPLE		
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)		
PROTEIN	<b>DETECTED (+)</b>	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)		
GLUCOSE	<b>DETECTED (++)</b>	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY ( GLUCOSE OXIDASE METHOD)		
KETONES	NOT DETECTED	NOT DETECTED
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)		
BLOOD	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE PHOTOMETRY ( BENZIDINE REACTION)		
BILIRUBIN	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		
UROBILINOGEN	NORMAL	NORMAL
METHOD : REFLECTANCE PHOTOMETRY (EHRlich'S REACTION)		
NITRITE	NOT DETECTED	NOT DETECTED
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)		

**MICROSCOPIC EXAMINATION, URINE**

*Shafira*

**Dr. Shafira Garg (MD, Pathology)**  
 Attending Consultant,47150

*Irneet*

**Dr. Irneet Mundi (MD,DNB Pathology)**  
 Associate Consultant, 34080

*Ritu Pankaj*

**Dr. Ritu Pankaj (MD,Pathology), PDCC**  
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MC-2559

**PATIENT NAME : RAM PARVESH**

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RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S)		NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS		NOT DETECTED	0-5	/HPF
CASTS		NOT DETECTED		
CRYSTALS		NOT DETECTED		
BACTERIA		NOT DETECTED	NOT DETECTED	
YEAST		NOT DETECTED	NOT DETECTED	

**Interpretation(s)**

**Dr. Shafira Garg (MD, Pathology)**  
 Attending Consultant,47150

**Dr. Irneet Mundi (MD,DNB Pathology)**  
 Associate Consultant, 34080

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## SPECIALISED CHEMISTRY - HORMONE

## THYROID PANEL, SERUM

T3 METHOD : SANDWICH (ECLIA)	115.0	80.00 - 200.00	ng/dL
T4 METHOD : SANDWICH (ECLIA)	7.39	5.10 - 14.10	µg/dL
TSH (ULTRASENSITIVE) METHOD : SANDWICH (ECLIA)	1.640	0.270 - 4.200	µIU/mL

## Interpretation(s)

\*\*End Of Report\*\*

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

Meenakshi Malhotra

Ritu Pankaj

Dr. Meenakshi Malhotra (MD,  
Pathology)  
Senior Consultant,48159

Dr. Ritu Pankaj (MD,Pathology),  
PDCC  
Additional Director, 30897



View Details



View Report

## PERFORMED AT :

CLINICAL LABORATORY  
Fortis Heart Institute & Multispeciality Hospital, Sector 62,Phase VIII,  
Mohali, 160062  
Punjab, India  
Tel : 0172-469-2222 Extn. 6726, 6727), 0172-469-2221 - CIN -  
L85110DL1996PLC076704  
Email : lab.mohali@fortishealthcare.com



Patient Ref. No. 6000003312621

Name: Mr. Ram Parvesh  
 UHID: 10500386 Date: 09/03/24  
 Age: 35 Gender: M

**Nursing Assessment**

Profile	
Height (cm): <u>166cm</u>	Waist Circumference (cm): <u>32 inches</u>
Weight (Kg.): <u>72 KG</u>	Body Mass Index:
Occupation: <u>Private job</u>	Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married

Vital Signs	
Pulse Rate (/min): <u>84/min</u>	Respiratory Rate (/min): <u>20.5/min</u>
Blood Pressure (mmHg): <u>120/80 mmHg</u>	Temperature (if febrile): <u>Afebrile</u>

Past History	
<input checked="" type="checkbox"/> Hypertension :	<input type="checkbox"/> Diabetes :
<input checked="" type="checkbox"/> Heart disease :	<input checked="" type="checkbox"/> Dyslipidemia :
<input checked="" type="checkbox"/> Asthma :	<input type="checkbox"/> Tuberculosis :
<input type="checkbox"/> Allergies :	
<input checked="" type="checkbox"/> Others :	

For Women	
LMP: <del>/</del>	Last Pap smear done in <del>/</del>
Menopause <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Last Mammography done in <del>/</del>
Consent for X-ray & Mammography <del>/</del>	

Current Medications
<u>Nil</u>

Signature, Name and Emp. ID of the Nurse: Reeta

2025

Name Mr. Ram Parvesh  
UHID : 10500386 Date : 09/03/24  
Age : 35 Gender : M

Internal Medicine Consultation

Relevant History:

Diagnosis:

Examination Findings:

Advice / Treatment Plan:

Investigations:

Name: Rampalvesh  
 UHID: 10500386 Date: 09/03/2024  
 Age: 35 yrs Gender: M

**Ophthalmology Consultation**

History: DM

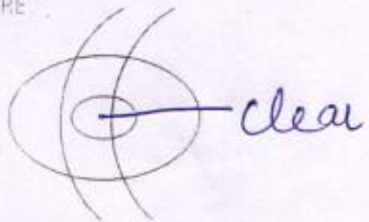
**Examination findings:**

Visual acuity  $\left\{ \begin{array}{l} R \text{ 6/6} \\ L \text{ 6/6} \end{array} \right.$  Visual acuity with glasses  $\left\{ \begin{array}{l} R \\ L \end{array} \right.$

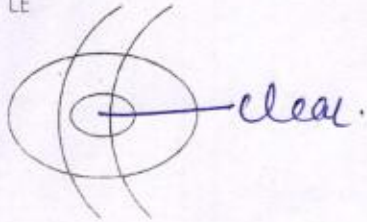
Colour Vision  $\left\{ \begin{array}{l} R \text{ WNL} \\ L \text{ WNL} \end{array} \right.$

**Slit Lamp Examination**

RE



LE

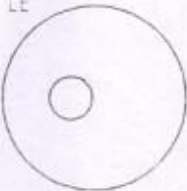


**Fundus Examination**

RE



LE



Diagnosis: NADBE

**Treatment**

**Spectacle prescription:**

Right eye

	SPH	CYL	AXIS	VA
Distance	<u>Plano</u>	<u>/</u>	<u>/</u>	<u>6/6</u>
Near	<u>Plano</u>	<u>/</u>	<u>/</u>	<u>N-6</u>

Left eye

	SPH	CYL	AXIS	VA
Distance	<u>Plano</u>	<u>/</u>	<u>/</u>	<u>6/6</u>
Near	<u>Plano</u>	<u>/</u>	<u>/</u>	<u>N-6</u>

Signature and stamp of the Ophthalmologist

[Signature]

09.03.2024 11:54:39  
Fortis Med Centre  
Sector 11  
Chandigarh

Room:

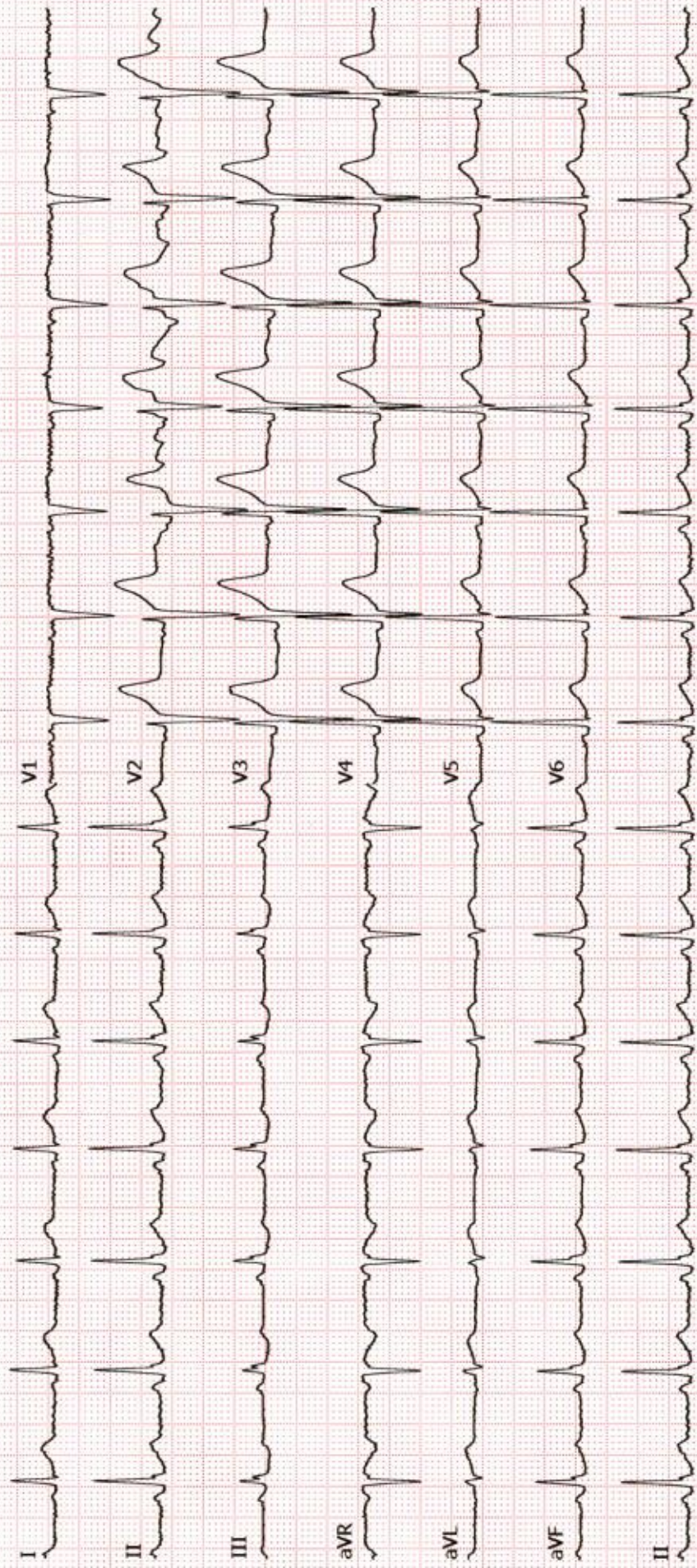
Location:  
Order Number:  
Visit:  
Indication:  
Medication 1:  
Medication 2:  
Medication 3:

87 bpm  
-- / -- mmHg

Technician:  
Ordering Ph:  
Referring Ph:  
Attending Ph:

QRS : 82 ms  
QT / QTcBaz : 340 / 409 ms  
PR : 132 ms  
P : 104 ms  
RR / PP : 688 / 689 ms  
P / QRS / T : 73 / 58 / 31 degrees

Normal sinus rhythm  
Normal ECG



**NAME: MR. RAM PARVESH****AGE AND SEX: 36Y/M****UHID NO:10500386****DATE:09/03/2024****ROI: WHOLE ABDOMEN**

Liver is normal in size, outline and echogenicity. No focal lesion seen. IHBR's are not dilated. Portal vein and hepatic veins are normal.

Gall bladder is normally distended with anechoic lumen. Wall thickness is normal. No calculus / focal lesion seen. No pericholecystic fluid / collection seen. CBD is normal.

Pancreas is visualized in region of head and proximal body and is normal in size, shape, outline and echotexture. No focal lesion seen. Distal body and tail are obscured by bowel gases.

Spleen is normal in size, outline and echotexture. No focal lesion seen.

Right kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Left kidney is normal in size, outline and echogenicity. Cortico-medullary differentiation is maintained. No hydronephrosis / calculus is seen.

Retroperitoneum is normal.

The urinary bladder is fully distended and is normal in outline and wall thickness. No calculi or growth seen.

Prostate is normal in size and shows normal outline and echo pattern. No focal lesion seen.

No free fluid is seen.

**Opinion: Normal study****Suggested clinical correlation.****Dr. ADITI PANWAR****PMC - 41230****Consultant Radiologist**



**RAM PARVESH 35 M**

**Study Date: 09/03/2024**

Patient ID: 10500386

Accession #:

Alt ID:

DOB:

Age:

Gender: M

Ht:

Wt:

BSA:

Institution: Fortis MEDCENTRE, Chandigarh

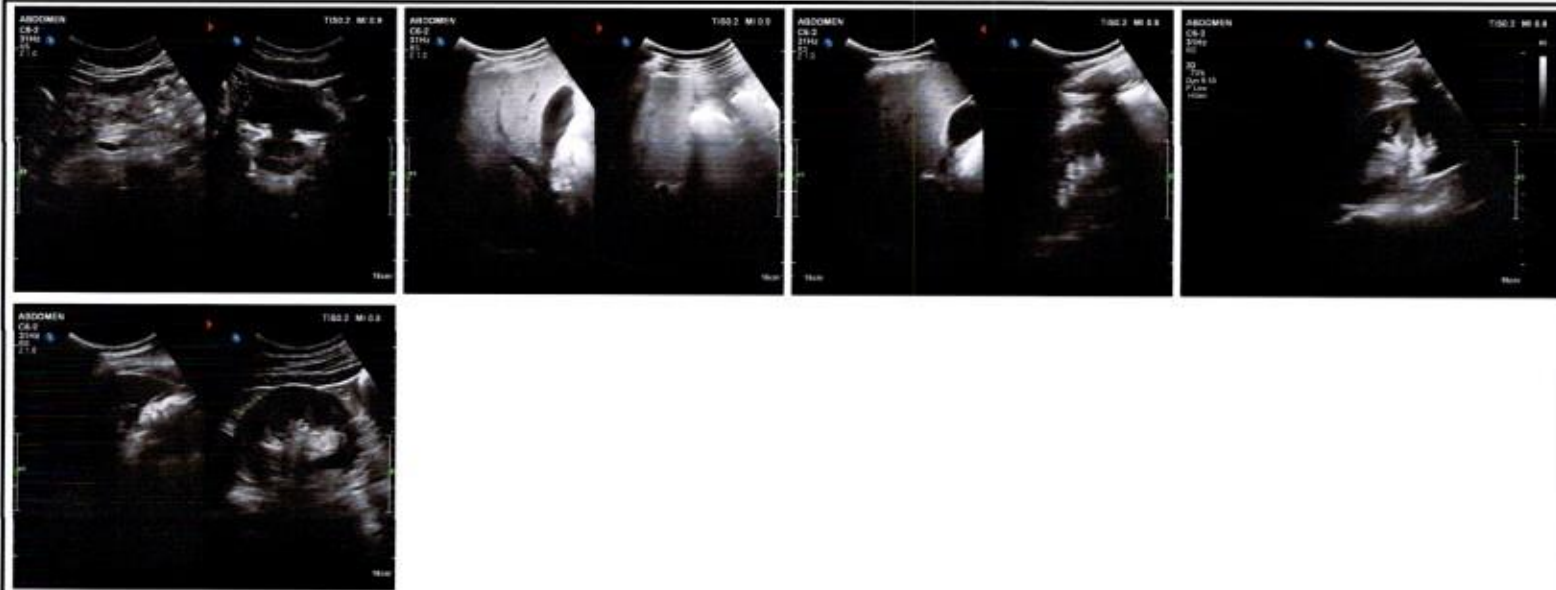
Referring Physician:

Physician of Record:

Performed By:

Comments:

### Images



### Signature

Signature:

Name(Print):

Date:

**DEPARTMENT OF FMC-RADIOLOGY LAB**

Date: 09/Mar/2024

**Name: Mr. Ram Parvesh****UHID | Episode No : 10500386 | 3186/24/10021****Age | Sex: 35 YEAR(S) | Male****Order No | Order Date: 10021/PN/OP/2403/8171 | 09-Mar-2024****Order Station : FRONTOFFICE-FMC****Admitted On | Reporting Date : 09-Mar-2024 11:37:24****Bed Name :****Order Doctor Name : Dr.SELF .****CHEST X-RAY ( PA VIEW )**

Both the domes of diaphragm are normal.

Both costophrenic angles are normal.

Both lung fields are clear.

Cardiac size and silhouette are normal.

Both hila and mediastinum are normal.

Bony cage and soft tissues are normal.

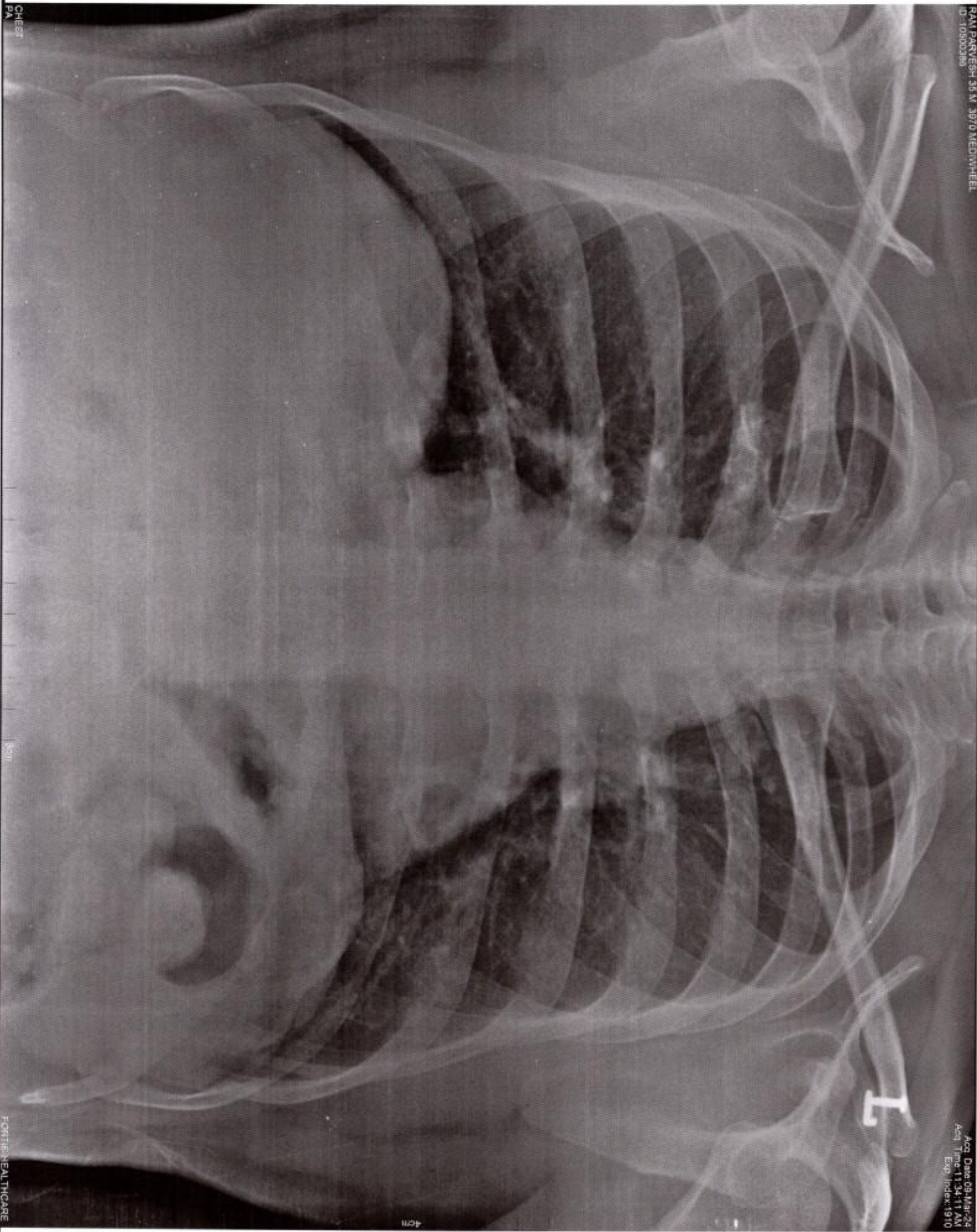
**IMPRESSION: NORMAL STUDY.**

**Please correlate clinically and with other relevant investigations.**

**Dr. ADITI PANWAR**

**PMC - 41230**

**Consultant Radiologist**



CHEST  
PA

30cm

Patient Name : Ram Parvesh Episode No. : 0  
UHID : 10500386 Sample ID : FHM24-R03565  
Age / Gender : 35 Year/ Male Sample Drawn :  
Ward : Sample Received : 09/Mar/2024 03:58 PM  
Diagnosis /  
Clinical Information :

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**Blood Group Report**  
**Provisional Report**

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Referred By : Reported :09/Mar/2024 05:22 PM  
Sample Type : EDTA  
Method : AUTOMATION  
Forward Blood Group : B Rh Positive  
Reverse Blood Group : B  
Final Blood Group : B Rh Positive  
Remark :

---

Tested By : bipasha

Verified By : bipasha

Approved By :

**Note :** Blood group is identified by ABO antigens (forward grouping) present on red cell membrane And anti-ABO antibodies (reverse grouping) present in the plasma. A grouping discrepancy is when there is a mismatch in forward and reverse Blood grouping. Special methods need to be Performed to solve such discrepancies.

In case of Newborn/cord blood grouping, only forward blood grouping would be done as the anti-ABO antibodies (for reverse grouping) Are not present till 4 to 6 months of age. Thus new born grouping should be considered as provisional report and should be supplemented by re-blood grouping after 4 to 6 months of age/ or by more sensitive tests like molecular blood grouping

"Blood grouping is done on the received sample. In case of any suspected discrepancy, Blood centre should be contacted , 1724692270"

\*\*\*\*\*End of Report \*\*\*\*\*

**Reference:**

Method section 2: Red cell typing; AABB technical manual 19th Ed  
Wong ECC, Punzalan RC. Neonatal and Pediatric  
Transfusion practice. Technical Manual,  
AABB, 19th Ed; p613-640