



Mediwheel
...Your wellness partner

011-41195959

Dear Pankajkumar Kantilal Barot,

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

Hospital Package Name : Mediwheel Full Body Health Checkup Male Below 40
Patient Package Name : Mediwheel Full Body Health Checkup Male Below 40
Name of Diagnostic/Hospital : Aashka Multispeciality Hospital
Address of Diagnostic/Hospital : Between Sargassan & Reliance Cross Road, Gandhinagar -0382421
City : Gandhi Nagar
State : Gujarat
Pincode : 382421
Appointment Date : 23-08-2024
Confirmation Status : Booking Confirmed
Preferred Time : 8:30am-9:00am
Booking Status : Booking Confirmed

Member Information		
Booked Member Name	Age	Gender
MR. BAROT PANKAJKUMAR KANTILAL	33 year	Male

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.



बैंक ऑफ बड़ोदा
Bank of Baroda



नाम
Name

Pankajkumar Kantilal Barot

कर्मचारी कूट क्र.
Employee Code No.

179832

जारीकर्ता प्राधिकारी
Issuing Authority

Beegst. P. K

धारक के हस्ताक्षर
Signature of Holder

23.08.2024 11:59:07 AM
MASHIKA HOSPITAL LTD.
SARGASAN
GANDHINAGAR

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

Room:

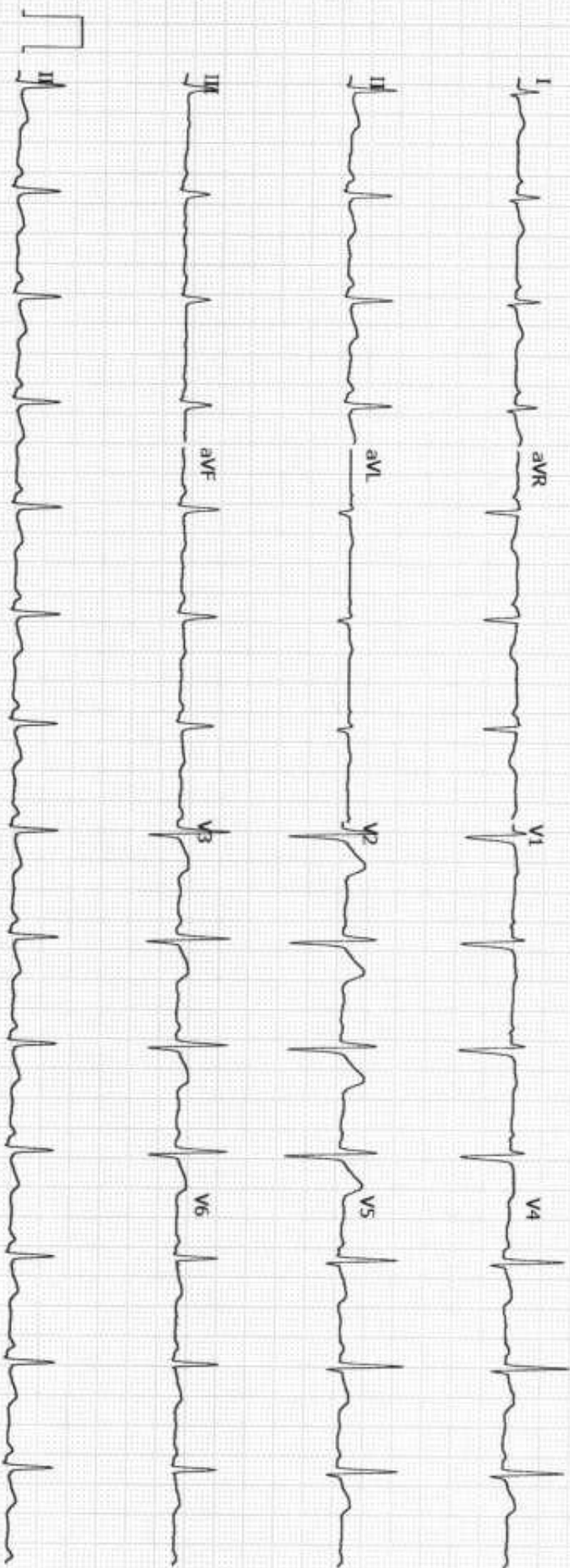
84 bpm

--/-- mmHg

Technician:
Ordering Ph:
Referring Ph:
Attending Ph:

QRS : 74 ms
QT / QTcBaz : 352 / 415 ms
PR : 126 ms
P : 86 ms
RR / PP : 712 / 714 ms
P / QRS / T : 52 / 68 / 53 degrees

Normal sinus rhythm
Nonspecific T wave abnormality
Abnormal ECG



GE MAC2000 1.1 125L™ V241 25 mm/s 10 mm/mV ADS 0.56-20 Hz 50 Hz

Unconfirmed
4x2.5x3_25_R1 1/1

PATIENT NAME: PANKAJKUMAR K BAROT

GENDER/AGE: Male / 34 Years


DATE: 23/08/24

DOCTOR: DR. HASIT JOSHI

OPDNO: O0323908

2D-ECHO

MITRAL VALVE	: MILD MVP	
AORTIC VALVE	: <u>NORMAL</u>	
TRICUSPID VALVE	: NORMAL	
PULMONARY VALVE	: NORMAL	
AORTA	: 29mm	
LEFT ATRIUM	: 32mm	
LV Dd / Ds	: 40/25mm	EF 63%
IVS / LVPW / D	: 9/9mm	
IVS	: INTACT	
IAS	: FLOPPY	
RA	: NORMAL	
RV	: NORMAL	
PA	: NORMAL	
PERICARDIUM	: NORMAL	
VEL	: PEAK	MEAN
M/S	: Gradient mm Hg	Gradient mm Hg
MITRAL	: 0.9/0.7m/s	
AORTIC	: 1.0m/s	
PULMONARY	: 1.0m/s	
COLOUR DOPPLER	: TRIVIAL MR / TR	
RVSP	: 28mmHg	
CONCLUSION	: MILD MVP / TRIVIAL MR; NORMAL LV SIZE / SYSTOLIC FUNCTION; TRIVIAL TR, NO PAH	


CARDIOLOGIST
DR. HASIT JOSHI (9825012235)

REPORT REPORT REPORT

PATIENT NAME: PANKAJKUMAR K BAROT

GENDER/AGE: Male / 34 Years

DATE: 23/08/24

DOCTOR:

OPDNO: O0323908

X-RAY CHEST PA

Both lung fields show increased broncho-vascular markings.

No evidence of collapse, consolidation, mediastinal lymph adenopathy, soft tissue infiltration or pleural effusion is seen.

Both hilar shadows and C.P. angles are normal.

Heart shadow appears normal in size. Aorta appears normal.

Bony thorax and both domes of diaphragm appear normal.

No evidence of cervical rib is seen on either side.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST

REPORT REPORT REPORT REPORT REPORT

PATIENT NAME:PANKAJKUMAR K BAROT

GENDER/AGE:Male / 34 Years

DATE:23/08/24

DOCTOR:

OPDNO:O0323908

SONOGRAPHY OF ABDOMEN AND PELVIS

LIVER: Liver appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen. No evidence of dilated IHBR is seen. Intrahepatic portal radicles appear normal. No evidence of solid or cystic mass lesion is seen.

GALL BLADDER: Gall bladder is physiologically distended and appears normal. No evidence of calculus or changes of cholecystitis are seen. No evidence of pericholecystic fluid collection is seen. CBD appears normal.

PANCREAS: Pancreas appears normal in size and shows normal parenchymal echoes. No evidence of pancreatitis or pancreatic mass lesion is seen.

SPLEEN: Spleen appears normal in size and shows normal parenchymal echoes. No evidence of focal or diffuse lesion is seen.

KIDNEYS: Both kidneys are normal in size, shape and position. Both renal contours are smooth. Cortical and central echoes appear normal. Bilateral cortical thickness appears normal. No evidence of renal calculus, hydronephrosis or mass lesion is seen on either side. No evidence of perinephric fluid collection is seen.

Right kidney measures about 10.1 x 4.0 cms in size.

Left kidney measures about 10.2 x 4.1 cms in size.

No evidence of suprarenal mass lesion is seen on either side.

Aorta, IVC and para aortic region appears normal.

No evidence of ascites is seen.

BLADDER: Bladder is normally distended and appears normal. No evidence of bladder calculus, diverticulum or mass lesion is seen. Prevoid bladder volume measures about 90 cc.

PROSTATE: Prostate appears normal in size and shows normal parenchymal echoes. No evidence of pathological calcification or solid or cystic mass lesion is seen. Prostate volume measures about 14 cc.

COMMENT: Normal sonographic appearance of liver, GB; Pancreas, spleen, kidneys, bladder and prostate.


DR. SNEHAL PRAJAPATI
CONSULTANT RADIOLOGIST



LABORATORY REPORT



Name : PANKAJKUMAR K BAROT	Sex/Age : Male / 34 Years	Case ID : 40802200914
Ref.By :	Dis. At :	Pt. ID : 4319482
Bill. Loc. : Aashka hospital		Pt. Loc. :
Reg Date and Time : 23-Aug-2024 10:02	Sample Type :	Mobile No. :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : 00323908
Report Date and Time :	Acc. Remarks : Normal	Ref Id2 : 024254129

Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
Glyco Hemoglobin (HbA1c)			
HbA1C	5.79	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes
Lipid Profile			
Cholesterol	206.83	mg/dL	110 - 200
HDL Cholesterol	36.4	mg/dL	48 - 77
Triglyceride	230.86	mg/dL	<150
VLDL	46.17	mg/dL	10 - 40
Chol/HDL	5.68		0 - 4.1
LDL Cholesterol	124.26	mg/dL	0.00 - 100.00
Plasma Glucose - F	109.47	mg/dL	70 - 100
Plasma Glucose - PP	163.69	mg/dL	70.0 - 140.0

Abnormal Result(s) Summary End

Note: (LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Aug-2024 10:02 Sample Type : Whole Blood EDTA Mobile No :
 Sample Date and Time : 23-Aug-2024 10:02 Sample Coll. By : Ref Id1 : OO323908
 Report Date and Time : 23-Aug-2024 10:28 Acc. Remarks : Normal Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF. INTERVAL	REMARKS
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HAEMOGRAM REPORT

HB AND INDICES

Haemoglobin	15.1	G%	13.00 - 17.00
RBC (Electrical Impedance)	5.23	millions/cumm	4.50 - 5.50
PCV(Calc)	45.45	%	40.00 - 50.00
MCV (RBC histogram)	86.9	fL	83.00 - 101.00
MCH (Calc)	28.8	pg	27.00 - 32.00
MCHC (Calc)	33.2	gm/dL	31.50 - 34.50
RDW (RBC histogram)	14.70	%	11.00 - 16.00

TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)

	Total WBC Count		EXPECTED VALUES	[Abs]	EXPECTED VALUES
	4790	/μL	4000.00 - 10000.00		
Neutrophil	50.0	%	40.00 - 70.00	2395	/μL 2000.00 - 7000.00
Lymphocyte	40.0	%	20.00 - 40.00	1916	/μL 1000.00 - 3000.00
Eosinophil	2.0	%	1.00 - 6.00	96	/μL 20.00 - 500.00
Monocytes	8.0	%	2.00 - 10.00	383	/μL 200.00 - 1000.00
Basophil	0.0	%	0.00 - 2.00	0	/μL 0.00 - 100.00

PLATELET COUNT (Optical)

Platelet Count	291000	/μL	150000.00 - 410000.00
Neut/Lympho Ratio (NLR)	1.25		0.78 - 3.53

SMEAR STUDY

RBC Morphology	Normocytic Normochromic RBCs.
WBC Morphology	Total WBC count within normal limits.
Platelet	Platelets are adequate in number.
Parasite	Malarial Parasite not seen on smear.

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah

M.D. (Pathologist)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT	Sex/Age : Male / 34 Years	Case ID : 40802200914
Ref.By :	Dis. At :	Pt. ID : 4319482
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 11:42	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
ESR Westergren Method	04	mm after 1hr	3 - 15	

Note: (LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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M.D. (Pathologist)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
Ref.By : Dis. At : Pt. ID : 4319482
Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 10:28	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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HAEMATOLOGY INVESTIGATIONS

BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology) (Both Forward and Reverse Group)

ABO Type	O
Rh Type	POSITIVE

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Aug-2024 10:02 Sample Type : Plasma Fluoride F, Plasma Fluoride PP, Serum Mobile No :
 Sample Date and Time : 23-Aug-2024 10:02 Sample Coll. By : Ref Id1 : OO323908
 Report Date and Time : 23-Aug-2024 11:06 Acc. Remarks : Normal Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Plasma Glucose - F <i>Photometric, Hexokinase</i>	H 109.47	mg/dL	70 - 100	
Plasma Glucose - PP	H 163.69	mg/dL	70.0 - 140.0	
BUN (Blood Urea Nitrogen) <i>GLDH</i>	18.7	mg/dL	8.90 - 20.80	
Uric Acid <i>Uricase</i>	6.49	mg/dL	3.5 - 7.2	
Creatinine	1.21	mg/dL	0.50 - 1.50	

Note (LL-VeryLow, L-Low, H-High, HH-VeryHigh , A-Abnormal)

Dr. Shreya Shah
 M.D. (Pathologist)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Whole Blood EDTA	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 11:06	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C	H 5.79	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) <i>Calculated</i>	119.47	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.
 Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.
 Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.
 Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.
 In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.
 The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh ,A-Abnormal)

Dr. Shreya Shah
 M.D. (Pathologist)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT	Sex/Age : Male / 34 Years	Case ID : 40802200914
Ref.By :	Dis. At :	Pt. ID : 4319482
Bill. Loc. : Aashka hospital		Pt. Loc :
Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Serum	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 11:06	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Lipid Profile

Cholesterol <i>Colorimetric, CHOD-POD</i>	H	206.83	mg/dL	110 - 200
HDL Cholesterol	L	36.4	mg/dL	48 - 77
Triglyceride <i>Glycerol Phosphate Oxidase</i>	H	230.86	mg/dL	<150
VLDL <i>Calculated</i>	H	46.17	mg/dL	10 - 40
Chol/HDL <i>Calculated</i>	H	5.68		0 - 4.1
LDL Cholesterol <i>Calculated</i>	H	124.26	mg/dL	0.00 - 100.00

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal <100	Desirable <200	Low <40	Normal <150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-199	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment
- For LDL Cholesterol level Please consider direct LDL value
- Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Detail test interpretation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assessment

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh ,A-Abnormal)

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LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc. :

Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Serum	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 11:18	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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BIOCHEMICAL INVESTIGATIONS

Liver Function Test

S.G.P.T. <i>UV with P5P</i>	53.0	U/L	16 - 63	
S.G.O.T. <i>UV with P5P</i>	36.40	U/L	15 - 37	
Alkaline Phosphatase <i>Enzymatic, PNPP-AMP</i>	106.0	U/L	46 - 116	
Gamma Glutamyl Transferase <i>L-Gamma-glutamyl-3-carboxy-4-nitroanilide Substrate</i>	42.72	U/L	0 - 55	
Proteins (Total) <i>Colorimetric, Biuret</i>	8.02	gm/dL	6.40 - 8.30	
Albumin <i>Bromocresol purple</i>	4.52	gm/dL	3.4 - 5	
Globulin <i>Calculated</i>	3.50	gm/dL	2 - 4.1	
A/G Ratio <i>Calculated</i>	1.29		1.0 - 2.1	
Bilirubin Total <i>Photometry</i>	0.46	mg/dL	0.3 - 1.2	
Bilirubin Conjugated <i>Diazotization reaction</i>	0.16	mg/dL	0 - 0.50	
Bilirubin Unconjugated <i>Calculated</i>	0.30	mg/dL	0 - 0.8	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Aug-2024 10:02 Sample Type : Serum Mobile No :
 Sample Date and Time : 23-Aug-2024 10:02 Sample Coll. By : Ref Id1 : OO323908
 Report Date and Time : 23-Aug-2024 11:06 Acc. Remarks : Normal Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Thyroid Function Test				
Triiodothyronine (T3)	129.75	ng/dL	70 - 204	
Thyroxine (T4) CMA	11.38	ng/dL	4.87 - 11.72	
TSH CMA	2.35	µIU/mL	0.4 - 4.2	

INTERPRETATIONS

- Circulating TSH measurement has been used for screening for euthyroidism, screening and diagnosis for hyperthyroidism & hypothyroidism. Suppressed TSH (<0.01 µIU/mL) suggests a diagnosis of hyperthyroidism and elevated concentration (>7 µIU/mL) suggest hypothyroidism. TSH levels may be affected by acute illness and several medications including dopamine and glucocorticoids. Decreased (low or undetectable) in Graves disease. Increased in TSH secreting pituitary adenoma (secondary hyperthyroidism), PRTN and in hypothalamic disease thyrotropin (tertiary hyperthyroidism). Elevated in hypothyroidism (along with decreased T4) except for pituitary & hypothalamic disease.
- Mild to modest elevations in patient with normal T3 & T4 levels indicates impaired thyroid hormone reserves & incipient hypothyroidism (subclinical hypothyroidism).
- Mild to modest decrease with normal T3 & T4 indicates subclinical hyperthyroidism.
- Degree of TSH suppression does not reflect the severity of hyperthyroidism, therefore, measurement of free thyroid hormone levels is required in patient with a suppressed TSH level.

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone. Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in pregnancy

First trimester
 Second trimester
 Third trimester

Reference range (microIU/ml)

0.24 - 2.00
 0.43-2.2
 0.8-2.5

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh) A-Abnormal)

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M.D. (Pathologist)

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Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 11:06	Acc. Remarks : Normal	Ref Id2 : O24254129

Interpretation Note:

Ultra sensitive-thyroid-stimulating hormone (TSH) is a highly effective screening assay for thyroid disorders. In patients with an intact pituitary-thyroid axis, s-TSH provides a physiologic indicator of the functional level of thyroid hormone activity. Increased s-TSH indicates inadequate thyroid hormone, and suppressed s-TSH indicates excess thyroid hormone. Transient s-TSH abnormalities may be found in seriously ill, hospitalized patients, so this is not the ideal setting to assess thyroid function. However, even in these patients, s-TSH works better than total thyroxine (an alternative screening test), when the s-TSH result is abnormal, appropriate follow-up tests T4 & free T3 levels should be performed. If TSH is between 5.0 to 10.0 & free T4 & free T3 level are normal then it is considered as subclinical hypothyroidism which should be followed up after 4 weeks & If TSH is > 10 & free T4 & free T3 level are normal then it is considered as overt hypothyroidism.

Serum triiodothyronine (T3) levels often are depressed in sick and hospitalized patients, caused in part by the biochemical shift to the production of reverse T3. Therefore, T3 generally is not a reliable predictor of hypothyroidism. However, in a small subset of hyperthyroid patients, hyperthyroidism may be caused by overproduction of T3 (T3 toxicosis). To help diagnose and monitor this subgroup, T3 is measured on all specimens with suppressed s-TSH and normal FT4 concentrations.

Normal ranges of TSH & thyroid hormones vary according trimester in pregnancy.

TSH ref range in Pregnancy	Reference range (microIU/ml)
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

	T3	T4	TSH
Normal Thyroid function	N	N	N
Primary Hyperthyroidism	↑	↑	↓
Secondary Hyperthyroidism	↑	↑	↑
Grave's Thyroiditis	↑	↑	↑
T3 Thyrotoxicosis	↑	N	N/↓
Primary Hypothyroidism	↓	↓	↑
Secondary Hypothyroidism	↓	↓	↓
Subclinical Hypothyroidism	N	N	↑
Patient on treatment	N	N/↑	↓

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh A-Abnormal)

Dr. Shreya Shah

M.D. (Pathologist)

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Neuberg Diagnostics Private Limited

Laboratory : "KEDAR" Opposite Krupa Petrol Pump, Near Parimal Garden, Ahmedabad - 380006 ☎ 079-40408181 / 61618181
 contact@neubergsupratech.com

Regd. Office : Plot No. 7, Industrial Estate, Rajiv Gandhi Salai, Perungudi, Chennai - 600096, Tamil Nadu, India. | CIN - U85300TN2017PTC114099
 www.neubergsupratech.com



LABORATORY REPORT



Name : PANKAJKUMAR K BAROT Sex/Age : Male / 34 Years Case ID : 40802200914
 Ref.By : Dis. At : Pt. ID : 4319482
 Bill. Loc. : Aashka hospital Pt. Loc :

Reg Date and Time : 23-Aug-2024 10:02	Sample Type : Spot Urine	Mobile No :
Sample Date and Time : 23-Aug-2024 10:02	Sample Coll. By :	Ref Id1 : OO323908
Report Date and Time : 23-Aug-2024 10:57	Acc. Remarks : Normal	Ref Id2 : O24254129

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
URINE EXAMINATION (STRIP METHOD AND FLOWCYTOMETRY)				

Physical examination

Colour : Pale yellow
 Transparency : Clear

Chemical Examination By Sysmex UC-3500

Sp.Gravity	1.025		1.003 - 1.035
pH	6.5		4.6 - 8
Leucocytes (ESTERASE)	Negative		Negative
Protein	Negative		Negative
Glucose	Negative		Negative
Ketone Bodies Urine	Negative		Negative
Urobilinogen	Negative		Negative
Bilirubin	Negative		Negative
Blood	Negative		Negative
Nitrite	Negative		Negative

Flowcytometric Examination By Sysmex UF-5000

Leucocyte	Nil	/HPF	Nil
Red Blood Cell	Nil	/HPF	Nil
Epithelial Cell	Present +	/HPF	Present(+)
Bacteria	Nil	/µL	Nil
Yeast	Nil	/µL	Nil
Cast	Nil	/HPF	Nil
Crystals	Nil	/HPF	Nil

Note: (LL-VeryLow, L-Low, H-High, HH-VeryHigh , A-Abnormal)

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Parameter	Unit	Expected value	Result/Notations				
			Trace	+	++	+++	++++
pH	-	4.6-8.0					
SG	-	1.003-1.035					
Protein	mg/dL	Negative (<10)	10	25	75	150	500
Glucose	mg/dL	Negative (<30)	30	50	100	300	1000
Bilirubin	mg/dL	Negative (0.2)	0.2	1	3	6	-
Ketone	mg/dL	Negative (<5)	5	15	50	150	-
Urobilinogen	mg/dL	Negative (<1)	1	4	8	12	-

Parameter	Unit	Expected value	Result/Notifications				
			Trace	+	++	+++	++++
Leukocytes (Strip)	/micro L	Negative (<10)	10	25	100	500	-
Nitrite(Strip)	-	Negative	-	-	-	-	-
Erythrocytes(Strip)	/micro L	Negative (<5)	10	25	50	150	250
Pus cells (Microscopic)	/hpf	<5	-	-	-	-	-
Red blood cells(Microscopic)	/hpf	<2	-	-	-	-	-
Cast (Microscopic)	/lpf	<2	-	-	-	-	-

----- End Of Report -----

For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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M.D. (Pathologist)

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DR. TAPAS RAVAL
MBBS . D.O
(FELLOW IN PHACO & MEDICAL
RATINA)
REG.NO.G-21350

UHID:	Date: 23/05/24	Time:
Patient Name: Pankaj Kumar	Age / Sex:	Height: 170
	Weight: 63.7.	
History:	C/O Pankaj eye chub.	
Allergy History:		
Nutritional Screening:	Well-Nourished / Malnourished / Obese	
Examination:	Vn 6/18 6/12 Vn 6/24 6/6 6/6 6/6	
Diagnosis:	Cataract - Right eye Refractive error	

Doctor Name:- Dr. Urvashi

UHID: 100323908	Date: 23/8/21	Time: 3:15 PM
Patient Name: Pankaj. Barot,	Age/Sex: 34/M,	Height: 170 cm
	Weight: 63.7 kg	
Chief Complain: No FIC/O. Routine Health checkup.		
History:		
Allergy History:		
Nutritional Screening: Well-Nourished / Malnourished / Obese		
Examination: T: Afebr P: 87/min. BP: 120/80 mmHg SpO2: 95% on RA RtLvs: clear.		
Diagnosis:		

Investigation

- mildly elevated FBS & PP2BS
- Pt had taken milk in the morning
- ↑ cholesterol Repeat.

Rx

No	Dosage Form	Name of drug (IN BLOCK LETTERS ONLY)	Dose	Route	Frequency	Duration

Advice:

- Repeat FBS and PP₂BS.
- F/U/C reports.
- Strict Diet control - avoid oily, fatty food, preservatives and sugar.
- Do exercise regularly.

Follow-up:

F/U/C FBS & PP₂BS

Consultant's Sign:

