

CONTO		/ AKKHITHMIA.	ARRHYPHMTA.		T TOLERANCE	IMPRESSIONS :			BP RESPONSE :		ION : THR ACHIEVED	SHRE . 140 / 88 mm u. or target heart	: 7:2 MAX NORK LOAD :	1 750 / 00 757 701 00 707	11:5	152 5.4 14 1.65 140 / 88 170 0.5 0.4 0.3	2255 2.7 10 107 130 / 80 139 1.2 0 0.6	0:11 1.3 0.1	78 130 / 80 101 0.9 -0.2		TIME Km/Hr & bpm mang x100 S1 LEVELL(MN)	2024 PROTOCOL :	TO COLUMN THE PROPERTY OF THE	THO GIT	MUMBAI		
	T:2 bpm 89 % of target heart rate 185 bpm : 140 / 88 mm Hg of target heart rate 185 bpm : THR ACHIEVED :	THR ACHIEVED TH	: 7:2 : 165 bpm 89 % of target heart rate 185 bpm : THR ACHIEVED :	: 7:2 : 165 bpm 89 % of target heart rate 185 bpm : THR ACHIEVED : THR ACHIEVED	: 7:2 : 165 bpm 89 % of target heart rate 185 bpm : THR ACHIEVED . : THR ACHIEVED .	TION : 7:2 bpm 89 % of target heart rate 185 bpm : 140 / 88 mm Hg MINATION : THR ACHIEVED	TION : 7:2 SURE : 140 / 88 mm Hg MINATION : THR ACHIEVED MINATION : THR ACHIEVED	: 7:2 MAX WORK LOAD : 165 bpm 89 % of target heart rate 185 bpm TION : THR ACHIEVED	: 7:2 MAX WORK LOAD : 165 bpm 89 % of target heart rate 185 bpm FION : THR ACHIEVED	: 7:2 MAX WORK LOAD : 165 bpm 89 % of target heart rate 185 bpm TION : THR ACHIEVED	: 7:2 : 165 bpm 89 % of target heart rate 185 bpm	: 7:2 O			7	1:5 140 / 88 142 1 0.1 0.6	1:2 5.4 14 145 140 / 88 175 0.7 0.4 0.3 1:5 1.1 102 140 / 88 142 1 1.1 0.1	2:55 4 12 107 130 / 80 139 1.2 0 0.6 1:2 5.4 12 125 140 / 88 175 0.5 0.4 0.3 1:5 5.4 14 165 140 / 88 231 0.7 1.1 0.1	2.7 10 107 130 / 80 101 1.3 0.8 0.9 102 125 140 / 88 142 1.1 0.1 0.8 1.1 0.1 1	0:11	0:11 2:55 2:55 2:55 4 12 1:5 1:5 1:5 1:5 1:5 1:5 1:5 1:5 1:5 1:5	OTAL STAGE SPEED GRADE H.R. B.P. RPP ST IEVEL(MM) OTAL STAGE SPEED GRADE H.R. B.P. RPP ST IEVEL(MM) NEDICATION : NIL	OTAL STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(NW) OTAL STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(NW) OTAL STAGE SPEED GRADE H.R. B.P. RPP OTAL STAGE SPEED OF ST LEVEL(NW) Spen mmHg x100 II VI V5 130 / 80 101 1.3 0.9 0.4 0.3 155 2:55 2:55 4 12 125 140 / 88 175 0.5 0.4 0.3 122 1:5 5.4 14 140 / 88 175 0.7 1.1 0.1 OTAL STAGE SPEED OF ST LEVEL(NW)	7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.7.	TOPELDMILL TEST REPORT STUCKE SPEED STICKE SPEED SP	MUNITALIA REPORT	
Time km/Hr % Time	ME Km/Hr % 130 / 80 101 0.9 -0.2 0.7 79 130 / 80 101 1.3 0.9 1.0 0.9 1.0 0.9 1.2 1.0 0.9 1.2 1.0 0.9 1.2 1.0 0.9 1.2 1.0 0.9 1.2 1.2 1.2 1.2 0.0 0.9 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2	ME Km/Hr & Mile Mile Mile Mile Mile Mile Mile Mile	TME Km/Hr % The maney x100 II V1 V5 130 / 80 101 0.9 -0.2 0.7 130 / 80 102 1.6 -0.1 0.9 1.5 1.5 1.6 -0.1 0.9 1.5 1	### Km/Hir & ppm mmHg x100 III VI V5 ### 12	:11	TIME TIME Km/Hr & Dpm mming x100 III VI VS 2:55 2:55 4 12 12 125 140 / 88 175 0.5 0.0 0.9 5:55 2:55 4 12 12 125 140 / 88 175 0.5 0.0 0.9 TION : 7:2 pm 89 \$ of target heart rate 185 bpm : 8.10 MEFS MINATION : THR ACHIEVED 100 100 100 100 100 100 100 100 100 1	TIME TIME Km/Hir & minty x100 II VI V5 2:55 2:55 4 12 10 10 10 10 10 10 10 10 10 10 10 10 10	TIME Km/Hr & mmHg x100 II V1 V5 12.55 2.77 10 10 10 10 0.9 -0.2 0.7 130 / 80 101 1.3 0.0 0.9 2.55 4 4 12 12 130 / 80 101 1.3 0.0 0.9 1.2 5.4 14 16 88 175 0.5 0.4 0.3 1.5 5.4 14 165 140 / 88 142 1 0.1 1.5 5.4 14 165 5pm 89 \$ of target heart rate 185 5pm TION: THR ACHIEVED 2. THR ACHIEVED 2. THR ACHIEVED	TIME Km/Hz 8 130 / 80 101 0.9 -0.2 0.7 10 130 / 80 101 0.9 1.6 -0.1 0.8 1.3 0.9 1.2 1.5 1.5 1.2 0.7 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2 1.2	TIME Km/Hz 8 130 80 101 0.9 -0.2 0.7 0.8 130 80 101 1.3 0.8 0.9	11.2 5.4 14 14 140 / 88 142 1 0.7 1.1 0.6 1.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.5 1.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1	0:11	THME Km/Hz & Dpm mmHg x100 II VI V5 0811 2.7 10 107 130 / 80 101 0.9 -0.1 0.9 2:55 4 12 125 140 / 88 175 0.5 0.4 0.3 1:5 5.4 14 165 140 / 88 142 1.7 1.1 0.16	TIME Km/Hr % 130 kg 101 0.9 -0.2 0.7 25.55 2.7 10 107 130 / 80 101 1.3 0 0.8 22.55 4 12 125 140 / 88 231 0.7 1.1 0.1 15.5 5.4 14 165 140 / 88 231 0.7 1.1 0.1	TIME Km/Hr % 130 km mmHg x100 II VI V5 1255 2.7 10 107 130 km 135 0.6 105 0.5 0.4 0.3	TIME Km/Hr & Dpm mmHg x100 II V1 V5 0:11 78 130 / 80 101 0.9 -0.2 0.7 2:55 2.7 10 107 130 / 80 139 1.2 0 0.6	TIME Km/Hr % Dpm mmHg x100 II V1 V5 78 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 102 1.6 -0.1 0.9 0:11 1.3 0.1	TIME Km/Hr 8 bpm mmHg x100 II VI LEVELL(MM) 78 130 / 80 101 0.9 -0.2 0.7	TIME Km/Hr 8 bpm mmHg x100 II VI V5	TIME Km/Hr & bpm mang x100 St LEVEL(MM)		77 HISTORY : INDICATION : MEDICATION :	3-2024 PROTOCOL HISTORY INDICATION MEDICATION	3-2024 PROTOCOL HISTORY INDICATION MEDICATION	3-2024 TREADMILL TEST AM HISTORY INDIGATION MEDICATION	3-2024 TREADMILL TEST AMMENTAL	
TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM) 11	SPEED SPEED ST LEVEL (MN) NS NS NS NS NS NS NS	TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM) 11	TAGE SPEED GRADE H.H. B.P. RRPP ST LEVEL(MM) 111 112 113 124 124 125 130 / 80 101 1.2 1.3 1.3 1.40 / 88 142 1.3 1.3 1.40 / 88 142 1.3 1.3 1.40 / 88 142 1.3 1.3 1.40 / 88 142 1.3 1.40 / 88 142 1.3 1.40 / 88 142 1.3 1.40 / 88 142 1.40 /	TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MW) 11	TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (NN) "INE KM/Hr & 130 / 80 101 0.9 -0.2 0.7 "55 4 12 125 140 / 88 175 0.5 "55 5.4 14 14 165 140 / 88 121 1.7 0.1 "165 bpm 89 % of target heart rate 185 bpm ; 8.10 METS " THR ACHIEVED 100	TIME TIME RM/HI & B.P. B.P. RPP ST LEVEL(NW) 2:55 2:55 4 12 10 107 130 / 80 101 0.9 -0.2 0.7 5:55 2:55 2:55 4 12 10 107 130 / 80 139 1.2 0.9 5:55 2:55 2:55 5.4 12 12 107 130 / 80 139 1.2 0.0 5:55 2:55 5.4 12 10 107 130 / 88 175 0.1 0.0 TIN NAX WORK LOAD : 8.10 METS MINATION : THR ACHIEVED HAM HG OF CATC TATE 185 DOM	TOTAL STAGE SPEED GRADE H.R. B.P. RPP 7100 II VI VS 72 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 101 1.3 0.9 0.9 5;55 2:55 4 12 12 125 140 / 88 175 0.5 0.4 0.3 122 1:5 5.4 14 14 16 162 140 / 88 142 0.7 1.1 0.6 0.1 0.6 0.1 0.6 0.1 0.1 0.5 0.1 0.1 0.5 0.1 0.1 0.5 0.1 0.1 0.5 0.1 0.1 0.1 0.5 0.1 0.1 0.1 0.5 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0.1	NIL STAGE SPEED GRADE H.R. B.P. RPP	TIME Km/Hz & MAR. B.P. RPP ST LEVEL(MM) E TIME Km/Hz & MAR. B.P. RPP ST LEVEL(MM) 2:55	N. SFAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (MM) 2 TIME Km/Hr 8 130 / 80 101 0.9 -0.2 0.7 2 2:55 2.7 10 107 130 / 80 101 1.3 0.0 2 2:55 4 12 125 140 / 88 175 0.5 0.4 0.3 1:5 5.4 14 14 102 140 / 88 142 1.7 0.1 1:5 5.4 14 14 102 140 / 88 142 1.7 0.1 E.: 140 / 88 mm Hg mm	NIL STAGE SPEED GRADE H.R. B.P. RPP X100 II VI V5 TIME Km/Hr \$ 130 / 80 101 1.3 0.3 2.55 4 12 125 140 / 88 175 0.5 1.5 5.4 14 14 165 140 / 88 142 1.7 1.5 5.4 14 140 / 88 142 1.7 1.5 5.4 15 5.4 140 / 88 142 1.7 1.5 5.4 15 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.4 15 100 100 0.5 1.5 5.5 5.5 5.5 5.5 5.5 5.5 5.5 5.5 5.5	AL STAGE SPEED GRADE #.R. B.P. RPP X100 II VI VS TIME Km/Hr & Dpm mmHg X100 II VI VS 0:11 78 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 101 1.3 0.8 2:55 4 12 125 140 / 88 175 0.4 0.3 1:5 5.4 14 14 140 / 88 142 1.0 1:5 0.4 0.1 1:5 0.4 0.1 1:5 0.4 0.1 1:5 0.5 0.4 0.3	TIME Km/Hr & Ppm manhg x100 II VI V5 TIME Km/Hr & 130 / 80 101 0.9 -0.2 0.7 0:11 78 130 / 80 101 0.9 -0.2 0.7 2:55 4 12 125 140 / 88 175 0.5 0.4 0.3 1:5 5.4 14 165 140 / 88 142 1.7 0:6	TIME Km/Hr & bpm mmHg x100 II VI V5 TIME Km/Hr & bpm mmHg x100 II V1 V5 0:11 78 130 / 80 101 0.9 -0.2 0.7 2:55 2.7 10 107 130 / 80 101 1.3 0.8 2:55 4 12 125 140 / 88 231 0.7 1:5 5.4 14 12 165 140 / 88 231 0.7 1:5 5.4 10 0.0	TIME Km/Hr & B.P. B.P. RPP ST LEVEL(MN) TIME Km/Hr & B.P. B.P. RPP TIME Km/Hr & B.P. B.P. RPP TIME NOT	TIME Km/Hr & B.P. RPP X100 II VI VS 0:11 78 130 / 80 101 0.9 -0.1 0.8 2:55 2.7 10 107 130 / 80 101 1.2 0 0.6	TIME Km/Hr & B.P. RPP ST LEVEL (MM) TIME Km/Hr & 130 / 80 101 1.3 0.9 78 130 / 80 101 1.3 0.9 78 130 / 80 101 1.3 0.9	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM) TIME Km/Hr & 130 / 80 101 0.9 -0.2 0.7	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM) TIME Km/Hr & bpm mmHg x100 II V1 V5	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (MM)	STAGE SPEED GRADE H.R. B.P. PPP	/ 77 INDICATION :	3-2024 PROTOCOL HISTORY / 77 INDICATION MEDICATION	3-2024 PROTOCOL HISTORY LATION MEDICATION HEDICATION	3-2024 TREADMILL TEST /M /M // 77 HISTORY : INDICATION : MEDICATION :	3-2024 TREADMILL TEST AM HISTORY INDICATION HEDICATION	
MACE SPEED GRADE E.H. B.P. RPP X100 II VI VS X100 II VI VS X100 II VI VI VS X100 II	AGE SPEED CPADE H.P. B.P. RPP STIEVEL(MM) 11	NGE SPEED GRADE H.H. B.P. RPP ST LEVEL(MM)	SPEED SPEED ST LEVEL(NM) ST	TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM) SPEED SP	SPEED GRADE H.R. B.P. RPP ST LEVEL(MN) SS SPEED	TOTAL STRAGE SPEED GRADE H.R. B.P. RPP TIME TIME Km/Hr 8 B.P. RPP TIME TIME TIME Km/Hr 8 B.P. RPP TIME TIME TIME TIME TIME TIME TIME TIME	TOTAL STACE SPEED GRADE H.H. B.P. RPP X100 II VI VS 2:55 2255 4 12 10 107 130 / 80 101 1.5 0.9 5:55 2255 4 12 125 140 / 88 131 0.7 TION 7:2 155 5.4 14 14 102 140 / 88 142 1.2 MAX WORK LOAD : 8.10 METS MAX WORK LOAD : 8.10 METS **MAX MORK LOAD : 8.10 METS	11. STAGE SPEED GRADE H.R. B.P. RPP KIDD II VI VS CALOS III VI VS CALOS III VI VS CALOS III VI	NI STAGE SPEED CRADE H.R. B.P. RPP RID ST LEVEL(MM) TIME Km/Hz & bpm mmHq x100 II VI V5 0:11 2.7 10 107 130 / 80 101 1.3 0.8 2:55 4 12 10 107 130 / 80 101 1.2 0.0 2:55 4 12 125 140 / 88 175 0.7 1:5 5.4 14 14 165 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 14 165 140 / 88 142 1.1 1:5 5.4 14 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 14 102 140 / 88 142 1.1 1:5 5.4 14 14 14 102 140 / 88 142 1.1 1:5 5.4 140 / 88 142	TIME Km/Hr & B.P. RPP ST LEVEL(MM) 2.55	TIME Km/Hr & F.H. B.P. RPP ST LEVEL(MM) 2 2:55	STAGE SPEED GRADE H.R. B.P. RPP RPP STILEVEL(MM) 11 STAGE Km/Hz & B.P. RmHg x100 II VI V5 120 0:11	TIME Km/Hr 8 B.P. RPP X100 II VI V5 130 / 80 101 0.9 -0.2 0.7 2555 2.7 10 102 100 100 0.9 2555 4 14 12 125 140 / 88 175 0.5 1:5 5.4 14 10 102 140 / 88 142 1 0.7 1:5 5.4 14 10 0.6	L. STAGE SPEED GRADE H.R. B.P. RPP RIPP ST LEVEL (MM) TIME Km/Hz & B.P. RPP X100 III VI VS 130 / 80 101 0.9 -0.2 0.7 2:55 2.7 10 107 130 / 80 101 1.3 0.9 2:55 4 12 125 140 / 88 231 0.7 1:5 5.4 14 165 140 / 88 231 0.7 1:5 0.4 0.3	L. STAGE SPEED GRADE H.R. B.P. RPP X100 II VI VS X100 III III VI VS X100 III III III III III III III III III	TIME Km/Hr % h.R. B.P. RPP ST LEVEL(MN) TIME Km/Hr % h.R. B.P. RPP TIME Km/Hr % h.R. B.P. RPP TIME No.9 -0.2 0:11 Z:55 Z-7 10 107 130 / 80 101 1.3 0.9 1.0 0.9 1.2 0.9 0.6	TIME Km/Hr & Dpm mmHg x100 II V1 V5 78 130 / 80 101 1.6 -0.1 0.9 0:11 78 130 / 80 101 1.3 0.9	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MN) TIME Km/Hr & Andrew	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (MM) TIME Km/Hr & Dpm mmHg x100 II V1	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MM)	STAGE SPEED GRADE H.R. B.P. COR TOWNS AND	77 TINDICAMION :	PROTOCOL :	PROTOCOL : HISTORY :	FREADMILL TEST PROTOCOL : HISTORY : TABLE TORY : TABLE TO	MUMBAI TEST TREADMILL TEST 2024 PROTOCOL : HISTORY :	
AGE SPEED GRADE H.R. B.P. RPP STIEVEL(MM) 11	AGE SPEED GRADE H.R. B.P. KPP ST LEVEL(MM) 11	AGE SPRED CRADE H.R. B.P. STLEVEL(MW) 11	SPEED SPEED STIEVEL(NA) NIL	SPEED SPEED STIEVEL(NM) NIL NIL	TAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MW) 111 122 130 / 80 101 0.9 0.7 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 130 / 80 101 1.3 0.9 140 / 88 175 0.5 0.4 0.3 140 / 88 142 1.1 0.1 140 / 88 142 1.1 0.6 140 / 88 142 1.1 0.1 140 / 88 142 1.1 0.1 140 / 88 142 1.1 0.1 140 / 88 142 1.1 0.1 140 / 88 142 1.1 0.1 140 / 88 142 1.1 140 / 88 142 1.1 140 / 88 142 1.1 140 / 88 142 1.1 140 / 88 142 1.1 140 / 88 142 1.1 150 / 80 101 1.1 150 / 80 101 1.2 150 / 80 101 1.2 150 / 80 101 1.3 150 / 80 10	TIME TIME KN/Hr & PPM IND NIL RPP IND NIL	TOTAL STACE SPEED GRADE H.H. B.P. RPP ST LEVEL(MM) 11 VI V5 2:55 2:55 2:55 4 12 10 107 130 / 80 101 1.3 0.9 5:55 2:55 2:55 4 12 12 107 130 / 80 101 1.3 0.9 1:2 1:2 1:2 5.4 14 165 140 / 88 231 0.7 1.1 0.1 EXURE : 140 / 88 mm Hg mm Hg may be of target heart rate 185 bpm : 8.10 METS 12 1.1	STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(NN) NIL	STAGE SPEED GRADE #.R. B.P. RPP X100 II VI VS 1 IND	STAGE SPEED GRADE H.F. B.P. RPP ST LEVEL(MM) NIL	AL STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL(MN) 21.56 22.55 24.11 25.55 24.12 10.0 11.0 12.0 140 / 88 142 1.5 2.12 140 / 88 142 1.5 2.14 2.25 2.4 2.5 2.4 2.5 2.4 2.5 2.5	TIME KM/Hr & B.P. RPP X100 II V5 TIME KM/Hr & B.P. B.P. RPP X100 II V5 0:11 78 130 / 80 101 0.9 -0.2 0.9 2:55 4 12 100 107 130 / 80 139 1.2 0 1:5 5.4 14 14 165 140 / 88 142 1 0.7 1.0 0.1 1:5 5.4 140 / 88 142 1 0.7 1.0 0.1 1:5 5.4 18 165 140 / 88 142 1 0.7 1.0 0.1 1:5 5.4 18 165 140 / 88 142 1 0.7 1.0 0.1	M. STAGE SPEED GRADE H.R. B.P. RPP X100 II VI VS X100 II	OTAL STAGE SPEED GRADE H.R. B.P. RPP IME TIME Km/Hr & Dpm mmHg x100 II VI V5 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 101 1.3 0 155 2:55 24 12 125 140 / 88 175 0.5 1.2 0.4 0.3 1.2 1.5 1.6 0.5 1.1 0 1.0 0.9 1.2 1.2 1.4 1.6 0.5 1.3 0.7 0.1 1.3 0.6 1.4 0.5 0.4 0.3	OTAL STAGE SPEED GRADE H.R. B.P. RPP IME TIME Km/Hz & DDm mmHg x100 II V1 V5 SS 2255 2.55 4 12 125 140 / 88 175 0.5 0.4 0.3	OTAL STAGE SPEED GRADE H.H. B.P. RPP IME TIME Km/Hr & Dom mmHg x1000 II VI V5 130 / 80 101 0.9 -0.2 0.7 78 130 / 80 101 1.3 0.9 1.55 2:55 2:55 2.7 10 10 10 1.3 0.6	OTAL STAGE SPEED GRADE H.R. B.P. RPP IME TIME Km/Hz & Dpm munhg x100 III VI V5 130 / 80 101 0.9 -0.2 0.7 79 130 / 80 101 1.3 0.9	OTAL STAGE SPEED GRADE H.R. B.P. RPP IME TIME KM/Hz & Dpm mumly x100 II V1 V5 78 130 / 80 101 0.9 -0.2 0.7	OTAL STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (MM) IME TIME Km/Hz & bpm mmHg x100 II V1	OTAL STAGE SPEED GRADE H.R. B.P. RPP ST LEVEL (MM)	OTAL STAGE SPEED CRADE H.R. P. P. P. P. P. C. T. COMM.		2024 PROTOCOL :	2024 PROTOCOL	TREADMILL TEST	MUMBAI TREADMILL TEST 2024 PROTOCOL	
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UNI-EM, Indoors. Tel.: +91-731-4030035, Fax: +91-731-4031180,E-Mail: em@electromedicals.net; Web: Web: Wew.uni-mp.com, TMC Ver.14.0.3

cian : NEHA THITE.

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Order Date : 02/03/2024 09:37 Age/Sex : 35 Year(s)/Male Report Date : 02/03/2024 12:23

UHID : SHHM.61378

Ref. Doctor : Facility : SEVENHILLS HOSPITAL,

MUMBAI

Mobile : 8000510880

Address : TILAK NAGAR, Chembur, Mumbai, Maharastra, 400071

2D ECHOCARDIOGRAPHY WITH COLOUR DOPPLER STUDY

Normal LV and RV systolic function.

Estimated LVEF = 60%

No LV regional wall motion abnormality at rest.

All valves are structurally and functionally normal.

No LV Diastolic dysfunction.

No pulmonary arterial hypertension.

No regurgitation across any other valves.

Normal forward flow velocities across all the cardiac valves.

Aorta and pulmonary artery dimensions: normal.

IAS / IVS: Intact.

No evidence of clot, vegetation, calcification, pericardial effusion.

COLOUR DOPPLER: NO MR/AR.

Operation to Operations

Dr.Ganesh Vilas Manudhane M.ch,MCH/DM

RegNo: 2011/06/1763

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self Mobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Blood Bank

Test Name Result

Sample No: O0317678A Collection Date: 02/03/24 09:38 Ack Date: 02/03/2024 12:23 Report Date: 02/03/24 13:27

BLOOD GROUPING/ CROSS-MATCHING BY SEMI AUTOMATION						
BLOOD GROUP (ABO)	'B'					
Rh Type Method - Column Agglutination	POSITIVE					

REMARK: THE REPORTED RESULTS PERTAIN TO THE SAMPLE RECEIVED AT THE BLOOD CENTRE.

Interpretation:

Blood typing is used to determine an individual's blood group, to establish whether a person is blood group A, B, AB, or O and whether he or she is Rh positive or Rh negative. Blood typing has the following significance,

- Ensure compatibility between the blood type of a person who requires a transfusion of blood or blood components and the ABO and Rh type of the unit of blood that will be transfused.
- Determine compatibility between a pregnant woman and her developing baby (fetus). Rh typing is especially important during pregnancy because a mother and her fetus could be incompatible.
- Determine the blood group of potential blood donors at a collection facility.
- Determine the blood group of potential donors and recipients of organs, tissues, or bone marrow, as part of a workup for a transplant procedure.

- End of Report -

Dr.Pooja Vinod Mishra MD Pathology

Jr Consultant Pathologist, MMC Reg No. 2017052191

RegNo: 2017/05/2191

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Result

Episode : OP

Test Name

Ref. Doctor: SelfMobile No: 8000510880

DOB : 12/07/1988

Unit

Facility: SEVENHILLS HOSPITAL, MUMBAI

Biological Reference Interval

HAEMATOLOGY

ic realite		Result	Offic		nogical reference inte
ample No: 00317678A	Collection Date :	02/03/24 09:38 Ack Da	te: 02/03/2024 10:11	Report Date :	02/03/24 10:40
OMPLETE BLOOD	COUNT (CBC) - EDTA	WHOLE BLOOD			
Total WBC Count		7.83		x10^3/ul	4.00 - 10.00
Neutrophils		62		%	40.00 - 80.00
Lymphocytes		32.9		%	20.00 - 40.00
Eosinophils		0.6 ▼ (L)		%	1.00 - 6.00
Monocytes		4.2		%	2.00 - 10.00
Basophils		0.3 ▼ (L)		%	1.00 - 2.00
Absolute Neutrophil Co	ount	4.85		x10^3/ul	2.00 - 7.00
Absolute Lymphocyte	Count	2.58		x10^3/ul	0.80 - 4.00
Absolute Eosinophil Co	ount	0.05		x10^3/ul	0.02 - 0.50
Absolute Monocyte Co	unt	0.33		x10^3/ul	0.12 - 1.20
Absolute Basophil Cou	nt	0.02		x10^3/ul	0.00 - 0.10
RBCs		5.26		x10^6/ul	4.50 - 5.50
Hemoglobin		15.5		gm/dl	13.00 - 17.00
Hematocrit		45.7		%	40.00 - 50.00
MCV		86.8		fl	83.00 - 101.00
MCH		29.4		pg	27.00 - 32.00



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self Mobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

MCHC	22.0	2000 / ell	21 50 24 50
	33.9	gm/dl	31.50 - 34.50
RED CELL DISTRIBUTION WIDTH-CV (RDW-CV)	12.4	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH-SD (RDW-SD)	40.8	fl	35.00 - 56.00
Platelet	244	x10^3/ul	150.00 - 410.00
Mean Platelet Volume (MPV)	11.2	fl	6.78 - 13.46
PLATELET DISTRIBUTION WIDTH (PDW)	16.6	%	9.00 - 17.00
PLATELETCRIT (PCT)	0.272	%	0.11 - 0.28

Method:-

HB Colorimetric Method.

RBC/PLT Electrical Impedance Method.

WBC data Flow Cytometry by Laser Method.

MCV,MCH,MCHC,RDW and rest parameters - Calculated.

All Abnormal Haemograms are reviewed confirmed microscopically.

NOTE: Wallach's Interpretation of Diagnostic Tests. 11th Ed, Editors: Rao LV. 2021

NOTE :-

The International Council for Standardization in Haematology (ICSH) recommends reporting of absolute counts of various WBC subsets for clinical decision making. This test has been performed on a fully automated 5 part differential cell counter which counts over 10,000 WBCs to derive differential counts. A complete blood count is a blood panel that gives information about the cells in a patient's blood, such as the cell count for each cell type and the concentrations of Hemoglobin and platelets. The cells that circulate in the bloodstream are generally divided into three types: white blood cells (leukocytes), red blood cells (erythrocytes), and platelets (thrombocytes). Abnormally high or low counts may be physiological or may indicate disease conditions, and hence need to be interpreted clinically.

- End of Report -

Dr.Ritesh Kharche MD, PGD



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: SelfMobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Consultant Pathologist and Director of

Laboratory Services RegNo: 2006/03/1680

MC-5288

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self **Mobile No**: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

HAEMATOLOGY

Test Name		Result	Unit	Biological Reference Interval
Sample No : C	00317678A Collection	Date: 02/03/24 09:38	Ack Date : 02/03/2024 10:11	Report Date : 02/03/24 13:12

ERYTHROCYTE SEDIMENTATION RATE (ESR)			
ESR	20	mm/hr	0 - 20

Method: Westergren Method

INTERPRETATION :-

ESR is a non-specific phenomenon, its measurement is clinically useful in disorders associated with an increased production of acute-phase proteins. It provides an index of progress of the disease in rheumatoid arthritis or tuberculosis, and it is of considerable value in diagnosis of temporal arteritis and polymyalgia rheumatica. It is often used if multiple myeloma is suspected, but when the myeloma is non-secretory or light chain, a normal ESR does not exclude this diagnosis.

An elevated ESR may occur as an early feature in myocardial infarction. Although a normal ESR cannot be taken to exclude the presence of organic disease, the vast majority of acute or chronic infections and most neoplastic and degenerative diseases are associated with changes in the plasma proteins that increased ESR values.

The ESR is influenced by age, stage of the menstrual cycle and medications taken (corticosteroids, contraceptive pills). It is especially low (0–1 mm) in polycythaemia, hypofibrinogenaemia and congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis, or sickle cells. In cases of performance enhancing drug intake by athletes the ESR values are generally lower than the usual value for the individual and as a result of the increase in haemoglobin (i.e. the effect of secondary polycythaemia).

End of Report

Dr.Ritesh Kharche MD, PGD

Consultant Pathologist and Director of Laboratory Services

RegNo: 2006/03/1680

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Result

Episode : OP

Test Name

Ref. Doctor : Self **Mobile No** : 8000510880

DOB : 12/07/1988

Unit

Facility: SEVENHILLS HOSPITAL, MUMBAI

Biological Reference Interval

Biochemistry

	Result	Offic	biological Reference Titterv
Sample No: 00317678A Collection Date	: 02/03/24 09:38 Ack Date	: 02/03/2024 10:11 Rep	ort Date : 02/03/24 11:23
GLYCOSLYATED HAEMOGLOBIN (HBA	10)		
HbA1c Method - Immunoturbidimetry	5.24	%	4 to 6% Non-diabetic 6.07.0% Excellen control 7.08.0% Fair to good control 8.010% Unsatisfactory control ABOVE 10% Poor control
Estimated Average Glucose (eAG) Method - Calculated	103.69	mg/dl	90 - 126



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self Mobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

NOTES :-

1. HbA1c is used for monitoring diabetic control. It reflects the mean plasma glucose over three months

- 2. HbA1c may be falsely low in diabetics with hemolytic disease. In these individuals a plasma fructosamine level may be used which evaluates diabetes over 15 days.
- 3. Inappropriately low HbA1c values may be reported due to hemolysis, recent blood transfusion, acute blood loss, hypertriglyceridemia, chronic liver disease. Drugs like dapsone, ribavirin, antiretroviral drugs, trimethoprim, may also cause interference with estimation of HbA1c, causing falsely low values.
- 4. HbA1c may be increased in patients with polycythemia or post-splenectomy.
- 5. Inappropriately higher values of HbA1c may be caused due to iron deficiency, vitamin B12 deficiency, alcohol intake, uremia, hyperbilirubinemia and large doses of aspirin.
- 6. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
- 7. Any sample with >15% HbA1c should be suspected of having a hemoglobin variant, especially in a non-diabetic patient. Similarly, below 4% should prompt additional studies to determine the possible presence of variant hemoglobin.
- 8. HbA1c target in pregnancy is to attain level <6 % .
- 9. HbA1c target in paediatric age group is to attain level < 7.5 %.

Method: turbidimetric inhibition immunoassay (TINIA) for hemolyzed whole blood

Reference : American Diabetes Associations. Standards of Medical Care in Diabetes 2015

GLUCOSE-PLASMA-FASTING			
Glucose,Fasting	92.11	mg/dl	70 - 110



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: SelfMobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

American Diabetes Association Reference Range :

Normal : < 100 mg/dl

Impaired fasting glucose(Prediabetes): 100 - 126 mg/dl

Diabetes : >= 126 mg/dl

References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation :-

Conditions that can result in an elevated blood glucose level include: Acromegaly, Acute stress (response to trauma, heart attack, and stroke for instance), Chronic kidney disease, Cushing syndrome, Excessive consumption of food, Hyperthyroidism, Pancreatitis.

A low level of glucose may indicate hypoglycemia, a condition characterized by a drop in blood glucose to a level where first it causes nervous system symptoms (sweating, palpitations, hunger, trembling, and anxiety), then begins to affect the brain (causing confusion, hallucinations, blurred vision, and sometimes even coma and death). A low blood glucose level (hypoglycemia) may be

seen with:Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin (insulinomas), Starvation.



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor : Self **Mobile No** : 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Triglycerides Method - glycerol Phosphate Oxidase/Peroxide	269.82	mg/dl	NORMAL : <150 Borderline High : 150-199 High : 200-499 Very High : > 500
HDL Cholesterol Method - Enzymatic immuno inhibition	40.25	mg/dl	Desirable - Above 60 Borderline Risk : 40-59 Undesirable - Below :40
LDL Cholesterol Method - Calculated	133.58 ▲ (H)	mg/dl	Desirable - Below : 130 Borderline Risk : 130-159 Undesirable - Above : 160
VLDL Cholesterol Method - Calculated	53.96 ▲ (H)	mg/dl	5 - 51
Total Cholesterol / HDL Cholesterol Ratio - Calculated Method - Calculated	5.66 ▲ (H)	RATIO	0 - 5
LDL / HDL Cholesterol Ratio - Calculated Method - Calculated	3.32	RATIO	0 - 3.6



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self **Mobile No**: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Note:

1) Biological Reference Interval is as per National Cholestrol Education Program (NCEP) Guidlines.

2) tests done on Fully Automated Biosystem BA-400 Biochemistry Analyser.

Interpretation

- 1. Triglycerides: When triglycerides are very high greater than 1000 mg/dL, there is a risk of developing pancreatitis in children and adults. Triglycerides change dramatically in response to meals, increasing as much as 5 to 10 times higher than fasting levels just a few hours after eating. Even fasting levels vary considerably day to day. Therefore, modest changes in fasting triglycerides measured on different days are not considered to be abnormal.
- 2. HDL-Cholesterol: HDL- C is considered to be beneficial, the so-called "good" cholesterol, because it removes excess cholesterol from tissues and carries it to the liver for disposal. If HDL-C is less than 40 mg/dL for men and less than 50 mg/dL for women, there is an increased risk of heart disease that is independent of other risk factors, including the LDL-C level. The NCEP guidelines suggest that an HDL cholesterol value greater than 60 mg/dL is protective and should be treated as a negative

risk factor.

3. LDL-Cholesterol: Desired goals for LDL-C levels change based on individual risk factors. For young adults, less than 120 mg/dL is acceptable. Values between 120-159 mg/dL are considered Borderline high. Values greater than 160 mg/dL are considered high. Low levels of LDL cholesterol may be seen in people with an inherited lipoprotein deficiency and in people with hyperthyroidism, infection, inflammation, or cirrhosis.

Uric Acid (Serum) Method - Uricase			
Uric Acid Method - Uricase	6.1	mg/dl	3.5 - 7.2

References:

1)Pack Insert of Bio system

2) TIETZ Textbook of Clinical chemistry and Molecular DiagnosticsEdited by: Carl A.burtis, Edward R. Ashwood, David e. Bruns

Interpretation:-

Uric acid is produced by the breakdown of purines. Purines are nitrogen-containing compounds found in the cells of the body,

including our DNA. Increased concentrations of uric acid can cause crystals to form in the joints, which can lead to the joint

inflammation and pain characteristic of gout. Low values can be associated with some kinds of liver or kidney diseases, Fanconi

syndrome, exposure to toxic compounds, and rarely as the result of an inherited metabolic defect (Wilson disease).



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor : Self **Mobile No** : 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

<u>Liver Function Test (LFT)</u>			
SGOT (Aspartate Transaminase) - SERUM Method - IFCC	26.27	IU/L	0 - 35
SGPT (Alanine Transaminase) - SERUM Method - IFCC	47.89 ▲ (H)	IU/L	0 - 45
Total Bilirubin - SERUM Method - Diazo	0.6	mg/dl	0 - 2
Direct Bilirubin SERUM Method - Diazotization	0.26	mg/dl	0 - 0.4
Indirect Bilirubin - Calculated Method - Calculated	0.34	mg/dl	0.1 - 0.8
Alkaline Phosphatase - SERUM Method - IFCC AMP Buffer	104.73	IU/L	43 - 115
Total Protein - SERUM Method - Biuret	7.05	gm/dl	6 - 7.8
Albumin - SERUM Method - Bromo Cresol Green(BCG)	4.47	gm/dl	3.5 - 5.2
Globulin - Calculated Method - Calculated	2.58	gm/dl	2 - 4
A:G Ratio Method - Calculated	1.73	:1	1 - 3



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self **Mobile No**: 8000510880

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Facility: SEVENHILLS HOSPITAL, MUMBAI

References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interperatation :-

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. 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 also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstonesgetting 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.

AST levels increase in 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 attck or strenuous activity. ALT is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. Elevated ALP levels are seen in Biliary Obstruction, Osteoblastic Bone Tumors, Osteomalacia, Hepatitis, Hyperparathyriodism, Leukemia, Lymphoma, paget `s disease, Rickets, Sarcoidosis etc.

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-including drugs etc. Serum 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, Waldenstrom's disease.

Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic - Human serum 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.

Renal Function Test (RFT)			
Urea - SERUM Method - Urease	15.94	mg/dl	15 - 39
BUN - SERUM Method - Urease-GLDH	7.45	mg/dl	4 - 18
Creatinine - SERUM Method - Jaffes Kinetic	0.87	mg/dl	0.5 - 1.3



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

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References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation:-

The blood urea nitrogen or BUN test is primarily used, along with the creatinine test, to evaluate kidney function in a wide range of circumstances, to help diagnose kidney disease, and to monitor people with acute or chronic kidney dysfunction or failure. It also may be used to evaluate a person's general health status.

GLUCOSE-PLASMA POST PRANDIAL			
Glucose,Post Prandial	123.47	mg/dl	70 - 140

American Diabetes Association Reference Range :

Post-Prandial Blood Glucose:

Non- Diabetic: Up to 140mg/dL Pre-Diabetic: 140-199 mg/dL Diabetic :>200 mg/dL

References:

1)Pack Insert of Bio system

2) Tietz Textbook Of Clinical Chemistry And Molecular Diagnostics, 6th Ed, Editors: Rifai et al. 2018

Interpretation :-

Conditions that can result in an elevated blood glucose level include: Acromegaly, Acute stress (response to trauma, heart attack, and stroke for instance), Chronic kidney disease, Cushing syndrome, Excessive consumption of food, Hyperthyroidism, Pancreatitis.

A low level of glucose may indicate hypoglycemia, a condition characterized by a drop in blood glucose to a level where first it causes nervous system symptoms (sweating, palpitations, hunger, trembling, and anxiety), then begins to affect the brain (causing confusion, hallucinations, blurred vision, and sometimes even coma and death). A low blood glucose level (hypoglycemia) may be

seen with:Adrenal insufficiency, Drinking excessive alcohol, Severe liver disease, Hypopituitarism, Hypothyroidism, Severe infections, Severe heart failure, Chronic kidney (renal) failure, Insulin overdose, Tumors that produce insulin (insulinomas),Starvation.



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex

: 35 Year(s) / Male UHID : SHHM.61378 **Order Date** : 02/03/2024 09:37

: OP **Episode**

Mobile No : 8000510880 **Ref. Doctor** : Self DOB : 12/07/1988

> **Facility** : SEVENHILLS HOSPITAL, MUMBAI

- End of Report

Dr.Ritesh Kharche MD, PGD

Consultant Pathologist and Director of

Laboratory Services RegNo: 2006/03/1680

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self Mobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Stool Examination

Test Name Result					
Sample No: 00317682D Collection Date: 02/03/24 0	9:44 Ack Date: 02/03/2024 10:12	Report Date :	02/03/24 13:55		
Gross and Chemical Examination					
Consistency	Semi-Solid				
COLOUR STOOL	Brown				
Visible Blood	Absent				
Mucus	Absent				
Occult Blood	NEGATIVE				
Microscopic Examination					
Pus cells	ABSENT				
Epithelial Cells	ABSENT				
RBC	Absent				
Parasites	Present				

End of Report

Dr.Ritesh Kharche MD, PGD

Consultant Pathologist and Director of Laboratory Services

RegNo: 2006/03/1680

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: SelfMobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

IMMUNOLOGY

Test Name		Resu	lt	Unit	Bio	logical Reference Interval
Sample No: 00317678C	Collection Date :	02/03/24 09	:38 Ack Date :	02/03/2024 10:12	Report Date :	02/03/24 11:00
T3 - SERUM			94.3		ng/dl	70.00 - 204.00
TFT- Thyroid Function Te	sts					
T4 - SERUM			8.71		ug/dL	4.60 - 10.50
TSH - SERUM			2.33		uIU/ml	0.40 - 4.50



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: Self **Mobile No**: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Reference Ranges (T3) Pregnancy:

First Trimester 81 - 190

Second Trimester & Third Trimester 100 - 260

Reference Ranges (TSH) Pregnancy:

1st Trimester : 0.1 – 2.5 2nd Trimester : 0.2 – 3.0 3rd Trimester : 0.3 – 3.0

Reference:

1. Clinical Chemistry and Molecular Diagnostics, Tietz Fundamentals, 7th Edition & Endocronology Guideliens

Interpretation :-

It is recommended that the following potential sources of variation should be considered while interpreting thyroid hormone results:

- 1. Thyroid hormones undergo rhythmic variation within the body this is called circadian variation in TSH secretion: Peak levels are seen between 2-4 am. Minimum levels seen between 6-10 am. This variation may be as much as 50% thus, influence of sampling time needs to be considered for clinical interpretation.
- 2. Circulating forms of T3 and T4 are mostly reversibly bound with Thyroxine binding globulins (TBG), and to a lesser extent with albumin and Thyroid binding PreAlbumin. Thus the conditions in which TBG and protein levels alter such as chronic liver disorders, pregnancy, excess of estrogens, androgens, anabolic steroids and glucocorticoids may cause misleading total T3, total T4 and TSH interpretations.
- 3. Total T3 and T4 levels are seen to have physiological rise during pregnancy and in patients on steroid treatment.
- 4. T4 may be normal the presence of hyperthyroidism under the following conditions: T3 thyrotoxicosis, Hypoproteinemia related reduced binding, during intake of certain drugs (eg Phenytoin, Salicylates etc)
- 5. Neonates and infants have higher levels of T4 due to increased concentration of TBG
- 6. TSH levels may be normal in central hypothyroidism, recent rapid correction of hypothyroidism or hyperthyroidism, pregnancy, phenytoin therapy etc.
- 7. TSH values of <0.03 uIU/mL must be clinically correlated to evaluate the presence of a rare TSH variant in certain individuals which is undetectable by conventional methods.
- 8. Presence of Autoimmune disorders may lead to spurious results of thyroid hormones
- 9. Various drugs can lead to interference in test results.
- 10. It is recommended that evaluation of unbound fractions, that is free T3 (fT3) and free T4 (fT4) for clinic-pathologic correlation, as these are the metabolically active forms.

End of Report -



Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor : Self **Mobile No** : 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Dr.Ritesh Kharche MD, PGD

Consultant Pathologist and Director of

Laboratory Services RegNo: 2006/03/1680

MC-5288

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Age/Sex : 35 Year(s) / Male

Episode : OP

Ref. Doctor: SelfMobile No: 8000510880

DOB : 12/07/1988

Facility: SEVENHILLS HOSPITAL, MUMBAI

Urinalysis

Test Name		Result			Biological Reference Interval	
Sample No : 00317682E	Collection Date :	02/03/24 09	2:44 Ack Date :	02/03/2024 10:12	Report Date :	02/03/24 13:55
URINE SUGAR AND	KETONE (FASTING)					
Sugar			Absent			
ketones			Absent			
Sample No : 00317728E	Collection Date :	02/03/24 12	2:03 Ack Date :	02/03/2024 12:21	Report Date :	02/03/24 13:55
URINE SUGAR AND	KETONE (PP)					
Sugar			Absent			
ketones			Absent			

- End of Report

Dr.Ritesh Kharche MD, PGD

Consultant Pathologist and Director of Laboratory Services

RegNo: 2006/03/1680

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Order Date : 02/03/2024 09:37 Age/Sex : 35 Year(s)/Male Report Date : 02/03/2024 14:07

UHID : SHHM.61378

Ref. Doctor : Facility : SEVENHILLS HOSPITAL,

MUMBAI

Mobile : 8000510880

Address : TILAK NAGAR, Chembur, Mumbai, Maharastra, 400071

USG ABDOMEN AND PELVIS

Liver is normal in size (13.2 cm) and echotexture. No focal liver parenchymal lesion is seen. Intrahepatic portal and biliary radicles are normal.

Gall-bladder is physiologically distended. No evidence of intraluminal calculus is seen. Wall thickness appears normal. No evidence of peri-cholecystic fluid is seen.

Portal vein and CBD are normal in course and calibre.

Visualised part of pancreas appears normal in size and echotexture. No evidence of duct dilatation or parenchymal calcification seen.

Spleen is normal in size (10 cm) and echotexture. No focal lesion is seen in the spleen.

Right kidney measures 9.0 X 5.3 cm. Left kidney measures 8.3 X 5.9 cm.

Both the kidneys are normal in size, shape and echotexture. Cortico-medullary differentiation is maintained. No evidence of calculus or hydronephrosis on either side.

Urinary bladder is well distended and appears normal. No evidence of intra-luminal calculus or mass lesion.

Prostate appears normal in size and echotexture.

There is no free fluid in abdomen and pelvis.

IMPRESSION

'No significant abnormality is detected.

Dr.Bhavesh Rajesh Dubey

MBBS,MD

RegNo: 2017/03/0656

: Mr. PARTHIV NAGINBHAI TANDEL Order Date : 02/03/2024 09:37 Patient Name : 35 Year(s)/Male Report Date : 02/03/2024 14:07 Age/Sex

: SHHM.61378 UHID

Facility Ref. Doctor : SEVENHILLS HOSPITAL,

MUMBAI : 8000510880 Mobile

: TILAK NAGAR, Chembur, Mumbai, Maharastra, 400071 Address

Patient Name : Mr. PARTHIV NAGINBHAI TANDEL Order Date : 02/03/2024 09:37 Age/Sex : 35 Year(s)/Male Report Date : 02/03/2024 15:56

UHID : SHHM.61378

Ref. Doctor : Facility : SEVENHILLS HOSPITAL,

MUMBAI

Mobile : 8000510880

Address : TILAK NAGAR, Chembur, Mumbai, Maharastra, 400071

X-RAY CHEST PA VIEW

Both lungs are clear.

The frontal cardiac dimensions are normal.

The pleural spaces are clear.

Both hilar shadows are normal in position and density.

No diaphragmatic abnormality is seen.

The soft tissues and bony thorax are normal.

IMPRESSION: No pleuroparenchymal lesion is seen.

Dr.Bhujang Pai MBBS,MD

Consultant RegNo: 49380