SPECTRUM
DIAGNOSTICS & HEALTH CARE

CERTIFICATE OF MEDICAL FITNESS

NAME: Bagewadi Rupa.S

AGE/ GENDER: 36y / F

HEIGHT: 153cm WEIGHT: 75 kg

IDENTIFICATION MARK:

BLOOD PRESSURE: 110/80mmHg

PULSE: 82/min

CVS: } Normal

RS:P

ANY OTHER DISEASE DIAGNOSED IN THE PAST: Nill

ALLERGIES, IF ANY: -Nill

LIST OF PRESCRIBED MEDICINES: -Nill

ANY OTHER REMARKS: NO.

I Certify that I have carefully examined Mr/Mrs. Bagewadi Rupa.S son/daughter of Ms Bharamappa who has signed in my presence. He/ she has no physical disease and is fit for employment.

Dr. BINDURAJ. R
MBBS, MD
Internal Medicine
Reg. No. [illegible]

Signature of candidate

Signature of Medical Officer

Place: Spectrum Diagnostics & health care

Date: 23/03/24

Disclaimer: The patient has not been checked for COVID. This certificate does not relate to the covid status of the patient examined

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Dr.Ashok S
Bsc.,MBBS., D.O.M.S
Consultant Opthalmologist
KMC No: 31827

DATE: 23.03.24.

EYE EXAMINATION

NAME: Mrs. Bhagavathi Rayas AGE: 36Y GENDER : F / M

	RIGHT EYE	LEFT EYE
Vision	6/6 : N	6/6 : N
Vision With glass		
Color Vision	Normal	Normal
Anterior segment examination	Normal	Normal
Fundus Examination	Normal	Normal
Any other abnormality	Nill	Nill
Diagnosis/ impression	Normal	Normal

Dr. ASHOK SARODHE
B.Sc., M.B.B.S., D.O.M.S.
Eye Consultant & Surgeon
KMC 31827

Consultant (Opthalmologist)

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NAME	AGE	GENDER
Mrs. Bagewadi Rupa S	36yrs	F

DENTAL EXAMINATION REPORT:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

C: CAVITY –

M: MISSING –

O: OTHERS – Generalised sensitivity.

ADVISED:

CLEANING / SCALING / ROOTS PLANNING / FLOSSING & POLISHING / OTHERS

REMARKS: Oral prophylaxis after a year.
Brushing advised with desensitizing toothpaste.

SIGNATURE OF THE DENTAL SURGEON

SEAL

DATE 23/3/24.

Dr. SACHDEV NAGARKAR
B.D.S., F.A.G.E., F.P.F.A. (USA)
Reg. No : 2247/A

ID: 3240040
MRS BAGEWADI RUPA S
Female 36Years

23-03-2024 10:19:49

For BPL

HR	: 94	bpm
P	: 91	ms
PR	: 141	ms
QRS	: 75	ms
QT/QTc	: 373/468	ms
P/QRS/T	: 59/38/-61	°
RV5/SV1	: 0.946/0.411	mV

Diagnosis Information:
Sinus Rhythm
T Wave Abnormality(I,II,V1,V2,V3,V4,V5,V6)

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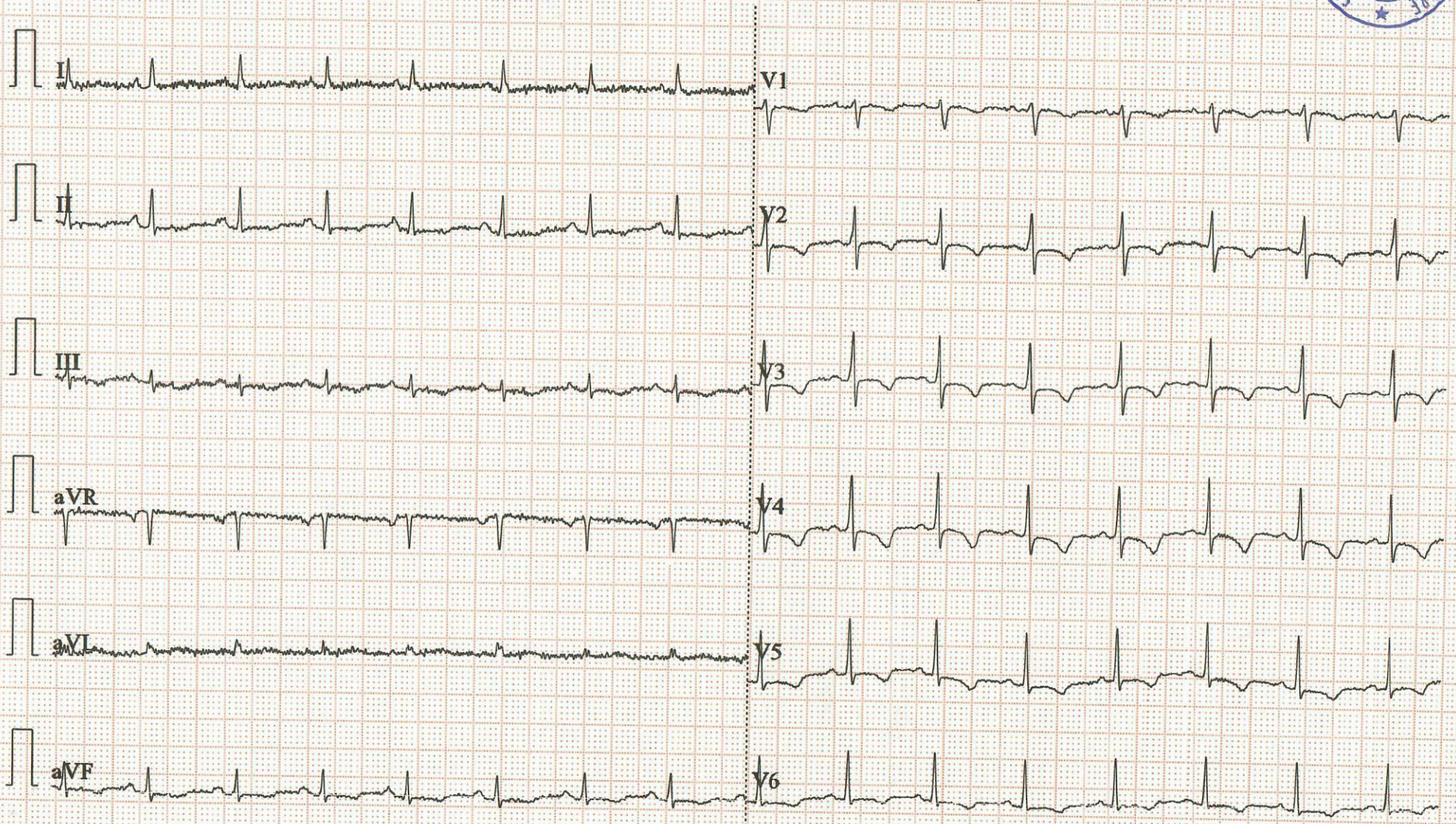
BENGALURU

Report Confirmed by:



0.15~35Hz AC50 25mm/s 10mm/mV 2*5.0s ♥94 V2.2 SEMIP V1.81 SPECTRUM DIAGNOSTICS & HEALTH CARE

SPECTRUM
DIAGNOSTICS & HEALTH CARE

NAME : MRS.BAGEWADI RUPA S	**DATE : 23/03/2024**
AGE/SEX : 36YEARS/FEMALE	**REG NO: 2303240040**
REF BY : APOLO CLINIC	

CHEST PA VIEW

- Visualised lungs are clear .
- Bilateral hila appears normal .
- Cardia is normal in size
- No pleural effusion

IMPRESSION: **No significant abnormality .**

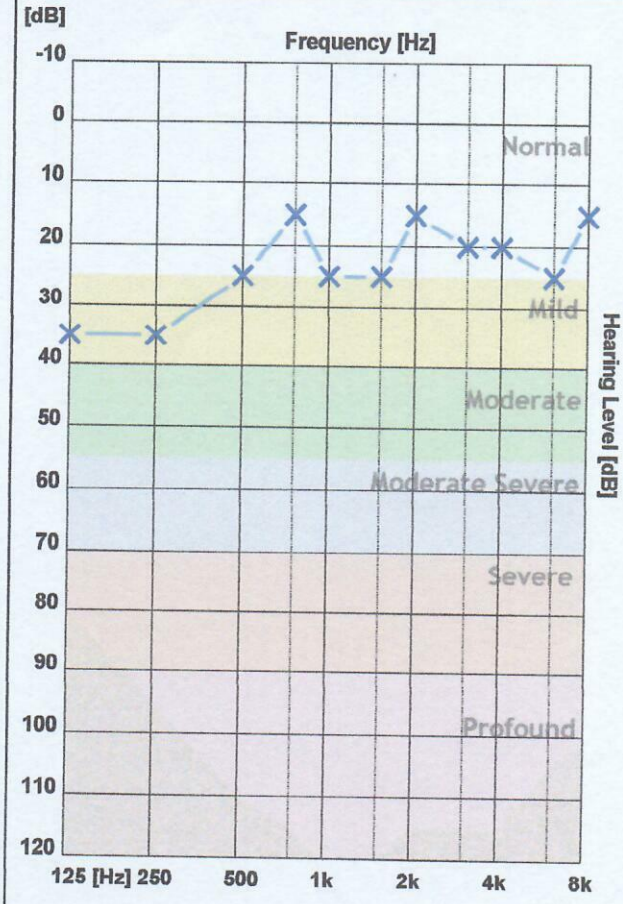
DR PRAVEEN B,DMRD ,DNB
Consultant Radiologist

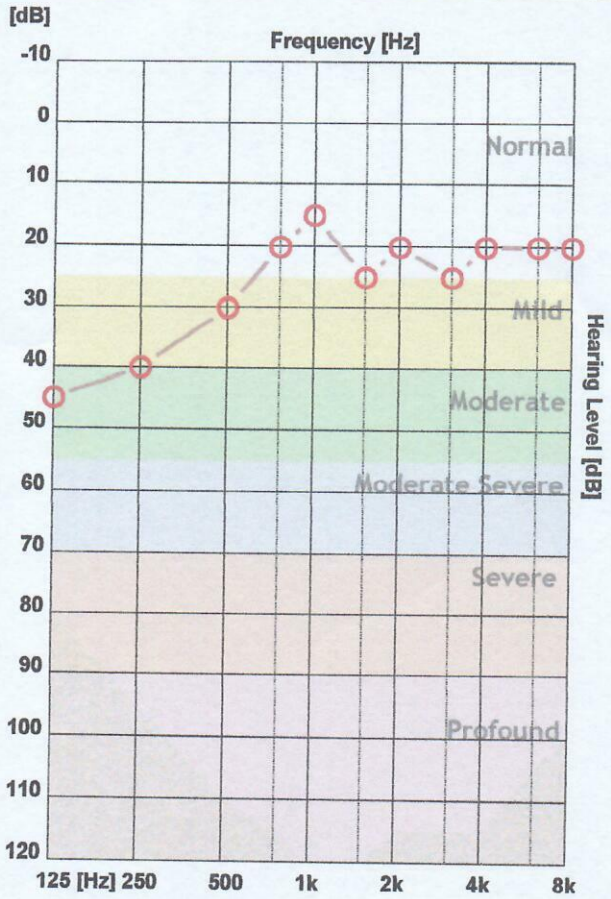
SPECTRUM DIAGNOSTICS

Bangalore

Patient ID : 0260
Name : BAGEWADI RUPA S
CR Number : 20240323123411
Registration Date : 23-Mar-2024

Age : 36
Gender : Female
Operator : spectrum diagnostics





	125 Hz	250 Hz	500 Hz	750 Hz	1000 H	1500 H	2000 H	3000 H	4000 H	6000 H	8000 H
X - Air Left	35	35	25	15	25	25	15	20	20	25	15
O - Air Right	45	40	30	20	15	25	20	25	20	20	20
> - Bone Left											
< - Bone Right											

	Average	High	Mid	Low
AIR Left	23.18 dB	20.00 dB	21.67 dB	27.50 dB
AIR Right	25.45 dB	21.25 dB	20.00 dB	33.75 dB

Clinical Notes :

Not Found

SPECTRUM DIAGNOSTICS AND HEALTH CARE BENGALURU

SPECTRUM
DIAGNOSTICS & HEALTH CARE

PATIENT NAME	MRS BAGEWADI RUPA S	ID NO	2303240040
AGE	36YEARS	SEX	FEMALE
REF BY	DR.APOLO CLINIC	DATE	23.03.2024

2D ECHO CARDIOGRAHIC STUDY

M-MODE

AORTA	22mm
LEFT ATRIUM	29mm
RIGHT VENTRICLE	20mm
LEFT VENTRICLE (DIASTOLE)	31mm
LEFT VENTRICLE(SYSTOLE)	27mm
VENTRICULAR SEPTUM (DIASTOLE)	10mm
VENTRICULAR SEPTUM (SYSTOLE)	11mm
POSTERIOR WALL (DIASTOLE)	09mm
POSTERIOR WALL (SYSTOLE)	11mm
FRACTIONAL SHORTENING	30%
EJECTION FRACTION	58%

DOPPLER /COLOUR FLOW

Mitral Valve Velocity : MVE- 0.94m/s MVA – 0.63m/s E/A-1.40

Tissue Doppler : e' (Septal) -10cm/s E/e'(Septal) -9

Velocity/ Gradient across the Pulmonic valve : 0.83m/s 3mmHg

Max. Velocity / Gradient across the Aortic valve : 1.19m/s 4mmHg

Velocity / Gradient across the Tricuspid valve : 1.87 m/s 19mmHg

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DIAGNOSTICS & HEALTH CARE

PATIENT NAME	MRS BAGEWADI RUPA S	ID NO	2303240040
AGE	36YEARS	SEX	FEMALE
REF BY	DR.APOLO CLINIC	DATE	23.03.2024

2D ECHO CARDIOGRAHIC STUDY

LEFT VENTRICLE	SIZE& THICKNESS	NORMAL
CONTRACTILITY	REGIONAL GLOBAL	NO RWMA

RIGHT VENTRICLE	:	NORMAL
LEFT ATRIUM	:	NORMAL
RIGHT ATRIUM	:	NORMAL
MITRAL VALVE	:	NORMAL
AORTIC VALVE	:	NORMAL
PULMONARY VALVE	:	NORMAL
TRICUSPID VALVE	:	NORMAL
INTER ATRIAL SEPTUM	:	INTACT
INTER VENTRICULAR SEPTUM	:	INTACT
PERICARDIUM	:	NORMAL
OTHERS	:	- NIL

IMPRESSION

- NO REGIONAL WALL MOTION ABNORMALITY PRESENT
- NORMAL VALVES AND DIMENSIONS
- NORMAL LV FUNCTION, LVEF- 58%
- TRIVIAL MR / TRIVIAL TR
- NO CLOT / VEGETATION / EFFUSION

Durga

DURGA V
ECHO TECHNICIAN

The science of radiology is based upon interpretation of shadows of normal and abnormal tissue. This is neither complete nor accurate; hence, findings should always be interpreted in to the light of clinico-pathological correction.

SPECTRUM
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NAME AND LAB NO	MRS BAGEWADI RUPA S	REG -40040
AGE & SEX	36 YRS	FEMALE
DATE AND AREA OF INTEREST	23.03.2024	ABDOMEN & PELVIS
REF BY	C/O APOLO CLINIC	

USG ABDOMEN AND PELVIS

LIVER: **Normal in size and shows diffuse increased echogenicity.**
No e/o IHBR dilatation. No evidence of focal lesion
Portal vein appears normal.
CBD appears normal.

GALL BLADDER: **Well distended. and shows multiple calculi largest measuring 8.8 mm**
Wall appears normal

SPLEEN: Normal in size and echotexture. No focal lesion

PANCREAS: Head and body appears normal . Tail obscured by bowel gas shadows

RETROPERITONEUM: Suboptimal visualised due to bowel gas.

RIGHT KIDNEY: Right kidney is normal in size & echotexture
No evidence of calculus/ hydronephrosis.

LEFT KIDNEY: .Left kidney is normal in size & echotexture
No evidence of calculus/ hydronephrosis.

URINARY BLADDER: Well distended. No wall thickening/ calculi.

UTERUS: Anteverted, Normal in size 8.3 x3.9 x4.3 cm and echotexture
Endometrium is normal.ET – 4.5 mm.

OVARIES: B/L ovaries normal in size and echotexture.
RO –3.0 x 1.8cm , LO –2.9 x1.5 cm
No obvious adnexal mass lesions .

- No evidence of ascites/pleural effusion.

IMPRESSION:

- ***Grade I fatty liver.***
- ***Cholelithiasis . No signs of cholecystitis .***

- ***Suggested clinical / lab correlation***

DR PRAVEEN B , DMRD , DNB
CONSULTANT RADIOLOGIST

SPECTRUM
DIAGNOSTICS & HEALTH CARE

MC-4196

Name	: MRS. BAGEWADI RUPA S			**Bill Date**	: 23-Mar-2024 09:09 AM
Age / Gender	: 36 years / Female	**UHID**	: 2303240040	**Sample Col. Date**	: 23-Mar-2024 09:09 AM
Ref. By Dr.	: Dr. APOLO CLINIC	2303240040		**Result Date**	: 23-Mar-2024 01:04 PM
Reg. No.	: 2303240040			**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
Complete Haemogram-Whole Blood EDTA				
Haemoglobin (HB)	**9.90**	g/dL	Male: 14.0-17.0 Female:12.0-15.0 Newborn:16.50 - 19.50	Spectrophotmeter
Red Blood Cell (RBC)	4.25	million/cumm	3.50 - 5.50	Volumetric Impedance
Packed Cell Volume (PCV)	**29.60**	%	Male: 42.0-51.0 Female: 36.0-45.0	Electronic Pulse
Mean corpuscular volume (MCV)	**69.70**	fL	78.0- 94.0	Calculated
Mean corpuscular hemoglobin (MCH)	**23.20**	pg	27.50-32.20	Calculated
Mean corpuscular hemoglobin concentration (MCHC)	33.30	%	33.00-35.50	Calculated
Red Blood Cell Distribution Width SD (RDW-SD)	**33.60**	fL	40.0-55.0	Volumetric Impedance
Red Blood Cell Distribution CV (RDW-CV)	**16.40**	%	Male: 11.80-14.50 Female:12.20-16.10	Volumetric Impedance
Mean Platelet Volume (MPV)	9.90	fL	8.0-15.0	Volumetric Impedance
Platelet	3.55	lakh/cumm	1.50-4.50	Volumetric Impedance
Platelet Distribution Width (PDW)	10.80	%	8.30 - 56.60	Volumetric Impedance
White Blood cell Count (WBC)	9620.00	cells/cumm	Male: 4000-11000 Female 4000-11000 Children: 6000-17500 Infants : 9000-30000	Volumetric Impedance
Neutrophils	60.50	%	40.0-75.0	Light scattering/Manual
Lymphocytes	33.40	%	20.0-40.0	Light scattering/Manual
Eosinophils	3.00	%	0.0-8.0	Light scattering/Manual

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Test Name	Result	Unit	Reference Value	Method
Monocytes	2.90	%	0.0-10.0	Light scattering/Manual
Basophils	0.20	%	0.0-1.0	Light scattering/Manual
Absolute Neutrophil Count	5.82	10^3/uL	2.0- 7.0	Calculated
Absolute Lymphocyte Count	3.21	10^3/uL	1.0-3.0	Calculated
Absolute Monocyte Count	0.28	10^3/uL	0.20-1.00	Calculated
Absolute Eosinophil Count	290.00	cells/cumm	40-440	Calculated
Absolute Basophil Count	0.02	10^3/uL	0.0-0.10	Calculated
Erythrocyte Sedimentation Rate (ESR)	18	mm/hr	Female : 0.0-20.0 Male : 0.0-10.0	Westergren

Peripheral Smear Examination-Whole Blood EDTA

Method: (Microscopy-Manual)

RBC'S : Are microcytic hypochromic.Poikilocytes like tear drop cells and pencil shaped cells are seen.
WBC'S : Are normal in total number, morphology and distribution.
Platelets : Adequate in number and normal in morphology.
No abnormal cells or hemoparasites are present.
Impression : Mild degree of Microcytic Hypochromic Anaemia.

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Dr. Nithun Reddy C,MD,Consultant Pathologist

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SCAN FOR LOCATION

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Ref. By Dr.	: Dr. APOLO CLINIC			**Result Date**	: 23-Mar-2024 02:52 PM
Reg. No.	: 2303240040	2303240040		**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
Blood Group & Rh Typing-Whole Blood EDTA				
Blood Group	O			Slide/Tube agglutination
Rh Type	Positive			Slide/Tube agglutination

Note: Confirm by tube or gel method.

Comments: ABO blood group system, the classification of human blood based on the inherited properties of red blood cells (erythrocytes) as determined by the presence or absence of the antigens A and B, which are carried on the surface of the red cells. Persons may thus have type A, type B, type O, or type AB blood.

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Test Name	Result	Unit	Reference Value	Method
Glycosylated Haemoglobin (HbA1c)-Whole Blood EDTA				
Glycosylated Haemoglobin (HbA1c)	6.90	%	Non diabetic adults :<5.7 At risk (Prediabetes) : 5.7 - 6.4 Diagnosing Diabetes :>= 6.5 Diabetes Excellent Control : 6-7 Fair to good Control : 7-8 Unsatisfactory Control :8-10 Poor Control :>10	HPLC
Estimated Average Glucose(eAG)	151.33	mg/dL		Calculated

Note: 1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.

2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Comments: HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.

Fasting Blood Sugar (FBS)-Plasma	104	mg/dL	60.0-110.0	Hexo Kinase

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Test Name	Result	Unit	Reference Value	Method

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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Test Name	Result	Unit	Reference Value	Method
Fasting Urine Glucose-Urine	Negative		Negative	Dipstick/Benedicts (Manual)
Calcium,Total- Serum	**7.60**	mg/dL	8.50-10.10	Spectrophotometry (O-Cresolphthalein complexone)

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Test Name	Result	Unit	Reference Value	Method
LFT-Liver Function Test -Serum				
Bilirubin Total-Serum	0.39	mg/dL	0.2-1.0	Caffeine Benzoate Diazotised Sulphanilic Acid
Bilirubin Direct-Serum	0.12	mg/dL	0.0-0.2	Direct Measure
Bilirubin Indirect-Serum	0.27	mg/dL	Female: 0.0 - 1.10	
Aspartate Aminotransferase (AST/SGOT)-Serum	17.00	U/L	Female: 15.0 - 37.0	UV with Pyridoxal - 5 - Phosphate
Alanine Aminotransferase (ALT/SGPT)-Serum	30.00	U/L	Female: 14.0 - 59.0	UV with Pyridoxal - 5 - Phosphate
Alkaline Phosphatase (ALP)-Serum	72.00	U/L	Female: 45.0 - 117.0	PNPP,AMP-Buffer
Protein, Total-Serum	8.20	g/dL	6.40-8.20	Biuret/Endpoint-With Blank
Albumin-Serum	3.60	g/dL	Female: 3.40 - 5.50	Bromocresol Purple
Globulin-Serum	**4.60**	g/dL	2.0-3.50	Calculated
Albumin/Globulin Ratio-Serum	**0.78**	Ratio	0.80-2.0	Calculated
Gamma-Glutamyl Transferase (GGT)-Serum	28.00	U/L	Male: 15.0-85.0 Female: 5.0-55.0	Other g-Glut-3-carboxy-4 nitro

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Test Name	Result	Unit	Reference Value	Method

Comments: Gamma-glutamyltransferase (GGT) is primarily present in kidney, liver, and pancreatic cells. Small amounts are present in other tissues. Even though renal tissue has the highest level of GGT, the enzyme present in the serum appears to originate primarily from the hepatobiliary system, and GGT activity is elevated in any and all forms of liver disease. It is highest in cases of intra- or posthepatic biliary obstruction, reaching levels some 5 to 30 times normal. GGT is more sensitive than alkaline phosphatase (ALP), leucine aminopeptidase, aspartate transaminase, and alanine aminotransferase in detecting obstructive jaundice, cholangitis, and cholecystitis; its rise occurs earlier than with these other enzymes and persists longer. Only modest elevations (2-5 times normal) occur in infectious hepatitis, and in this condition, GGT determinations are less useful diagnostically than are measurements of the transaminases. High elevations of GGT are also observed in patients with either primary or secondary (metastatic) neoplasms. Elevated levels of GGT are noted not only in the sera of patients with alcoholic cirrhosis but also in the majority of sera from persons who are heavy drinkers. Studies have emphasized the value of serum GGT levels in detecting alcohol-induced liver disease. Elevated serum values are also seen in patients receiving drugs such as phenytoin and phenobarbital, and this is thought to reflect induction of new enzyme activity.

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DIAGNOSTICS & HEALTH CARE

MC-4196

Name	: MRS. BAGEWADI RUPA S			**Bill Date**	: 23-Mar-2024 09:09 AM
Age / Gender	: 36 years / Female	**UHID**	: 2303240040	**Sample Col. Date**	: 23-Mar-2024 09:09 AM
Ref. By Dr.	: Dr. APOLO CLINIC	2303240040		**Result Date**	: 23-Mar-2024 02:52 PM
Reg. No.	: 2303240040			**Report Status**	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
KFT (Kidney Function Test) :				
Blood Urea Nitrogen (BUN)-Serum	7.60	mg/dL	7.0-18.0	GLDH,Kinetic Assay
Creatinine-Serum	0.61	mg/dL	Male: 0.70-1.30 Female: 0.55-1.02	Modified kinetic Jaffe
Uric Acid-Serum	5.10	mg/dL	Male: 3.50-7.20 Female: 2.60-6.00	Uricase PAP
Sodium (Na+)-Serum	140.2	mmol/L	135.0-145.0	Ion-Selective Electrodes (ISE)
Potassium (K+)-Serum	4.21	mmol/L	3.5 to 5.5	Ion-Selective Electrodes (ISE)
Chloride(Cl-)-Serum	99.60	mmol/L	96.0-108.0	Ion-Selective Electrodes (ISE)

Comments: Renal Function Test (RFT), also called kidney function tests, are a group of tests performed to evaluate the functions of the kidneys. The kidneys play a vital role in removing waste, toxins, and extra water from the body. They are responsible for maintaining a healthy balance of water, salts, and minerals such as calcium, sodium, potassium, and phosphorus. They are also essential for blood pressure control, maintenance of the body's pH balance, making red blood cell production hormones, and promoting bone health. Hence, keeping your kidneys healthy is essential for maintaining overall health. It helps diagnose inflammation, infection or damage in the kidneys. The test measures Uric Acid, Creatinine, BUN and electrolytes in the blood to determine the health of the kidneys. Risk factors for kidney dysfunction such as hypertension, diabetes, cardiovascular disease, obesity, elevated cholesterol or a family history of kidney disease. It may also be when has signs and symptoms of kidney disease, though in early stage often no noticeable symptoms are observed. Kidney panel is useful for general health screening; screening patients at risk of developing kidney disease; management of patients with known kidney disease. Estimated GFR is especially important in CKD patients CKD for monitoring, it helps to identify disease at early stage in those with risk factors for CKD (diabetes, hypertension, cardiovascular disease, and family history of kidney disease). Early recognition and intervention are important in slowing the progression of CKD and preventing its complications.

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Test Name	Result	Unit	Reference Value	Method
Thyroid function tests (TFT)-Serum				
Tri-Iodo Thyronine (T3)-Serum	1.08	ng/mL	Female: 0.60 - 1.81	Chemiluminescence Immunoassay (CLIA)
Thyroxine (T4)-Serum	9.30	µg/dL	Female: 5.50 - 12.10	Chemiluminescence Immunoassay (CLIA)
Thyroid Stimulating Hormone (TSH)-Serum	2.71	µIU/mL	Female: 0.35 - 5.50	Chemiluminescence Immunoassay (CLIA)

Comments: Triiodothyronine (T3) assay is a useful test for hyperthyroidism in patients with low TSH and normal T4 levels. It is also used for the diagnosis of T3 toxicosis. It is not a reliable marker for Hypothyroidism. This test is not recommended for general screening of the population without a clinical suspicion of hyperthyroidism.
Reference range: Cord: (37 Weeks): 0.5-1.41, Children:1-3 Days: 1.0-7.40,1-11 Months: 1.05-2.45,1-5 Years: 1.05-2.69,6-10 Years: 0.94-2.41,11-15 Years: 0.82-2.13,Adolescents (16-20 Years): 0.80-2.10
Reference range: Adults: 20-50 Years: 0.70-2.04, 50-90 Years: 0.40-1.81,
Reference range in Pregnancy: First Trimester : 0.81-1.90,Second Trimester : 1.0-2.60
Increased Levels: Pregnancy, Graves disease, T3 thyrotoxicosis, TSH dependent Hyperthyroidism, increased Thyroid-binding globulin (TBG).
Decreased Levels: Nonthyroidal illness, hypothyroidism , nutritional deficiency, systemic illness, decreased Thyroid-binding globulin (TBG).

Comments: Total T4 levels offer a good index of thyroid function when TBG is normal and non-thyroidal illness is not present. This assay is useful for monitoring treatment with synthetic hormones (synthetic T3 will cause low total T4).It also helps to monitor treatment of Hyperthyroidism with Thiouracil or other anti-thyroid drugs.
Reference Range: Males : 4.6-10.5,Females : 5.5-11.0,> 60 Years: 5.0-10.70,Cord :7.40-13.10,Children:1-3 Days :11.80-22.60,1-2 Weeks : 9.90-16.60,1-4 Months: 7.20-14.40,1-5 Years : 7.30-15.0,5-10 Years: 6.4-13.3
1-15 Years: 5.60-11.70,Newborn Screen:1-5 Days: >7.5,6 Days : >6.5
Increased Levels: Hyperthyroidism, increased TBG, familial dysalbuminemic hyperthyroxinemia,Increased transthyretin, estrogen therapy, pregnancy.
Decreased Levels: Primary hypothyroidism, pituitary TSH deficiency, hypothalamic TRH deficiency, non thyroidal illness, decreased TBG.

Comments:TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies. It is important to confirm any TSH abnormality in a fresh specimen drawn after ~ 3 weeks before assigning a diagnosis, as the cause of an isolated TSH abnormality.
Reference range in Pregnancy: I- trimester:0.1-2.5; II -trimester:0.2-3.0; III- trimester:0.3-3.0
Reference range in Newborns: 0-4 days: 1.0-39.0; 2-20 Weeks:1.7-9.1
Increased Levels: Primary hypothyroidism, Subclinical hypothyroidism, TSH dependent Hyperthyroidism and Thyroid hormone resistance.
Decreased Levels: Graves disease, Autonomous thyroid hormone secretion, TSH deficiency.

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Test Name	Result	Unit	Reference Value	Method
Urine Routine Examination-Urine				
Physical Examination				
Colour	Pale Yellow		Pale Yellow	Visual
Appearance	Clear		Clear	Visual
Reaction (pH)	5.50		5.0-7.5	Dipstick
Specific Gravity	1.020		1.000-1.030	Dipstick
Biochemical Examination				
Albumin	Negative		Negative	Dipstick/Precipitation
Glucose	Negative		Negative	Dipstick/Benedicts
Bilirubin	Negative		Negative	Dipstick/Fouchets
Ketone Bodies	Negative		Negative	Dipstick/Rotheras
Urobilinogen	Normal		Normal	Dipstick/Ehrlichs
Nitrite	Negative		Negative	Dipstick
Microscopic Examination				
Pus Cells	2-4	hpf	0.0-5.0	Microscopy
Epithelial Cells	4-6	hpf	0.0-10.0	Microscopy
RBCs	2-4	hpf	Absent	Microscopy
Casts	Absent		Absent	Microscopy
Crystals	Absent		Absent	Microscopy
Others	Absent		Absent	Microscopy

Comments: The kidneys help infiltration of the blood by eliminating waste out of the body through urine.They also regulate water in the body by conserving electrolytes, proteins, and other compounds. But due to some conditions and abnormalities in kidney function, the urine may encompass some abnormal constituents, which are not normally present.A complete urine examination helps in detecting such abnormal constituents in urine. Several disorders can be detected byidentifying and measuring the levels of such substances. Blood cells, bilirubin, bacteria, pus cells, epithelial cells may be present in urine due to kidney disease or infection. Routine urine examination helps to diagnose kidney diseases, urinary tract infections, diabetes and other metabolic disorders.

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Reg. No.	: 2303240040			Report Status	: Final
C/o	: Apollo Clinic				

Test Name	Result	Unit	Reference Value	Method
Post prandial Blood Glucose (PPBS)-Plasma	126	mg/dL	70-140	Hexo Kinase

Comments: Glucose, also called dextrose, one of a group of carbohydrates known as simple sugars (monosaccharides). Glucose has the molecular formula $C_6H_{12}O_6$. It is found in fruits and honey and is the major free sugar circulating in the blood of higher animals. It is the source of energy in cell function, and the regulation of its metabolism is of great importance (fermentation; gluconeogenesis). Molecules of starch, the major energy-reserve carbohydrate of plants, consist of thousands of linear glucose units. Another major compound composed of glucose is cellulose, which is also linear. Dextrose is the molecule D-glucose. Blood sugar, or glucose, is the main sugar found in the blood. It comes from the food you eat, and it is body's main source of energy. The blood carries glucose to all of the body's cells to use for energy. Diabetes is a disease in which your blood sugar levels are too high.Usage: Glucose determinations are useful in the detection and management of Diabetes mellitus.

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

Comments: Conditions which can lead to lower postprandial glucose levels as compared to fasting glucose are excessive insulin release, rapid gastric emptying & brisk glucose absorption.

Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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Test Name	Result	Unit	Reference Value	Method
Lipid Profile-Serum				
Cholesterol Total-Serum	175.00	mg/dL	Female: 0.0 - 200	Cholesterol Oxidase/Peroxidase
Triglycerides-Serum	179.00	mg/dL	Female: 0.0 - 150	Lipase/Glycerol Dehydrogenase
High-density lipoprotein (HDL) Cholesterol-Serum	41.00	mg/dL	Female: 40.0 - 60.0	Accelerator/Selective Detergent
Non-HDL cholesterol-Serum	134	mg/dL	Female: 0.0 - 130	Calculated
Low-density lipoprotein (LDL) Cholesterol-Serum	98	mg/dL	Female: 0.0 - 100.0	Cholesterol esterase and cholesterol oxidase
Very-low-density lipoprotein (VLDL) cholesterol-Serum	36	mg/dL	Female: 0.0 - 40	Calculated
Cholesterol/HDL Ratio-Serum	4.27	Ratio	Female: 0.0 - 5.0	Calculated

Interpretation:

Parameter	Desirable	Borderline High	High	Very High
Total Cholesterol	<200	200-239	>240	
Triglycerides	<150	150-199	200-499	>500
Non-HDL cholesterol	<130	160-189	190-219	>220
Low-density lipoprotein (LDL) Cholesterol	<100	100-129	160-189	>190

Comments: As per Lipid Association of India (LAI), for routine screening, overnight fasting preferred but not mandatory. Indians are at very high risk of developing Atherosclerotic Cardiovascular (ASCVD). Among the various risk factors for ASCVD such as dyslipidemia, Diabetes Mellitus, sedentary lifestyle, Hypertension, smoking etc., dyslipidemia has the highest population attributable risk for MI both because of direct association with disease pathogenesis and very high prevalence in Indian population. Hence monitoring lipid profile regularly for effective management of dyslipidemia remains one of the most important healthcare targets for prevention of ASCVD. In addition, estimation of ASCVD risk is an essential, initial step in the management of individuals requiring primary prevention of ASCVD. In the context of lipid management, such a risk estimate forms the basis for several key therapeutic decisions, such as the need for and aggressiveness of statin therapy.

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Test Name	Result	Unit	Reference Value	Method
Postprandial Urine glucose-Urine	Negative		Negative	Dipstick/Benedicts (Manual)

Note: Additional tests available for Diabetic control are Glycated Hemoglobin (HbA1c), Fructosamine & Microalbumin urine

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Probable causes : Early Type II Diabetes / Glucose intolerance, Drugs like Salicylates, Beta blockers, Pentamidine etc.,Alcohol ,Dietary – Intake of excessive carbohydrates and foods with high glycemic index ? Exercise in between samples ? Family history of Diabetes, Idiopathic, Partial / Total Gastrectomy.

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