

Visit ID	: YOD677533	UHID/MR No	: YOD.0000653443
Patient Name	: Mr. KRISHNA KANTH D	Client Code	: YOD-DL-0021
Age/Gender	: 33 Y 0 M 0 D /M	Barcode No	: 11007896
DOB	:	Registration	: 08/Apr/2024 08:28AM
Ref Doctor	: SELF	Collected	: 08/Apr/2024 08:39AM
Client Name	: MEDI WHEELS	Received	: 08/Apr/2024 09:25AM
Client Add	: F-701, Lado Sarai, Mehravli, N	Reported	: 08/Apr/2024 10:24AM
Hospital Name	:		

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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ESR (ERYTHROCYTE SEDIMENTATION RATE)

Sample Type : WHOLE BLOOD EDTA

ERYTHROCYTE SEDIMENTATION RATE	8	mm/1st hr	0 - 15	Capillary Photometry
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COMMENTS:

ESR is an acute phase reactant which indicates presence and intensity of an inflammatory process. It is never diagnostic of a specific disease. It is used to monitor the course or response to treatment of certain diseases. Extremely high levels are found in cases of malignancy, hematologic diseases, collagen disorders and renal diseases.

Increased levels may indicate: Chronic renal failure (e.g., nephritis, nephrosis), malignant diseases (e.g., multiple myeloma, Hodgkin disease, advanced Carcinomas), bacterial infections (e.g., abdominal infections, acute pelvic inflammatory disease, syphilis, pneumonia), inflammatory diseases (e.g. temporal arteritis, polymyalgia rheumatic, rheumatoid arthritis, rheumatic fever, systemic lupus erythematosus [SLE]), necrotic diseases (e.g., acute myocardial infarction, necrotic tumor, gangrene of an extremity), diseases associated with increased proteins (e.g., hyperfibrinogenemia, macroglobulinemia), and severe anemias (e.g., iron deficiency or B12 deficiency).

Falsely decreased levels may indicate: Sickle cell anemia, spherocytosis, hypofibrinogenemia, or polycythemia vera.

Verified By :

Mamatha



Approved By :



**DR PRANITHA ANAPINDI
MD , CONSULTANT PATHOLOGIST**

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DEPARTMENT OF HAEMATOLOGY

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BLOOD GROUP ABO & RH Typing

Sample Type : WHOLE BLOOD EDTA

ABO	O			
Rh Typing	POSITIVE			

Method : Hemagglutination Tube method by forward and reverse grouping

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups.

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings. Advsiel cross matching before transfusion

Verified By :

Mamatha



Approved By :

A. Pranitha

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CBC(COMPLETE BLOOD COUNT)

Sample Type : WHOLE BLOOD EDTA

HAEMOGLOBIN (HB)	15.9	g/dl	13.0 - 17.0	Cyanide-free SLS method
RBC COUNT(RED BLOOD CELL COUNT)	5.96	million/cmm	4.50 - 5.50	Impedance
PCV/HAEMATOCRIT	50.6	%	40.0 - 50.0	RBC pulse height detection
MCV	84.9	fL	83 - 101	Automated/Calculated
MCH	26.7	pg	27 - 32	Automated/Calculated
MCHC	31.5	g/dl	31.5 - 34.5	Automated/Calculated
RDW - CV	15.3	%	11.0-16.0	Automated Calculated
RDW - SD	46	fl	35.0-56.0	Calculated
MPV	9.0	fL	6.5 - 10.0	Calculated
PDW	16	fL	8.30-25.00	Calculated
PCT	0.331	%	0.15-0.62	Calculated
TOTAL LEUCOCYTE COUNT	6,400	cells/ml	4000 - 11000	Flow Cytometry

DLC (by Flow cytometry/Microscopy)

NEUTROPHIL	49.8	%	40 - 80	Impedance
LYMPHOCYTE	42.4	%	20 - 40	Impedance
EOSINOPHIL	1.8	%	01 - 06	Impedance
MONOCYTE	5.3	%	02 - 10	Impedance
BASOPHIL	0.7	%	0 - 1	Impedance
PLATELET COUNT	3.65	Lakhs/cumm	1.50 - 4.10	Impedance

Verified By :

Mamatha



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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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THYROID PROFILE (T3,T4,TSH)

Sample Type : SERUM

T3	1.31	ng/ml	0.60 - 1.78	CLIA
T4	10.99	ug/dl	4.82-15.65	CLIA
TSH	3.53	uIU/mL	0.30 - 5.60	CLIA

INTERPRETATION:

- Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
- Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
- Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
- Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propranolol and propylthiouracil.
- Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
- Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.
- Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance.
- TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.

9. REFERENCE RANGE :

PREGNANCY	TSH in uIU/mL
1st Trimester	0.60 - 3.40
2nd Trimester	0.37 - 3.60
3rd Trimester	0.38 - 4.04

(References range recommended by the American Thyroid Association)

Comments:

- During pregnancy, Free thyroid profile (FT3, FT4 & TSH) is recommended.
- TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations.

Verified By :

J. Krishna Kishore



Approved By :

Suryadeep Pratap
SURYADEEP PRATAP
 Senior Biochemist

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LIVER FUNCTION TEST(LFT)

Sample Type : SERUM

TOTAL BILIRUBIN	0.71	mg/dl	0.3 - 1.2	JENDRASSIK & GROFF
CONJUGATED BILIRUBIN	0.13	mg/dl	0 - 0.2	DPD
UNCONJUGATED BILIRUBIN	0.58	mg/dl		Calculated
AST (S.G.O.T)	26	U/L	< 50	KINETIC WITHOUT P5P-IFCC
ALT (S.G.P.T)	45	U/L	< 50	KINETIC WITHOUT P5P-IFCC
ALKALINE PHOSPHATASE	156	U/L	30 - 120	IFCC-AMP BUFFER
TOTAL PROTEINS	7.1	gm/dl	6.6 - 8.3	Biuret
ALBUMIN	4.7	gm/dl	3.5 - 5.2	BCG
GLOBULIN	2.4	gm/dl	2.0 - 3.5	Calculated
A/G RATIO	1.96			Calculated

Verified By :
J. Krishna Kishore



Approved By :

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Senior Biochemist

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Biological Ref. Range	Method
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LIPID PROFILE

Sample Type : SERUM

TOTAL CHOLESTEROL	203	mg/dl	Refere Table Below	Cholesterol oxidase/peroxidase
H D L CHOLESTEROL	51	mg/dl	> 40	Enzymatic/ Immunoinhibiton
L D L CHOLESTEROL	111	mg/dl	Refere Table Below	Enzymatic Selective Protein
TRIGLYCERIDES	203	mg/dl	Optimal < 150 Borderline High 150 - 199 High 200 - 499 Very High >= 500	GPO
VLDL	40.6	mg/dl	< 35	Calculated
T. CHOLESTEROL/ HDL RATIO	3.98		Refere Table Below	Calculated
TRIGLYCEIDES/ HDL RATIO	3.98	Ratio	< 2.0	Calculated
NON HDL CHOLESTEROL	152	mg/dl	< 130	Calculated

Interpretation

NATIONAL CHOLESTEROL EDUCATION PROGRAMME (NCEP)	TOTAL CHOLESTEROL	TRIGLYCERIDE	LDL CHOLESTEROL	NON HDL CHOLESTEROL
Optimal	<200	<150	<100	<130
Above Optimal	-	-	100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

REMARKS	Cholesterol : HDL Ratio
Low risk	3.3-4.4
Average risk	4.5-7.1
Moderate risk	7.2-11.0
High risk	>11.0

- Note:**
- Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol
 - NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL.
 - Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved
 - Additional testing for Apolipoprotein B, hsCRP, Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement

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HBA1C

Sample Type : WHOLE BLOOD EDTA

HBA1c RESULT	7.0	%	Normal Glucose tolerance (non-diabetic): <5.7% Pre-diabetic: 5.7-6.4% Diabetic Mellitus: >6.5%	HPLC
ESTIMATED AVG. GLUCOSE	154	mg/dl		

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.
 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 .

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DEPARTMENT OF BIOCHEMISTRY

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BLOOD UREA NITROGEN (BUN)

Sample Type : Serum

SERUM UREA	38	mg/dL	13 - 43	Urease GLDH
Blood Urea Nitrogen (BUN)	17.8	mg/dl	5 - 25	GLDH-UV

Increased In:

Impaired kidney function, Reduced renal blood flow {CHF, Salt and water depletion, (vomiting, diarrhea, diuresis, sweating), Shock}, Any obstruction of urinary tract, Increased protein catabolism, AMI, Stress

Decreased In:

Diuresis (e.g. with over hydration), Severe liver damage, Late pregnancy, Infancy, Malnutrition, Diet (e.g., low-protein and high-carbohydrate, IV feedings only), Inherited hyperammonemias (urea is virtually absent in blood)

Limitations:

Urea levels increase with age and protein content of the diet.

Verified By :

J. Krishna Kishore



Approved By :

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FBS (GLUCOSE FASTING)

Sample Type : FLOURIDE PLASMA

FASTING PLASMA GLUCOSE	157	mg/dl	70 - 100	HEXOKINASE
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INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

Verified By :

J. Krishna Kishore



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DEPARTMENT OF BIOCHEMISTRY

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PPBS (POST PRANDIAL GLUCOSE)

Sample Type : FLOURIDE PLASMA

POST PRANDIAL PLASMA GLUCOSE	205	mg/dl	<140	HEXOKINASE
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INTERPRETATION:

Increased In

- Diabetes Mellitus
- Stress (e.g., emotion, burns, shock, anesthesia)
- Acute pancreatitis
- Chronic pancreatitis
- Wernicke encephalopathy (vitamin B1 deficiency)
- Effect of drugs (e.g. corticosteroids, estrogens, alcohol, phenytoin, thiazides)

Decreased In

- Pancreatic disorders
- Extrapancreatic tumors
- Endocrine disorders
- Malnutrition
- Hypothalamic lesions
- Alcoholism
- Endocrine disorders

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SERUM CREATININE

Sample Type : SERUM

SERUM CREATININE	0.73	mg/dl	0.70 - 1.30	KINETIC-JAFFE
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Increased In:

- Diet: ingestion of creatinine (roast meat), Muscle disease: gigantism, acromegaly,
- Impaired kidney function.

Decreased In:

- Pregnancy: Normal value is 0.4-0.6 mg/dL. A value >0.8 mg/dL is abnormal and should alert the clinician to further diagnostic evaluation.
- Creatinine secretion is inhibited by certain drugs (e.g., cimetidine, trimethoprim).

Verified By :
J. Krishna Kishore



Approved By :

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URIC ACID -SERUM

Sample Type : SERUM

SERUM URIC ACID	6.5	mg/dl	3.5 - 7.20	URICASE - PAP
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Interpretation

Uric acid is the final product of purine metabolism in the human organism. Uric acid measurements are used in the diagnosis and treatment of numerous renal and metabolic disorders, including renal failure, gout, leukemia, psoriasis, starvation or other wasting conditions, and of patients receiving cytotoxic drugs.

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J. Krishna Kishore



Approved By :

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BUN/CREATININE RATIO

Sample Type : SERUM				
Blood Urea Nitrogen (BUN)	17.8	mg/dl	5 - 25	GLDH-UV
SERUM CREATININE	0.73	mg/dl	0.70 - 1.30	KINETIC-JAFFE
BUN/CREATININE RATIO	24.30	Ratio	6 - 25	Calculated

Verified By :
J. Krishna Kishore



Approved By :


SURYADEEP PRATAP
 Senior Biochemist

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DEPARTMENT OF RADIOLOGY**2D ECHO DOPPLER STUDY**

MITRAL VALVE : Normal
AORTIC VALVE : Normal
TRICUSPID VALVE : Normal
PULMONARY VALVE : Normal
RIGHT ATRIUM : Normal
RIGHT VENTRICLE : Normal
LEFT ATRIUM : 3.4 cms
LEFT VENTRICLE :
EDD : 4.0 cm IVS(d) : 1.1 cm LVEF : 68 %
ESD : 2.4 cm PW (d) : 1.1 cm FS : 34 %
No RWMA
IAS : Intact
IVS : Intact
AORTA : 2.6 cms
PULMONARY ARTERY : Normal
PERICARDIUM : Normal
IVS/ SVC/ CS : Normal
PULMONARY VEINS : Normal
INTRA CARDIAC MASSES : No

Verified By :
D.Madhav Kumar



Approved By :


Dr. D. Madhav Kumar
PGDDRM (U.K.)
MBBS, PGDCC (Dip. Cardiology)
Cardiologist

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DEPARTMENT OF RADIOLOGY

DOPPLER STUDY :

MITRAL FLOW : E: 1.0 m/sec, A:0.6 m/sec.
AORTIC FLOW : 1.1 m/sec
PULMONARY FLOW : 0.8 m/sec
TRICUSPID FLOW : TRJV :1.8 m/sec, RVSP :21 mmHg

COLOUR FLOW MAPPING: TRIVIAL TR

IMPRESSION :

- * NORMAL SIZED CARDIAC CHAMBERS
- * NO RWMA OF LV
- * NORMAL LV SYSTOLIC FUNCTION
- * NORMAL LV FILLING PATTERN
- * TRIVIAL TR (RVSP:21mmHg)
- * NO PE / CLOT / PAH

Verified By :
D.Madhav Kumar



Approved By :


Dr. D. Madhav Kumar
PGDDRM (U.K.)
MBBS, PGDCC (Dip. Cardiology)
Cardiologist

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Patient Name	: Mr. KRISHNA KANTH D	Client Code	: YOD-DL-0021
Age/Gender	: 33 Y 0 M 0 D /M	Barcode No	: 11007896
DOB	:	Registration	: 08/Apr/2024 08:28AM
Ref Doctor	: SELF	Collected	: 08/Apr/2024 08:39AM
Client Name	: MEDI WHEELS	Received	: 08/Apr/2024 09:27AM
Client Add	: F-701, Lado Sarai, Mehravli, N	Reported	: 08/Apr/2024 11:32AM
Hospital Name	:		

DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Biological Ref. Range	Method
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CUE (COMPLETE URINE EXAMINATION)

Sample Type : SPOT URINE

PHYSICAL EXAMINATION

TOTAL VOLUME	20 ml	ml		
COLOUR	Yellow			
APPEARANCE	Clear			
SPECIFIC GRAVITY	1.027		1.003 - 1.035	Bromothymol Blue

CHEMICAL EXAMINATION

pH	5.5		4.6 - 8.0	Double Indicator
PROTEIN	Negative		NEGATIVE	Protein - error of Indicators
GLUCOSE(U)	Negative		NEGATIVE	Glucose Oxidase
UROBILINOGEN	0.1	mg/dl	< 1.0	Ehrlichs Reaction
KETONE BODIES	Negative		NEGATIVE	Nitroprasside
BILIRUBIN - TOTAL	Negative		Negative	Azocoupling Reaction
BLOOD	Negative		NEGATIVE	Tetramethylbenzidine
LEUCOCYTE	Negative		Negative	Azocoupling reaction
NITRITE	Negative		NEGATIVE	Diazotization Reaction

MICROSCOPIC EXAMINATION

PUS CELLS	2-3	cells/HPF	0-5	
EPITHELIAL CELLS	1-2	/hpf	0 - 5	
RBCs	Nil	Cells/HPF	Nil	
CRYSTALS	Nil	Nil	Nil	
CASTS	Nil	/HPF	Nil	
BUDDING YEAST	Nil		Nil	
BACTERIA	Nil		Nil	
OTHER	Nil			

***** End Of Report *****

Verified By :
M.ANIL KUMAR



Approved By :

A. Pranitha

DR PRANITHA ANAPINDI
MD , CONSULTANT PATHOLOGIST