

Patient Name : Mr. Karanam Rama Manohar
Age / Gender : 29 Y / Male
Referred By : Dr. Gail Chaudhari
SID No. : 40013453

Reg.Date / Time : 29/03/2024 / 11:50:35
Report Date / Time : 29/03/2024 / 19:00:05
MR No. : 0849446

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Partial Test Report

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

HAEMOGLOBIN, RED CELL COUNT & INDICES

HAEMOGLOBIN (Spectrophotometry)	14.3	gm%	13-17
PCV (Electrical Impedance)	42.9	%	40 - 50
MCV (Calculated)	87.3	fL	83-101
MCH (Calculated)	29.2	pg	27.0 - 32.0
MCHC (Calculated)	33.4	g/dl	31.5-34.5
RDW-CV (Calculated)	14	%	11.6-14.0
RDW-SD (Calculated)	50	fL	36 - 46
TOTAL RBC COUNT (Electrical Impedance)	4.91	Million/cmm	4.5-5.5
TOTAL WBC COUNT (Electrical Impedance)	7660	/cumm	4000-10000

DIFFERENTIAL WBC COUNT

NEUTROPHILS (Flow cell)	50.5	%	40-80
LYMPHOCYTES (Flow cell)	35.1	%	20-40
EOSINOPHILS (Flow cell)	5.0	%	1-6
MONOCYTES (Flow cell)	8.0	%	2-10
BASOPHILS (Flow cell)	1.4	%	1-2

ABSOLUTE WBC COUNT

ABSOLUTE NEUTROPHIL COUNT (Calculated)	3860	/cumm	2000-7000
ABSOLUTE LYMPHOCYTE COUNT (Calculated)	2690	/cumm	1000-3000

Contd ...

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HAEMATOLOGY

ABSOLUTE WBC COUNT

ABSOLUTE EOSINOPHIL COUNT (Calculated)	380	/cumm	200-500
ABSOLUTE MONOCYTE COUNT (Calculated)	610	/cumm	200-1000
ABSOLUTE BASOPHIL COUNT (Calculated)	110	/cumm	0-220
PLATELET COUNT (Electrical Impedance)	342000	/cumm	150000-410000
MPV (Calculated)	8.7	fL	6.78-13.46
PDW (Calculated)	12.2	%	11-18
PCT (Calculated)	0.300	%	0.15-0.50

PERIPHERAL BLOOD SMEAR

COMMENTS (Microscopic) Normocytic Normochromic RBCs

Sample Collected at : Andheri West
Sample Collected on : 29 Mar 2024 12:45
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Dr.Rahul Jain

MD,PATHOLOGY

Consultant Pathologist

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HAEMATOLOGY

EDTA Blood **ABO BLOOD GROUP**

BLOOD GROUP (Erythrocyte-Magnetized Technology)	O
Rh TYPE (Erythrocyte-Magnetized Technology)	POSITIVE

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CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	16	mm / 1 hr	0-15
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Notes : The given result is measured at the end of first hour.

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BIOCHEMISTRY

**COMPREHENSIVE LIVER PROFILE
SERUM**

BILIRUBIN TOTAL (Diazotization)	0.59	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.11	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	0.48	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	36	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	50	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	78	U/L	40-129
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	24	U/L	<70
TOTAL PROTEIN (Colorimetric)	7.70	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.70	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	3.00	gm/dl	2.0-3.5
A/G RATIO (Calculation)	1.6		1-2

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BIOCHEMISTRY

**COMPREHENSIVE RENAL PROFILE
SERUM**

CREATININE (Jaffe Method)	0.9	mg/dl	0.6 - 1.3
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	6.0	mg/dl	6 - 20
BUN/CREATININE RATIO (Calculation)	6.7		10 - 20
URIC ACID (Uricase Enzyme)	6.4	mg/dl	3.7 - 7.7
CALCIUM (Bapta Method)	9.6	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	3.2	mg/dl	2.5-4.5

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BIOCHEMISTRY

LIPID PROFILE

SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	163	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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Notes : Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	122	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	42	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	97	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	24	mg/dl	15-40
SERUM	CHOL / HDL RATIO	3.9		3-5
SERUM	LDL /HDL RATIO (Calculation)	2.3		0 - 3.5

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BIOCHEMISTRY

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	94	mg/dl	70 - 110
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Notes : An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	89	mg/dl	70 - 140
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BIOCHEMISTRY

EDTA WHOLE BLOOD **GLYCOSYLATED HAEMOGLOBIN (HbA1C)**

HbA1C (High Performance Liquid Chromatography)	5.6	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	114	mg/dl	

Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations. HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required. HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria. References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

Urine	URINE GLUCOSE FASTING (Urodip)	ABSENT	
Urine	URINE GLUCOSE POST PRANDIAL (Urodip)	ABSENT	

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Healthspring Corporate Office, 5th Floor, East Wing Forbes Building, Charanjit Rai Marg, Fort, Mumbai- 400001

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IMMUNOLOGY

THYROID PROFILE - TOTAL SERUM

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.55	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	10.07	ug/dl	4.6 - 10.5
THYROID STIMULATING HORMONE (TSH) (ECLIA)	2.489	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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CLINICAL PATHOLOGY

Urine URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		
APPEARANCE (Visual Examination)	CLEAR		

CHEMICAL EXAMINATION

SP.GRAVITY (Indicator System)	1.005		1.005 - 1.030
REACTION(pH) (Double indicator)	ACIDIC		
PROTEIN (Protein-error-of-Indicators)	ABSENT		
GLUCOSE (GOD-POD)	ABSENT		Absent
KETONES (Legal's Test)	ABSENT		Absent
OCCULT BLOOD (Peroxidase activity)	ABSENT		Absent
BILIRUBIN (Fouchets Test)	ABSENT		Absent
UROBILINOGEN (Ehrlich Reaction)	NORMAL		
NITRITE (Griess Test)	ABSENT		

MICROSCOPIC EXAMINATION

ERYTHROCYTES (Microscopy)	ABSENT	/hpf	0-2
PUS CELLS (Microscopy)	2-4	/hpf	0-5
EPITHELIAL CELLS (Microscopy)	1-2	/hpf	0-5
CASTS (Microscopy)	ABSENT		
CRYSTALS (Microscopy)	ABSENT		
ANY OTHER FINDINGS	NIL		

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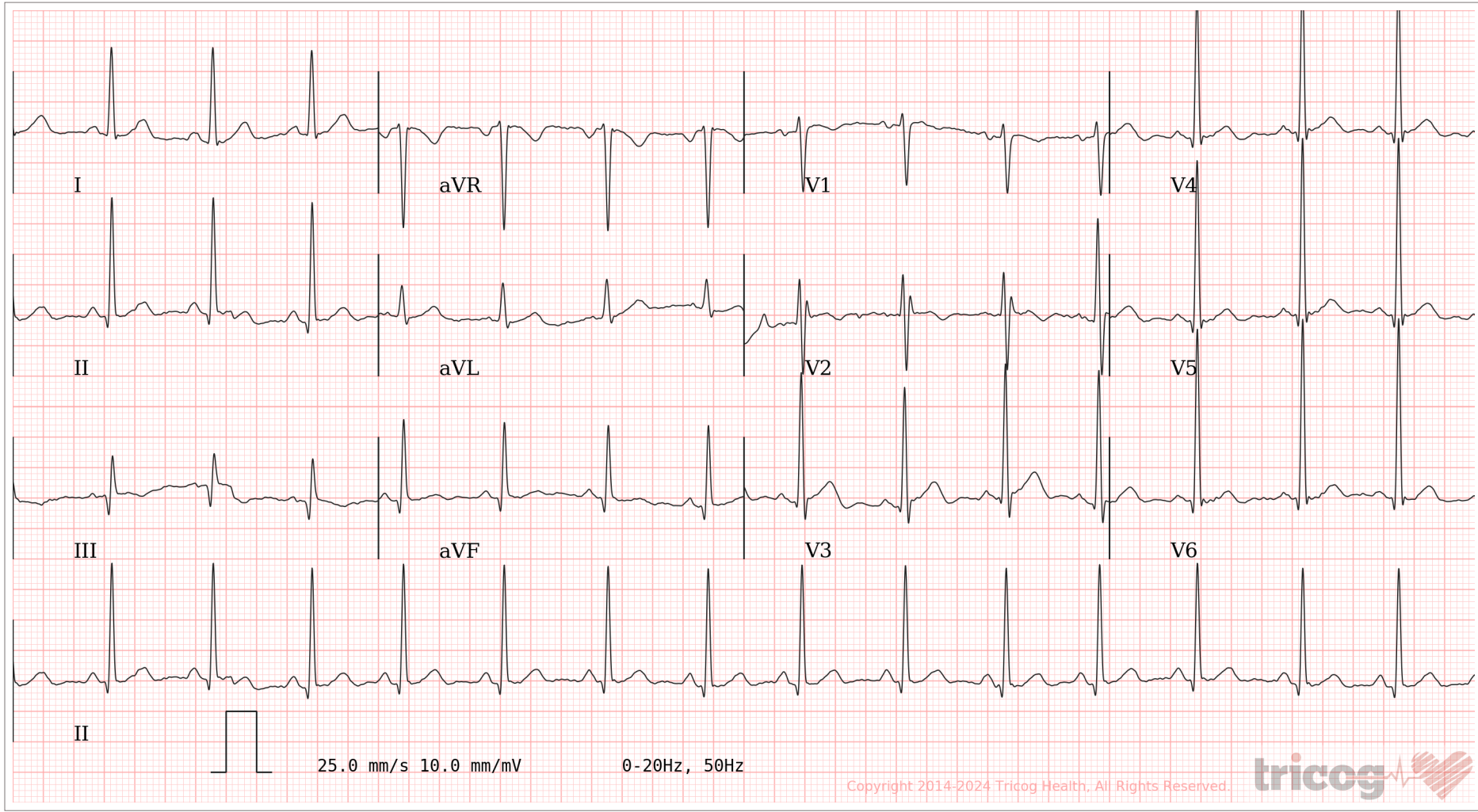
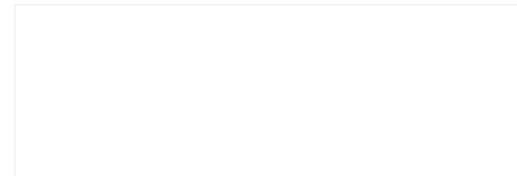
MD,PATHOLOGY

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 Patient ID: 0849446
 Patient Name: Karanam Rama Manohar

Date and Time: 29th Mar 24 10:58 AM



AR: 92bpm VR: 93bpm QRSD: 86ms QT: 332ms QTcB: 413ms PRI: 138ms P-R-T: 48° 41° 5°

Sinus Rhythm. q in lead III. rsr' Pattern in V2. LVH criteria noted but age less than 35, Please evaluate further. Please correlate clinically.

AUTHORIZED BY



Dr. Charit
MD, DM: Cardiology

REPORTED BY



Dr Surekha B

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PCT (Calculated)	0.300	%	0.15-0.50

PERIPHERAL BLOOD SMEAR

COMMENTS
(Microscopic)

Normocytic Normochromic RBCs

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EDTA Blood **ABO BLOOD GROUP**

BLOOD GROUP (Erythrocyte-Magnetized Technology)	O
Rh TYPE (Erythrocyte-Magnetized Technology)	POSITIVE

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*Tests not included in NABL accredited scope



Patient Name : Mr. Karanam Rama Manohar
Age / Gender : 29 Y / Male
Referred By : Dr. Gail Chaudhari
SID No. : 40013453

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HAEMATOLOGY

CBC-Haemogram & ESR, blood

EDTA WHOLE BLOOD

ESR(ERYTHROCYTE SEDIMENTATION RATE) (Photometric Capillary)	16	mm / 1 hr	0-15
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Notes : The given result is measured at the end of first hour.

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BIOCHEMISTRY

**COMPREHENSIVE LIVER PROFILE
SERUM**

BILIRUBIN TOTAL (Diazotization)	0.59	mg/dl	0.2 - 1.3
BILIRUBIN DIRECT (Diazotization)	0.11	mg/dl	0.1-0.4
BILIRUBIN INDIRECT (Calculation)	0.48	mg/dl	0.2 - 0.7
ASPARTATE AMINOTRANSFERASE(SGOT) (IFCC)	36	U/L	<40
ALANINE TRANSAMINASE (SGPT) (IFCC without Peroxidase)	50	U/L	<41
ALKALINE PHOSPHATASE (Colorimetric IFCC)	78	U/L	40-129
GAMMA GLUTAMYL TRANSFERASE (GGT) (IFCC)	24	U/L	<70
TOTAL PROTEIN (Colorimetric)	7.70	gm/dl	6.6-8.7
ALBUMIN (Bromocresol Green)	4.70	gm/dl	3.5 - 5.2
GLOBULIN (Calculation)	3.00	gm/dl	2.0-3.5
A/G RATIO (Calculation)	1.6		1-2

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BIOCHEMISTRY

**COMPREHENSIVE RENAL PROFILE
SERUM**

CREATININE (Jaffe Method)	0.9	mg/dl	0.6 - 1.3
BLOOD UREA NITROGEN (BUN) (Kinetic with Urease)	6.0	mg/dl	6 - 20
BUN/CREATININE RATIO (Calculation)	6.7		10 - 20
URIC ACID (Uricase Enzyme)	6.4	mg/dl	3.7 - 7.7
CALCIUM (Bapta Method)	9.6	mg/dl	8.6-10
PHOSPHORUS (Phosphomolybdate)	3.2	mg/dl	2.5-4.5

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BIOCHEMISTRY

LIPID PROFILE

SERUM	TOTAL CHOLESTEROL (Enzymatic colorimetric (PHOD))	163	mg/dl	Desirable : < 200 Borderline: 200-239 High : > 239
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Notes : Elevated concentrations of free fatty acids and denatured proteins may cause falsely elevated HDL cholesterol results.

Abnormal liver function affects lipid metabolism; consequently, HDL and LDL results are of limited diagnostic value. In some patients with abnormal liver function, the HDL cholesterol result may significantly differ from the DCM (designated comparison method) result due to the presence of lipoproteins with abnormal lipid distribution.

Reference: Dati F, Metzmann E. Proteins Laboratory Testing and Clinical Use, Verlag: DiaSys; 1. Auflage (September 2005), page 242-243; ISBN-10: 3000171665.

SERUM	TRIGLYCERIDES (Enzymatic Colorimetric GPO)	122	mg/dl	Normal : <150 Borderline : 150-199 High : 200-499 Very High : >499
SERUM	CHOLESTEROL HDL - DIRECT (Homogenize Enzymatic Colorimetry)	42	mg/dl	Low:<40 High:>60
SERUM	LDL CHOLESTEROL (Calculation)	97	mg/dl	Optimal : <100 Near Optimal/ Above optimal :100-129 Borderline High: 130-159 High : 160-189 Very High : >= 190
SERUM	VLDL (Calculation)	24	mg/dl	15-40
SERUM	CHOL / HDL RATIO	3.9		3-5
SERUM	LDL /HDL RATIO (Calculation)	2.3		0 - 3.5

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BIOCHEMISTRY

FLOURIDE PLASMA	BLOOD GLUCOSE FASTING (Hexokinase)	94	mg/dl	70 - 110
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Notes : An early-morning increase in blood sugar (glucose) which occurs to some extent in all individuals, more relevant to people with diabetes can be seen (The dawn phenomenon) . Chronic Somogyi rebound is another explanation of phenomena of elevated blood sugars in the morning. Also called the Somogyi effect and posthypoglycemic hyperglycemia, it is a rebounding high blood sugar that is a response to low blood sugar.

References:

<http://www.ucdenver.edu/academics/colleges/medicalschool/centers/BarbaraDavis/Documents/book-understandingdiabetes/ud06.pdf>, Understanding Diabetes.

FLOURIDE PLASMA	BLOOD GLUCOSE POST PRANDIAL (Hexokinase)	89	mg/dl	70 - 140
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BIOCHEMISTRY

EDTA WHOLE BLOOD **GLYCOSYLATED HAEMOGLOBIN (HbA1C)**

HbA1C (High Performance Liquid Chromatography)	5.6	%(NGSP)	Non Diabetic Range: <= 5.6 Prediabetes :5.7-6.4 Diabetes: >= 6.5
ESTIMATED AVERAGE BLOOD GLUCOSE (Calculated)	114	mg/dl	


Notes : HbA1c reflects average plasma glucose over the previous eight to 12 weeks (1). The use of HbA1c can avoid the problem of day-to-day variability of glucose values, and importantly it avoids the need for the person to fast and to have preceding dietary preparations.

HbA1c can be used to diagnose diabetes and that the diagnosis can be made if the HbA1c level is =6.5% (2). Diagnosis should be confirmed with a repeat HbA1c test, unless clinical symptoms and plasma glucose levels >11.1mmol/l (200 mg/dl) are present in which case further testing is not required.

HbA1c may be affected by a variety of genetic, hematologic and illness-related factors (Annex 1, https://www.who.int/diabetes/publications/report-hba1c_2011.pdf) (3). The most common important factors worldwide affecting HbA1c levels are haemoglobinopathies (depending on the assay employed), certain anaemias, and disorders associated with accelerated red cell turnover such as malaria.

References: (1). Nathan DM, Turgeon H, Regan S. Relationship between glycated haemoglobin levels and mean glucose levels over time. Diabetologia, 2007, 50:2239-2244. (2). International Expert Committee report on the role of the A1C assay in the diagnosis of diabetes. Diabetes Care, 2009, 32:1327-1334. (3). Gallagher EJ, Bloomgarden ZT, Le Roith D. Review of hemoglobin A1c in the management of diabetes. Journal of Diabetes, 2009, 1:9-17.

Urine	URINE GLUCOSE FASTING (Urodip)	ABSENT	
Urine	URINE GLUCOSE POST PRANDIAL (Urodip)	ABSENT	

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IMMUNOLOGY

THYROID PROFILE - TOTAL SERUM

TOTAL TRIIODOTHYRONINE (T3) (ECLIA)	1.55	ng/ml	0.7-2.04
TOTAL THYROXINE (T4) (ECLIA)	10.07	ug/dl	4.6 - 10.5
THYROID STIMULATING HORMONE (TSH) (ECLIA)	2.489	uIU/ml	0.27 - 4.20

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IMMUNOLOGY

Notes : TSH is formed in specific cells of the anterior pituitary gland and is subject to a circadian Variation. The Release of TSH is the central regulating mechanism for the biological action of thyroid hormones. TSH has a stimulating action in all stages of thyroid hormone (T3/T4) formation and secretion and it also has a growth effect on Thyroid gland. Even very slight changes in the concentrations of the free thyroid hormones (FT3/FT4) bring about much greater opposite changes in the TSH level. The determination of TSH serves as the initial test in thyroid diagnostics. (1)

Patterns of Thyroid Function Tests (2)

- Low TSH, Low FT4 - Central hypothyroidism.
- Low TSH, Normal FT4, Normal FT3- Subclinical hyperthyroidism.
- Low TSH, High FT4- Hashimoto's thyroiditis, Grave's disease, Molar pregnancy, Choriocarcinoma, Hyperemesis, Thyrotoxicosis, Lithium, Multinodular goiter, Toxic adenoma, Thyroid carcinoma, Iodine ingestion.
- Normal TSH, Low FT4- Hypothyroxinemia, Nonthyroidal illness, Possible secondary hypothyroidism, Medications.
- Normal TSH, High FT4- Euthyroid hyperthyroxinemia, Thyroid hormone resistance, Familial dysalbuminemic hyperthyroxinemia, Medications (Amiodarone, beta-blockers, Oral contrast), Hyperemesis, Acute psychiatric illness, Rheumatoid factor.
- High TSH, Low FT4- Primary hypothyroidism.
- High TSH, Normal FT4- Subclinical hypothyroidism, Nonthyroidal illness, Suggestive of follow-up and recheck.
- High TSH, High FT4- TSH mediated hyperthyroidism

Note:

1. Isolated Low TSH -especially in the range of 0.1 to 0.4 often seen in elderly & associated with Non-Thyroidal illness
2. Isolated High TSH especially in the range of 4.7 to 15 uIU/ml is commonly associated with Physiological & Biological TSH Variability.
3. Normal changes in thyroid function tests during pregnancy include a transient suppression of thyroid-stimulating hormone. T4 and total T3 steadily increase during pregnancy to approximately 1.5 times the non-pregnant level. Free T4 and Free T3 gradually decrease during pregnancy

References:

1. Pim-eservices.roche.com. (2018). Customer Self-Service Technical Documentation Portal.
2. "Interpretation of Thyroid Function Tests". 2018. Obfocus.Com.
3. Interpretation of thyroid function tests. Dayan et al. The Lancet, Vol 357, February 24, 2001.
4. Interpretation of thyroid function tests. Supit et al. South Med journal, 2002, 95, 481-485.

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CLINICAL PATHOLOGY

Urine URINE ANALYSIS

PHYSICAL EXAMINATION

VOLUME (Volumetric)	30		
COLOR (Visual Examination)	PALE YELLOW		
APPEARANCE (Visual Examination)	CLEAR		

CHEMICAL EXAMINATION

SP.GRAVITY (Indicator System)	1.005		1.005 - 1.030
REACTION(pH) (Double indicator)	ACIDIC		
PROTEIN (Protein-error-of-Indicators)	ABSENT		
GLUCOSE (GOD-POD)	ABSENT		Absent
KETONES (Legal's Test)	ABSENT		Absent
OCCULT BLOOD (Peroxidase activity)	ABSENT		Absent
BILIRUBIN (Fouchets Test)	ABSENT		Absent
UROBILINOGEN (Ehrlich Reaction)	NORMAL		
NITRITE (Griess Test)	ABSENT		

MICROSCOPIC EXAMINATION

ERYTHROCYTES (Microscopy)	ABSENT	/hpf	0-2
PUS CELLS (Microscopy)	2-4	/hpf	0-5
EPITHELIAL CELLS (Microscopy)	1-2	/hpf	0-5
CASTS (Microscopy)	ABSENT		
CRYSTALS (Microscopy)	ABSENT		
ANY OTHER FINDINGS	NIL		

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భారత ప్రభుత్వం

GOVERNMENT OF INDIA

కరణం రామ మనోహర్

Karanam Rama Manohar



పుట్టిన సంవత్సరం / Year of Birth: 1994

పురుషుడు / Male

6256 4514 2830



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CamScanner

అధార్ - సామాన్యుని హక్కు



R

RAMA MANOHAR 29YRS
29/03/2024



PATIENT'S NAME - Karanam Rama Manohar
AGE/GENDER - 29yr / male
DOCTOR'S NAME - Dr Gail
DATE - 29/3/2024

VISION SCREENING

	RE	RE	LE	LE
	Glasses	UNAIDED	Glasses -	UNAIDED
DISTANT		6/6		6/6
NEAR		N6		N6
COLOUR	normal.			
Recommendations				

VITALS

Pulse - 117	B.P- 150/100	SpO2 98
Height 164	Weight - 67.	BMI-
Waist - 92	Hip - 98.	Waist/Hip Ratio-
Chest - 90	Inspiration-	Expiration-

CENTRE NAME - Ashiwara

SIGN & STAMP-



29/3/2024.

Karanam Rama Manohar

The above patient has high BP of 150/110 hence his TMT was not done. He has been prescribed medications. He will reschedule his appointment.

Sincerely,



Today I am not giving stool test

K. Rama Manu

K. RAMA MANOHAR





Name : RAMA MANOHAR	Age : 29YRS
Gender : MALE	Date : 29/03/2024

X-RAY CHEST PA VIEW

X-ray of the chest in P.A. projection reveals that the bony thorax is normal.

Lung fields and pleural spaces are clear on both sides.

The silhouettes of the heart and aorta are normal in size and configuration.

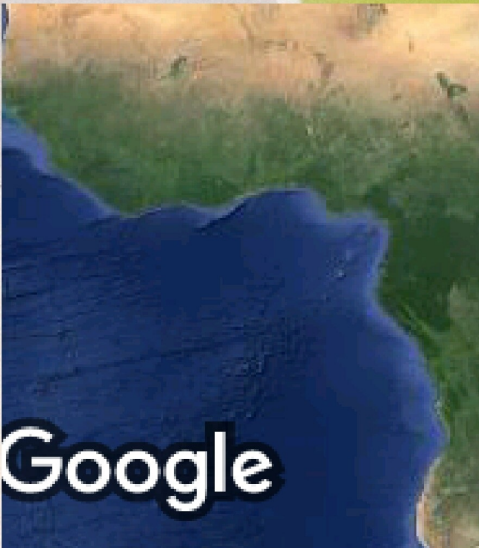
Both domes of the diaphragm are normal in position, contour and outline.

IMPRESSION: NO EVIDENCE OF ANY DISEASE IS SEEN IN THE CHEST.

Dr. Nitish Kotwal
MBBS, DMRD (Bom)
Consultant Radiologist And Sonologist..
Online reporting done hence no signature



GPS Map Camera



Mumbai, Maharashtra, India

Shri Krishna Complex, KL Walawalkar Marg, Corner of new link road and fun cinemas lane, Veera Desai Industrial Estate, Andheri West, Mumbai, Maharashtra 400053, India
Lat 19.13548°

Long 72.832394°

29/03/24 09:45 AM GMT +05:30