

Patient Name : Mr.BHARAT KUMAR  
Age/Gender : 38 Y 5 M 30 D/M  
UHID/MR No : SKOR.0000195502  
Visit ID : SKOROPV281946  
Ref Doctor : Dr.SELF  
Emp/Auth/TPA ID : 9949901091

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Reported : 24/Feb/2024 11:25AM  
Status : Final Report  
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**DEPARTMENT OF HAEMATOLOGY**

**PERIPHERAL SMEAR , WHOLE BLOOD EDTA**

RBCs are normocytic normochromic.  
WBCs are normal in number with normal distribution and morphology.  
Platelets are adequate.  
No hemoparasites or abnormal cells seen.

**IMPRESSION:NORMOCYTIC NORMOCHROMIC BLOOD PICTURE.**

*Anushree R*

Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
Consultant Pathologist

SIN No:BED240048480



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**DEPARTMENT OF HAEMATOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

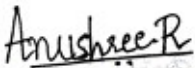
Test Name	Result	Unit	Bio. Ref. Range	Method
<b>HEMOGRAM , WHOLE BLOOD EDTA</b>				
<b>HAEMOGLOBIN</b>	14.2	g/dL	13-17	Spectrophotometer
PCV	41.10	%	40-50	Electronic pulse & Calculation
RBC COUNT	4.85	Million/cu.mm	4.5-5.5	Electrical Impedence
MCV	85	fL	83-101	Calculated
MCH	29.2	pg	27-32	Calculated
MCHC	34.4	g/dL	31.5-34.5	Calculated
R.D.W	13.4	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	5,400	cells/cu.mm	4000-10000	Electrical Impedence
<b>DIFFERENTIAL LEUCOCYTIC COUNT (DLC)</b>				
NEUTROPHILS	61	%	40-80	Electrical Impedence
LYMPHOCYTES	34	%	20-40	Electrical Impedence
EOSINOPHILS	01	%	1-6	Electrical Impedence
MONOCYTES	04	%	2-10	Electrical Impedence
BASOPHILS	00	%	<1-2	Electrical Impedence
<b>ABSOLUTE LEUCOCYTE COUNT</b>				
NEUTROPHILS	3294	Cells/cu.mm	2000-7000	Calculated
LYMPHOCYTES	1836	Cells/cu.mm	1000-3000	Calculated
EOSINOPHILS	54	Cells/cu.mm	20-500	Calculated
MONOCYTES	216	Cells/cu.mm	200-1000	Calculated
Neutrophil lymphocyte ratio (NLR)	1.79		0.78- 3.53	Calculated
<b>PLATELET COUNT</b>	247000	cells/cu.mm	150000-410000	Electrical impedence
<b>ERYTHROCYTE SEDIMENTATION RATE (ESR)</b>	08	mm at the end of 1 hour	0-15	Modified Westergren
<b>PERIPHERAL SMEAR</b>				

RBCs are normocytic normochromic.

WBCs are normal in number with normal distribution and morphology.

Platelets are adequate.

Page 2 of 14



Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
Consultant Pathologist



SIN No:BED240048480

**Apollo Speciality Hospitals Private Limited**

(Formerly known as a Nova Speciality Hospitals Private Limited)

CIN- U85100TG2009PTC099414

Regd Off:1-10-62/62,5th Floor, Ashoka RaghupathiChambers, Begumpet, Hyderabad, Telangana - 500016

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**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

No hemoparasites or abnormal cells seen.

**IMPRESSION:NORMOCYTIC NORMOCHROMIC BLOOD PICTURE.**

*Anushree R*

Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
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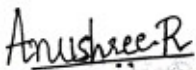
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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>BLOOD GROUP ABO AND RH FACTOR , WHOLE BLOOD EDTA</b>				
BLOOD GROUP TYPE	AB			Forward & Reverse Grouping with Slide/Tube Aggluti
Rh TYPE	POSITIVE			Forward & Reverse Grouping with Slide/Tube Agglutination



Dr. Anushree R  
 M.B.B.S,M.D(Pathology)  
 Consultant Pathologist

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**DEPARTMENT OF BIOCHEMISTRY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, FASTING , NAF PLASMA	107	mg/dL	70-100	GOD - POD

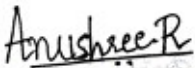
**Comment:**

As per American Diabetes Guidelines, 2023

Fasting Glucose Values in mg/dL	Interpretation
70-100 mg/dL	Normal
100-125 mg/dL	Prediabetes
≥126 mg/dL	Diabetes
<70 mg/dL	Hypoglycemia

**Note:**

- The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL and/or a random / 2 hr post glucose value of > or = 200 mg/dL on at least 2 occasions.
- Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis & is considered critical.



Dr. Anushree R  
 M.B.B.S, M.D(Pathology)  
 Consultant Pathologist

SIN No:PLF02112380



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**DEPARTMENT OF BIOCHEMISTRY**

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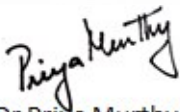
Test Name	Result	Unit	Bio. Ref. Range	Method
<b>GLUCOSE, POST PRANDIAL (PP), 2 HOURS , SODIUM FLUORIDE PLASMA (2 HR)</b>	<b>150</b>	mg/dL	70-140	GOD - POD

Result Rechecked

**Comment:**

It is recommended that FBS and PPBS should be interpreted with respect to their Biological reference ranges and not with each other.

Conditions which may lead to lower postprandial glucose levels as compared to fasting glucose levels may be due to reactive hypoglycemia, dietary meal content, duration or timing of sampling after food digestion and absorption, medications such as insulin preparations, sulfonylureas, amylin analogues, or conditions such as overproduction of insulin.



Dr Priya Murthy  
 M.B.B.S.,M.D(Pathology)  
 Consultant Pathologist

SIN No:PLP1423340







Patient Name : Mr.BHARAT KUMAR  
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**DEPARTMENT OF BIOCHEMISTRY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>HBA1C (GLYCATED HEMOGLOBIN) , WHOLE BLOOD EDTA</b>				
HBA1C, GLYCATED HEMOGLOBIN	<b>6.3</b>	%		HPLC
ESTIMATED AVERAGE GLUCOSE (eAG)	134	mg/dL		Calculated

**Comment:**

Reference Range as per American Diabetes Association (ADA) 2023 Guidelines:

REFERENCE GROUP	HBA1C %
NON DIABETIC	<5.7
PREDIABETES	5.7 – 6.4
DIABETES	≥ 6.5
DIABETICS	
EXCELLENT CONTROL	6 – 7
FAIR TO GOOD CONTROL	7 – 8
UNSATISFACTORY CONTROL	8 – 10
POOR CONTROL	>10

**Note:** Dietary preparation or fasting is not required.

- HbA1C is recommended by American Diabetes Association for Diagnosing Diabetes and monitoring Glycemic Control by American Diabetes Association guidelines 2023.
- Trends in HbA1C values is a better indicator of Glycemic control than a single test.
- Low HbA1C in Non-Diabetic patients are associated with Anemia (Iron Deficiency/Hemolytic), Liver Disorders, Chronic Kidney Disease. Clinical Correlation is advised in interpretation of low Values.
- Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present.
- In cases of Interference of Hemoglobin variants in HbA1C, alternative methods (Fructosamine) estimation is recommended for Glycemic Control
  - A: HbF >25%
  - B: Homozygous Hemoglobinopathy.
 (Hb Electrophoresis is recommended method for detection of Hemoglobinopathy)

**DR.SHIVARAJA SHETTY**  
M.B.B.S,M.D(Biochemistry)  
CONSULTANT BIOCHEMIST

SIN No:EDT240021806



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**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIPID PROFILE , SERUM</b>				
TOTAL CHOLESTEROL	155	mg/dL	<200	CHE/CHO/POD
TRIGLYCERIDES	136	mg/dL	<150	
HDL CHOLESTEROL	<b>35</b>	mg/dL	>40	CHE/CHO/POD
NON-HDL CHOLESTEROL	120	mg/dL	<130	Calculated
LDL CHOLESTEROL	92.8	mg/dL	<100	Calculated
VLDL CHOLESTEROL	27.2	mg/dL	<30	Calculated
CHOL / HDL RATIO	4.43		0-4.97	Calculated

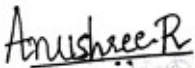
Result Rechecked

**Comment:**

Reference Interval as per National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.

	Desirable	Borderline High	High	Very High
TOTAL CHOLESTEROL	< 200	200 - 239	≥ 240	
TRIGLYCERIDES	<150	150 - 199	200 - 499	≥ 500
LDL	Optimal < 100 Near Optimal 100-129	130 - 159	160 - 189	≥ 190
HDL	≥ 60			
NON-HDL CHOLESTEROL	Optimal <130; Above Optimal 130-159	160-189	190-219	>220

1. Measurements in the same patient on different days can show physiological and analytical variations.
2. NCEP ATP III identifies non-HDL cholesterol as a secondary target of therapy in persons with high triglycerides.
3. Primary prevention algorithm now includes absolute risk estimation and lower LDL Cholesterol target levels to determine eligibility of drug therapy.
4. Low HDL levels are associated with Coronary Heart Disease due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
5. As per NCEP guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
6. VLDL, LDL Cholesterol Non HDL Cholesterol, CHOL/HDL RATIO, LDL/HDL RATIO are calculated parameters when Triglycerides are below 400 mg/dL. When Triglycerides are more than 400 mg/dL LDL cholesterol is a direct measurement.



Dr. Anushree R  
M.B.B.S, M.D(Pathology)  
Consultant Pathologist

SIN No:SE04640363





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**DEPARTMENT OF BIOCHEMISTRY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>LIVER FUNCTION TEST (LFT) , SERUM</b>				
BILIRUBIN, TOTAL	0.50	mg/dL	0.1-1.2	Azobilirubin
BILIRUBIN CONJUGATED (DIRECT)	0.10	mg/dL	0.1-0.4	DIAZO DYE
BILIRUBIN (INDIRECT)	0.40	mg/dL	0.0-1.1	Dual Wavelength
ALANINE AMINOTRANSFERASE (ALT/SGPT)	18	U/L	4-44	JSCC
ASPARTATE AMINOTRANSFERASE (AST/SGOT)	17.0	U/L	8-38	JSCC
ALKALINE PHOSPHATASE	62.00	U/L	32-111	IFCC
PROTEIN, TOTAL	7.70	g/dL	6.7-8.3	BIURET
ALBUMIN	<b>5.20</b>	g/dL	3.8-5.0	BROMOCRESOL GREEN
GLOBULIN	2.50	g/dL	2.0-3.5	Calculated
A/G RATIO	<b>2.08</b>		0.9-2.0	Calculated

Result Rechecked

**Comment:**

LFT results reflect different aspects of the health of the liver, i.e., hepatocyte integrity (AST & ALT), synthesis and secretion of bile (Bilirubin, ALP), cholestasis (ALP, GGT), protein synthesis (Albumin)

Common patterns seen:

**1. Hepatocellular Injury:**

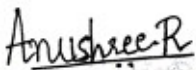
- AST – Elevated levels can be seen. However, it is not specific to liver and can be raised in cardiac and skeletal injuries.
- ALT – Elevated levels indicate hepatocellular damage. It is considered to be most specific lab test for hepatocellular injury. Values also correlate well with increasing BMI.
- Disproportionate increase in AST, ALT compared with ALP.
- Bilirubin may be elevated.
- AST: ALT (ratio) – In case of hepatocellular injury AST: ALT > 1 In Alcoholic Liver Disease AST: ALT usually >2. This ratio is also seen to be increased in NAFLD, Wilson's's diseases, Cirrhosis, but the increase is usually not >2.

**2. Cholestatic Pattern:**

- ALP – Disproportionate increase in ALP compared with AST, ALT.
- Bilirubin may be elevated.
- ALP elevation also seen in pregnancy, impacted by age and sex.
- To establish the hepatic origin correlation with GGT helps. If GGT elevated indicates hepatic cause of increased ALP.

**3. Synthetic function impairment:**

- Albumin- Liver disease reduces albumin levels.
- Correlation with PT (Prothrombin Time) helps.



Dr. Anushree R  
M.B.B.S, M.D(Pathology)  
Consultant Pathologist

SIN No:SE04640363



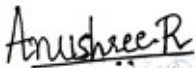
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**DEPARTMENT OF BIOCHEMISTRY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>RENAL PROFILE/KIDNEY FUNCTION TEST (RFT/KFT) , SERUM</b>				
CREATININE	0.82	mg/dL	0.6-1.1	ENZYMATIC METHOD
UREA	21.00	mg/dL	17-48	Urease
BLOOD UREA NITROGEN	9.8	mg/dL	8.0 - 23.0	Calculated
URIC ACID	6.50	mg/dL	4.0-7.0	URICASE
CALCIUM	9.20	mg/dL	8.4-10.2	CPC
PHOSPHORUS, INORGANIC	3.10	mg/dL	2.6-4.4	PNP-XOD
SODIUM	144	mmol/L	135-145	Direct ISE
POTASSIUM	4.6	mmol/L	3.5-5.1	Direct ISE
CHLORIDE	106	mmol/L	98 - 107	Direct ISE



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Test Name	Result	Unit	Bio. Ref. Range	Method
<b>GAMMA GLUTAMYL TRANSEPTIDASE (GGT) , SERUM</b>	34.00	U/L	16-73	Glycylglycine Kinetic method

*Anushree R*

Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
Consultant Pathologist

SIN No:SE04640363





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**DEPARTMENT OF IMMUNOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>THYROID PROFILE TOTAL (T3, T4, TSH) , SERUM</b>				
TRI-iodothyronine (T3, TOTAL)	1.03	ng/mL	0.7-2.04	CLIA
THYROXINE (T4, TOTAL)	9.73	µg/dL	5.48-14.28	CLIA
THYROID STIMULATING HORMONE (TSH)	1.382	µIU/mL	0.34-5.60	CLIA

**Comment:**

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

- TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH activates production of T3 (Triiodothyronine) and its prohormone T4 (Thyroxine). Increased blood level of T3 and T4 inhibit production of TSH.
- TSH is elevated in primary hypothyroidism and will be low in primary hyperthyroidism. Elevated or low TSH in the context of normal free thyroxine is often referred to as sub-clinical hypo- or hyperthyroidism respectively.
- Both T4 & T3 provides limited clinical information as both are highly bound to proteins in circulation and reflects mostly inactive hormone. Only a very small fraction of circulating hormone is free and biologically active.
- Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, medication & circulating antibodies.

TSH	T3	T4	FT4	Conditions
High	Low	Low	Low	Primary Hypothyroidism, Post Thyroidectomy, Chronic Autoimmune Thyroiditis
High	N	N	N	Subclinical Hypothyroidism, Autoimmune Thyroiditis, Insufficient Hormone Replacement Therapy.
N/Low	Low	Low	Low	Secondary and Tertiary Hypothyroidism
Low	High	High	High	Primary Hyperthyroidism, Goitre, Thyroiditis, Drug effects, Early Pregnancy
Low	N	N	N	Subclinical Hyperthyroidism
Low	Low	Low	Low	Central Hypothyroidism, Treatment with Hyperthyroidism
Low	N	High	High	Thyroiditis, Interfering Antibodies
N/Low	High	N	N	T3 Thyrotoxicosis, Non thyroidal causes
High	High	High	High	Pituitary Adenoma; TSHoma/Thyrotropinoma



**DR.SHIVARAJA SHETTY**  
M.B.B.S,M.D(Biochemistry)  
CONSULTANT BIOCHEMIST

SIN No:SPL24031974



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**DEPARTMENT OF CLINICAL PATHOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
<b>COMPLETE URINE EXAMINATION (CUE) , URINE</b>				
<b>PHYSICAL EXAMINATION</b>				
COLOUR	PALE YELLOW		PALE YELLOW	Visual
TRANSPARENCY	CLEAR		CLEAR	Visual
pH	5.8		5-7.5	Bromothymol Blue
SP. GRAVITY	1.010		1.002-1.030	Dipstick
<b>BIOCHEMICAL EXAMINATION</b>				
URINE PROTEIN	NEGATIVE		NEGATIVE	PROTEIN ERROR OF INDICATOR
GLUCOSE	NEGATIVE		NEGATIVE	GOD-POD
URINE BILIRUBIN	NEGATIVE		NEGATIVE	AZO COUPLING
URINE KETONES (RANDOM)	NEGATIVE		NEGATIVE	NITROPRUSSIDE
UROBILINOGEN	NORMAL		NORMAL	EHRlich
BLOOD	NEGATIVE		NEGATIVE	Dipstick
NITRITE	NEGATIVE		NEGATIVE	Dipstick
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	PYRROLE HYDROLYSIS
<b>CENTRIFUGED SEDIMENT WET MOUNT AND MICROSCOPY</b>				
PUS CELLS	5 - 6	/hpf	0-5	Microscopy
EPITHELIAL CELLS	2 - 3	/hpf	<10	MICROSCOPY
RBC	NIL	/hpf	0-2	MICROSCOPY
CASTS	NIL		0-2 Hyaline Cast	MICROSCOPY
CRYSTALS	ABSENT		ABSENT	MICROSCOPY
OTHERS	ABSENT			MICROSCOPY

*Anushree R*

Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
Consultant Pathologist

SIN No:UR2290573





Patient Name : Mr.BHARAT KUMAR  
Age/Gender : 38 Y 5 M 30 D/M  
UHID/MR No : SKOR.0000195502  
Visit ID : SKOROPV281946  
Ref Doctor : Dr.SELF  
Emp/Auth/TPA ID : 9949901091

Collected : 24/Feb/2024 09:55AM  
Received : 24/Feb/2024 11:03AM  
Reported : 24/Feb/2024 11:22AM  
Status : Final Report  
Sponsor Name : ARCOFEMI HEALTHCARE LIMITED

**DEPARTMENT OF CLINICAL PATHOLOGY**

**ARCOFEMI - MEDIWHEEL - FULL BODY HEALTH PLUS BELOW 40Y MALE - PAN INDIA - FY2324**

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE GLUCOSE(FASTING)	NEGATIVE		NEGATIVE	Dipstick

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

*Anushree R*

Dr. Anushree R  
M.B.B.S,M.D(Pathology)  
Consultant Pathologist

SIN No:UF010759

