

Laxmi Sedgir

37 yrs / Female

19/02/2024

No fresh complaints
backache on & off

NO MH

NO SH.

LMP - 20/01/24, regular

OH - G₂ P₂ A₀ L₂ D₀

G₁ - male, 19 yrs, healthy, FTND

G₂ - male, 18 yrs, healthy, FTND

Ht - 151 cm

Wt - 71 kg

BMI - 31.1 kg/m²

(obese class I)

FM - Father - BA ~~BA~~
mother - healthy

BP - 120/80 mmHg

P - 80/min

SpO₂ - 98%

Pt is fit and can resume

her normal duties

* consult with physician for blood changes
cholesterol, s. LDL raised.



HELPLINE

022 - 2588 3531

S-1, Vedant Complex,
Vartak Nagar, Thane (W) 400 606

www.siddhivinayakhospitals.org



Lopmi Saldar

Female
Years 37

Req. No.

120/80mmHg

BP 99%

SPO2 98%

Diagnosis Information:

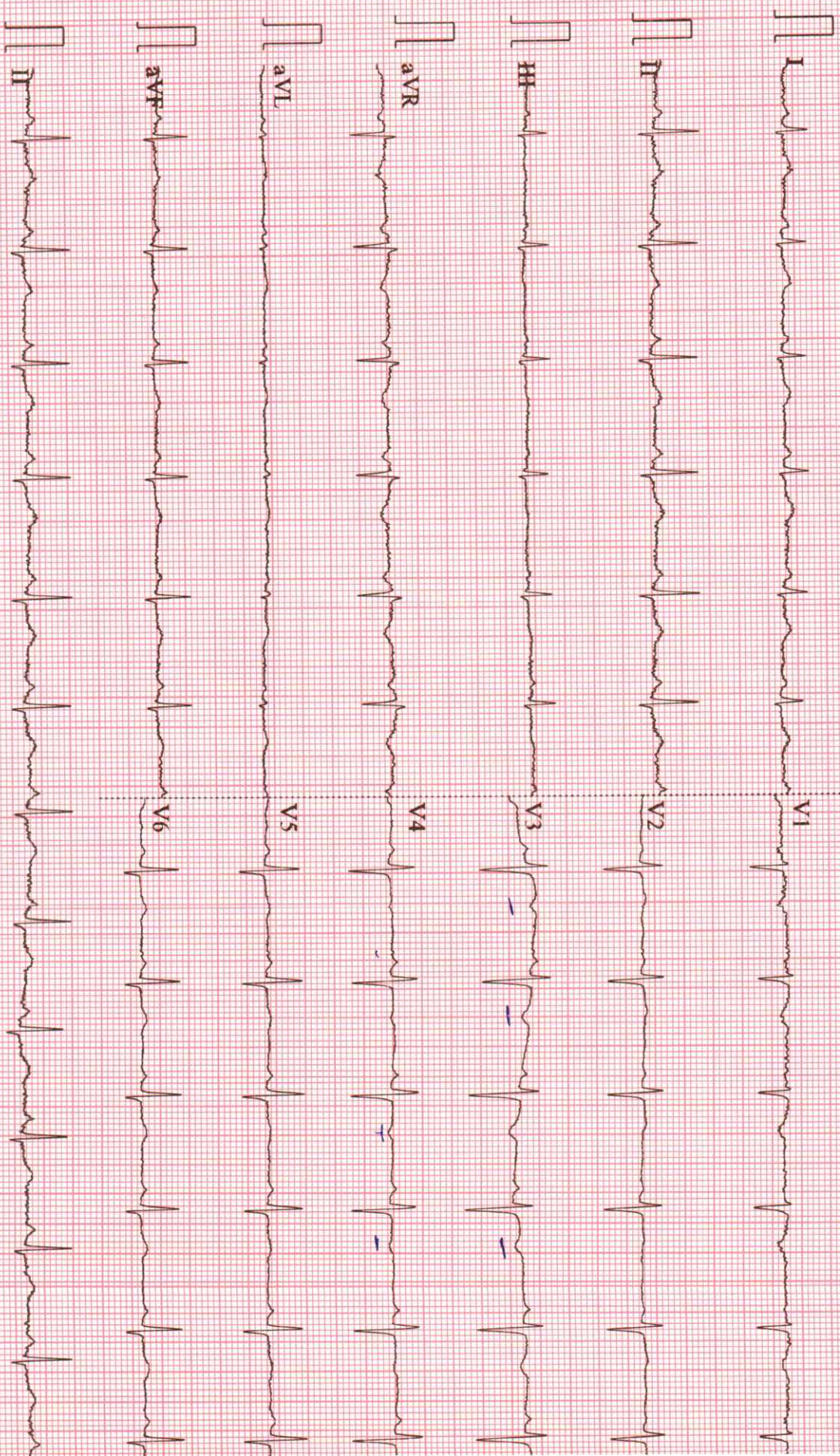
Sinus Rhythm

T Wave Abnormality(V3,V5)

HR	: 79	bpm
P	: 97	ms
PR	: 141	ms
QRS	: 84	ms
QT/QTcBz	: 379/436	ms
P/QRST	: 50/58/40	ms
RV5/SV1	: 0.616/0.509	mV

Report Confirmed by:

Handwritten signature





Name - Mrs. Laxmi Sadgir	Sonography, Colour Doppler, 3D / 4D USG
Ref by Dr.- Siddhivinayak Hospital	Age - Y/F
	Date - /12/2023

USG ABDOMEN & PELVIS

FINDINGS:

The **liver** dimension is normal in size (14.1 cm). It appears normal in morphology with raised **echogenicity**. No evidence of intrahepatic ductal dilatation.

The **GB**-gallbladder is distended normally with no stones within.

The **CBD**- common bile duct is normal. The portal vein is normal.

The **pancreas** appears normal in morphology.

The **spleen** is normal in size 9.7cm and morphology

Both **kidneys** demonstrate normal morphology. Both kidneys show normal cortical echogenicity.

The right kidney measures 10.3 x 4.0 cm.

The left kidney measures 10.1 x 4.2 cm.

Urinary bladder: normally distended. Wall thickness - normal.

Uterus : normal in size and morphology. Size: 7.9 x 3.3 x 4.5 cm.

Endometrium: 6.9 mm, it appears normal in morphology.

Right ovary is normal in size and morphology.

Left ovary is normal in size and morphology.

Adnexa appear normal

No free fluid is seen.

IMPRESSION:

- Fatty Liver (Grade I)

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST





Name - Mrs. Laxmi Sadgir	Age - 37 Y/F
Ref by Dr.- Siddhivinayak Hospital	Date - 19/02/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.



Name - Mrs . Laxmi Sadgir	Age - 37 Y/M
Ref by Dr.- Siddhivinayak Hospital	Date - 19/02/2024

X- Ray chest (PA VIEW)

No obvious active parenchymal lesion seen in both lungs.

Cardiac and aortic shadows appear normal

No evidence of pleural of effusion is seen.

Both domes of diaphragm appear normal.

No obvious bony lesion is seen.

IMPRESSION:

- No significant abnormality seen.

Adv.: Clinical and lab correlation.

DR. AMOL BENDRE
MBBS; DMRE
CONSULTANT RADIOLOGIST

Note: The above report represents interpretation of various radiographic / sonographic shadows, and hence has its own limitations. This report has to be co-related clinic-pathologically by the referring / physician and it does NOT represent the sole diagnosis.





2D ECHOCARDIOGRAM & COLOUR DOPPLER REPORT

NAME	: MRS.LAXMI SADGIR
AGE	: 37 YR/F
DATE OF EXAMINATION	: 19/02/2024
REF BY	: SIDDHIVINAYAK HOSPITAL
ECHOCARDIOGRAM DONE BY	: DR.SANDIP FULPAGARE

Mitral Valve	:	Normal.	
Aortic Valve	:	Normal.	
Pulmonary Valve	:	Normal.	
Tricuspid Valve	:	Normal.	
Interatrial septum	:	Intact.	
Interventricular septum	:	Intact.	
RA	:	Normal	
RV	:	Normal	
LA	:	3.7cm	
LV	:	Normal, No RWMA.	
LV Dimensions			
LVID (d): 4.4 cm		LVID (s):2.5 cm	LVEF: 60%
IVS (d): 1.0 cm		LVPW (d):1.0cm	
Aorta		2.7cm	
Pericardium	:	Normal.	
IVC / Other findings			

DOPPLER MEASUREMENTS:-

MV: E = 0.4, A= 0.7, DT = 160 ms.
Aortic flow velocity = 1.2 m/s.
Pulmonary flow velocity = 0.7 m/s.
MR: Nil, AR: Nil, TR: Nil, PR: Nil

IMPRESSION:-

Normal Sized cardiac chambers.
No RWMA, Good LV Systolic Function. (LVEF- 60 %)
Normal Valves.
RA/ RV Normal, Good RV systolic function.
No pericardial effusion/ Clot.

DR. SANDIP FULPAGARE,
MD (MEDICINE), DNB (CARDIOLOGY).FESC.



OPHTHAL CHECK UP SCREENING

NAME OF EMPLOYEE LAXMI SADGIR

AGE 37

DATE - 19.02.2024

Specs : With Glasses

	RT Eye	Lt Eye
NEAR	N/6	N/6
DISTANT	6/9	6/6
Color Blind Test	NORMAL	



SIDDHIVINAYAK HOSPITALS



Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***LIPID PROFILE**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL CHOLESTEROL (CHOLESTEROL OXIDASE, ESTERASE, PEROXIDASE)	245.0	mg/dL	Desirable blood cholesterol: - <200 mg/dl. Borderline high blood cholesterol: - 200 - 239 mg/dl. High blood cholesterol: - >239 mg/dl.
S.HDL CHOLESTEROL (DIRECT MEASURE - PEG)	44.3	mg/dL	Major risk factor for heart : <30 mg/dl. Negative risk factor for heart disease : >=80 mg/dl.
S. TRIGLYCERIDE (ENZYMATIC, END POINT)	82.4	mg/dL	Desirable level : <161 mg/dl. High : >= 161 - 199 mg/dl. Borderline High : 200 - 499 mg/dl. Very high : >499mg/dl.
VLDL CHOLESTEROL (CALCULATED VALUE)	16	mg/dL	UPTO 40
S.LDL CHOLESTEROL (CALCULATED VALUE)	184	mg/dL	Optimal: <100 mg/dl. Near Optimal: 100 - 129 mg/dl. Borderline High: 130 - 159 mg/dl. High : 160 - 189mg/dl. Very high : >= 190 mg/dl.
LDL CHOL/HDL RATIO (CALCULATED VALUE)	4.15		UPTO 3.5
CHOL/HDL CHOL RATIO (CALCULATED VALUE)	5.53		<5.0

Above reference ranges are as per ADULT TREATMENT PANEL III recommendation by NCEP (May 2015).

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



COMPLETE BLOOD COUNT

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
HEMOGLOBIN	12.5	gm/dl	12.0 - 15.0
HEMATOCRIT (PCV)	37.5	%	36 - 46
RBC COUNT	4.19	x10 ⁶ /uL	4.5 - 5.5
MCV	90	fl	80 - 96
MCH	29.8	pg	27 - 33
MCHC	33	g/dl	33 - 36
RDW-CV	12.5	%	11.5 - 14.5
TOTAL LEUCOCYTE COUNT	3820	/cumm	4000 - 11000
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	51	%	40 - 80
LYMPHOCYTES	39	%	20 - 40
EOSINOPHILS	04	%	0 - 6
MONOCYTES	06	%	2 - 10
BASOPHILS	00	%	0 - 1
PLATELET COUNT	153000	/cumm	150000 - 450000
MPV	12.4	fl	6.5 - 11.5
PDW	16.4	%	9.0 - 17.0
PCT	0.190	%	0.200 - 0.500
RBC MORPHOLOGY	Normocytic Normochromic		
WBC MORPHOLOGY	Leukopenia		
PLATELETS ON SMEAR	Adequate		

Method : EDTA Whole Blood- Tests done on Automated Six Part Cell Counter.RBC and Platelet count by Electric Impedance ,WBC by SF Cube method and Differential by flow cytometry . Hemoglobin by Cyanide free reagent for hemoglobin test (Colorimetric Method).Rest are calculated parameters.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
pooja_jadhav

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>URINE ROUTINE EXAMINATION</u>			
<u>PHYSICAL EXAMINATION</u>			
VOLUME	20ml		
COLOUR	Pale Yellow		Pale Yellow
APPEARANCE	Clear		Clear
<u>CHEMICAL EXAMINATION</u>			
REACTION (methyl red and Bromothymol blue indicator)	Acidic		Acidic
SP. GRAVITY (Bromothymol blue indicator)	1.010		1.005 - 1.022
PROTEIN (Protein error of PH indicator)	Absent		Absent
BLOOD (Peroxidase Method)	Absent		Absent
SUGAR (GOD/POD)	Absent		Absent
KETONES (Acetoacetic acid)	Absent		Absent
BILE SALT & PIGMENT (Diazonium Salt)	Absent		Absent
UROBILINOGEN (Red azodye)	Normal		Normal
LEUKOCYTES (pyrrole amino acid ester diazonium salt)	Absent		Absent
NITRITE (Diazonium compound With tetrahydrobenzo quinolin 3-phenol)	Absent		Negative
<u>MICROSCOPIC EXAMINATION</u>			
RED BLOOD CELLS	Absent		Absent
PUS CELLS	2-3	/ HPF	0 - 5
EPITHELIAL	1-3	/ HPF	0 - 5
CASTS	Absent		

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



URINE ROUTINE EXAMINATION

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
CRYSTALS	Absent		
BACTERIA	Absent		Absent
YEAST CELLS	Absent		Absent
ANY OTHER FINDINGS	Absent		Absent

REMARK Result relates to sample tested. Kindly correlate with clinical findings.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name	: Mrs. LAXMI SADGIR (A)	Collected On	: 19/2/2024 9:26 am
Lab ID.	: 184188	Received On	: 19/2/2024 9:36 am
Age/Sex	: 37 Years / Female	Reported On	: 19/2/2024 8:12 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



IMMUNO ASSAY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>TFT (THYROID FUNCTION TEST)</u>			
SPACE		Space	-
SPECIMEN	Serum		
T3	107.9	ng/dl	84.63 - 201.8
T4	9.36	µg/dl	5.13 - 14.06
TSH	1.33	µIU/ml	0.270 - 4.20
T3 (Triiodo Thyronine hormone)	T4 (Thyroxine)	TSH(Thyroid stimulating hormone)	
AGE	RANGE	AGE	RANGES
1-30 days	100-740	1-14 Days	11.8-22.6
1-11 months	105-245	1-2 weeks	9.9-16.6
1-5 yrs	105-269	1-4 months	7.2-14.4
6-10 yrs	94-241	4 -12 months	7.8-16.5
11-15 yrs	82-213	1-5 yrs	7.3-15.0
0.1-2.5			
15-20 yrs	80-210	5-10 yrs	6.4-13.3
0.20-3.0			
		11-15 yrs	5.6-11.7
0.30-3.0			

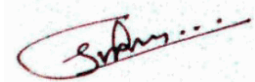
INTERPRETATION :

TSH stimulates the production and secretion of the metabolically active thyroid hormones, thyroxine (T4) and triiodothyronine (T3), by interacting with a specific receptor on the thyroid cell surface. The synthesis and secretion of TSH is stimulated by Thyrotropin releasing hormone (TRH), in response to low levels of circulating thyroid hormones. Elevated levels of T3 and T4 suppress the production of TSH via a classic negative feedback mechanism. Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
 Priyanka_Deshmukh



DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD GROUP			
SPECIMEN	WHOLE BLOOD EDTA & SERUM		
* ABO GROUP	'O'		
RH FACTOR	POSITIVE		
Method: Slide Agglutination and Tube Method (Forward grouping & Reverse grouping)			
Result relates to sample tested, Kindly correlate with clinical findings.			
----- END OF REPORT -----			

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



***RENAL FUNCTION TEST**

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
BLOOD UREA (Urease UV GLDH Kinetic)	15.2	mg/dL	13 - 40
BLOOD UREA NITROGEN (Calculated)	7.10	mg/dL	5 - 20
S. CREATININE (Enzymatic)	0.70	mg/dL	0.6 - 1.4
S. URIC ACID (Uricase)	4.6	mg/dL	2.6 - 6.0
S. SODIUM (ISE Direct Method)	141.5	mEq/L	137 - 145
S. POTASSIUM (ISE Direct Method)	4.54	mEq/L	3.5 - 5.1
S. CHLORIDE (ISE Direct Method)	105.7	mEq/L	98 - 110
S. PHOSPHORUS (Ammonium Molybdate)	4.27	mg/dL	2.5 - 4.5
S. CALCIUM (Arsenazo III)	8.8	mg/dL	8.6 - 10.2
PROTEIN (Biuret)	6.47	g/dl	6.4 - 8.3
S. ALBUMIN (BGC)	3.96	g/dl	3.2 - 4.6
S.GLOBULIN (Calculated)	2.51	g/dl	1.9 - 3.5
A/G RATIO calculated	1.58		0 - 2

NOTE

BIOCHEMISTRY TEST DONE ON FULLY AUTOMATED (EM 200)
ANALYZER.

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 4 1 8 8 *

Peripheral smear examination

TEST NAME	RESULTS
SPECIMEN RECEIVED	Whole Blood EDTA.
RBC	Normocytic Normochromic.
WBC	Total leukocytes count is reduced on smear. Neutrophils :51 % Lymphocytes :39 % Eosinophils :04 % Monocytes :06 % Basophils :00 %
PLATELET	Adequate on smear.
HEMOPARASITE	No Parasites seen.
IMPRESSION	Leukopenia.

Result relates to sample tested, Kindly correlate with clinical findings.
----- END OF REPORT -----

Checked By
pooja_jadhav

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



LIVER FUNCTION TEST

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
TOTAL BILLIRUBIN (Method-Diazo)	2.28	mg/dL	0.2 - 1.2
DIRECT BILLIRUBIN (Method-Diazo)	0.78	mg/dL	0.0 - 0.4
INDIRECT BILLIRUBIN Calculated	1.50	mg/dL	0 - 0.8
SGOT(AST) (UV without PSP)	17.7	U/L	0 - 37
SGPT(ALT) UV Kinetic Without PLP (P-L-P)	20.1	U/L	UP to 40
ALKALINE PHOSPHATASE (Method-ALP-AMP)	42.0	U/L	42 - 98
S. PROTIEN (Method-Biuret)	6.47	g/dl	6.4 - 8.3
S. ALBUMIN (Method-BCG)	3.96	g/dl	3.5 - 5.2
S. GLOBULIN Calculated	2.51	g/dl	1.90 - 3.50
A/G RATIO Calculated	1.58		0 - 2

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
pooja_jadhav

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



* 1 8 4 1 8 8 *

HAEMATOLOGY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
ESR			
ESR	29	mm/1hr.	0 - 20

METHOD - WESTERGREN

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist



Name	: Mrs. LAXMI SADGIR (A)	Collected On	: 19/2/2024 9:26 am
Lab ID.	: 184188	Received On	: 19/2/2024 9:36 am
Age/Sex	: 37 Years / Female	Reported On	: 19/2/2024 8:12 pm
Ref By	: SIDDHIVINAYAK HOSPITAL CGHS /ESIS	Report Status	: FINAL



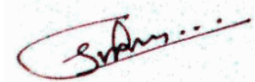
BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
<u>GLYCOCELATED HEMOGLOBIN (HBA1C)</u>			
HBA1C (GLYCOSALATED HAEMOGLOBIN)	5.4	%	Hb A1c > 8 Action suggested < 7 Goal < 6 Non - diabetic level
AVERAGE BLOOD GLUCOSE (A. B. G.)	108.0	mg/dL	65.1 - 136.3
METHOD Particle Enhanced Immunoturbidimetry			
HbA1c : Glycosylated hemoglobin concentration is dependent on the average blood glucose concentration which is formed progressively and irreversibly over a period of time and is stable till the life of the RBC/erythrocytes.Average Blood Glucose (A.B.G) is calculated value from HbA1c : Glycosylated hemoglobin concentration in whole Blood.It indicates average blood sugar level over past three months.			
<u>BLOOD GLUCOSE FASTING & PP</u>			
BLOOD GLUCOSE FASTING	88.6	mg/dL	70 - 110
BLOOD GLUCOSE PP	100.7	mg/dL	70 - 140

Method (GOD-POD). DONE ON FULLY AUTOMATED ANALYSER (EM200).

1. Fasting is required (Except for water) for 8-10 hours before collection for fasting specimen. Last dinner should consist of bland diet.
2. Don't take insulin or oral hypoglycemic agent until after fasting blood sample has been drawn

Checked By
 Priyanka_Deshmukh



DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist





Name : Mrs. LAXMI SADGIR (A) Collected On : 19/2/2024 9:26 am
Lab ID. : 184188 Received On : 19/2/2024 9:36 am
Age/Sex : 37 Years / Female Reported On : 19/2/2024 8:12 pm
Ref By : SIDDHIVINAYAK HOSPITAL CGHS /ESIS Report Status : FINAL



BIOCHEMISTRY

TEST NAME	RESULTS	UNIT	REFERENCE RANGE
-----------	---------	------	-----------------

INTERPRETATION

- Normal glucose tolerance : 70-110 mg/dl
- Impaired Fasting glucose (IFG) : 110-125 mg/dl
- Diabetes mellitus : ≥ 126 mg/dl

POSTPRANDIAL/POST GLUCOSE (75 grams)

- Normal glucose tolerance : 70-139 mg/dl
- Impaired glucose tolerance : 140-199 mg/dl
- Diabetes mellitus : ≥ 200 mg/dl

CRITERIA FOR DIAGNOSIS OF DIABETES MELLITUS

- Fasting plasma glucose ≥ 126 mg/dl
- Classical symptoms + Random plasma glucose ≥ 200 mg/dl
- Plasma glucose ≥ 200 mg/dl (2 hrs after 75 grams of glucose)
- Glycosylated haemoglobin $> 6.5\%$

***Any positive criteria should be tested on subsequent day with same or other criteria.

GAMMA GT 13.7 U/L 5 - 55

Result relates to sample tested, Kindly correlate with clinical findings.

----- END OF REPORT -----

Checked By
Priyanka_Deshmukh

DR. SMITA RANVEER.
M.B.B.S.M.D. Pathology(Mum)
Consultant Histocytopathologist

