Park Hospital
(A Unit of Umkal Health Care Pvt. Ltd.)
GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF HAEMATOLOGY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
Age/Sex	: 46 Years 2 Months 6 Days / Female	**Referal Doctor**	: Dr.R.M.O	
Type	: OPD	**Requisition Date**	: 16/08/2024	8.34 AM
TPA/Corporate	:	**Sample Collection Dt.**	: 16/08/2024	01:40 PM
IP No.	:	**Sample Receiving Dt.**	: 16/08/2024	01:50 pm
		Reporting Dt.	: 16/08/2024	04:28 PM

COMPLETE HAEMOGRAM

Tests	Results		Reference Range	Units	Method	Specimen Type
HAEMOGLOBIN	12.3		12.0 - 15.0	gms/dL	COLORIMETRY	Whole Blood-EDTA
TOTAL LEUCOCYTE COUNT	7290		4000 - 11000	/µL	Impedance	Whole Blood-EDTA
DIFFERENTIAL COUNT						
NEUTROPHILS	61		40 - 80	%	FLOW CYTOMETRY	
LYMPHOCYTES	32		20 - 40	%	FLOW CYTOMETRY	Whole Blood-EDTA
MONOCYTES	04		2 - 10	%	FLOW CYTOMETRY	Whole Blood-EDTA
EOSINOPHILS	03		1 - 6	%	FLOW CYTOMETRY	
BASOPHILS	00		0 - 2	%	FLOW CYTOMETRY	Whole Blood-EDTA
RED BLOOD CELL COUNT	4.77		3.8 - 4.8	millions/µL	ELECTRICAL IMPEDANCEIMPEDANCE	Whole Blood-EDTA
PACKED CELL VOLUME	37.5		36 - 46	%	CALCULATED	Whole Blood-EDTA
MEAN CORPUSCULAR VOLUME	**78.6**	*L*	80 - 100	fL	MEASURED	Whole Blood-EDTA
MEAN CORPUSCULAR HAEMOGLOBIN	**25.8**	*L*	27 - 32	Picogrames	CALCULATED	Whole Blood-EDTA
MEAN CORPUSCULAR HB CONC	32.8		31.5 - 34.5	%	CALCULATED	Whole Blood-EDTA
PLATELET COUNT	221		150 - 410	THOUSAND/ CUMM	ELECTRICAL IMPEDANCE	Whole Blood-EDTA

Abnormal CBC result help to diagnose:
Infection
Inflammation
Cancer
Leukemia
- Autoimmune condition (diswases in wich the bodys immune system attacks the body
- Bone marrow failoure
- Abnormal Development of bone marrow

Anemia
- Dehydration, in which the production of red blood cells is abnormal)
- Effects of chemotherapy
- Effects of ceratin antibiotics
- Effects of a number of medications in long-term or even short-term use

***** END OF THE REPORT *****

DR.NISHA TIWARI
MBBS, MD (MICRO)
CONSULTANT MICROBIOLOGIST

DR.SONY SINGH
MBBS, MD
CONSULTANT MICROBIOLOGIST

Dr. ARTI NIGAM
MBBS, MD (PATHOLOGY)
CONSULTANT PATHOLOGIST
HOD PATHLAB

Note :- Any discrepancy noted in test may be referred back to the lab for remedial action.

H = High L= Low P = Panic

(This is only professional opinion and not the diagnosis, Please correlate clinically)

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MC - 5330

Park Hospital

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GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF BICCHEMISTRY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
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BLOOD SUGAR FASTING

Tests	Results	Reference Range	Units	Method	Specimen Type
PLASMA GLUCOSE FASTING	84.63	70 - 100	mg/dl	god trinders	Plasma

***** END OF THE REPORT *****

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DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
Age/Sex	: 46 Years 2 Months 6 Days / Female	**Referal Doctor**	: Dr.R.M.O	
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		Reporting Dt.	: 16/08/2024	05:09 PM

BLOOD SUGAR P.P

Tests	Results	Reference Range	Units	Method	Specimen Type
FASTING PP					
BLOOD SUGAR P.P.	105.07	70 - 140	mg/dl	god trinders	Plasma

*Results of these tests should always be interpreted in conjunction with patients medical history, clinical presentation and other findings.
*Performed on fully Automated Dimension X-Pand plus BioChemistry Analyser.
*External Quality Control by Biorad Laboratory.

***** END OF THE REPORT *****

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, MD (MICRO)
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LIVER FUNCTION TEST

Tests	Results		Reference Range	Units	Method	Specimen Type
LFT						
TOTAL BILIRUBIN	0.63		0.1 - 1.2	mg/dL	DIAZO	Serum
DIRECT BILIRUBIN	0.22		0 - 0.3	mg/dL	DIAZO	Serum
INDIRECT BILIRUBIN	0.41		0.1 - 0.9	mg/dL	Calculated	Serum
SGOT (AST)	38.21		0 - 45	U/L	IFCC WITHOUT PYRIDOXAL PHOSPHATE	Serum
SGPT (ALT)	**54.79**	*H*	0 - 45	U/L	IFCC WITHOUT PYRIDOXAL PHOSPHATE	Serum
ALKALINE PHOSPHATASE	93.25		39 - 118	IU/L	MODIFIED IFCC KINETIC	Serum
TOTAL PROTEINS	6.99		6.4 - 8.0	g/dL	Biuret	Serum
ALBUMIN	4.35		3.5 - 5.2	g/dL	BCG DYE END POINT	Serum
GLOBULIN	2.64		2.0 - 3.5	g/dL	Calculated	Serum
A/G RATIO	1.65		1.0 - 2.0		Calculated	Serum

1 In an asymptomatic patient, Non alcoholic fatty liver disease (NAFLD) is the most common cause of increased AST,ALT levels NAFLD is considered as hepatic manifestation of metabolic syndrome.
2 In most type of liver disease ALT activity is higher than that of AST. Exception may be seen in Alcoholic Hepatitis, Hepatic Cirrhosis and Liver Neoplasia. In a patient with Chronic liver disease, AST: ALT ratio >1 is highly suggestive of advanced liver fibrosis
3 In know cases of chronic liver disease due to viral Hepatitis B & C, Alcoholic liver disease or NAFLD, Enhanced liver fibrosis (ELF) test may be used to evaluate liver fibrosis.

The Level of bilirubin which is referred to as critical for the baby and when phototherapy is given for treatment is:
24 - 48 hours old: total serum bilirubin level above 15 mg/dL
48 - 72 hours old: total serum bilirubin level above 18 mg/dL
> 72 hours old: total serum bilirubin level above 20 mg/dL

***** END OF THE REPORT *****

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DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
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KIDNEY FUNCTION TEST

Tests	Results	Reference Range	Units	Method	Specimen Type
KFT					
UREA	22.71	13 - 45	mg/dL	UREASE-GLDH FIXED TIME	Serum
CREATININE	0.70	0.6 - 1.40	mg/dL	JAFFE INTIAL RATE	Serum
URIC ACID	3.53	2.5 - 6.8	mg/dL	URICASE-TOOS	Serum
SODIUM	138	133 - 146	meq/L	ISE DIRECT	Serum
POTASSIUM	4.6	3.5 - 5.3	meq/L	ISE DIRECT	Serum
SERUM CHLORIDE	105	98 - 107	meq/l		

CAUSES OF INCREASE CREATININE LEVEL

1 Blocked urinary tract
2 Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
3 Loss of body fluid (dehydration)
4 Muscle problems, such as breakdown of muscle fibers (rhabdomyolysis)
5 problems during pregnancy, such as seizures caused by eclampsia or high blood pressure caused by preeclampsia.

Causes of high levels of Urea:-

Kidney dysfunction- Acute kidney injury, chronic kidney disease, kidney failure
Dehydration- Inadequate fluid intake, excessive fluid loss
Urinary tract obstruction- Blockage in the urinary system
High protein intake- Consuming large amounts of protein- rich foods
Medications- certain medications, such as diuretics or corticosteroids.

Causes of low levels of Urea

Liver disease- Severe liver damage or dysfunction
Malnutrition- Inadequate protein intake or malabsorption
Overhydration- Excessive fluid intake or fluid retention
Pregnancy- Normal physiological change during pregnancy
Certain medications- Certain medications, such as antibiotics or diuretics.

***** END OF THE REPORT *****

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DEPARTMENT OF HORMONES

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
Age/Sex	: 46 Years 2 Months 6 Days / Female	**Referal Doctor**	: Dr.R.M.O	
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T3 T4 TSH

Tests	Results	Reference Range	Units	Method	Specimen Type
TRI-IODOTHYRONINE (T3)	1.43	0.69 - 2.15	ng/ml	Chemiluminescence	Serum
THYROXINE (T4)	9.02	5.01 - 12.45	µg/dL	Chemiluminescence	
THYROID STIMULATING HORMONE (TSH)	1.27	0.5-5.50 ,	µIU/ml		Serum

***** END OF THE REPORT *****

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GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF CLINICAL PATHOLOGY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
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URINE ROUTINE MICROSCOPY

Tests	Results	Reference Range	Units	Method	Specimen Type
PHYSICAL EXAMINATION U					
VOLUME	30		ml	Visual	Urine
COLOUR	Pale Yellow	Pale Yellow		Visual	Urine
APPEARANCE	Clear	Clear		Visual	
SPECIFIC GRAVITY	1.015	1.005 - 1.030		BROMTHYMOL BLUE	Urine
CHEMICAL EXAMINATION .U					
PH	6.0	4.5 - 8.0		Double Indicator	Urine
BLOOD	NIL	NIL		oxidase-peroxide	Urine
URINE PROTEIN	NIL	NIL		tetrabromophenol blue	Urine
KETONES	NIL	NIL		NITOPRUSSIDE	Urine
BILIRUBIN	NIL	NIL		Diazotized dichloroaniline	Urine
UROBILINOGEN	NORMAL	NORMAL		Elrich REACTION	Urine
GLUCOSE/URINE	NIL	NIL		GODPOD/Benedicts	Urine
MICROSCOPIC EXAMINATION .U					
PUS CELL	2-4	2—3/HPF		Microscopy	Urine
RED BLOOD CELLS	Nil	NIL		Microscopy	Urine
EPITHELIAL CELL..	1-2	4—5/HPF		Microscopy	Urine
CASTS	NIL	NIL		Microscopy	Urine
CRYSTALS	NIL	NIL		Microscopy	
BACTERIA	NIL	NIL		Microscopy	Urine
OTHER	NIL				
MACROPHAGES.	NIL	NIL		Microscopy	Urine

***** END OF THE REPORT *****

DR.NISHA TIWARI MBBS, MD (MICRO) CONSULTANT MICROBIOLOGIST	DR.SONY SINGH MBBS, MD CONSULTANT MICROBIOLOGIST	Dr. ARTI NIGAM MBBS, MD (PATHOLOGY) CONSULTANT PATHOLOGIST HOD PATHLAB

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DEPARTMENT OF HAEMATOLOGY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
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BLOOD GROUP and RH TYPE

Tests	Results	Reference Range	Units	Method	Specimen Type
BLOOD GROUP	"B" Positive			SLIDE METHOD	Whole Blood EDTA

***** END OF THE REPORT *****

DR.NISHA TIWARI
MBBS, MD (MICRO)
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MC - 5330

Park Hospitals®

EVERY LIFE MATTERS

DEPARTMENT OF RADIOLOGY

Patient Name	Mrs. PRADHUMAN YADAV		
Reg No	67628	**Collection Dt.&Tm.**	: 16/08/2024
Age/Sex	46 Years 2 Months 6Days / Female	**Uploading Dt.&Tm.**	: 16/08/2024
Ref. Doctor	Self	**Printing Dt.&Tm.**	: 16/08/2024
Type	OPD	**Req. No.**	: 24606701
		Consultant Doctor	: Dr. R.M.O
		RoomType	:

CHEST AP

Both lung fields appear normal.

Both domes of diaphragm are normal.

Both costophrenic angles are normal.

Both hila are normal.

PLEASE CORRELATE CLINICALLY.

Note: This Report is not for Medicolegal purpose.

Dr .Sonali Sharma
Senior Consultant Radiology
MD Radiodiagnosis, Fellowship Breast Imaging & Intervention. Liver Transplant and Hepatobiliary Imaging Specialist.
HMC Regn. No. 19460

Dr. Nobal Chandrakar
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Dr .Niyati Sharma
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H-Block, Palam Vihar, Gurugram, Haryana - 122017
Ph.: 0124 4777000, Mobile No. : 9891424242, 8695000000, Emergency No.: 99166 99166

the health care providers

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EVERY LIFE MATTERS

DEPARTMENT OF RADIOLOGY

Patient Name	Mrs. PRADHUMAN YADAV		
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Type	OPD	**Req. No.**	: 24606701
		Consultant Doctor	: Dr. R.M.O
		RoomType	:

ULTRA SOUND W/A

Liver: Liver is normal in size **& shows grade I fatty infiltration**. No focal lesion seen. Intrahepatic biliary radicals are normal.

Gall Bladder: Gall bladder is distended. No calculus seen. Gall bladder shows normal wall thickness. CBD and Portal Vein are normal.

Pancreas: Pancreas is normal in size, shape and echotexture. No peri-pancreatic collection seen.

Spleen: Spleen is normal in size, shape and echotexture.

Kidneys: Both kidneys are normal in size, shape and site. Echotexture of sinus and cortex is normal. No pelvi-calyceal dilatation seen. No calculus/ mass lesion seen. Cortico-medullary differentiation maintained.

Urinary Bladder: Urinary bladder is empty.

IMPRESSION: GRADE I FATTY INFILTRATION OF LIVER.

ADV.: CLINICAL CORRELATION.

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DEPARTMENT OF HAEMATOLOGY

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ESR

Tests	Results		Reference Range	Units	Method	Specimen Type
ESR	**40**	*H*	0 - 20	mm at the end of 1st hr	Westergren	Whole Blood-EDTA

ESR is a non specific phenomenon. Its measurement is clinically useful in disorders associated with an increased production of acute phase proteins.

Causes of High ESR values:
Anemia
Tuberculosis
Multiple myeloma
Leukemia, lymphomas, carcinomas of the breast and lungs
Rheumatoid arthritis, SLE
Myocardial infarct

Causes of Low ESR values: (0-1mm)
Polycythaemia
Hypofibrinogenaemia
Congestive cardiac failure
Abnormalities of the red cells such as poikilocytosis, spherocytosis, or sickle cells.

(Manual Modified Westergren/Automated)
Sedimentation rate (mm in 1 hour at 20 3 deg C)
Men

17-50 yrs	0-10 mm/hr
51-60 yrs	0-12 mm/hr
61-70 yrs	0-14 mm/hr
70 yrs	0-30 mm/hr

Women

17-50 yrs	0-12 mm/hr
51-60 yrs	0-19 mm/hr
61-70 yrs	0-20 mm/hr
70 yrs	0-35 mm/hr

***** END OF THE REPORT *****

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DEPARTMENT OF BIOCHEMISTRY

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LIPID PROFILE (TOTAL CHOLESTEROL LDL HDL TREIGYLCERIDES)

Tests	Results		Reference Range	Units	Method	Specimen Type
LIPID PROFILE						
TOTAL CHOLESTEROL	187.81		0 - 200	mg/dL	Trinders end point	Serum
SERUM TRIGLYCERIDES	**251.34**	*H*	35 - 170	mg/dl	GPO-TRINDER END POINT	Serum
HDL-CHOLESTEROL	34.03		>60 - .	mg/dl	DIRECT	Serum
LDL	103.51		50 - 135	mg/dl	calculated	Serum
VLDL CHOLESTEROL	**50.27**	*H*	7 - 34	mg/dL	calculated	Serum
TOTAL CHOLESTEROL/HDL RATIO	**5.52**	*H*	2.0 - 5.0	mg/dl	calculated	Serum
LDL CHOLESTEROL/HDL RATIO	**3.04**	*H*	1 - 3	mg/dL	calculated	Serum

According to the recommendation of the European society, the following Clinical interpretation is taken into consideration

Chol - <200 mg/dl
Trigly - <200 mg/dl - No Lipid metabolism deficiency
Choles - 200 - 300 mg/dl - Deficiency in lipid

met - HDLecholesterol is<35 mg/dl

Chol - >300 mg/dl
Tri - >200 mg/dl - Deficiency in lipid metabolism

***** END OF THE REPORT *****

IA TIWARI D (MICRO) MICROBIOLOGIST	DR.SONY SINGH MBBS, MD CONSULTANT MICROBIOLOGIST	Dr. ARTI NIGAM MBBS, MD (PATHOLOGY) CONSULTANT PATHOLOGIST HOD PATHLAB

Note :- Any discrepancy noted In test may be referred back to the lab for remedial action.

MC - 5330
(This is only professional opinion and not the diagnosis, Please correlate clinically)
H-Block, Palam Vihar, Gurugram, Haryana - 122017 | Ph.: 0124 4777000, Mobile No. : 9891424242, 8695000000

Park Hospital
(A Unit of Umkal Health Care Pvt. Ltd.)
GROUP SUPER SPECIALITY HOSPITAL

DEPARTMENT OF BIOCHEMISTRY

Patient Name	: Mrs. PRADHUMAN YADAV	**Sample ID**	: 217114	
UHID	: 67628	**Bill/Req. No.**	: 24606701	
Age/Sex	: 46 Years 2 Months 6 Days / Female	**Referal Doctor**	: Dr.R.M.O	
Type	: OPD	**Requisition Date**	: 16/08/2024	8.34 AM
TPA/Corporate	:	**Sample Collection Dt.**	: 16/08/2024	01:40 PM
IP No.	:	**Sample Receiving Dt.**	: 16/08/2024	01:50 pm
		Reporting Dt.	: 16/08/2024	05:09 PM

HB A1 C

Tests	Results	Reference Range	Units	Method	Specimen Type
HBA1C	6.0	Non-Diabetics 4.0 - 6.0In DiabeticsGood Control 6.1 - 6.8Fair Control 6.9 - 7.6Poor Control > 7.6	%	HPLC	Whole Blood EDTA
ESTIMATED AVERAGE GLUCOSE	126.2		mg/dl		

1. HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
2. HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Low normal haemoglobin(below 4%) in a non-diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia(especially severe iron deficiency & haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.
5. To calculate the eAG from the HbA1C value, the following equation is used: eAG(mg/dl) = 28.7*A1c-
6. Interference of Haemoglobinopathies in HbA1c estimation.
   For HPLC > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
   If heterozygous hemoglobinopathy is detected, fructosamine is recommended for monitoring glycemic status
   Homozygous state detected (D10/ turbo is corrected for HbS and HbC trait).
7. In diabetic patients, following values can be considered as a tool for monitoring the glycemic control
   Excellent Control - 6 to 7 %, Fair to Good Control - 7 to 8 %, Unsatisfactory Control - 8 to 10 %
   Poor Control - More than 10 % .

Note: Hemoglobin electrophoresis (HPLC method) is recommended for detecting hemoglobinopathy.

***** END OF THE REPORT *****

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