**CLIENT CODE :** C000040663

**CLIENT'S NAME AND ADDRESS :**
RELIANCE GENERAL INSURANCE CO. LTD. (CREDIT CLIENT)
5TH FLOOR, CHINTAMANI AVENUE, NEXT TO VIRWANI INDUSTRIAL EST
GOREGAON (EAST),
MUMBAI 400063
MAHARASHTRA INDIA
11-30913454 9818484089

SRL LIMITED
M R Square, Sy. No. 7/3, Brookfield Main Road, Opp. Main Hyper City,
BANGLORE, 560060
KARNATAKA, INDIA
Tel : 080-41254661,62,63,64, Fax : CIN - U74899PB1995PLC045956
Email : wellness.itpl@srl.in

**PATIENT NAME : KRITI JAIN** PATIENT ID :

ACCESSION NO : **0075QH000264** AGE : 24 Years SEX : Female DATE OF BIRTH : 26/07/1993

DRAWN : RECEIVED : 05/08/2017 08:40 REPORTED : 06/08/2017 09:47

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| **RELIANCE ANNUAL HEALTH CHECKS PACKAGE FOR FICO** | | | | |
| **MEDICAL EXAMINATION REPORT** | | | | |
| TYPE OF EXAMINATION | ANNUAL | | | |
| **COMPLETE BLOOD COUNT** | | | | |
| RED BLOOD CELL COUNT | 4.71 | | 3.8 - 4.8 | mil/µL |
| HEMOGLOBIN | 13.4 | | 12.0 - 15.0 | g/dL |
| HEMATOCRIT | 38.5 | | 36 - 46 | % |
| MEAN CORPUSCULAR VOL | **82.0** | **Low** | 83 - 101 | fL |
| MEAN CORPUSCULAR HGB. | 28.5 | | 27.0 - 32.0 | pg |
| MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION | 33.9 | | 31.5 - 34.5 | g/dL |
| RED CELL DISTRIBUTION WIDTH | 14.0 | | 11.6 - 14.0 | % |
| PLATELET COUNT | 271 | | 150 - 410 | thou/µL |
| MEAN PLATELET VOLUME | 8.0 | | 6.8 - 10.9 | fL |
| WHITE BLOOD CELL COUNT | 5.10 | | 4.0 - 10.0 | thou/µL |
| **WBC DIFFERENTIAL COUNT** | | | | |
| SEGMENTED NEUTROPHILS | 58 | | 40 - 80 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| EOSINOPHILS | 03 | | 1 - 6 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| LYMPHOCYTES | 35 | | 20 - 40 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| MONOCYTES | 04 | | 2 - 10 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| BASOPHILS | 00 | | < 1 - 2 | % |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| DIFFERENTIAL COUNT PERFORMED ON: | EDTA SMEAR | | | |
| **MORPHOLOGY** | | | | |
| RBC | PREDOMINANTLY NORMOCYTIC NORMOCHROMIC, OCCASIONAL MICROCYTIC HYPOCHROMIC RBCs SEEN | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| WBC | NORMAL IN COUNT, MORPHOLOGY AND DISTRIBUTION | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| PLATELETS | ADEQUATE<br>NO HEMOPARASITES SEEN | | | |
| METHOD : MICROSCOPIC EXAMINATION | | | | |
| IMPRESSION | NORMOCYTIC NORMOCHROMIC BLOOD PICTURE | | | |

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| **ERYTHRO SEDIMENTATION RATE, BLOOD** | | | | |
| SEDIMENTATION RATE (ESR) | 10 | | 0 - 20 | mm at 1 hr |
| **GLUCOSE, FASTING, PLASMA** | | | | |
| GLUCOSE, FASTING, PLASMA | 89 | | 74 - 99 | mg/dL |
| **GLUCOSE, POST-PRANDIAL, PLASMA** | | | | |
| GLUCOSE, POST-PRANDIAL, PLASMA | 95 | | 74 - 140 | mg/dL |
| **CORONARY RISK PROFILE (LIPID PROFILE), SERUM** | | | | |
| CHOLESTEROL | **208** | **High** | < 200 Desirable<br>200 - 239 Borderline High<br>>/= 240 High | mg/dL |
| TRIGLYCERIDES | 83 | | < 150 Normal<br>150 - 199<br>Borderline High<br>200 - 499 High<br>>/=500 Very High | mg/dL |
| HDL CHOLESTEROL | **61** | **High** | < 40 Low<br>>/=60 High | mg/dL |
| DIRECT LDL CHOLESTEROL | **132** | **High** | < 100 Optimal<br>100 - 129<br>Near or above optimal<br>130 - 159<br>Borderline High<br>160 - 189<br>High<br>>/= 190<br>Very High | mg/dL |
| CHOL/HDL RATIO | 3.4 | | 3.3 - 4.4 Low Risk<br>4.5 - 7.0 Average Risk<br>7.1 - 11.0 Moderate Risk<br>> 11.0 High Risk | |
| LDL/HDL RATIO | 2.2 | | 0.5 - 3.0 Desirable/Low Risk<br>3.1 - 6.0 Borderline/Moderate Risk<br>>6.0 High Risk | |
| VERY LOW DENSITY LIPOPROTEIN | 16.6 | | </= 30.0 | mg/dL |
| **SERUM BLOOD UREA NITROGEN** | | | | |
| BLOOD UREA NITROGEN | 7 | | 6 - 20 | mg/dL |
| **CREATININE, SERUM** | | | | |
| CREATININE | 0.81 | | 0.60 - 1.10 | mg/dL |
| **URIC ACID, SERUM** | | | | |
| URIC ACID | 5.2 | | 2.6 - 6.0 | mg/dL |
| METHOD : SPECTROPHOTOMETRY, URICASE | | | | |
| **BILIRUBIN, TOTAL, SERUM** | | | | |
| BILIRUBIN, TOTAL | 0.70 | | 0.2 - 1.0 | mg/dL |
| **ASPARTATE AMINOTRANSFERASE, SERUM** | | | | |

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| ASPARTATE AMINOTRANSFERASE (AST/SGOT) | **10** | **Low** | 15 - 37 | U/L |
| METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE | | | | |
| **ALANINE AMINOTRANSFERASE, SERUM** | | | | |
| ALANINE AMINOTRANSFERASE (ALT/SGPT) | 12 | | < 34.0 | U/L |
| METHOD : SPECTROPHOTOMETRY, UV WITH PYRIDOXAL -5-PHOSPHATE | | | | |
| **URINALYSIS** | | | | |
| COLOR | PALE YELLOW | | | |
| APPEARANCE | CLEAR | | | |
| PH | 7.5 | | 4.7 - 7.5 | |
| SPECIFIC GRAVITY | 1.015 | | 1.003 - 1.035 | |
| GLUCOSE | NOT DETECTED | | | |
| PROTEIN | NOT DETECTED | | NOT DETECTED | |
| KETONES | NOT DETECTED | | NOT DETECTED | |
| BLOOD | NOT DETECTED | | NOT DETECTED | |
| BILIRUBIN | NOT DETECTED | | NOT DETECTED | |
| UROBILINOGEN | NORMAL | | NORMAL | |
| NITRITE | NOT DETECTED | | NOT DETECTED | |
| WBC | 3-5 | | 0-5 | /HPF |
| EPITHELIAL CELLS | **8-10** | | 0-5 | /HPF |
| RED BLOOD CELLS | NOT DETECTED | | NOT DETECTED | /HPF |
| CASTS | NOT DETECTED | | | |
| CRYSTALS | NOT DETECTED | | NOT DETECTED | |
| BACTERIA | NOT DETECTED | | NOT DETECTED | |
| REMARKS | LEUCOCYTE ESTERASE : NEGATIVE | | | |
| **TOTAL TSH, SERUM** | | | | |
| TSH 3RD GENERATION | 0.871 | | 0.55 - 4.78 | µIU/mL |
| METHOD : CHEMILUMINESCENCE | | | | |
| **ELECTROCARDIOGRAM** | | | | |
| ECG | WITHIN NORMAL LIMITS | | | |
| **MEDICAL HISTORY** | | | | |
| RELEVANT PRESENT HISTORY | NOT SIGNIFICANT | | | |
| RELEVANT PAST HISTORY | NOT SIGNIFICANT | | | |
| RELEVANT PERSONAL HISTORY | NOT SIGNIFICANT | | | |
| RELEVANT FAMILY HISTORY | NOT SIGNIFICANT | | | |
| **ANTHROPOMETRIC DATA & BMI** | | | | |
| HEIGHT IN METERS | 1.68 | | | mts |
| WEIGHT IN KGS. | 62 | | | Kgs |

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| BMI | 22 | BMI & Weight Status as follows:<br>Below 18.5: Underweight<br>18.5 - 24.9: Normal<br>25.0 - 29.9: Overweight<br>30.0 and Above: Obese | kg/sqmts |
| **GENERAL EXAMINATION** | | | |
| BLOOD PRESSURE | 120/80 | | |
| PULSE | REGULAR, ALL PERIPHERAL PULSES WELL FELT | | |
| RESPIRATORY RATE | NORMAL | | |
| LYMPHONODE | NORMAL | | |
| EDEMA | NORMAL | | |
| **BASIC EYE EXAMINATION** | | | |
| DISTANT VISION RIGHT EYE WITHOUT GLASSES | NORMAL | | |
| DISTANT VISION LEFT EYE WITHOUT GLASSES | NORMAL | | |
| NEAR VISION RIGHT EYE WITHOUT GLASSES | NORMAL | | |
| NEAR VISION LEFT EYE WITHOUT GLASSES | NORMAL | | |
| COLOUR VISION | NORMAL | | |
| **SUMMARY** | | | |
| RELEVANT HISTORY | NOT SIGNIFICANT | | |
| RELEVANT GP EXAMINATION FINDINGS | NOT SIGNIFICANT | | |
| RELEVANT LAB INVESTIGATIONS | WITHIN NORMAL LIMITS | | |
| RELEVANT NON PATHOLOGY DIAGNOSIS | NO ABNORMALITIES DETECTED | | |
| REMARKS / RECOMMENDATIONS | NONE | | |

**Comments**

*NOTE: NON PATH TEST ARE REVIEWED BY
Consultant Physician: Dr. Vijayalakshmi MBBS,MD.
Radiologist : Dr.Thilak Babu , MBBS, DMRD
Dental Surgeon : Dr. Mrudula Veginati , BDS.

**Interpretation(s)**
COMPLETE BLOOD COUNT-
The cell morphology is well preserved for 24hrs. However after 24-48 hrs a progressive increase in MCV and HCT is observed leading to a decrease in MCHC. A direct smear is recommended for an accurate differential count and for examination of RBC morphology.

TEST METHOD: Spectrophotometric/ Electronic Impedence/ Calculation
ERYTHRO SEDIMENTATION RATE, BLOOD-
Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythaemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.
GLUCOSE, FASTING, PLASMA-
ADA 2012 guidelines for adults as follows:
Pre-diabetics: 100 - 125 mg/dL
Diabetic: > or = 126 mg/dL

(Ref: Tietz 4th Edition & ADA 2012 Guidelines)
CORONARY RISK PROFILE (LIPID PROFILE), SERUM-
Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a

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cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk.It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the ""good"" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely.HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease.
Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Recommendations:
Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.
SERUM BLOOD UREA NITROGEN-Causes of Increased levels
Pre renal
• High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
• Renal Failure
Post Renal
• Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels
• Liver disease
• SIADH.
CREATININE, SERUM-
Higher than normal level may be due to:
• Blockage in the urinary tract
• Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
• Loss of body fluid (dehydration)
• Muscle problems, such as breakdown of muscle fibers
• Problems during pregnancy, such as seizures (eclampsia)), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:
• Myasthenia Gravis
• Muscular dystrophy
BILIRUBIN, TOTAL, SERUM-Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice).

An elevated bilirubin level in a newborn may be temporary and resolve itself within a few days to two weeks. However, if the bilirubin level is above a critical threshold or rapidly increases, an investigation of the cause is needed so appropriate treatment can be initiated.

Source:
1) Teitz
2) Wallach"s interpretation of diagnostic tests, 9th ed
ASPARTATE AMINOTRANSFERASE, SERUM-
Aminotransferase (AST) is an enzyme found in various parts of the body .AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.
ALANINE AMINOTRANSFERASE, SERUM-
Alanine aminotransferase (ALT) test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. . AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.
URINALYSIS-
Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain

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medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.
Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.
Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.
pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.
Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia
TOTAL TSH, SERUM-
Below mentioned are the guidelines for Pregnancy related reference ranges for TSH.

| Levels in Pregnancy | TSH (µIU/mL) |
|---|---|
| First Trimester | 0.1 - 2.5 |
| 2nd Trimester | 0.2 – 3.0 |
| 3rd Trimester | 0.3 – 3.0 |

NOTE: TSH concentrations in apparently normal euthyroid subjects are known to be highly skewed, with a strong tailed distribution towards higher TSH values. This is well documented in the pediatric population including the infant age group.

ELECTROCARDIOGRAM-
'Wellness consultation for the above reports will be provided on select dates at your office location. In case you miss your onsite check up, you may visit any of SRLs wellness centres in your city at a subsequent date by appointment.'

****End Of Report****
**Please visit www.srlworld.com for related Test Information for this accession**

**Dr. Rojaramani Potluri**
**Lab Head**