

**Patient Name :** MR. SANJAI KUMAR

**Age / Gender :** 51 years / Male

**MR No. / IPD No. :** /

**Patient Type / Bed No. :** I /

**Referred By :** ARCOFEMI HEALTH CARE  
PVT.LIMITED ( MEDIWHEEL )



**Registration Time :** Mar 08, 2025, 09:56 a.m.

**Receiving Time :** Mar 08, 2025, 09:56 a.m.

**Reporting Time :** Mar 08, 2025, 01:16 p.m.



250308051

**Panel :** Dr Arcofemi Health Care PVT.limited ( MediWheel )

**Client Code :** ACROFEMI HEALTH CARE PVT. LTD.  
(MEDIWHEEL)

Test Description	Value(s)	Unit(s)	Reference Range
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### HAEMATOLOGY

#### Complete Haemogram - Hb RBC count and indices, TLC, DLC, PLATELET, ESR.(EDTA Whole Blood)

Hemoglobin (Hb) Method : Whole Blood, SLS-haemoglobin	16.5	g/dL	13.0 - 17.0
Erythrocyte (RBC) Count Method : Whole Blood, DC detection	5.44	x 10 <sup>6</sup> /uL	4.5 - 5.5
HCT Method : Whole Blood, RBC pulse height detection	50.4	%	42 - 52
Mean Cell Volume (MCV) Method : Whole Blood, Electrical Impedence	92.6	fL	78 - 100
Mean Cell Haemoglobin (MCH) Method : Whole Blood, Calculated	30.3	pg	27 - 31
Mean Corpuscular Hb Conc. (MCHC) Method : Whole Blood, Calculated	32.7	g/dL	32.0 - 35.0
Red Cell Distribution Width (RDW) CV Method : Whole Blood, Calculated	12.2	%	11.5 - 14.0
Total Leucocytes (WBC) Count Method : Whole Blood, Flow cytometry	7.4	x 10 <sup>3</sup> /uL	4-10
<b>DLC (Differential Leucocytes Count)</b>			
Neutrophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	44.2	%	40 - 80
Lymphocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	<b>40.1</b>	%	20 - 40
Monocytes Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	8.8	%	2 - 10
Eosinophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	<b>6.5</b>	%	1 - 6
Basophils Method : Whole Blood, Fluorescence /Flowcytometry/ Microscopy	0.4	%	0 - 2
Absolute Neutrophil Count Method : Whole Blood, Calculated	3.27	x 10 <sup>3</sup> /uL	2.0 - 7.0
Absolute Lymphocyte Count Method : Whole Blood, Calculated	2.97	x 10 <sup>3</sup> /uL	1 - 3
Absolute Monocyte Count Method : Whole Blood, Calculated	0.65	x 10 <sup>3</sup> u/L	0.2-1.0
Absolute Eosinophil Count Method : Whole Blood, Calculated	0.48	x 10 <sup>3</sup> /uL	0.02 - 0.5
Absolute Basophils Count Method : Whole Blood, Calculated	0.03	x 10 <sup>3</sup> /uL	0.02 - 0.1
Platelet Count Method : Whole Blood, DC Detection	271	x 10 <sup>3</sup> /uL	150 - 450

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Test Description	Value(s)	Unit(s)	Reference Range
ESR - Erythrocyte Sedimentation Rate Method : Whole blood , Modified Westergren Method	10	mm/hr	<10

**Interpretation:**

It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever,. It is also increased in multiple myeloma, hypothyroidism.

Tests done on Automated Six Part Cell Counter.

\*\*\*END OF REPORT\*\*\*



Dr. Arti Tripathi  
MD Pathology  
Lab Director  
DMC No: 43012

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Test Description	Value(s)	Unit(s)	Reference Range
<b><u>CLINICAL PATHOLOGY</u></b>			
<b><u>Urine Glucose ( Fasting &amp; PP)</u></b>			
Glucose Fasting (Urine ) Method : Oxidase Reaction/ Manual	Negative		Negative
Glucose Post Prandial (Urine) Method : Oxidase Reaction/ Manual	Negative		Negative

\*\*\*END OF REPORT\*\*\*



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Test Description	Value(s)	Unit(s)	Reference Range
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**IMMUNOLOGY**

**T3, T4, TSH ( Thyroid Profile Total),Serum**

(Triiodothyronine) T3-Total <small>Method : ECLIA</small>	1.32	ng/mL	0.80 - 2.00
(Thyroxine) T4-Total <small>Method : ECLIA</small>	8.52	ug/dL	5.10 - 14.10
TSH-Ultrasensitive <small>Method : ECLIA</small>	3.45	uIU/mL	0.27-4.20

**Interpretation**

The Biological reference interval provided is for Adults.  
 For age specific reference interval, please refer to the table given below.

TSH	T3/T3	T4/T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hypothyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non Thyroidal illness/Secondary Hyperthyroidism

TSH (mU/mL)			
Children	New Born	0.7	15.2
	6 days - 3 Months	0.72	11
	4 -12 Months	0.73	8.35
	1-6 Years	0.7	5.97
	7-11 Years	0.6	4.84
	12-20 years	0.51	4.3
Adults		0.27	4.20

TSH levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentration are observed during the afternoon. diurnal variation in TSH levels is approx 50%+/-, hence time of the day can influence the measured serum concentration.

\*\*\*END OF REPORT\*\*\*

  
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**HAEMATOLOGY**

**Blood Group (ABO)**

Blood Group	"A"
Method : Forward and Reverse by Slide method	
RH Factor	Negative

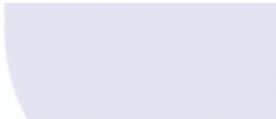
**Methodology**  
This is done by forward and reverse grouping by slide agglutination method.

**Interpretation**  
Newborn baby does not produce ABO antibodies until 3 to 6 months of age. So the blood group of the Newborn baby is done by ABO antigen grouping (forward grouping) only, antibody grouping (reverse grouping) is not required. Confirmation of the New-born's blood group is indicated when the A and B antigen expression and the isoagglutinins are fully developed (2-4 years).

\*\*\*END OF REPORT\*\*\*



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**BIOCHEMISTRY**

**LFT (Liver Function Test,Serum)**

<b>Total Protein</b> Method : Biuret Method	8.6	g/dL	6.6 - 8.7
<b>Albumin</b> Method : Bromocresol Green (BCG)	4.8	g/L	3.5 - 5.2
<b>Globulin</b> Method : Calculated	<b>3.80</b>	g/dL	1.8 - 3.6
<b>A G Ratio</b> Method : Calculated	1.26	ratio	1.2 - 2.2
<b>SGOT</b> Method : IFCC with Pyridoxal Phosphate	23	U/L	5 to 40
<b>SGPT</b> Method : IFCC with Pyridoxal Phosphate	23	U/L	10-50
<b>Alkaline Phosphatase ALP</b> Method : PNP AMP Kinetic	77	U/L	40-129
<b>GGT-Gamma Glutamyl Transferase</b> Method : IFCC	34	U/L	8-61
<b>Bilirubin Total</b> Method : Diazo Method	0.50	mg/dL	0.2-1.2
<b>Bilirubin Direct</b> Method : Diazo Method	0.20	mg/dL	0.09 - 0.30
<b>Bilirubin Indirect</b> Method : Calculated	0.30	mg/dL	0.1 - 1.0

**Interpretation:**

**SGOT/ SGPT:** Increased in Acute viral hepatitis, Biliary tract obstruction (cholangitis, choledocholithiasis), Alcoholic hepatitis and Cirrhosis, liver abscess, metastatic or primary liver cancer; non-alcoholic steatohepatitis; right heart failure. Decreased in Pyridoxine (vit B6) deficiency.

**Alkaline Phosphatase:** Increased in Obstructive hepatobiliary disease, Bone disease (physiologic bone growth, Paget disease, Osteomalacia, Osteogenic sarcoma, Bone metastases), Hyperparathyroidism, Rickets, Pregnancy (third trimester). Decreased in Hypophosphatasia.

**GGT:** Increased in Liver disease Acute viral or toxic hepatitis, Chronic or subacute hepatitis, Alcoholic hepatitis, Cirrhosis, Biliary tract obstruction.

**Protein:** Moderate-to-marked hyperproteinemia maybe due to multiple myeloma and other malignant paraproteinemias, Hypoproteinemia may be due to decreased production or increased protein loss.

**Albumin:** Increased in Dehydration, Shock, Hemoconcentration. Decreased in hepatic synthesis(Chronic liver disease, malnutrition, malabsorption, malignancy), Increased losses (Nephrotic syndrome, Burns, Trauma, Hemorrhage with fluid replacement, acute or chronic glomerulonephritis), Hemodilution (pregnancy, CHF) and Drugs (estrogens).

**Bilirubin:** Elevated levels of bilirubin (jaundice) might indicate liver damage or disease or certain types of anemia.

\*\*\*END OF REPORT\*\*\*

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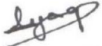


250308051

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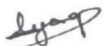
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Lab Director  
DMC No: 43012

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<b>BIOCHEMISTRY</b>			
<b><u>Lipid Profile,Serum</u></b>			
<b>Cholesterol-Total</b> Method : CHOD-POD	249	mg/dL	Desirable: < 200 Borderline: 200-239 High: > 240 Ref: The National Cholesterol Education Program (NCEP) Adult Treatment Panel III Report.
<b>Triglycerides</b> Method : GPO-POD	123	mg/dL	Normal: < 150 Borderline High: 150-199 High: 200-499 Very High: > 500
<b>Cholesterol-HDL Direct</b> Method : Homogenous Enzymatic	42	mg/dL	No Risk - $\geq$ 60 mg/dL Moderate risk - 35-55 mg/dL High risk - < 40 mg/dL
<b>LDL Cholesterol</b> Method : Calculate	182.40	mg/dL	Optimal: < 100 Near optimal/above optimal: 100-129 Borderline high: 130-159 High: 160-189 Very High: $\geq$ 190
<b>Non - HDL Cholesterol</b> Method : Calculated	207	mg/dL	Desirable: < 130 mg/dL Borderline High: 130-159mg/dL High: 160-189 mg/dL Very High: > or = 190 mg/dL
<b>VLDL Cholesterol</b> Method : Calculated	24.60	mg/dL	0 - 30
<b>CHOL/HDL RATIO</b> Method : Calculated	5.93	Ratio	3.5 - 5.0
<b>LDL/HDL RATIO</b> Method : Calculated	4.34	Ratio	Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0- 6.0 Elevated / High risk - > 6.0

**Note:** 08-10 hours fasting sample is required.

\*\*\*END OF REPORT\*\*\*



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**BIOCHEMISTRY**

**KFT (Renal Function Test,Serum)**

<b>Urea</b> Method : Urease-GLDH	25.9	mg/dL	16.6-48.5
<b>Creatinine</b> Method : Jaffe Method	1.00	mg/dL	0.9-1.3
<b>Uric Acid</b> Method : Uricase-POD	4.7	mg/dL	3.4-7.0
<b>Potassium</b> Method : ISE Direct	-	mmol/L	3.5-5.3

**Interpretation :**

**Urea:-** Increased in renal diseases,urinary obstructions, shock, congestive heart failure .Decreased in liver failure and pregnancy.

**Creatinine :-** Elevated in renal dysfunction, reduced renal blood flow shock, dehydration, Congestive heart failure, Diabetes Acromegaly. Decreased levels are found in Muscular Dystrophy.

**Uric acid:-** Increased in Gout, Arthritis, impaired renal functions and starvation.Decreased in Wilson's disease, Fanconis Syndrome and Yellow Atrophy of Liver.

**Sodium:-**Increased in Excessive dietary salt ,Diuretic therapy,Adrenal insufficiency,Salt-wasting nephropathy and Vomiting.Decreased levels are seen in Hyperaldsteronism ,Hyponatremia,Prerenal Azotemia,Renal Failure and Glomerulonephritis.

**Potassium:-** Low levels is common in vomiting, diarrhea, alcoholism, and folic acid deficiency. Increase level are seen in end-stage renal failure, hemolysis, trauma, Addison's disease, metabolic acidosis, acute starvation, dehydration, and with rapid potassium infusion.

**Chloride:-** Increased in dehydration, renal tubular acidosis, acute renal failure, metabolic acidosis, diabetes insipidus, adrenocortical hyperfunction. Decreased in overhydration, chronic respiratory acidosis, salt-losing nephritis, metabolic alkalosis.

\*\*\*END OF REPORT\*\*\*



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**BIOCHEMISTRY**

**Glucose ( Fasting),Plasma**

<b>Glucose Fasting</b> <small>Method : Hexokinase</small>	95	mg/dL	Normal: 74-100 Impaired Glucose Tolerance: 100-125 Diabetes mellitus: $\geq 126$ (on more than one occasion) (American diabetes association guidelines 2025)
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**Interpretation**

Glycemic goals for Diabetes

Fasting Plasma Glucose	80-130 mg/dL
Post Prandial Plasma Glucose	<180 mg/dL

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

\*\*\*END OF REPORT\*\*\*



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**BIOCHEMISTRY**

**Glucose (PP),Plasma**

<b>Blood Glucose-Post Prandial</b> <small>Method : Hexokinase</small>	75	mg/dL	Normal :74 - 140 Prediabetes : 140-199 (2 hrs of OGTT) Diabetes : > 200 2 hrs
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Interpretation

Glycemic goals for Diabetes

Fasting Plasma Glucose	80-130 mg/dL
Post Prandial Plasma Glucose	<180 mg/dL

Glucose is the major carbohydrate present in the peripheral blood. Oxidation of glucose is the major source of cellular energy in the body. The concentration of glucose in blood is controlled within the narrow limits by many hormones, the most important of which are produced by the pancreas. The most frequent cause of hyperglycaemia is diabetes mellitus resulting from deficiency in insulin secretion or action. These include pancreatitis, thyroid dysfunction, renal failure, and liver disease. Hypoglycaemia is less frequently observed. A variety of conditions may cause low blood glucose levels such as insulinoma, hypopituitarism, or insulin induced hypoglycaemia.

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**HAEMATOLOGY**

**Glycated Hb (HbA1c)**

<b>HbA1c (Glycated Hemoglobin)</b>	<b>5.8</b>	<b>%</b>	Non-Diabetic : <5.7 Pre Diabetes : 5.7 - 6.4 Diabetes : ≥ 6.5
<small>Method : EDTA Whole blood, HPLC, NGSP certified</small>			

**Estimated Average Glucose :** 119.76 mg/dL

**Interpretations**

- HbA1c has been used as one of the key biomarkers in identifying patients with Diabetes . American Diabetes Association (ADA) and several clinical groups have endorsed utility of HbA1c testing using a cut off value of 6.5%. The average concentration of blood glucose(eBG) is reflected in this test over a period of the past three months.
- Therapeutic goals for monitoring Diabetes.
  - Goal of therapy < 7% HbA1c.
  - Action suggested > 8 % HbA1c
- Patients with shortened red cell survival( hemolytic disease), recent significant blood loss have lower HbA1c values .
- High HbA1c is associated with Iron deficiency ,patients with polycythemia or post splenectomy.

**Note :** The presence of hemoglobin variants can interfere with measurement of HbA1c.

\*\*\*END OF REPORT\*\*\*



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**IMMUNOLOGY**

**PSA Total (Prostate Specific Antigen),Serum**

<b>Prostate-specific antigen (Total)</b>	0.68	ng/mL	0.0-4.40
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Method : ECLIA

**INTERPRETAION**

- Prostate-specific antigen (PSA) is a glycoprotein produced by the prostate gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels.
- If total prostate-specific antigen (PSA) concentration is < 2.0 ng/mL, the probability of prostate cancer in asymptomatic men is low. When total PSA concentration is > 10.0 ng/mL, the probability of cancer is high and further testing is recommended.

**Note :-**

- Normal results do not eliminate the possibility of prostate cancer.
- The test specimens should be obtained before the patients undergoing prostate manipulation procedures like biopsy/transurethral resection.

\*\*\*END OF REPORT\*\*\*



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Lab Director  
DMC No: 43012

<b>Patient Name :</b> MR. SANJAI KUMAR <b>Age / Gender :</b> 51 years / Male <b>MR No. / IPD No. :</b> / <b>Patient Type / Bed No. :</b> I / <b>Referred By :</b> ARCOFEMI HEALTH CARE PVT.LIMITED ( MEDIWHEEL )		<b>Registration Time :</b> Mar 08, 2025, 09:56 a.m. <b>Receiving Time :</b> Mar 08, 2025, 09:56 a.m. <b>Reporting Time :</b> Mar 08, 2025, 01:16 p.m.  250308051 <b>Panel :</b> Dr Arcofemi Health Care PVT.limited ( MediWheel ) <b>Client Code :</b> ACROFEMI HEALTH CARE PVT. LTD. (MEDIWHEEL)
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Test Description	Value(s)	Unit(s)	Reference Range
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**CLINICAL PATHOLOGY**

**Urine (RE/ME)**

**Physical Examination :**

Volume Method : Visual Observation	30		mL
Colour Method : Visual Observation	Pale Yellow		Pale Yellow
Appearance Method : Visual Observation	Clear		Clear
Reaction (pH) Method : Double Indicator method	6.0		4.5 - 8.0
Specific Gravity Method : Ionic Concentration	1.020		1.010 - 1.030

**Chemical Examination (Dipstick Method) Urine**

Urine Protein Method : Protein Ionisation Heat Test (Acidic Acid)	Absent		Absent
Urine Glucose (sugar) Method : Oxidase Reaction/Benedict's	Absent		Absent
Blood (Urine) Method : Peroxidase Reaction	Absent		Absent

**Microscopic Examination Urine**

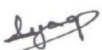
Red Blood Cells Method : Microscopy	Absent	/hpf	Absent
Pus Cells (WBCs) Method : Microscopy	2 - 4	/hpf	0 - 5
Epithelial Cells Method : Microscopy	2 - 4	/hpf	0 - 4
Cast Method : Microscopy	Absent		Absent
Crystals Method : Microscopy	Absent		Absent
Amorphous Material Method : Microscopy	Absent		Absent
Yeast Cells Method : Microscopy	Absent		Absent
Others Method : Microscopy	Absent		

Remarks:-

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Test Description	Value(s)	Unit(s)	Reference Range
Epithelial cells			Urolithiasis bladder carcinoma or hydronephrosis ,ureteric stents or bladdercatheters for prolonged periods of time.
Granular casts			Low intratubular pH,high urine osmolality and sodium concentration, interaction with Bence-Jones protein
Hyaline casts			Physical stress, fever, dehydration,acute congestive heart failure, renal diseases.
Calcium Oxalate			Metabolic stone disease, primary or secondary hyperoxaluria, intravenous infusion of large doses of VitaminC, the use of vasodilator naftidrofuryl oxalate or the gastrointestinal lipase inhibitor orlistat, ingestion of ethylene glycol or of star fruit( A verrhoa carambola)or its juice
Uric acid			Arthritis
Bacteria			Urinary infection when present in significant numbers and with pus cells.
Trichomonas vaginalis			Vaginitis, cervicitis or salpingitis

\*\*\*END OF REPORT\*\*\*



Dr. Arti Tripathi  
MD Pathology  
Lab Director  
DMC No: 43012