Lab No.	: GAR/11-03-2023/SR7392620	**Lab Add.**	: Newtown, Kolkata-700156
Patient Name	: **MADHABI ADHIKARI**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 28 Y 11 M 22 D	**Collection Date**	: 11/Mar/2023 10:12AM
Gender	: F	**Report Date**	: 11/Mar/2023 05:09PM

Test Name	Result	Unit	Bio Ref. Interval	Method
PDF Attached				
GLYCATED HAEMOGLOBIN (HBA1C) , *EDTA WHOLE BLOOD*				
GLYCATED HEMOGLOBIN (HBA1C)	5.4	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	35.0	mmol/mol		HPLC

Clinical Information and Laboratory clinical interpretation on Biological Reference Interval:
Low risk / Normal / non-diabetic : <5.7% (NGSP) / < 39 mmol/mol (IFCC)
Pre-diabetes/High risk of Diabetes : 5.7%- 6.4% (NGSP) / 39 - < 48 mmol/mol (IFCC)
Diabetics-HbA1c level : >/= 6.5% (NGSP) / > 48 mmol/mol (IFCC)

Analyzer used : Bio-Rad-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemic targets
Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemic control.
Ø The timing and frequency of SMBG should be tailored based on patients' individual treatment, needs, and goals.
Ø Patients should undergo HbA1c testing at least twice a year if they are meeting treatment goals and have stable glycemic control.
Ø If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.
Ø **For most adults who are not pregnant, HbA1c levels should be <7% to help reduce microvascular complications and macrovascular disease . Action suggested >8% as it indicates poor control.**
Ø Some patients may benefit from HbA1c goals that are stringent.
Result alterations in the estimation has been established in many circumstances, such as after acute/ chronic blood loss, for example, after surgery, blood transfusions, hemolytic anemia, or high erythrocyte turnover; vitamin B_{12}/ folate deficiency, presence of chronic renal or liver disease; after administration of high-dose vitamin E / C; or erythropoietin treatment.
Reference: Glycated hemoglobin monitoring BMJ 2006; 333;586-8

References:
1. *Chamberlain JJ, Rhinehart AS, Shaefer CF, et al. Diagnosis and management of diabetes: synopsis of the 2016 American Diabetes Association Standards of Medical Care in Diabetes. Ann Intern Med. Published online 1 March 2016. doi:10.7326/M15-3016.*
2. *Mosca A, Goodall I, Hoshino T, Jeppsson JO, John WG, Little RR, Miedema K, Myers GL, Reinauer H, Sacks DB, Weykamp CW. International Federation of Clinical Chemistry and Laboratory Medicine, IFCC Scientific Division. Global standardization of glycated hemoglobin measurement: the position of the IFCC Working Group. Clin Chem Lab Med. 2007;45(8):1077-1080.*

Dr NEEPA CHOWDHURY
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Lab No. : SR7392620 **Name : MADHABI ADHIKARI** **Age/G : 28 Y 11 M 22 D / F** **Date : 11-03-2023**

PHOSPHORUS-INORGANIC, BLOOD , *GEL SERUM*				
PHOSPHORUS-INORGANIC,BLOOD	3.1	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV
SODIUM, BLOOD , *GEL SERUM*				
SODIUM,BLOOD	139.00	mEq/L	132 - 146 mEq/L	ISE INDIRECT
GLUCOSE, FASTING , *BLOOD, NAF PLASMA*				
GLUCOSE,FASTING	80	mg/dL	Impaired Fasting-100-125 .~Diabetes- >= 126.~Fasting is defined as no caloric intake for at least 8 hours.	Gluc Oxidase Trinder

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

***CHLORIDE, BLOOD ,** .				
CHLORIDE,BLOOD	106.00	mEq/L	99-109 mEq/L	ISE INDIRECT
POTASSIUM, BLOOD , *GEL SERUM*				
POTASSIUM,BLOOD	4.10	mEq/L	3.5-5.5 mEq/L	ISE INDIRECT
THYROID PANEL (T3, T4, TSH) , *GEL SERUM*				
T3-TOTAL (TRI IODOTHYRONINE)	1.11	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.2	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	1.73	µIU/mL	0.55-4.78 µIU/mL	CLIA

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

References:

1. Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of
individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. Eur J Endocrinol 2001;145:409-13.

2. Bellantone R, Lombardi CP, Bossola M, Ferrante A,Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. Cancer 2001;92:2273-9.

BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]
Trimester specific TSH LEVELS during pregnancy:
FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL
SECOND TRIMESTER: 0.20 -3.50 µ IU/mL
THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

References:

1. *Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan.Thyroid.Mar 2017.315-389.http://doi.org/10.1089/thy.2016.0457*

2. *Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective.*

Indian J Endocr Metab 2018;22:1-4.

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Lab No. : SR7392620	Name : MADHABI ADHIKARI		Age/G : 28 Y 11 M 22 D / F	Date : 11-03-2023
UREA,BLOOD , *GEL SERUM*	**17.1**	mg/dL	19-49 mg/dL	Urease with GLDH
URIC ACID, BLOOD , *GEL SERUM*				
URIC ACID,BLOOD	4.10	mg/dL	2.6-6.0 mg/dL	Uricase/Peroxidase
CREATININE, BLOOD	**0.41**	mg/dL	0.5-1.1 mg/dL	Jaffe, alkaline picrate, kinetic
CALCIUM, BLOOD				
CALCIUM,BLOOD	9.30	mg/dL	8.7-10.4 mg/dL	Arsenazo III
TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .				
TOTAL PROTEIN	7.70	g/dL	5.7-8.2 g/dL	BIURET METHOD
ALBUMIN	4.7	g/dL	3.2-4.8 g/dL	BCG Dye Binding
GLOBULIN	3.00	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.57		1.0 - 2.5	Calculated

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Lab No. : SR7392620 **Name : MADHABI ADHIKARI** **Age/G : 28 Y 11 M 22 D / F** **Date : 11-03-2023**

URINE ROUTINE ALL, ALL , *URINE*

PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	SLIGHTLY HAZY			
CHEMICAL EXAMINATION				
pH	6.5		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015		1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	NOT DETECTED		NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	NOT DETECTED		NOT DETECTED	Dipstick(glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	NOT DETECTED		NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	PRESENT(+)		NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	NEGATIVE		NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	NEGATIVE		NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	NEGATIVE		NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	Dipstick (ester hydrolysis reaction)
MICROSCOPIC EXAMINATION				
LEUKOCYTES (PUS CELLS)	0-1	/hpf	0-5	Microscopy
EPITHELIAL CELLS	4-6	/hpf	0-5	Microscopy
RED BLOOD CELLS	2-3	/hpf	0-2	Microscopy
CAST	NOT DETECTED		NOT DETECTED	Microscopy
CRYSTALS	NOT DETECTED		NOT DETECTED	Microscopy
BACTERIA	NOT DETECTED		NOT DETECTED	Microscopy
YEAST	NOT DETECTED		NOT DETECTED	Microscopy

Note:

1. All urine samples are checked for adequacy and suitability before examination.
2. Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
3. The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
4. Negative nitrite test does not exclude urinary tract infections.
5. Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
6. False positive results for glucose, protein, nitrite, urobilinogen, bilirubin can occur due to use of certain drugs, therapeutic dyes, ascorbic acid, cleaning agents used in urine collection container.
7. Discrepancy between results of leukocyte esterase and blood obtained by chemical methods with corresponding pus cell and red blood cell count by microscopy can occur due to cell lysis.
8. Contamination from perineum and vaginal discharge should be avoided during collection, which may falsely elevate epithelial cell count and show presence of bacteria and/or yeast in the urine.

ESR (ERYTHROCYTE SEDIMENTATION RATE) , *EDTA WHOLE BLOOD*

1stHour	**33**	mm/hr	0.00 - 20.00 mm/hr	Westergren

CBC WITH PLATELET (THROMBOCYTE) COUNT , *EDTA WHOLE BLOOD*

HEMOGLOBIN	12.1	g/dL	12 - 15	PHOTOMETRIC
WBC	8.6	*10^3/µL	4 - 10	DC detection method
RBC	4.14	*10^6/µL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE) COUNT	177	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	57	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	34	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	07	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	02	%	1 - 6 %	Flowcytometry/Microscopy

Lab No. : SR7392620	Name : MADHABI ADHIKARI		Age/G : 28 Y 11 M 22 D / F	Date : 11-03-2023
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				
HEMATOCRIT / PCV	36.4	%	36 - 46 %	Calculated
MCV	88.0	fl	83 - 101 fl	Calculated
MCH	29.2	pg	27 - 32 pg	Calculated
MCHC	33.2	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTION WIDTH	**14.9**	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTION WIDTH	35.1	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUME	14.3		7.5 - 11.5 fl	Calculated

BLOOD GROUP ABO+RH [GEL METHOD] , *EDTA WHOLE BLOOD*

ABO	O	Gel Card
RH	POSITIVE	Gel Card

TECHNOLOGY USED: GEL METHOD

ADVANTAGES :

- Gel card allows simultaneous forward and reverse grouping.
- Card is scanned and record is preserved for future reference.
- Allows identification of Bombay blood group.
- Daily quality controls are run allowing accurate monitoring.

Historical records check not performed.

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Lab No. : SR7392620 **Name : MADHABI ADHIKARI** **Age/G : 28 Y 11 M 22 D / F** **Date : 12-03-2023**

GLUCOSE, PP , *BLOOD, NAF PLASMA*

GLUCOSE,PP	135	mg/dL	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.	Gluc Oxidase Trinder

The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water. In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

LIPID PROFILE , *GEL SERUM*

CHOLESTEROL-TOTAL	136.00	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	99.00	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	44.00	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	72.0	mg/dL	OPTIMAL : <100 mg/dL, Near optimal/ above optimal : 100-129 mg/dL, Borderline high : 130-159 mg/dL, High : 160-189 mg/dL, Very high : >=190 mg/dL	Calculated
VLDL	20	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	3.1		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated

Reference: *National Cholesterol Education Program. Executive summary of the third report of The National Cholesterol Education Program (NCEP) Expert Panel on detection, evaluation, and treatment of high blood cholesterol in adults (Adult Treatment Panel III).* JAMA. *May 16 2001;285(19):2486-97.*

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Lab No.	: GAR/11-03-2023/SR7392620	**Lab Add.**	:
Patient Name	: **MADHABI ADHIKARI**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 28 Y 11 M 22 D	**Collection Date:**	
Gender	: F	**Report Date**	: 12/Mar/2023 08:49AM

X-RAY REPORT OF CHEST (PA)

FINDINGS :

No active lung parenchymal lesion is seen.

Both the hila are normal in size, density and position.

Mediastinum is in central position. Trachea is in midline.

Domes of diaphragm are smoothly outlined. Position is within normal limits.

Lateral costo-phrenic angles are clear.

The cardio-thoracic ratio is normal.

Bony thorax reveals no definite abnormality.

IMPRESSION :

Normal study.

Dr. Anoop Sastry
MBBS, DMRT(CAL)
CONSULTANT RADIOLOGIST
Registration No.: WB-36628

Suraksha DIAGNOSTICS

Lab No.	: GAR/11-03-2023/SR7392620	**Lab Add.**	:
Patient Name	: **MADHABI ADHIKARI**	**Ref Dr.**	: Dr.MEDICAL OFFICER
Age	: 28 Y 11 M 22 D	**Collection Date:**	
Gender	: F	**Report Date**	: 11/Mar/2023 04:06PM

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

Clinical Indication	Part of regular study.
Heart Rate	71 beats /min
Rhythm	Regular.
PR	116 ms
QRS	84 ms
QTc	425 ms
Axis	Normal.
P-wave morphology	Normal.
Impression	**Regular, narrow complex rhythm of sino-atrial origin, at 71 bpm.**

Dr. SOUMIK CHATTERJEE
Consultant Physician (GOLD MEDALIST)
Diagnostic Cardiac & Vascular Imaging
National Excellence Award Honoree

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SURAKSHA DIAGNOSTIC,RAJARHAT,KOLKATA **PATIENT REPORT**
BIO-RAD VARIANT-II TURBO CDM5.4. SN-16122 **V2TURBO_A1c_2.0**

Patient Data

Sample ID:	C02135000696
Patient ID:	SR7392620
Name:	
Physician:	
Sex:	
DOB:	

Comments:

Analysis Data

Analysis Performed:	11/MAR/2023 16:15:45
Injection Number:	5571U
Run Number:	131
Rack ID:	0003
Tube Number:	1
Report Generated:	11/MAR/2023 16:37:00
Operator ID:	ASIT

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.4	0.162	27815
A1b	---	0.9	0.222	17350
F	---	1.5	0.277	30212
LA1c	---	1.5	0.405	30792
A1c	5.4	---	0.511	86307
P3	---	3.3	0.787	65095
P4	---	1.2	0.866	24063
Ao	---	85.8	0.987	1705544

Total Area: 1,987,180

HbA1c (NGSP) = 5.4 % HbA1c (IFCC) = 35 mmol/mol