



Lab No. : KNK/10-06-2023/SR7743313
 Patient Name : SUPARNA SADHUKHAN
 Age : 27 Y 3 M 14 D
 Gender : F

Lab Add. : Newtown, Kolkata-700156
 Ref Dr. : Dr.MEDICAL OFFICER
 Collection Date: 10/Jun/2023 09:56AM
 Report Date : 11/Jun/2023 11:19AM



Test Name	Result	Unit	Bio Ref. Interval	Method
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[PDF Attached](#)

GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD

GLYCATED HEMOGLOBIN (HBA1C)	4.9	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	30.0	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 glycemc targets

- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemc 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 glycemc control.
- Ø If a patient changes treatment plans or does not meet his or her glycemc 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 B₁₂/ 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
 MBBS MD (Biochemistry)
 Consultant Biochemist



Suraksha
DIAGNOSTICS

Lab No. : SR7743313 Name : SUPARNA SADHUKHAN Age/G : 27 Y 3 M 14 D / F Date : 10-06-2023

PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM

PHOSPHORUS-INORGANIC,BLOOD 3.3 mg/dL 2.4-5.1 mg/dL Phosphomolybdate/UV

□

Dr NEEPA CHOWDHURY
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Consultant Biochemist

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***SODIUM, BLOOD , GEL SERUM**

SODIUM,BLOOD 139 mEq/L 136 - 145 mEq/L ISE DIRECT

***POTASSIUM, BLOOD , GEL SERUM**

POTASSIUM,BLOOD 4.10 mEq/L 3.5 - 5.5 mEq/L ISE DIRECT

UREA,BLOOD , GEL SERUM

11.0 mg/dL 19 - 49 mg/dL Urease with GLDH

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

HEMOGLOBIN 12.3 g/dL 12 - 15 PHOTOMETRIC
WBC 6.5 *10³/μL 4 - 10 DC detection method
RBC 4.27 *10⁶/μL 3.8 - 4.8 DC detection method
PLATELET (THROMBOCYTE) COUNT 150 *10³/μL 150 - 450*10³/μL DC detection method/Microscopy

DIFFERENTIAL COUNT

NEUTROPHILS 60 % 40 - 80 % Flowcytometry/Microscopy
LYMPHOCYTES 33 % 20 - 40 % Flowcytometry/Microscopy
MONOCYTES 05 % 2 - 10 % Flowcytometry/Microscopy
EOSINOPHILS 02 % 1 - 6 % Flowcytometry/Microscopy
BASOPHILS 00 % 0-0.9% Flowcytometry/Microscopy

CBC SUBGROUP

HEMATOCRIT / PCV 39.5 % 36 - 46 % Calculated
MCV 92.5 fl 83 - 101 fl Calculated
MCH 28.8 pg 27 - 32 pg Calculated
MCHC **31.1** gm/dl 31.5-34.5 gm/dl Calculated
RDW - RED CELL DISTRIBUTION WIDTH **15.7** % 11.6-14% Calculated
PDW-PLATELET DISTRIBUTION WIDTH 42.7 fL 8.3 - 25 fL Calculated
MPV-MEAN PLATELET VOLUME 16.3 7.5 - 11.5 fl Calculated

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

1stHour **26** mm/hr 0.00 - 20.00 mm/hr Westergren

***TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .**

TOTAL PROTEIN 8.20 g/dL 5.7-8.2 g/dL BIURET METHOD
ALBUMIN 4.0 g/dL 3.2-4.8 g/dL BCG Dye Binding
GLOBULIN **4.20** g/dl 1.8-3.2 g/dl Calculated
AG Ratio **0.95** 1.0 - 2.5 Calculated

***URINE ROUTINE ALL, ALL , URINE**

PHYSICAL EXAMINATION

COLOUR PALE YELLOW
APPEARANCE SLIGHTLY HAZY

CHEMICAL EXAMINATION

pH 6 4.8 - 7.4 DIPSTICK
SPECIFIC GRAVITY **1.015** 1.016-1.022 DIPSTICK
PROTEIN NOT DETECTED NOT DETECTED DIPSTICK(Protein Error Principle)/MANUAL
GLUCOSE NOT DETECTED NOT DETECTED DIPSTICK (Glucose Oxidase - peroxidase)/ MANUAL
KETONES (ACETOACETIC ACID, ACETONE) NOT DETECTED NOT DETECTED Dipstick (Legals test)/Manual
BLOOD NEGATIVE NOT DETECTED DIPSTICK(Pseudo Peroxidase Method)

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BILIRUBIN	ABSENT		NEGATIVE	DIPSTICK(Azo-Diazo Reaction)/MANUAL
UROBILINOGEN	NORMAL		NORMAL	DIPSTICK(Diazonium Ion Reaction)/MANUAL
NITRITE	NEGATIVE		NEGATIVE	DIPSTICK(GRIESS TEST)
LEUCOCYTE ESTERASE	NEGATIVE		NEGATIVE	DIPSTICK
<u>MICROSCOPIC EXAMINATION</u>				
LEUKOCYTES (PUS CELLS)	4 - 5	/hpf	0-5	Microscopy
EPITHELIAL CELLS	2 - 3	/hpf	0-5	Microscopy
RED BLOOD CELLS	NOT DETECTED	/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
OTHERS	NIL			

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.

***GLUCOSE, PP , BLOOD, NAF PLASMA**

GLUCOSE,PP	105	mg/dL	Impaired Glucose Tolerance-140 mg/dL to 199 mg/dL. Diabetes >= 200 mg/dL.	Hexokinase Method
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***THYROID PANEL (T3, T4, TSH) , GEL SERUM**

T3-TOTAL (TRI IODOTHYRONINE)	1.03	ng/ml	0.60-1.81 ng/ml	CLIA
T4-TOTAL (THYROXINE)	8.5	µg/dL	3.2-12.6 µg/dL	CLIA
TSH (THYROID STIMULATING HORMONE)	2.85	µIU/mL	0.35-5.5 µIU/mL	CLIA

BIOLOGICAL REFERENCE INTERVAL : [ONLY FOR PREGNANT MOTHERS]

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER	: 0.10	2.50 µ IU/mL
SECOND TRIMESTER	: 0.20	3.00 µ IU/mL
THIRD TRIMESTER	: 0.30	3.00 µ IU/mL

References :

1. Indian Thyroid Society guidelines for management of thyroid dysfunction during pregnancy. *Clinical Practice Guidelines*, New Delhi: Elsevier; 2012.
2. Stagnaro-Green A, Abalovich M, Alexander E, Azizi F, Mestman J, Negro R, et al. Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum. *Thyroid* 2011; 21: 1081-25.
3. Dave A, Maru L, Tripathi M. Importance of Universal screening for thyroid disorders in first trimester of pregnancy. *Indian J Endocr Metab [serial online]* 2014 [cited 2014 Sep 25]; 18: 735-8. Available from: <http://www.ijem.in/text.asp?2014/18/5/735/139221>.

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***CALCIUM, BLOOD**

CALCIUM,BLOOD 8.80 mg/dL 8.7-10.4 mg/dL Modified OCPC

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

ABO B 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.

GLUCOSE, FASTING , BLOOD, NAF PLASMA

GLUCOSE,FASTING 95 mg/dL Impaired Fasting-100-125 mg/dL. Hexokinase Method
 Diabetes- >= 126 mg/dL.
 Fasting is defined as no caloric intake for at least 8 hours.

***LIPID PROFILE , GEL SERUM**

CHOLESTEROL-TOTAL	170	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	CHOD – PAP
TRIGLYCERIDES	174	mg/dL	Normal: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	ENZYMATIC (END POINT)
HDL CHOLESTEROL	44	mg/dl	< 40 - Low 40-59- Optimum 60 - High	ENZYMATIC (PEG)
LDL CHOLESTEROL DIRECT	103	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	HOMOGENOUS ENZYMATICAL
VLDL	23	mg/dL	< 40 mg/dl	Calculated
CHOL HDL Ratio	3.9		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated

CREATININE, BLOOD

0.62 mg/dL 0.5-1.1 mg/dL Jaffe, alkaline picrate, kinetic

***URIC ACID, BLOOD , GEL SERUM**

URIC ACID,BLOOD 4.80 mg/dL 2.6-6 mg/dL URICASE

***CHLORIDE, BLOOD , .**

CHLORIDE,BLOOD 102 mEq/L 98 - 107 mEq/L ISE DIRECT



DR. SHABNAM PARVIN
MD (Pathology)
Consultant Pathologist

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E.C.G. REPORT

DATA		
HEART RATE	97	Bpm
PR INTERVAL	148	Ms
QRS DURATION	72	Ms
QT INTERVAL	336	Ms
QTC INTERVAL	431	Ms
AXIS		
P WAVE	37	Degree
QRS WAVE	20	Degree
T WAVE	19	Degree
IMPRESSION	:	Normal sinus rhythm, within normal limits.

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ACRay

Dr. A C RAY
Department of Non-invasive
Cardiology

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X-RAY REPORT OF CHEST (PA) VIEW

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.

DR. VIMLESH JI VIMAL
MBBS (Cal)
MD, DMRD(IPGME & R)
Consultant Radiologist
Reg No 61436

Patient Data

Sample ID: D02135188958
 Patient ID: SR7743313
 Name:
 Physician:
 Sex:
 DOB:

Analysis Data

Analysis Performed: 10/JUN/2023 17:50:34
 Injection Number: 2407U
 Run Number: 60
 Rack ID:
 Tube Number: 10
 Report Generated: 10/JUN/2023 17:55:01
 Operator ID: ASIT

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
Unknown	---	0.1	0.111	2580
A1a	---	0.9	0.162	19114
A1b	---	0.8	0.224	19013
F	---	1.0	0.272	22761
LA1c	---	1.6	0.393	36571
A1c	4.9	---	0.497	90474
P3	---	3.1	0.773	70586
P4	---	1.1	0.856	25513
Ao	---	87.2	0.976	1956664

Total Area: 2,243,277

HbA1c (NGSP) = 4.9 % HbA1c (IFCC) = 30 mmol/mol

