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AAROGYAM DIAGNOSTICS
(A UNIT OF CULPAM HEALTH CARE PVT. LTD.)

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|---|---|---|---|---|---|
| **Date** | **25/09/2021** | **Srl No.** | **14** | **Patient Id** | **2109250014** |
| **Name** | **Mrs. RANU MISHRA** | **Age** | **33 Yrs.** | **Sex** | **F** |
| **Ref. By Dr.BOB** | | | | | |

| Test Name | Value | Unit | Normal Value |
|---|---|---|---|

## HAEMATOLOGY

| | | | |
|---|---|---|---|
| HB A1C | 5.1 | % | |

**EXPECTED VALUES :-**

| | | |
|---|---|---|
| Metabolicaly healthy patients | = | 4.8 - 5.5 % HbAIC |
| Good Control | = | 5.5 - 6.8 % HbAIC |
| Fair Control | = | 6.8-8.2 % HbAIC |
| Poor Control | = | >8.2 % HbAIC |

**REMARKS:-**

In vitro quantitative determination of **HbAIC** in whole blood is utilized in long term monitoring of glycemia .

The **HbAIC** level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose.

It is recommended that the determination of **HbAIC** be performed at intervals of 4-6 weeksduring Diabetes
Mellitus therapy.

Results of **HbAIC** should be assessed in conjunction with the patient's medical history, clinical examinations
and other findings.

****** End Of Report ******

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**CONSULTANT PATHOLOGIST**

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|---|---|---|---|
| COMPLETE BLOOD COUNT (CBC) | | | |
| HAEMOGLOBIN (Hb) | **11.2** | gm/dl | 11.5 - 16.5 |
| TOTAL LEUCOCYTE COUNT (TLC) | 4,800 | /cumm | 4000 - 11000 |
| DIFFERENTIAL LEUCOCYTE COUNT (DLC) | | | |
| NEUTROPHIL | 58 | % | 40 - 75 |
| LYMPHOCYTE | 38 | % | 20 - 45 |
| EOSINOPHIL | 02 | % | 01 - 06 |
| MONOCYTE | 02 | % | 02 - 10 |
| BASOPHIL | 00 | % | 0 - 0 |
| ESR (WESTEGREN`s METHOD) | 13 | mm/Ist hr. | 0 - 20 |
| R B C COUNT | 3.89 | Millions/cmm | 3.8 - 4.8 |
| P.C.V / HAEMATOCRIT | **33.6** | % | 35 - 45 |
| M C V | 86.38 | fl. | 80 - 100 |
| M C H | 28.79 | Picogram | 27.0 - 31.0 |
| M C H C | 33.3 | gm/dl | 33 - 37 |
| PLATELET COUNT | 2.86 | Lakh/cmm | 1.50 - 4.00 |
| BLOOD GROUP ABO | "AB" | | |
| RH TYPING | POSITIVE | | |

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|---|---|---|---|
| | **BIOCHEMISTRY** | | |
| BLOOD SUGAR FASTING | 93.1 | mg/dl | 70 - 110 |
| SERUM CREATININE | 1.26 | mg% | 0.5 - 1.3 |
| BLOOD UREA | 22.5 | mg /dl | 15.0 - 45.0 |
| SERUM URIC ACID | 3.8 | mg% | 2.5 - 6.0 |
| **LIVER FUNCTION TEST (LFT)** | | | |
| BILIRUBIN TOTAL | 0.62 | mg/dl | 0 - 1.0 |
| CONJUGATED (D. Bilirubin) | 0.18 | mg/dl | 0.00 - 0.40 |
| UNCONJUGATED (I.D.Bilirubin) | 0.44 | mg/dl | 0.00 - 0.70 |
| TOTAL PROTEIN | 7.0 | gm/dl | 6.6 - 8.3 |
| ALBUMIN | 3.7 | gm/dl | 3.4 - 4.8 |
| GLOBULIN | 3.3 | gm/dl | 2.3 - 3.5 |
| A/G RATIO | **1.121** | | |
| SGOT | 24.6 | IU/L | 5 - 35 |
| SGPT | 27.4 | IU/L | 5.0 - 45.0 |
| ALKALINE PHOSPHATASE<br>IFCC Method | 73.1 | U/L | 35.0 - 104.0 |
| GAMMA GT | 25.3 | IU/L | 6.0 - 42.0 |
| **LFT INTERPRET** | | | |
| **LIPID PROFILE** | | | |
| TRIGLYCERIDES | 102.3 | mg/dL | 40.0 - 165.0 |
| TOTAL CHOLESTEROL | 162.2 | mg/dL | 123.0 - 199.0 |

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| Test Name | Value | Unit | Normal Value |
|---|---|---|---|
| H D L CHOLESTEROL DIRECT | 42.8 | mg/dL | 40.0 - 79.4 |
| V L D L | 20.46 | mg/dL | 4.7 - 22.1 |
| L D L CHOLESTEROL DIRECT | 98.94 | mg/dL | 63.0 - 129.0 |
| TOTAL CHOLESTEROL/HDL RATIO | 3.79 | | 0.0 - 4.97 |
| LDL / HDL CHOLESTEROL RATIO | 2.312 | | 0.00 - 3.55 |
| THYROID PROFILE | | | |
| T3 | 1.12 | ng/ml | 0.60 - 1.81 |
| T4<br>Chemiluminescence | 8.7 | ug/dl | 4.5 - 10.9 |
| TSH<br>Chemiluminescence | 1.53 | uIU/ml | |

**REFERENCE RANGE**

| | | |
|---|---|---|
| PAEDIATRIC AGE GROUP | | |
| 0-3 DAYS | 1-20 | ulu/ ml |
| 3-30 DAYS | 0.5 - 6.5 | ulu/ml |
| I MONTH -5 MONTHS | 0.5 - 6.0 | ulu/ml |
| 6 MONTHS- 18 YEARS | 0.5 - 4.5 | ulu/ml |
| ADULTS | 0.39 - 6.16 | uIu/ml |

**Note**: TSH levels are subject to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm to 6 am. Nadir concentrations are observed during the afternoon.
Diurnal variation in TSH level approximates ± 50 %, hence time of the day has influence on the measured serum TSH concentration.

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Assay performed on enhanced chemi lumenescence system ( Centaur-Siemens)

Serum T3,T4 & TSH measurements form the three components of Thyroid screening panel, useful in diagnosing various disorders of Thyroid gland function.

1. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH level.

2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 levels along with depressed TSH values.

3. Normal T4 levels are accompanied by increased T3 in patients with T3 thyrotoxicosis.

4. Slightly elevated T3 levels may be found in pregnancy and estrogen therapy, while depressed levels may be encountered in severe illness, renal failure and during therapy with drugs like propranolol and propyl thiouracil.

5. Although elevated TSH levels are nearly always indicative of primary hyporthyroidism, and may be seen in secondary thyrotoxicosis.

## URINE EXAMINATION TEST

**PHYSICAL EXAMINATION**

| | | |
|---|---|---|
| QUANTITY | 20 | ml. |
| COLOUR | PALE YELLOW | |
| TRANSPARENCY | CLEAR | |
| SPECIFIC GRAVITY | 1.020 | |
| PH | 6.0 | |

**CHEMICAL EXAMINATION**

| | | |
|---|---|---|
| ALBUMIN | NIL | |

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| Test Name | Value | Unit | Normal Value |
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| SUGAR | NIL | | |
| **MICROSCOPIC EXAMINATION** | | | |
| PUS CELLS | 0-1 | /HPF | |
| RBC'S | NIL | /HPF | |
| CASTS | NIL | | |
| CRYSTALS | NIL | | |
| EPITHELIAL CELLS | 0-1 | /HPF | |
| BACTERIA | NIL | | |
| OTHERS | NIL | | |

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