Suraksha DIAGNOSTICS

| | | | |
|---|---|---|---|
| **Lab No.** | : GAR/18-03-2023/SR7422125 | **Lab Add.** | : Newtown, Kolkata-700156 |
| **Patient Name** | : **KAUSTAV BAGCHI** | **Ref Dr.** | : Dr.MEDICAL OFFICER |
| **Age** | : 39 Y 8 M 13 D | **Collection Date** | : 18/Mar/2023 10:19AM |
| **Gender** | : M | **Report Date** | : 18/Mar/2023 03:22PM |

| Test Name | Result | Unit | Bio Ref. Interval | Method |
|---|---|---|---|---|
| **BILIRUBIN (DIRECT) ,** *GEL SERUM* | | | | |
| BILIRUBIN (DIRECT) | 0.10 | mg/dL | <0.2 mg/dL | Vanadate oxidation |
| **POTASSIUM, BLOOD ,** *GEL SERUM* | | | | |
| POTASSIUM,BLOOD | 4.10 | mEq/L | 3.5-5.5 mEq/L | ISE INDIRECT |
| **UREA,BLOOD ,** *GEL SERUM* | 19.3 | mg/dL | 19-49 mg/dL | Urease with GLDH |
| **URIC ACID, BLOOD ,** *GEL SERUM* | | | | |
| URIC ACID,BLOOD | **7.80** | mg/dL | 3.5-7.2 mg/dL | Uricase/Peroxidase |
| **BILIRUBIN (TOTAL) ,** *GEL SERUM* | | | | |
| BILIRUBIN (TOTAL) | 0.90 | mg/dL | 0.3-1.2 mg/dL | Vanadate oxidation |
| **PHOSPHORUS-INORGANIC, BLOOD ,** *GEL SERUM* | | | | |
| PHOSPHORUS-INORGANIC,BLOOD | 3.6 | mg/dL | 2.4-5.1 mg/dL | Phosphomolybdate/UV |
| **ALKALINE PHOSPHATASE ,** *GEL SERUM* | | | | |
| ALKALINE PHOSPHATASE | 84 | U/L | 46-116 U/L | IFCC standardization |
| **CREATININE, BLOOD** | 0.82 | mg/dL | 0.7-1.3 mg/dL | Jaffe, alkaline picrate, kinetic |
| **SODIUM, BLOOD ,** *GEL SERUM* | | | | |
| SODIUM,BLOOD | 137 | mEq/L | 132 - 146 mEq/L | ISE INDIRECT |
| ***CHLORIDE, BLOOD ,** . | | | | |
| CHLORIDE,BLOOD | 103 | mEq/L | 99-109 mEq/L | ISE INDIRECT |

Dr NEEPA CHOWDHURY
MBBS MD (Biochemistry)
Consultant Biochemist

| Lab No. : SR7422125 | Name : KAUSTAV BAGCHI | Age/G : 39 Y 8 M 13 D / M | Date : 18-03-2023 |
|---|---|---|---|

**SGOT/AST ,** *GEL SERUM*

| | | | | |
|---|---|---|---|---|
| SGOT/AST | **43** | U/L | 13-40 U/L | Modified IFCC |

**SGPT/ALT ,** *GEL SERUM*

| | | | | |
|---|---|---|---|---|
| SGPT/ALT | **83** | U/L | 7-40 U/L | Modified IFCC |

**CALCIUM, BLOOD**

| | | | | |
|---|---|---|---|---|
| CALCIUM,BLOOD | 9.40 | mg/dL | 8.7-10.4 mg/dL | Arsenazo III |

**LIPID PROFILE ,** *GEL SERUM*

| | | | | |
|---|---|---|---|---|
| CHOLESTEROL-TOTAL | 185 | mg/dL | Desirable: < 200 mg/dL<br>Borderline high: 200-239 mg/dL<br>High: > or =240 mg/dL | Enzymatic |
| TRIGLYCERIDES | **321** | mg/dL | Normal:: < 150,<br>BorderlineHigh::150-199,<br>High:: 200-499,<br>VeryHigh::>500 | GPO-Trinder |
| HDL CHOLESTEROL | **31** | mg/dl | < 40 - Low<br>40-59- Optimum<br>60 - High | Elimination/catalase |
| LDL CHOLESTEROL DIRECT | **123** | mg/dL | OPTIMAL : <100 mg/dL,<br>Near optimal/ above optimal : 100-129 mg/dL,<br>Borderline high : 130-159 mg/dL,<br>High : 160-189 mg/dL,<br>Very high : >=190 mg/dL | Elimination / Catalase |
| VLDL | 31 | mg/dl | < 40 mg/dl | Calculated |
| CHOL HDL Ratio | 6.0 | | 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.*

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

| | | | | |
|---|---|---|---|---|
| TOTAL PROTEIN | 7.70 | g/dL | 5.7-8.2 g/dL | BIURET METHOD |
| ALBUMIN | 4.6 | g/dL | 3.2-4.8 g/dL | BCG Dye Binding |
| GLOBULIN | 3.10 | g/dl | 1.8-3.2 g/dl | Calculated |
| AG Ratio | 1.48 | | 1.0 - 2.5 | Calculated |

Dr. SUPARBA CHAKRABARTI
MBBS, MD(BIOCHEMISTRY)
Consultant Biochemist



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E-mail: info@surakshanet.com | Website: www.surakshanet.com

**Lab No. : SR7422125** **Name : KAUSTAV BAGCHI** **Age/G : 39 Y 8 M 13 D / M** **Date : 18-03-2023**

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

| | | | | |
|---|---|---|---|---|
| HEMOGLOBIN | **12.8** | g/dL | 13 - 17 | PHOTOMETRIC |
| WBC | 6.8 | *10^3/µL | 4 - 10 | DC detection method |
| RBC | **4.36** | *10^6/µL | 4.5 - 5.5 | DC detection method |
| PLATELET (THROMBOCYTE) COUNT | 177 | *10^3/µL | 150 - 450*10^3/µL | DC detection method/Microscopy |
| ***DIFFERENTIAL COUNT*** | | | | |
| NEUTROPHILS | 49 | % | 40 - 80 % | Flowcytometry/Microscopy |
| LYMPHOCYTES | 38 | % | 20 - 40 % | Flowcytometry/Microscopy |
| MONOCYTES | 06 | % | 2 - 10 % | Flowcytometry/Microscopy |
| EOSINOPHILS | **07** | % | 1 - 6 % | Flowcytometry/Microscopy |
| BASOPHILS | 00 | % | 0-0.9% | Flowcytometry/Microscopy |
| ***CBC SUBGROUP*** | | | | |
| HEMATOCRIT / PCV | **39.4** | % | 40 - 50 % | Calculated |
| MCV | 90.4 | fl | 83 - 101 fl | Calculated |
| MCH | 29.3 | pg | 27 - 32 pg | Calculated |
| MCHC | 32.5 | gm/dl | 31.5-34.5 gm/dl | Calculated |
| RDW - RED CELL DISTRIBUTION WIDTH | **14.7** | % | 11.6-14% | Calculated |
| PDW-PLATELET DISTRIBUTION WIDTH | 31.5 | fL | 8.3 - 25 fL | Calculated |
| MPV-MEAN PLATELET VOLUME | 13.8 | | 7.5 - 11.5 fl | Calculated |

**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.***

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

| | | | |
|---|---|---|---|
| ***PHYSICAL EXAMINATION*** | | | |
| COLOUR | PALE YELLOW | | |
| APPEARANCE | SLIGHTLY HAZY | | |
| ***CHEMICAL EXAMINATION*** | | | |
| pH | 5.0 | 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 | NOT DETECTED | 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) |

| Lab No. : SR7422125 | Name : KAUSTAV BAGCHI | | Age/G : 39 Y 8 M 13 D / M | Date : 18-03-2023 |
|---|---|---|---|---|
| LEUCOCYTE ESTERASE | POSITIVE(+) | | NEGATIVE | Dipstick (ester hydrolysis reaction) |
| ***MICROSCOPIC EXAMINATION*** | | | | |
| LEUKOCYTES (PUS CELLS) | 3-5 | /hpf | 0-5 | Microscopy |
| EPITHELIAL CELLS | 1-2 | /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 |

**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 | 20 | mm/hr | 0.00 - 20.00 mm/hr | Westergren |

Dr Mansi Gulati
Consultant Pathologist
MBBS, MD, DNB (Pathology)



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**Lab No. : SR7422125** **Name : KAUSTAV BAGCHI** **Age/G : 39 Y 8 M 13 D / M** **Date : 18-03-2023**

**GLUCOSE, FASTING ,** *BLOOD, NAF PLASMA*

| | | | | |
|---|---|---|---|---|
| GLUCOSE,FASTING | 90 | mg/dL | Impaired Fasting-100-125 .<br>Diabetes- >= 126.<br>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.*

PDF Attached

**GLYCATED HAEMOGLOBIN (HBA1C) ,** *EDTA WHOLE BLOOD*

| | | | | |
|---|---|---|---|---|
| GLYCATED HEMOGLOBIN (HBA1C) | 5.5 | % | ***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION *** | |
| HbA1c (IFCC) | 37.0 | 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.*

**URIC ACID, URINE, SPOT URINE**

| | | | | |
|---|---|---|---|---|
| URIC ACID, SPOT URINE | **21.00** | mg/dL | 37-92 mg/dL | URICASE |

***ESTIMATED TWICE***

**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) | 5.1 | µg/dL | 3.2-12.6 µg/dL | CLIA |

| | | | | |
|---|---|---|---|---|
| TSH (THYROID STIMULATING HORMONE) **4.87** | 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.*

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

| | | | | |
|---|---|---|---|---|
| GLUCOSE,PP | **158** | mg/dL | Impaired Glucose Tolerance-140 to 199.<br>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.*

DR. ANANNYA GHOSH
MBBS, MD (Biochemistry)
Consultant Biochemist

| | | | |
|---|---|---|---|
| **Lab No.** | : GAR/18-03-2023/SR7422125 | **Lab Add.** | : |
| **Patient Name** | : **KAUSTAV BAGCHI** | **Ref Dr.** | : Dr.MEDICAL OFFICER |
| **Age** | : 39 Y 8 M 13 D | **Collection Date** | : |
| **Gender** | : M | **Report Date** | : 18/Mar/2023 02:32PM |

## 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

| | | | |
|---|---|---|---|
| **Lab No.** | : GAR/18-03-2023/SR7422125 | **Lab Add.** | : |
| **Patient Name** | : **KAUSTAV BAGCHI** | **Ref Dr.** | : Dr.MEDICAL OFFICER |
| **Age** | : 39 Y 8 M 13 D | **Collection Date** | : |
| **Gender** | : M | **Report Date** | : 18/Mar/2023 12:07PM |

## DEPARTMENT OF ULTRASONOGRAPHY
## REPORT ON EXAMINATION OF WHOLE ABDOMEN

**LIVER**
Liver is mildly enlarged in size (149 mm) having normal shape and shows grade-I fatty change. No focal parenchymal lesion is evident.Intrahepatic biliary radicles are not dilated.Branches of portal vein are normal.

**PORTA**
The appearance of porta is normal. Common Bile duct is normal (4.8 mm) with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal (9.5 mm) at porta.

**GALL BLADDER**
Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected. Sonographic Murphys sign is negative.

**PANCREAS**
Echogenecity appears within limits, without any focal lesion. Shape, size & position appears normal. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

**SPLEEN**
Spleen is normal in size (88 mm). Homogenous and smooth echotexture without any focal lesion. Splenic vein at hilum appears normal. No definite collaterals could be detected.

**KIDNEYS**
Both kidneys are normal in shape, size (Rt. kidney 116 mm. & Lt. kidney 121 mm) & position. Cortical echogenecity appears normal maintaining corticomedullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected.

**URETERS**
Visualised part of upper ureters are not dilated.

**URINARY BLADDER**
Urinary bladder is distended, wall thickness appeared normal. No intraluminal pathology (calculi / mass) could be detected.

**PROSTATE**
Prostate is normal in size.Echotexture appears within normal limits. No focal alteration of its echogenecity could bedetectable.
It measures : 35 mm x 31 mm x 24 mm.
Approximate weight could be around = 14 gms.

**IMPRESSION**

**Mild hepatomegaly with grade-I fatty change.**



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| | | | |
|---|---|---|---|
| **Lab No.** | : GAR/18-03-2023/SR7422125 | **Lab Add.** | : |
| **Patient Name** | : **KAUSTAV BAGCHI** | **Ref Dr.** | : Dr.MEDICAL OFFICER |
| **Age** | : 39 Y 8 M 13 D | **Collection Date** | : |
| **Gender** | : M | **Report Date** | : 18/Mar/2023 12:07PM |

***-----Please correlate clinically.***

***Kindly note***

***Ø Ultrasound is not the modality of choice to rule out subtle bowel lesion.***
***Ø Please Intimate us for any typing mistakes and send the report for correction within 7 days.***
***Ø The science of Radiological diagnosis is based on the interpretation of various shadows produced by both the normal and abnormal tissues and are not always conclusive. Further biochemical and radiological investigation & clinical correlation is required to enable the clinician to reach the final diagnosis.***
***The report and films are not valid for medico-legal purpose.***
***Patient Identity not verified.***

Kalpana Gupta (Chakravarty)

**KALPANA GUPTA (CHAKRAVARTY)**
Consultant Sonologist
Reg – 39975 (WB)

Suraksha DIAGNOSTICS

| | | | |
|---|---|---|---|
| **Lab No.** | : GAR/18-03-2023/SR7422125 | **Lab Add.** | : |
| **Patient Name** | : **KAUSTAV BAGCHI** | **Ref Dr.** | : Dr.MEDICAL OFFICER |
| **Age** | : 39 Y 8 M 13 D | **Collection Date** | : |
| **Gender** | : M | **Report Date** | : 18/Mar/2023 03:25PM |

## *DEPARTMENT OF CARDIOLOGY*
## *REPORT OF E.C.G.*

| | |
|---|---|
| Clinical Indication | Part of regular study. |
| Heart Rate | 81 beats /min |
| Rhythm | Regular. |
| PR | 152 ms |
| QRS | 144 ms |
| QTc | 427 ms |
| Axis | Normal. |
| P-wave morphology | Normal. |
| Impression | **Regular, narrow complex rhythm of sino-atrial origin, at 81 bpm.**<br><br>**Right bundle branch block, classical pattern.** |

**DR SOUMIK CHATTERJEE**
CONSULTANT PHYSICIAN (GOLD MEDALIST)
National Excellence Award Honoree



Suraksha Diagnostic Private Limited
E-mail: info@surakshanet.com | Website: www.surakshanet.com

**SURAKSHA DIAGNOSTIC, RAJARHAT, KOLKATA.** **PATIENT REPORT**
**BIO-RAD VARIANT TURBO CDM 5.4** **s/n 15893** **V2TURBO_A1c_2.0**

**Patient Data**

| | |
|---|---|
| Sample ID: | C02135012426 |
| Patient ID: | SR7422125 |
| Name: | |
| Physician: | |
| Sex: | |
| DOB: | |

Comments:

**Analysis Data**

| | |
|---|---|
| Analysis Performed: | 18/MAR/2023 15:45:24 |
| Injection Number: | 9146U |
| Run Number: | 210 |
| Rack ID: | 0004 |
| Tube Number: | 8 |
| Report Generated: | 18/MAR/2023 15:57:53 |
| Operator ID: | ASIT |

| Peak Name | NGSP % | Area % | Retention Time (min) | Peak Area |
|---|---|---|---|---|
| A1a | --- | 0.8 | 0.155 | 23242 |
| A1b | --- | 1.1 | 0.215 | 31343 |
| F | --- | 0.8 | 0.267 | 23669 |
| LA1c | --- | 1.7 | 0.399 | 47853 |
| A1c | 5.5 | --- | 0.506 | 129827 |
| P3 | --- | 3.3 | 0.791 | 94520 |
| P4 | --- | 1.2 | 0.870 | 33433 |
| Ao | --- | 86.5 | 0.984 | 2465231 |

Total Area: 2,849,117

**HbA1c (NGSP) = 5.5 %** HbA1c (IFCC) = 37 mmol/mol