Neuberg Labcore
CLINICAL LABORATORIES

LABORATORY REPORT

Name	: **Mrs. MAMTA CHAUHAN**	Sex/Age	: **Female / 33 Years**	Case ID	: **40308001452**
Ref. By	: Mediwheel Full Body Health Checkup	Dis. At	:	Pt. ID	:
Bill. Loc.	: Health packages			Pt. Loc	:

Reg Date and Time	: 29-Mar-2024 10:12	Sample Type	: Serum	Mobile No.	: 7765829625
Sample Date and Time	: 29-Mar-2024 10:18	Sample Coll. By	: non	Ref Id1	:
Report Date and Time	: 29-Mar-2024 17:50	Acc. Remarks	: -	Ref Id2	:

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Vitamin D (Total) *CMIA*	L	**6.99**	ng/mL	< 10 Deficiency 10 - 20 Insufficiency 20 - 32 Normal Level 32 - 100 Sufficiency > 100 Toxicity	
Follicle Stimulating Hormone *CMIA*		**15.4**	mIU/mL	3.85-8.78 Mid Follicular phase 4.54-22.51 Mid cycle peak 1.79-5.12 Mid luteal phase 16.7-113.5 Post Menopausal	

INTERPRETATIONS:

Useful for an adjunct in the evaluation of menstrual irregularities, Evaluating patients with suspected hypogonadism , Predicting ovulation , Evaluating infertility & Diagnosing pituitary disorders.

In both males and females, primary hypogonadism results in an elevation of basal follicle-stimulating hormone (FSH) and luteinizing hormone (LH) levels.

FSH and LH are generally elevated in:

-Primary gonadal failure , Complete testicular feminization syndrome, Precocious puberty (either idiopathic or secondary to a central nervous system lesion), Menopause (postmenopausal FSH levels are generally >40 IU/L), Primary ovarian hypofunction in females , Primary hypogonadism in males.

Normal or decreased FSH in:

-Polycystic ovary disease in females

FSH and LH are both decreased in failure of the pituitary or hypothalamus.

CAUTIONS:

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedures, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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Printed On : 29-Apr-2024 16:48

Labcore Speciality Laboratory
Add. : Windward Business Park, New India Mills Compound, Jetalpur Road, Vadodara - 390020. **Phone** : 0265 - 2963364, 2963365
Email : labcorelab@gmail.com **For Home Visit :** 7624011254 / 9081660099 **Mon. to Sat. 8-00 am to 8-00 pm**

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Biochemical Investigation

Anti Mullerian Hormone *ECLIA*	L	**0.29**	ng/mL	0.67 - 7.55	Please correlate clinically &/or repeat with fresh sample.

Antimullerian hormone (AMH) is also known as mullerian-inhibiting substance. It is produced by Sertoli cells of the testis in males and by ovarian granulose cells in females. AMH has been predominantly known for its role in male sexual differentiation.

In women:

· AMH use for evaluating Fertility Potential, Assessing ovarian status, including ovarian reserve and ovarian responsiveness, as part of an evaluation for infertility and assisted reproduction protocols such as in vitro fertilization, Assessment of menopausal status, including premature ovarian failure, Assessing ovarian function in patients with polycystic ovarian syndrome, Monitoring patients with antimullerian hormone-secreting ovarian granulosa cell tumors, Evaluation of infants with ambiguous genitalia and other intersex conditions, Evaluating testicular function in infants and children.

· In patients with polycystic ovarian syndrome, AMH concentrations may be 2- to 5-fold higher than age-appropriate reference range values. Such high levels predict anovulatory and irregular cycles.

· Serum AMH concentrations are increased in some patients with ovarian granulosa cell tumors, which comprise approximately 10% of ovarian tumors, which also secrete inhibin A and inhibin B. Elevated levels of any of these markers can indicate the presence of such a neoplasm in a woman with an ovarian mass.

General interpretation for fertility potential in reproductive woman:

AMH level	
Very Low Level	<0.3 ng/ml
Low Level	0.3-0.6 ng/ml
Low Normal Range	0.7-0.9 ng/ml
Normal Range	>1.0 ng/ml

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HAEMOGRAM REPORT

TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
HB AND INDICES					
Haemoglobin *Photometric Method*	L	**11.7**	G%	12.0 - 15.0	
RBC (Electrical Impedance)	L	**3.43**	millions/cumm	3.80 - 4.80	
PCV(Calc)	L	**35.40**	%	36.00 - 46.00	
MCV (RBC histogram)	H	**103.2**	fL	83.00 - 101.00	
MCH (Calc)	H	**34.1**	pg	27.00 - 32.00	
MCHC (Calc)		**33.0**	gm/dL	31.50 - 34.50	
RDW (RBC histogram)		**11.50**	%	11.00 - 16.00	
TOTAL AND DIFFERENTIAL WBC COUNT					
Total WBC Count		**6410**	/µL	4000.00 - 10000.00	
Neutrophil		**53**	%	40.00 - 70.00	
Lymphocyte		**39**	%	20.00 - 40.00	
Eosinophil		**03**	%	1.00 - 6.00	
Monocytes		**05**	%	2.00 - 10.00	
Basophil		**00**	%	0.00 - 2.00	
Neutrophil *Calculated*		**3397**	/µL	2000.00 - 7000.00	
Lymphocyte *Calculated*		**2500**	/µL	1000.00 - 3000.00	
Eosinophil *Calculated*		**192**	/µL	20.00 - 500.00	
Monocyte *Calculated*		**321**	/µL	200.00 - 1000.00	
Basophil *Calculated*		**0**	/µL	0.00 - 100.00	
PLATELET COUNT					
Platelet Count		**152000**	/µL	150000.00 - 410000.00	
MPV	H	**13.30**	fL	6.5 - 12	

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh ,A-Abnormal)

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PDW	H	**16.8**		8 - 13
ESR *Westergren Method*		**12**	mm after 1hr	3 - 20

Method:
TLC-SF cube technology(Flow Cytometry+ fluorescence),
DC by microscopy,
Platelet count by electrical impedance+/-SF cube technology

BIOCHEMICAL INVESTIGATIONS

Plasma Glucose - F *Photometric,Hexokinase*	H	**104.77**	mg/dL	70 - 100
Plasma Glucose - PP *Photometric,Hexokinase*		**95.14**	mg/dL	70 - 140

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TEST		RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BUN (Blood Urea Nitrogen) *GLDH*		**7.4**	mg/dL	7.00 - 18.70	
Uric Acid *Uricase-Peroxidase method*		**4.42**	mg/dL	2.6 - 6.2	
Creatinine *Jaffe compensated*	L	**0.48**	mg/dL	0.55 - 1.02	

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
Liver Function Test				
S.G.P.T. *IFCC*	**34.36**	U/L	0 - 59	
S.G.O.T. *IFCC*	**25.22**	U/L	15 - 37	
Alkaline Phosphatase *Modified IFCC method*	**89.37**	U/L	40 - 150	
Proteins (Total) *Biuret*	**7.43**	g/dL	6.4 - 8.2	
Albumin *Bromo Cresol Green*	**4.31**	g/dL	3.4 - 5.0	
Globulin *Calculated*	**3.12**	gm/dL	2 - 4.1	
A/G Ratio *Calculated*	**1.4**		1.0 - 2.1	
Bilirubin Total *Diazotized Sulfanilic Acid Method*	**0.61**	mg/dL	0.2 - 1.0	
Bilirubin Conjugated *Diazotized Sulfanilic Acid Method*	**0.19**	mg/dL		
Bilirubin Unconjugated *Calculated*	**0.42**	mg/dL	0 - 0.8	

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
Lipid Profile				
Cholesterol *Colorimetric, CHOD-POD*	**157.96**	mg/dL	110 - 200	
HDL Cholesterol	**46.1**	mg/dL	40 - 60	
Triglyceride *GPO-POD*	**95.64**	mg/dL	40 - 200	
VLDL *Calculated*	**19.13**	mg/dL	10 - 40	
Chol/HDL *Calculated*	**3.43**		0 - 4.1	
LDL Cholesterol *Calculated*	**92.73**	mg/dL	0.00 - 100.00	

NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP

LDL CHOLESTEROL	CHOLESTEROL	HDL CHOLESTEROL	TRIGLYCERIDES
Optimal<100	Desirable<200	Low<40	Normal<150
Near Optimal 100-129	Border Line 200-239	High >60	Border High 150-199
Borderline 130-159	High >240	-	High 200-499
High 160-189	-	-	-

- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment
- For LDL Cholesterol level Please consider direct LDL value
  Risk assessment from HDL and Triglyceride has been revised. Also LDL goals have changed.
- Detail test interpreation available from the lab
- All tests are done according to NCEP guidelines and with FDA approved kits.
- LDL Cholesterol level is primary goal for treatment and varies with risk category and assesment

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
HAEMATOLOGY INVESTIGATIONS				
BLOOD GROUP AND RH TYPING (Erythrocyte Magnetized Technology) (Both Forward and Reverse Group)				
ABO Type	**B**			
Rh Type	**POSITIVE**			

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
BIOCHEMICAL INVESTIGATIONS				
Thyroid Function Test				
Triiodothyronine (T3) *ECLIA*	**0.89**	ng/mL	0.70 - 2.04	
Thyroxine (T4) *ECLIA*	**5.64**	µg/dL	5.5 - 11.0	
TSH *ECLIA*	**1.780**	µIU/mL	0.40 - 4.20	

INTERPRETATIONS

Useful for Monitoring patients on thyroid replacement therapy, Confirmation of thyroid-stimulating hormone (TSH) suppression in thyroid cancer patients on thyroxine therapy, for Prediction of thyrotropin-releasing hormone-stimulated TSH response, as An aid in the diagnosis of primary hyperthyroidism, for Differential diagnosis of hypothyroidism.

The ability to quantitate circulating levels of thyroid-stimulating hormone (TSH) is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low or normal. Concentrations of 5.1 mIU/ml to 7.0 mIU/ml are considered borderline hypothyroid

CAUTIONS

Sick, hospitalized patients may have falsely low or transiently elevated thyroid stimulating hormone.

Some patients who have been exposed to animal antigens, either in the environment or as part of treatment or imaging procedure, may have circulating antianimal antibodies present. These antibodies may interfere with the assay reagents to produce unreliable results.

TSH ref range in Pregnacy	**Reference range (microIU/ml)**
First trimester	0.24 - 2.00
Second trimester	0.43-2.2
Third trimester	0.8-2.5

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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Glycated Haemoglobin Estimation				
HbA1C *Immunoturbidimetric*	**5.2**	% of total Hb	<5.7: Normal 5.7-6.4: Prediabetes >=6.5: Diabetes	
Estimated Avg Glucose (3 Mths) *Calculated*	**102.54**	mg/dL	Not available	

Please Note change in reference range as per ADA 2021 guidelines.

Interpretation :

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy,comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Pending Services
Stool Examination
Urine Examination

---------- End Of Report ----------

For test performed on specimens received or collected from non-NSRL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NSRL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

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