DIAGNOSTIC REPORT

MC-2559

Fortis HOSPITAL Mohali

PATIENT NAME : AMIT KUMAR **REF. DOCTOR :** SELF

FORTIS MOHALI-CHC -SPLZD
FORTIS HOSPITAL # MOHALI,
MOHALI 160062
7087030817

ACCESSION NO : **0006WE011801**
PATIENT ID : FH.11716120
CLIENT PATIENT ID: UID:11716120
ABHA NO :

AGE/SEX : 33 Years Male
DRAWN : 13/05/2023 09:46:00
RECEIVED : 13/05/2023 13:53:25
REPORTED : 13/05/2023 16:18:37

CLINICAL INFORMATION :

UID:11716120 REQNO-1521799
CORP-OPD
BILLNO-1002123OPCS007376
BILLNO-1002123OPCS007376

Test Report Status **Final**	Results	Biological Reference Interval	Units

HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB) METHOD : SLS- HEMOGLOBIN DETECTION METHOD	16.8	13.0 - 17.0	g/dL
RED BLOOD CELL (RBC) COUNT METHOD : HYDRODYNAMIC FOCUSING	5.27	4.5 - 5.5	mil/µL
WHITE BLOOD CELL (WBC) COUNT METHOD : FLOWCYTOMETRY	5.23	4.0 - 10.0	thou/µL
PLATELET COUNT METHOD : HYDRO DYNAMIC FOCUSING METHOD / MICROSCOPY	179	150 - 410	thou/µL

RBC AND PLATELET INDICES

HEMATOCRIT (PCV) METHOD : HYDRODYNAMIC FOCUSING	**50.2 High**	40.0 - 50.0	%
MEAN CORPUSCULAR VOLUME (MCV) METHOD : CALCULATED PARAMETER	95.3	83.0 - 101.0	fL
MEAN CORPUSCULAR HEMOGLOBIN (MCH) METHOD : CALCULATED PARAMETER	31.9	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC) METHOD : CALCULATED PARAMETER	33.5	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH (RDW) METHOD : CALCULATED PARAMETER	13.5	11.6 - 14.0	%
MENTZER INDEX METHOD : CALCULATED PARAMETER	18.1		
MEAN PLATELET VOLUME (MPV) METHOD : CALCULATED PARAMETER	**13.8 High**	6.8 - 10.9	fL

WBC DIFFERENTIAL COUNT

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Senior Consultant,30897

Shafira

Dr. Shafira Garg (MD, Pathology)
Attending Consultant,47150

Meenakshi Malhotra

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NEUTROPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	54	40.0 - 80.0	%
LYMPHOCYTES METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	36	20.0 - 40.0	%
MONOCYTES METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	7	2.0 - 10.0	%
EOSINOPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	3	1 - 6	%
BASOPHILS METHOD : FLOW CYTOMETRY+LEISHMAIN STAIN+MICROSCOPY	00	0 - 2	%
ABSOLUTE NEUTROPHIL COUNT METHOD : CALCULATED PARAMETER	2.82	2.0 - 7.0	thou/µL
ABSOLUTE LYMPHOCYTE COUNT METHOD : CALCULATED PARAMETER	1.88	1.0 - 3.0	thou/µL
ABSOLUTE MONOCYTE COUNT METHOD : CALCULATED PARAMETER	0.37	0.2 - 1.0	thou/µL
ABSOLUTE EOSINOPHIL COUNT METHOD : CALCULATED PARAMETER	0.16	0.02 - 0.50	thou/µL
NEUTROPHIL LYMPHOCYTE RATIO (NLR) METHOD : CALCULATED PARAMETER	1.5		

Interpretation(s)
RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait
(<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 106504
This ratio element is a calculated parameter and out of NABL scope.

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HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD

E.S.R	03	0 - 14	mm at 1 hr

METHOD : WESTERGREN METHOD

Interpretation(s)
ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-**TEST DESCRIPTION** :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition.CRP is superior to ESR because it is more sensitive and reflects a more rapid change.
TEST INTERPRETATION
Increase in: Infections, Vasculities, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.
Finding a very accelerated ESR**(>100 mm/hour)** in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).
In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.
Decreased in: Polycythermia vera, Sickle cell anemia

LIMITATIONS
False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia
False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :
1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition;2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin;3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis,10th edition.

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BIOCHEMISTRY			
LIVER FUNCTION PROFILE, SERUM			
BILIRUBIN, TOTAL	0.90	UPTO 1.2	mg/dL
METHOD : DIAZONIUM ION, BLANKED (ROCHE)			
BILIRUBIN, DIRECT	0.25	0.00 - 0.30	mg/dL
METHOD : DIAZOTIZATION			
BILIRUBIN, INDIRECT	**0.65 High**	0.00 - 0.60	mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN	7.5	6.6 - 8.7	g/dL
METHOD : BIURET			
ALBUMIN	4.9	3.97 - 4.94	g/dL
METHOD : BROMOCRESOL GREEN			
GLOBULIN	2.6	2.0 - 4.0 Neonates - Pre Mature: 0.29 - 1.04	g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO	1.9	1.0 - 2.0	RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE(AST/SGOT)	**54 High**	0 - 40	U/L
ALANINE AMINOTRANSFERASE (ALT/SGPT)	**118 High**	0 - 41	U/L
METHOD : UV WITHOUT PYRIDOXAL-5 PHOSPHATE			
ALKALINE PHOSPHATASE	**136 High**	40 - 129	U/L
METHOD : PNPP - AMP BUFFER			
GAMMA GLUTAMYL TRANSFERASE (GGT)	**163 High**	8 - 61	U/L
METHOD : GAMMA GLUTAMYLCARBOXY 4NITROANILIDE			
LACTATE DEHYDROGENASE	208	135 - 225	U/L
METHOD : LACTATE -PYRUVATE UV			
GLUCOSE FASTING,FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)	82	74 - 106	mg/dL
METHOD : HEXOKINASE			

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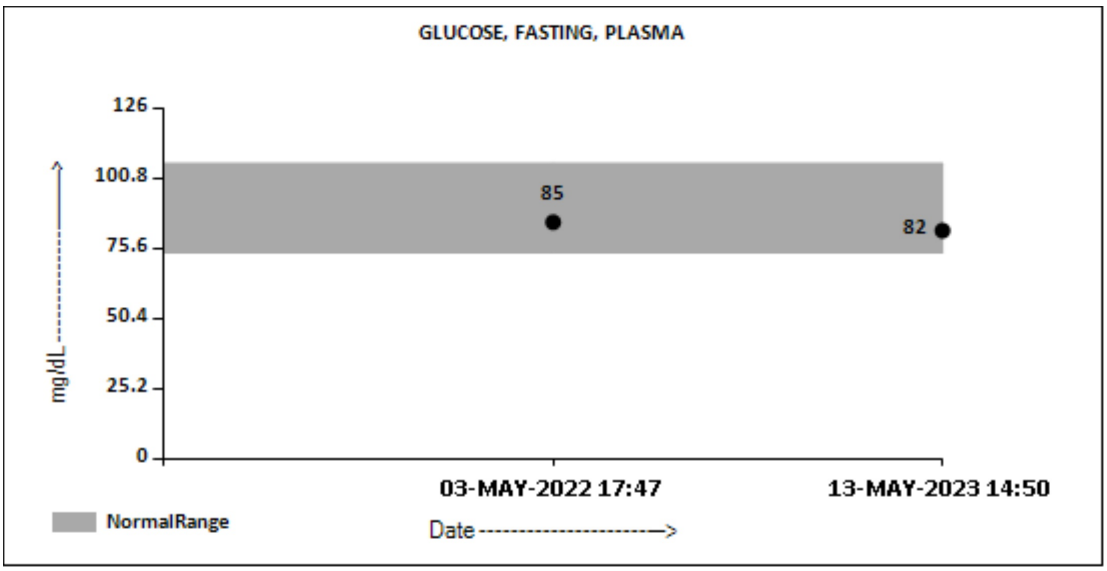

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN	17	6 - 20	mg/dL

METHOD : UREASE - UV

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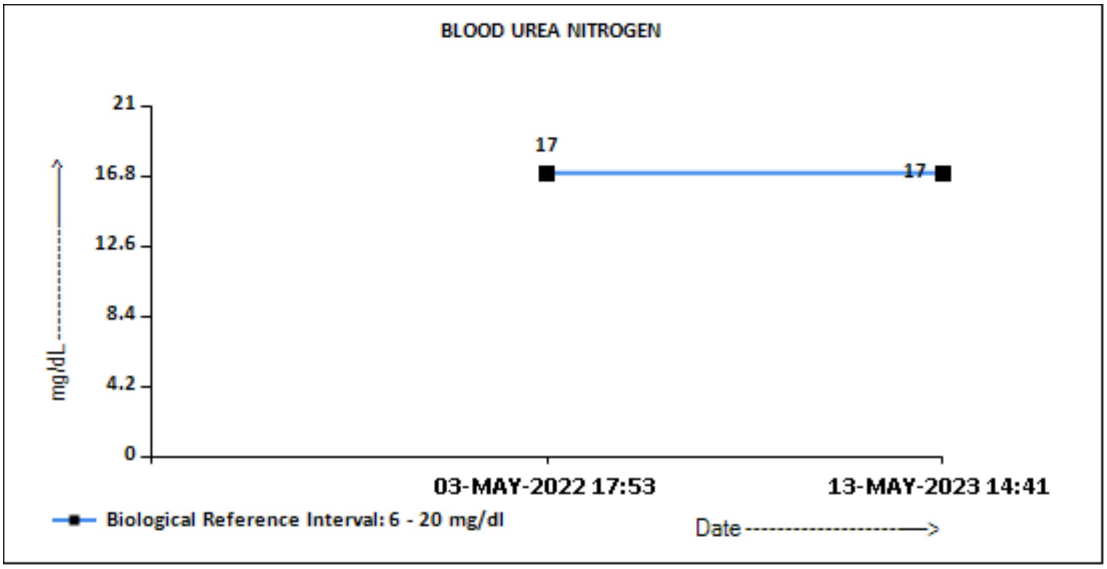

URIC ACID, SERUM

URIC ACID	5.5	3.4 - 7.0	mg/dL

METHOD : URICASE, COLORIMETRIC

GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD

HBA1C	4.8	Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021)	%

METHOD : HPLC

ESTIMATED AVERAGE GLUCOSE(EAG)	91.1	< 116.0	mg/dL

METHOD : CALCULATED PARAMETER

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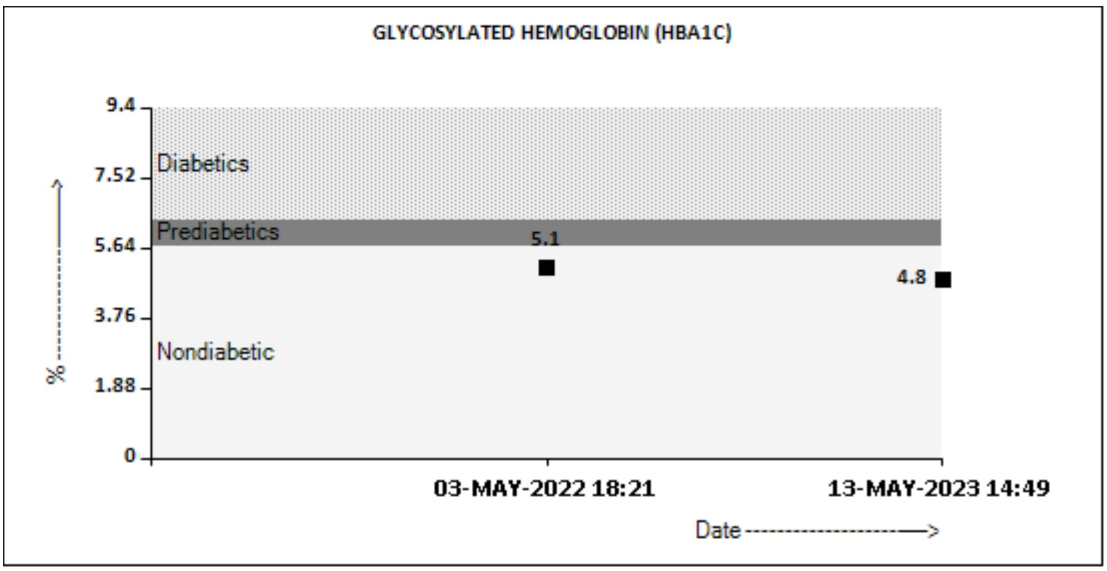

CREATININE EGFR

CREATININE	1.00	0.70 - 1.20	mg/dL
METHOD : ALKALINE PICRATE-KINETIC			
AGE	33		years

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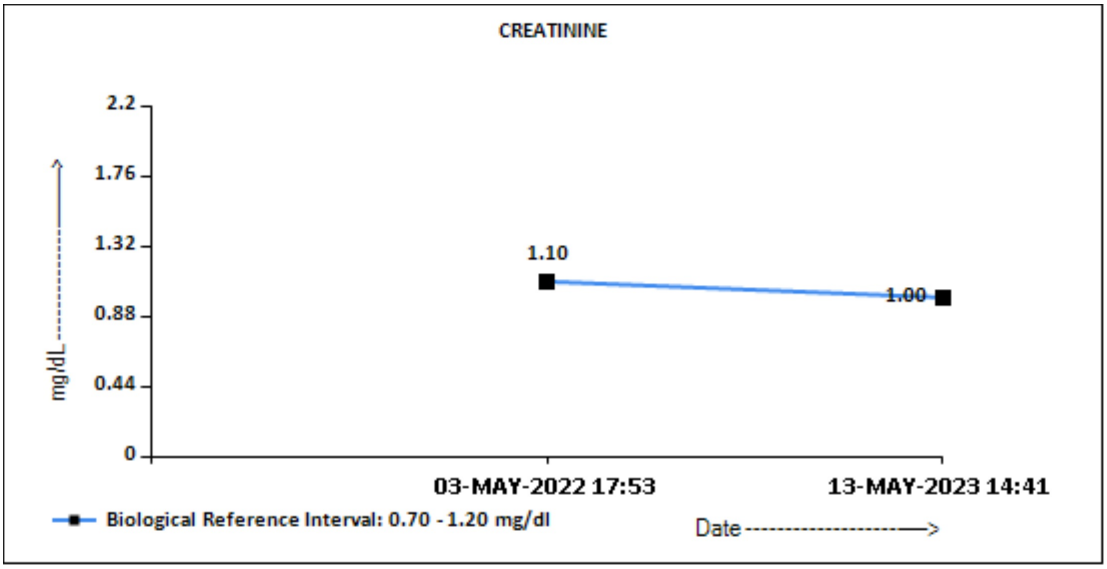
GLOMERULAR FILTRATION RATE (MALE)	86	GFR of +90 normal or minimal kidney damage with normal GFR 89- 60 mild decrease 59-30 moderate decrease 29-15 severe decrease < 15 kidney failure (units: mL/min/1.73mSq.)	



GLUCOSE POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	**162 High**	Non-Diabetes 70 - 140	mg/dL

METHOD : HEXOKINASE

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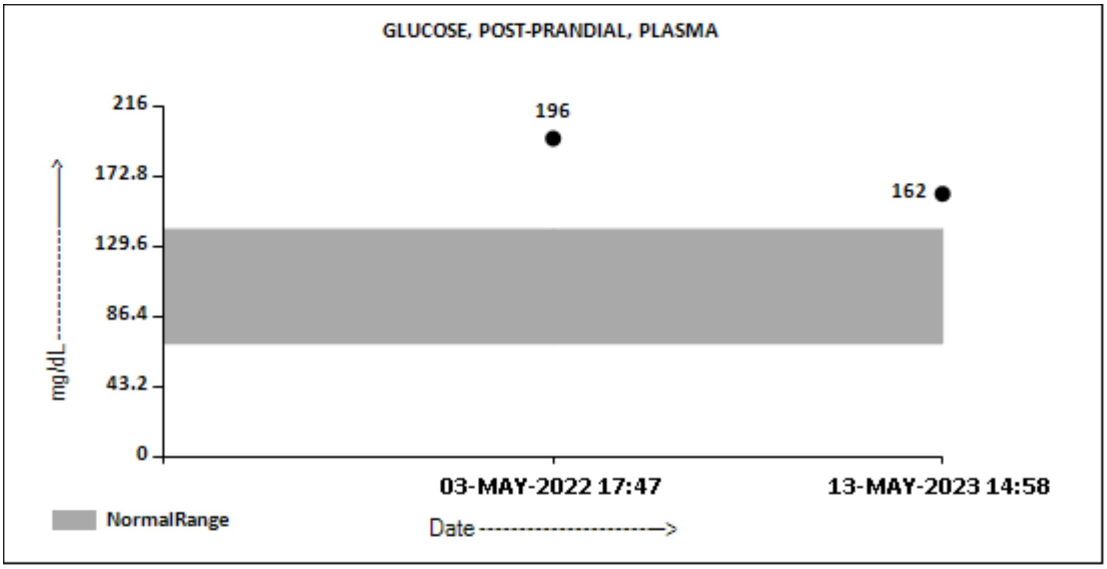

Interpretation(s)
LIVER FUNCTION PROFILE, SERUM-
Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice.**Elevated levels** results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors &Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.
AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver,liver cancer,kidney failure,hemolytic anemia,pancreatitis,hemochromatosis. AST levels may also increase after a heart attack or strenuous activity.ALT test measures the amount of this enzyme in the blood.ALT is found mainly in the liver, but also in smaller amounts in the kidneys,heart,muscles, and pancreas.It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health.AST levels increase during acute hepatitis,sometimes due to a viral infection,ischemia to the liver,chronic hepatitis,obstruction of bile ducts,cirrhosis.
ALP is a protein found in almost all body tissues.Tissues with higher amounts of ALP include the liver,bile ducts and bone.Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Pagets disease,Rickets,Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia,Malnutrition,Protein deficiency,Wilsons disease.
GGT is an enzyme found in cell membranes of many tissues mainly in the liver,kidney and pancreas.It is also found in other tissues including intestine,spleen,heart, brain and seminal vesicles.The highest concentration is in the kidney,but the liver is considered the source of normal enzyme activity.Serum GGT has been widely used as an

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FORTIS HOSPITAL # MOHALI,
MOHALI 160062
7087030817

ACCESSION NO : **0006WE011801**
PATIENT ID : FH.11716120
CLIENT PATIENT ID: UID:11716120
ABHA NO :

AGE/SEX : 33 Years Male
DRAWN : 13/05/2023 09:46:00
RECEIVED : 13/05/2023 13:53:25
REPORTED : 13/05/2023 16:18:37

CLINICAL INFORMATION :

UID:11716120 REQNO-1521799
CORP-OPD
BILLNO-1002123OPCS007376
BILLNO-1002123OPCS007376

Test Report Status **Final**	Results	Biological Reference Interval	Units

index of liver dysfunction.Elevated serum GGT activity can be found in diseases of the liver,biliary system and pancreas.Conditions that increase serum GGT are obstructive liver disease,high alcohol consumption and use of enzyme-inducing drugs etc.
Total Protein also known as total protein,is a biochemical test for measuring the total amount of protein in serum.Protein in the plasma is made up of albumin and globulin.Higher-than-normal levels may be due to:Chronic inflammation or infection,including HIV and hepatitis B or C,Multiple myeloma,Waldenstroms disease.Lower-than-normal levels may be due to: Agammaglobulinemia,Bleeding (hemorrhage),Burns,Glomerulonephritis,Liver disease, Malabsorption,Malnutrition,Nephrotic syndrome,Protein-losing enteropathy etc.
Albumin is the most abundant protein in human blood plasma.It is produced in the liver.Albumin constitutes about half of the blood serum protein.Low blood albumin levels (hypoalbuminemia) can be caused by:Liver disease like cirrhosis of the liver, nephrotic syndrome,protein-losing enteropathy,Burns,hemodilution,increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc
GLUCOSE FASTING,FLUORIDE PLASMA-**TEST DESCRIPTION**
Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and sothat no glucose is excreted in the urine.
Increased in:Diabetes mellitus, Cushing' s syndrome (10 – 15%), chronic pancreatitis (30%). Drugs:corticosteroids,phenytoin, estrogen, thiazides.
Decreased in :Pancreatic islet cell disease with increased insulin,insulinoma,adrenocortical insufficiency,hypopituitarism,diffuse liver disease, malignancy(adrenocortical,stomach,fibrosarcoma),infant of a diabetic mother,enzyme deficiency diseases(e.g.galactosemia),Drugs-insulin,ethanol,propranolol;sulfonylureas,tolbutamide,and other oral hypoglycemic agents.
NOTE: While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values),there is wide fluctuation within individuals.Thus, glycosylated hemoglobin(HbA1c) levels are favored to monitor glycemic control.
High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment,Renal Glyosuria,Glycaemic index & response to food consumed,Alimentary Hypoglycemia,Increased insulin response & sensitivity etc.
BLOOD UREA NITROGEN (BUN), SERUM-**Causes of Increased** levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.
URIC ACID, SERUM-**Causes of Increased levels:**-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome **Causes of decreased levels**-Low Zinc intake,OCP,Multiple Sclerosis
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD-**Used For**:

1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patients metabolic control has remained continuously within the target range.
1. eAG (Estimated average glucose) converts percentage HbA1c to md/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :
1. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss,hemolytic anemia) will falsely lower HbA1c test results.Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
2.Vitamin C & E are reported to falsely lower test results.(possibly by inhibiting glycation of hemoglobin.
3. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia,uremia, hyperbilirubinemia, chronic alcoholism,chronic ingestion of salicylates & opiates addiction are reported to interfere with some assay methods,falsely increasing results.
4. Interference of hemoglobinopathies in HbA1c estimation is seen in

a) Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b) Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c) HbF > 25% on alternate paltform (Boronate affinity chromatography) is recommended for testing of HbA1c.Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy
CREATININE EGFR-GFR— Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.
A GFR of 60 or higher is in the normal range.
A GFR below 60 may mean kidney disease.
A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal

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Email : srl.mohali@fortishealthcare.com

Patient Ref. No. 6000003029242

DIAGNOSTIC REPORT

MC-2559

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FORTIS MOHALI-CHC -SPLZD
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Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

This equation takes into account several factors that impact creatinine production, including age, gender, and race. In children, eGFR is calculated using original schwartz equation.

The equation has not been validated in children & will only be reported for patients > 16 years of age. The equation is normalized for an average adult body surface area of 1.73m², weight & height adjustment is not necessary.

The IDMS Traceable MDRD equation has not been validated in children & will only be reported for patients = 18 years of age. The equation is normalized for an average adult body surface area of 1.73m², weight & height adjustment is not necessary. Estimation of GFR in children and adolescence (0- < 18 years) is performed by bedside IDMS- Traceable Schwartz formula
GLUCOSE POST-PRANDIAL, PLASMA-Spectrophotometry Hexokinase

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MC-2559

Fortis HOSPITAL Mohali

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BIOCHEMISTRY - LIPID			
LIPID PROFILE, SERUM			
CHOLESTEROL, TOTAL	**244 High**	< 200 Desirable 200 - 239 Borderline High >/= 240 High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
TRIGLYCERIDES	**217 High**	< 150 Normal 150 - 199 Borderline High 200 - 499 High >/= 500 Very High	mg/dL
METHOD : ENZYMATIC ASSAY			
HDL CHOLESTEROL	47	< 40 Low >/=60 High	mg/dL
METHOD : DIRECT MEASURE - PEG			
LDL CHOLESTEROL, DIRECT	**154 High**	< 100 Optimal 100 - 129 Near or above optimal 130 - 160 Borderline High 161 - 189 High >/= 190 Very High	mg/dL
METHOD : CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE			
NON HDL CHOLESTEROL	**197 High**	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL
VERY LOW DENSITY LIPOPROTEIN	**43.4 High**	Desirable value : 10 - 35	mg/dL
METHOD : CALCULATED PARAMETER			
CHOL/HDL RATIO	**5.2 High**	3.3-4.4 Low Risk 4.5-7.0 Average Risk 7.1-11.0 Moderate Risk > 11.0 High Risk	

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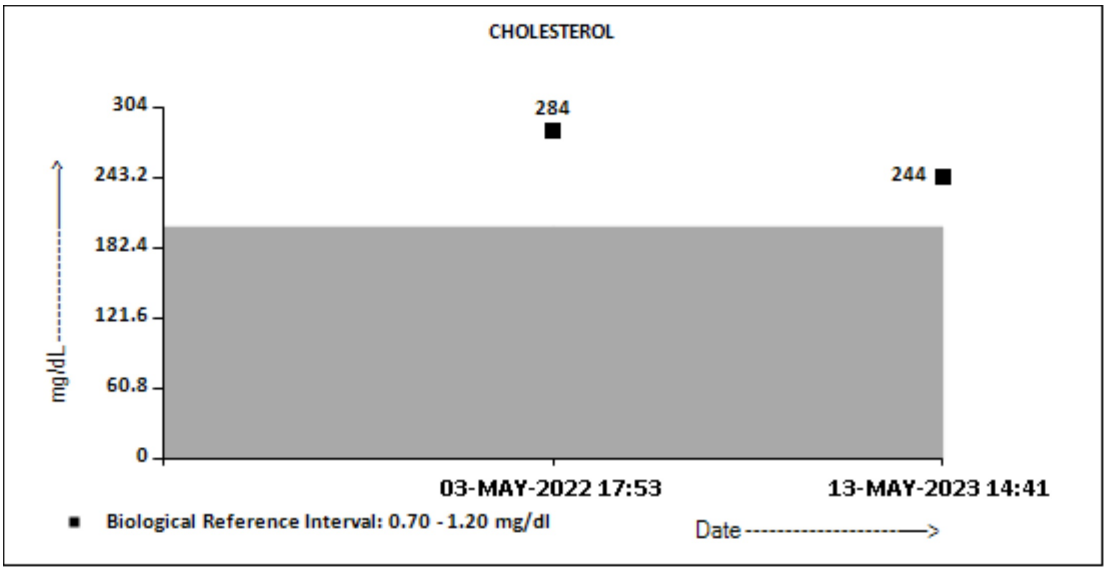
LDL/HDL RATIO	**3.3 High**	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk >6.0 High Risk	

METHOD : CALCULATED PARAMETER



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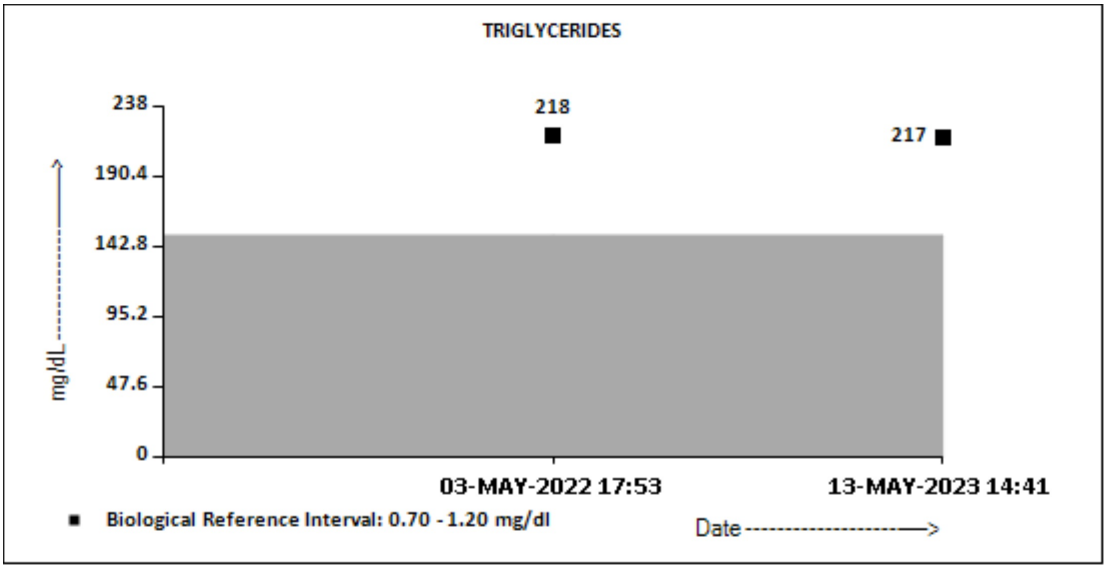

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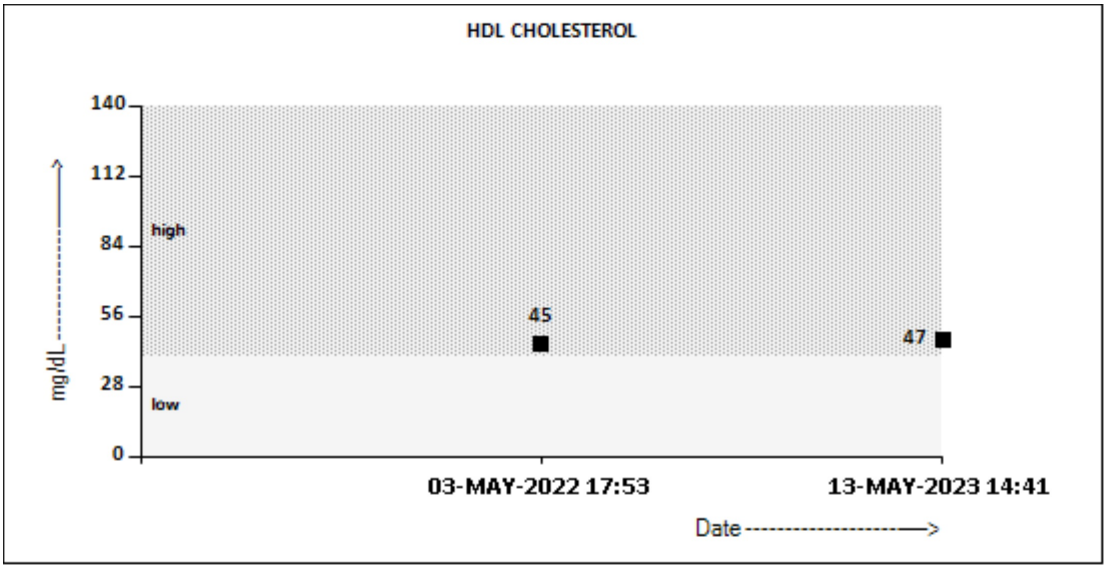

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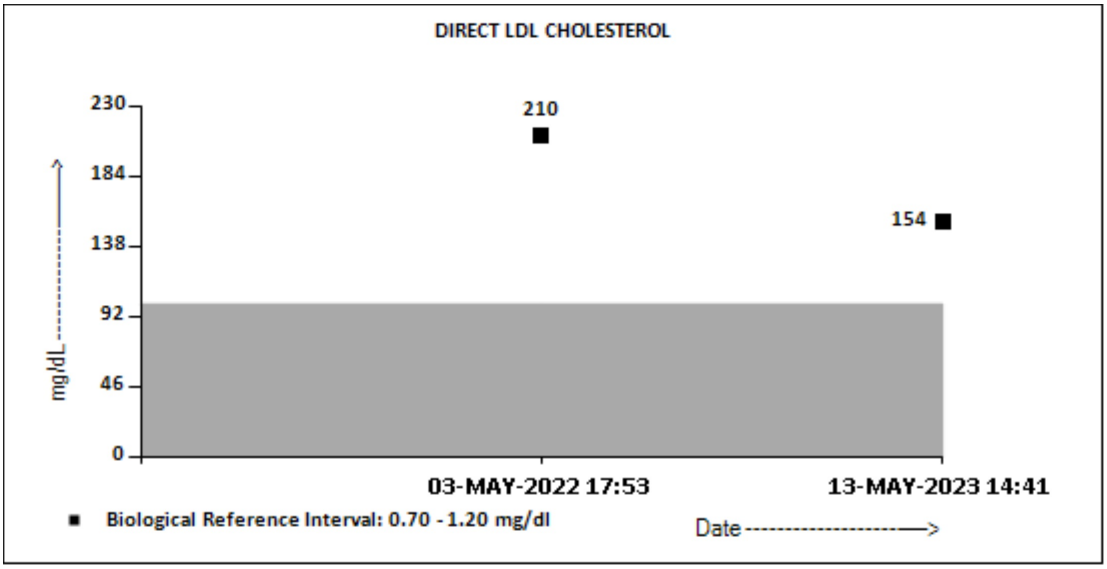

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CLINICAL PATH - URINALYSIS

URINALYSIS

PHYSICAL EXAMINATION, URINE

COLOR	YELLOW		
METHOD : MANUAL EXAMINATION			
APPEARANCE	CLEAR		
METHOD : MANUAL EXAMINATION			

CHEMICAL EXAMINATION, URINE

PH	5.5	4.7 - 7.5	
METHOD : DOUBLE INDICATOR PRINCIPLE			
SPECIFIC GRAVITY	>=1.030	1.003 - 1.035	
METHOD : REFLECTANCE PHOTOMETRY (IONIC CONCENTRATION)			
PROTEIN	**DETECTED (TRACE)**	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (PROTEIN ERROR INDICATOR)			
GLUCOSE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (GLUCOSE OXIDASE METHOD)			
KETONES	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTION PHOTOMETRY (NITROPRUSSIDE)			
BLOOD	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE PHOTOMETRY (BENZIDINE REACTION)			
BILIRUBIN	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			
UROBILINOGEN	NORMAL	NORMAL	
METHOD : REFLECTANCE PHOTOMETRY (EHRLICH'S REACTION)			
NITRITE	NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (DIAZO REACTION)			

MICROSCOPIC EXAMINATION, URINE

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RED BLOOD CELLS METHOD : MICROSCOPY	NOT DETECTED	NOT DETECTED	/HPF
PUS CELL (WBC'S) METHOD : REFLECTANCE PHOTOMETRY & MICROSCOPY	NOT DETECTED	0-5	/HPF
EPITHELIAL CELLS METHOD : MICROSCOPY	NOT DETECTED	0-5	/HPF
CASTS METHOD : MICROSCOPY	NOT DETECTED		
CRYSTALS METHOD : MICROSCOPY	NOT DETECTED		
BACTERIA METHOD : MICROSCOPY	NOT DETECTED	NOT DETECTED	
YEAST	NOT DETECTED	NOT DETECTED	

Interpretation(s)

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CLINICAL PATH - STOOL ANALYSIS

STOOL: OVA & PARASITE

PHYSICAL EXAMINATION,STOOL

COLOUR	YELLOW		
CONSISTENCY	WELL FORMED		
MUCUS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
VISIBLE BLOOD	ABSENT	ABSENT	
ADULT PARASITE	NOT DETECTED		
METHOD : MANUAL			

MICROSCOPIC EXAMINATION,STOOL

PUS CELLS	NOT DETECTED		/hpf
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION			
CYSTS	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
OVA	NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION			
LARVAE	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			
TROPHOZOITES	NOT DETECTED	NOT DETECTED	
METHOD : MICROSCOPIC EXAMINATION			

Interpretation(s)

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AGE/SEX : 33 Years Male
DRAWN : 13/05/2023 09:46:00
RECEIVED : 13/05/2023 13:53:25
REPORTED : 13/05/2023 16:18:37

CLINICAL INFORMATION :

UID:11716120 REQNO-1521799
CORP-OPD
BILLNO-1002123OPCS007376
BILLNO-1002123OPCS007376

Test Report Status **Final**	Results	Biological Reference Interval	Units
SPECIALISED CHEMISTRY - HORMONE			
THYROID PANEL, SERUM			
T3	119.4	80.00 - 200.00	ng/dL
METHOD : SANDWICH (ECLIA)			
T4	8.48	5.10 - 14.10	µg/dL
METHOD : SANDWICH (ECLIA)			
TSH (ULTRASENSITIVE)	2.520	0.270 - 4.200	µIU/mL
METHOD : SANDWICH (ECLIA)			

Interpretation(s)

****End Of Report****
Please visit www.srlworld.com for related Test Information for this accession

Meenakshi Malhotra

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Senior Consultant,48159

Ritu Pankaj

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