

Lab No.	: SIL/24-06-2023/SR780	00044	Lab Add.	: Sevoke Road, Siliguri	
Patient Name			Ref Dr.	: Dr.MEDICAL OFFICE	2053/07/4 3012
Age	: 35 Y 0 M 11 D			Date: 24/Jun/2023 10:27A	
Gender	: F		Report Da	ate : 24/Jun/2023 12:01Pl	
Test Name		Result	Unit	Bio Ref. Interval	Method
*DOTASSIUM R	BLOOD, GEL SERUM				
POTASSIUM, BL		4.80	mEq/L	3.1-5.5 mEq/L	ISE INDIRECT
		1.00	·	·	
UREA,BLOOD , (	GEL SERUM	14.0	mg/dl	12.8-42.8 mg/dl	UREASE-COLORIMETRIC
*GLUCOSE EAS	TING , BLOOD, NAF PLASM	٨			
GLUCOSE, FAST		94	mg/dl	70 - 100 mg/dL	Hexokinase Method
	-INORGANIC, BLOOD, GE				
PHOSPHORUS-I	NORGANIC, BLOOD	3.2	mg/dl	2.5-4.5 mg/dl	UV PHOSPHOMOLYBDATE
<b>*TOTAL PROTEI</b>	N [BLOOD] ALB:GLO RAT	10 , .			
TOTAL PROTEI		7.17	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN		3.5	g/dl	3.4-5.0 g/dl	ВСР
GLOBULIN		3.68	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio		0.95		1.0 - 2.5	Calculated
CREATININE, BL	OOD	0.66	mg/dl	0.55 - 1.02 mg/dl	ALKALINE PICRATE
*LIPID PROFILE	E , GEL SERUM				
CHOLESTEROL	-TOTAL	166	mg/dl	Desirable: < 200 mg/dL Borderline high: 200-239 High: > or =240 mg/dL	CHOLESTEROL OXIDASE, ESTERASE,PEROXIDASE
TRIGLYCERIDES	5	97	mg/dl	NORMAL < 150 BORDERLINE HIGH 150-199 HIGH 200-499 VERY HIGH > 500	ENZYMATIC, END POINT
HDL CHOLESTE	ROL	44	mg/dl	NO RISK : >60 mg/dL, MODERATE RISK : 40-60 mg/dL, HIGH RISK : <40 mg/dL	DIRECT MEASURE-PEG
LDL CHOLESTEI	ROL DIRECT	112	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	
VLDL		11	mg/dL	< 40 mg/dl	Calculated
CHOL HDL Ratio	)	3.8		LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	Calculated
*URIC ACID, BL	.OOD , GEL SERUM				
URIC ACID, BLO	OD	5.25	mg/dl	2.4 - 5.7 mg/dl	URICASE
*CHLORIDE, BL	OOD , .				
CHLORIDE,BLO		104	mEq/L	98 - 107 mEq/L	ISE INDIRECT
	EL (T3, T4, TSH), GEL SEF		na/ml	0.60 - 1.81 ng/ml	CLIA
T3-TOTAL (TRI T4-TOTAL (TH	IODOTHYRONINE)	0.81 7.3	ng/ml microgram/dl	4.5 - 10.9 microgram/dl	CLIA
	STIMULATING HORMONE)		µIU/mL	0.35-5.5µIU/mL	CLIA
	moentino honimone)	0.70		/	



#### Lab No. : SR7800044 Name : TUMPA KAR

Age/G : 35 Y 0 M 11 D / F Date : 24-06-2023

<u>BIOLOGICAL REFERENCE INTERVAL</u>: [ONLY FOR PREGNANT MOTHERS] Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER: 0.102.50 µ IU/mLSECOND TRIMESTER: 0.203.00 µ IU/mLTHIRD TRIMESTER: 0.303.00 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.

*CALCIUM, BLOOD CALCIUM,BLOOD	8.58	mg/L	8.6-10.0 mg/dl	OCPC
* <b>SODIUM, BLOOD</b> , GEL SERUM SODIUM,BLOOD	138	mEq/L	136 - 145 mEq/L	ISE INDIRECT
				little
				DR. SANJAY KR. AGARWALA MD CONSULTANT BIOCHEMIST



Lab No. : SR7800044 Na	me : TUMPA KAR		Age/G : 35 Y 0 M 11 D / F	Date : 24-06-2023
*ESR (ERYTHROCYTE SEDIME	NTATION RATE), E	DTA WHOLE BLOOD		
1stHour	26	mm/hr	0.00 - 20.00 mm/hr	Westergren
· · · · · · · · · · · · · · · · · · ·				
*CBC WITH PLATELET (THRON	, ,			
HEMOGLOBIN	12.6	g/dL	12 - 15	PHOTOMETRIC
WBC	7.3	*10^3/µL	4 - 10	DC detection method
RBC	4.35	*10^6/µL	3.8 - 4.8	DC detection method
PLATELET (THROMBOCYTE)	OUNT 318	*10^3/µL	150 - 450*10^3/µL	DC detection method/Microscopy
DIFFERENTIAL COUNT				
NEUTROPHILS	64	%	40 - 80 %	Flowcytometry/Microscopy
LYMPHOCYTES	32	%	20 - 40 %	Flowcytometry/Microscopy
MONOCYTES	02	%	2 - 10 %	Flowcytometry/Microscopy
EOSINOPHILS	02	%	1 - 6 %	Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9%	Flowcytometry/Microscopy
CBC SUBGROUP				
HEMATOCRIT / PCV	37.3	%	36 - 46 %	Calculated
MCV	86.0	fl	83 - 101 fl	Calculated
MCH	29.0	pg	27 - 32 pg	Calculated
MCHC	33.9	gm/dl	31.5-34.5 gm/dl	Calculated
RDW - RED CELL DISTRIBUTIO	N WIDTH 14.5	%	11.6-14%	Calculated
PDW-PLATELET DISTRIBUTIO	NWIDTH 14.4	fL	8.3 - 25 fL	Calculated
MPV-MEAN PLATELET VOLUM	E 9.7		7.5 - 11.5 fl	Calculated
RBC	ANISOPO	CHROMIC. MILD DIKILOCYTOSIS.		
WBC.	NORMAL	MORPHOLOGY.		
PLATELET	ADEQUA	TE ON SMEAR.		

Ac

Dr. Ankush Chakraborty MBBS, MD (Path), IFCAP Reg. No. 65992 (WBMC)

#### Lab No. : SIL/24-06-2023/SR7800044







Lab No. : SR7800044 Name : TUMPA KAR

Age/G : 35 Y 0 M 11 D / F Date : 25-06-2023

#### PDF Attached

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

GLYCATED HEMOGLOBIN (HBA1C)	4.8	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS, PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	
HbA1c (IFCC)	29.0	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.

 $\emptyset$  If a patient changes treatment plans or does not meet his or her glycemic goals, HbA1c testing should be done quarterly.  $\emptyset$  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.

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



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Age/G : 35 Y 0 M 11 D / F

Date : 24-06-2023

*URINE ROUTINE ALL, ALL , URINE PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW			
APPEARANCE	CLEAR			
CHEMICAL EXAMINATION				
рН	6.0		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.015		1.005 - 1.030	Dipstick (ion concentration method)
PROTEIN	ABSENT		NOT DETECTED	Dipstick (protein error of pH indicators)/Manual
GLUCOSE	ABSENT		NOT DETECTED	Dipstick(glucose-oxidase-peroxidase method)/Manual
KETONES (ACETOACETIC ACID, ACETONE)	ABSENT		NOT DETECTED	Dipstick (Legals test)/Manual
BLOOD	ABSENT		NOT DETECTED	Dipstick (pseudoperoxidase reaction)
BILIRUBIN	ABSENT		NEGATIVE	Dipstick (azo-diazo reaction)/Manual
UROBILINOGEN	ABSENT		NEGATIVE	Dipstick (diazonium ion reaction)/Manual
NITRITE	ABSENT		NEGATIVE	Dipstick (Griess test)
LEUCOCYTE ESTERASE	ABSENT		NEGATIVE	Dipstick (ester hydrolysis reaction)
MICROSCOPIC EXAMINATION				
LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	10-15	/hpf	0-5	Microscopy
RED BLOOD CELLS	ABSENT	/hpf	0-2	Microscopy
CAST	ABSENT		NOT DETECTED	Microscopy
CRYSTALS	ABSENT		NOT DETECTED	Microscopy
BACTERIA	ABSENT		NOT DETECTED	Microscopy
YEAST	ABSENT		NOT DETECTED	Microscopy
OTHERS	ABSENT			

#### 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.

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

ABO	В	Gel Card
RH	POSITIVE	Gel Card

# Gel technology Dia Med ID Micro typing system is the latest technology in transfusion Medicine. It gives more reproducible and standardized test results.

It more repaid, reliable, very sensitive and objective , and hence more consistent and comparable results are obtained. Single used cards are individualised for every patient and results can be photographed / scanned and stored for future use.

Special instruments that are used only for this technology also reduce risk of any contamination.

#### Ref:- WHO technical manual on transfusion medicine-Second Edition 2003

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## (RESULTS ALSO VERIFIED BY : FORWARD AND REVERSE GROUPING (TUBE AND SLIDE METHOD)

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.

**DR.BARNALI PAUL** MBBS, MD(PATH)



Lab Add.:Ref Dr.: Dr.MEDICAL OFFICERCollection Date:



Report Date : 24/Jun/2023 12:50PM

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

HEART RATE	: 68 /min.
RHYTHM	: Regular sinus.
P-WAVE	: Normal
P - R INTERVAL	: 160 ms,
QRS DURATION	: 80 ms
QRS CONFIGURATION	: NORMAL
QRS VOLTAGE	: R/S in V1 1/2 mm.
	R/S in V6 6/4 mm.
QRS AXIS	: 0°
Q- Waves	: No significant Q-wave.
QT TIME	: 386ms.
ST SEGMENT	: Normal.
T WAVE	: Inversion V1-V4
ROTATION	: Normal.
OTHER FINDINGS	: Nil.
IMPRESSION	: ANTERO SEPTAL ISCHAEMIA

Dr. ARABINDA SAHA (MD,DM) CONSULTANT CARDIOLOGIST

Lab No. : SIL/24-06-2023/SR7800044



Lab Add. : Ref Dr. : Dr.MEDICAL OFFICER Collection Date:



Report Date : 24/Jun/2023 06:57PM

## DEPARTMENT OF ULTRASONOGRAPHY REPORT ON EXAMINATION OF WHOLE ABDOMEN

## **LIVER**

Liver is normal in size having normal shape, **with 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 with no intraluminal pathology (Calculi /mass) could be detected at its visualsed part. Portal vein is normal 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. 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 95 mm. & Lt. kidney 92 mm.) axes & position. Cortical echogenecity appears normal maintaining cortico-medullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted. No hydronephrotic changes detected. 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.

## <u>UTERUS</u>

Uterus is anteverted, normal in size (88 mm. x 33 mm. x 43 mm). Endometrium (collapsed wall) is in midline. Myometrium appears smooth & homogenous without any detectable/sizable focal lesion. Cervix looks normal. Pouch of Douglas is free.

## **OVARIES**

Ovaries are normal in size, shape, position, margin and echotexture.

## **IMPRESSION :**

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Lab Add. : Ref Dr. : Dr.MEDICAL OFFICER Collection Date : 24/Jun/2023 06:57PM



Grade I fatty change in liver.

## NB : No evidence of sludge seen at gall bladder at present.

(Please correlate clinically & with other investigation. Follow up suggested).

## 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.

<u>The report and films are not valid for medico-legal purpose.</u>

Patient Identity not verified.





Lab Add. : Ref Dr. : Dr.MEDICAL OFFICER Collection Date:



Report Date : 24/Jun/2023 01:17PM

## DEPARTMENT OF RADIOLOGY X-RAY REPORT OF CHEST (PA)

# FINDINGS:

- Cardiac size appears within normal limits. Margin is well visualised and cardiac silhoutte is smoothly outlined. Shape is within normal limit.
- Prominence of bronchovascular marking seen. No definite active lung lesion seen.
- · Lateral costo-phrenic angles are clear.
- Domes of diaphragm are smoothly outlined. Position is within normal limits.

# IMPRESSION : Prominence of bronchovascular marking - - Bronchitis.

(Please correlate clinically & with other investigation. Follow up suggested).

DR. MUKTI SARKAR MD. CONSULTANT RADIOLOGIST

## SURAKSHA DIAGNOSTIC, RAJARHAT, KOLKATA. BIO-RAD VARIANT TURBO CDM 5.4 s/n 15893

## PATIENT REPORT V2TURBO\_A1c\_2.0

Patient Data		Analysis Data	
Sample ID:	D02135191236	Analysis Performed:	25/JUN/2023 11:56:51
Patient ID:	SR7800044	Injection Number:	4983U
Name:		Run Number:	124
Physician:		Rack ID:	0006
Sex:		Tube Number:	10
DOB:		Report Generated:	25/JUN/2023 12:10:31
		Operator ID:	ANUP

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a		1.0	0.161	22698
A1b		0.7	0.224	16699
F		0.8	0.271	19412
LA1c		1.5	0.392	36185
A1c	4.8		0.494	96185
P3		3.1	0.773	73829
P4		1.1	0.854	26677
Ao		87.7	0.974	2084291

Total Area: 2,375,977

HbA1c (NGSP) = 4.8 % HbA1c (IFCC)



