



Lab No. : ASN/25-03-2023/SR7450679
Patient Name : SRIPARNA MONDAL
Age : 31 Y 6 M 4 D
Gender : F

Lab Add. : Newtown, Kolkata-700156
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date: 26/Mar/2023 09:32AM
Report Date : 27/Mar/2023 01:36PM



Test Name	Result	Unit	Bio Ref. Interval	Method
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BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD

ABO	O			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.

Dr. PANKTI PATEL
MBBS , MD (PATHOLOGY)
CONSULTANT PATHOLOGIST

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CREATININE, BLOOD , GEL SERUM	0.60	mg/dL	0.60 - 1.1 mg/dl ENZYMATIC
*CHLORIDE, BLOOD , .			
CHLORIDE,BLOOD	105	mEq/L	98 - 107 mEq/L ISE DIRECT
*CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD			
HEMOGLOBIN	11.2	g/dL	12 - 15 PHOTOMETRIC
WBC	6.0	*10 ³ /μL	4 - 10 DC detection method
RBC	3.61	*10 ⁶ /μL	3.8 - 4.8 DC detection method
PLATELET (THROMBOCYTE) COUNT	151	*10 ³ /μL	150 - 450*10 ³ /μL DC detection method/Microscopy
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS	46	%	40 - 80 % Flowcytometry/Microscopy
LYMPHOCYTES	45	%	20 - 40 % Flowcytometry/Microscopy
MONOCYTES	05	%	2 - 10 % Flowcytometry/Microscopy
EOSINOPHILS	04	%	1 - 6 % Flowcytometry/Microscopy
BASOPHILS	00	%	0-0.9% Flowcytometry/Microscopy
<u>CBC SUBGROUP</u>			
HEMATOCRIT / PCV	33.5	%	36 - 46 % Calculated
MCV	92.8	fl	83 - 101 fl Calculated
MCH	31.0	pg	27 - 32 pg Calculated
MCHC	33.4	gm/dl	31.5-34.5 gm/dl Calculated
RDW - RED CELL DISTRIBUTION WIDTH	14.6	%	11.6-14% Calculated
PDW-PLATELET DISTRIBUTION WIDTH	32.5	fL	8.3 - 25 fL Calculated
MPV-MEAN PLATELET VOLUME	14.7		7.5 - 11.5 fl Calculated
*ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD			
1stHour	21	mm/hr	0.00 - 20.00 mm/hr Westergren
*GLUCOSE, PP , BLOOD, NAF PLASMA			
GLUCOSE,PP	97*		(70 - 140 mg/dl) GOD POD

The lower value of PPBG compared to that of FBG, may be interpreted having due to regard to the history of the case with particular reference to Diabetes, If any including the time and dose of antidiabetic drug administered, if any.

*Note: Blood glucose level is maintained by a very complex integrated mechanism involving critical interplay of release of hormones and action of enzymes on key metabolic pathways resulting in a smooth transition normally from a high level of glucose influx following meal / glucose intake to a basal level after 2 – 3 hrs or so. Excluding alimentary hypoglycaemia, renal glycosuria, hereditary fructose intolerance and Galactosemia , the possible causes of post prandial reactive hypoglycaemia (PRH) include high insulin sensitivity, exaggerated response of insulin and glucagon like peptide 1(GLP-1), defects in counter-regulation, very lean and /or anxious individuals, after massive weight reduction etc

***THYROID PANEL (T3, T4, TSH) , GEL SERUM**

T3-TOTAL (TRI IODOTHYRONINE)	0.80	ng/ml	0.9 - 2.2 ng/ml CLIA
T4-TOTAL (THYROXINE)	6.1	5.5-16 microgram/dl	5.5-16 microgram/dl CLIA
TSH (THYROID STIMULATING HORMONE)	2.20	μIU/mL	0.5-4.7 μIU/mL CLIA

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

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FIRST TRIMESTER : 0.10 2.50 µ IU/mL
 SECOND TRIMESTER : 0.20 3.00 µ IU/mL
 THIRD TRIMESTER : 0.30 3.00 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>.

UREA, BLOOD 23.9 mg/dl 12.8-42.8 mg/dl UREASE-GLDH

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

PHYSICAL EXAMINATION

COLOUR PALE YELLOW
 APPEARANCE SLIGHTLY HAZY

CHEMICAL EXAMINATION

pH	7.0		4.6 - 8.0	Dipstick (triple indicator method)
SPECIFIC GRAVITY	1.020		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)
LEUCOCYTE ESTERASE	TRACE		NEGATIVE	Dipstick (ester hydrolysis reaction)

MICROSCOPIC EXAMINATION

LEUKOCYTES (PUS CELLS)	1-2	/hpf	0-5	Microscopy
EPITHELIAL CELLS	12-15	/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

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and/or yeast in the urine.

[PDF Attached](#)

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

GLYCATED HEMOGLOBIN (HBA1C)	4.9	%	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***
HbA1c (IFCC)	30.0	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 : BIORAD D-10

Method : HPLC

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 B₁₂/ 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.

***POTASSIUM, BLOOD , GEL SERUM**

POTASSIUM,BLOOD	4.00	mEq/L	3.1-5.5 mEq/L	ISE DIRECT
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***TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .**

TOTAL PROTEIN	7.10	g/dL	6.6 - 8.7 g/dL	BIURET METHOD
ALBUMIN	4.3	g/dl	3.5-5.2 g/dl	BCG
GLOBULIN	2.80	g/dl	1.8-3.2 g/dl	Calculated
AG Ratio	1.54		1.0 - 2.5	Calculated

***SODIUM, BLOOD , GEL SERUM**

SODIUM,BLOOD	138	mEq/L	136 - 145 mEq/L	ISE DIRECT
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***CALCIUM, BLOOD**

CALCIUM,BLOOD	9.00	mg/dL	8.6 - 10.2 mg/dl	ARSENAZO III
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*URIC ACID, BLOOD , GEL SERUM

URIC ACID,BLOOD 4.50 mg/dl 2.4 - 5.7 mg/dl URICASE

*GLUCOSE, FASTING , BLOOD, NAF PLASMA

GLUCOSE,FASTING 100 mg/dL (70 - 110 mg/dl) GOD POD

□



Dr Sayak Biswas
MBBS, MD
Consultant Pathologist



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PHOSPHORUS-INORGANIC, BLOOD , GEL SERUM

PHOSPHORUS-INORGANIC,BLOOD	4.2	mg/dL	2.4-5.1 mg/dL	Phosphomolybdate/UV
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LIPID PROFILE , GEL SERUM

CHOLESTEROL-TOTAL	128	mg/dL	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	Enzymatic
TRIGLYCERIDES	52	mg/dL	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	GPO-Trinder
HDL CHOLESTEROL	54	mg/dl	< 40 - Low 40-59- Optimum 60 - High	Elimination/catalase
LDL CHOLESTEROL DIRECT	67	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	Elimination / Catalase
VLDL	7	mg/dl	< 40 mg/dl	Calculated
CHOL HDL Ratio	2.4		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.

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

DEPARTMENT OF PATHOLOGY
REPORT ON EXAMINATION OF CERVICAL SMEAR FOR EXFOLIATIVE

SITE :

Conventional cervicovaginal cytology.

SPECIMEN ADEQUACY :

Adequate for evaluation but limited by evaluation endocervical cell.

GENERAL DIAGNOSTIC CATEGORIZATION :

Negative for intraepithelial lesion / malignancy.

MICROSCOPY :

Smear show predominantly intermediate & superficial squamous cells in a background containing lactobacilli.

Metaplastic cell - few.

Inflammatory cell - not seen.

Dysplastic cell - not seen on smear examined.

IMPRESSION :

Smear Negative for Dysplasia..

Note : Please correlate clinically.

ENCL :Two (02) slides.

□



Dr Sayak Biswas
MBBS, MD
Consultant Pathologist

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Patient Name : SRIPARNA MONDAL
Age : 31 Y 6 M 4 D
Gender : F

Lab Add. : ASANSOL
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date:
Report Date : 25/Mar/2023 03:40PM



DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

DATA

HEART RATE	:	75 bpm
PR INTERVAL	:	132 ms
QRS DURATION	:	76 ms
QT INTERVAL	:	383 ms
QTC INTERVAL	:	428 ms

AXIS

P WAVE	:	55 degree
QRS WAVE	:	64 degree
T WAVE	:	37 degree

IMPRESSION : Normal sinus rhythm, within normal limit.

ACR

Dr. A C RAY
Department of Non-invasive
Cardiology

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Lab Add. : ASANSOL
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Collection Date:
Report Date : 25/Mar/2023 05:26PM



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.

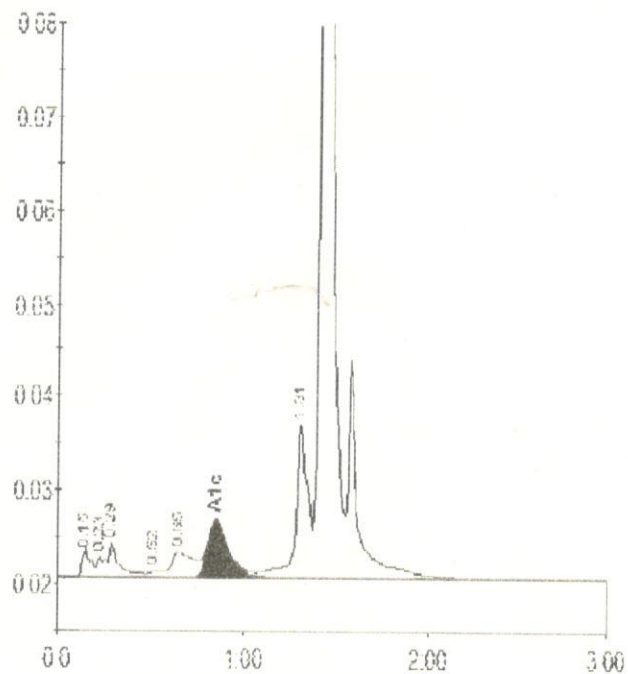
IMPRESSION :

Normal study.

DR. ANIL SIDRAM GAIKWAD
MBBS, DNB (RADIO-DIAGNOSIS)

Patient report

Bio-Rad DATE: 26/03/2023
 D-10 TIME: 03:41 PM
 S/N: #DJ4D012104 Software version: 4.30-2
 Sample ID: C02135103393
 Injection date 26/03/2023 03:41 PM
 Injection #: 7 Method: HbA1c
 Rack #: --- Rack position: 7



Peak table - ID: C02135103393

Peak	R.time	Height	Area	Area%
A1a	0.15	3100	9605	0.7
Unknown	0.23	2289	7173	0.5
A1b	0.29	3558	14459	1.1
F	0.52	819	4580	0.3
LA1c/CHb-1	0.65	2752	22229	1.7
A1c	0.85	6168	48232	4.9
P3	1.31	16413	75973	5.7
A0	1.42	458765	1152019	86.3
Total Area:		1334269		

Concentration:	%	mmol/mol
A1c	4.9	30