



**TEST REPORT**

**Reg. No** : 2206100969  
**Name** : SUNIL KUMAR  
**Age/Sex** : 36 Years / Male  
**Ref. By** :  
**Client** : MEDIWHEEL WELLNESS

**Reg. Date** : 08-Jun-2022  
**Collected On** : 08-Jun-2022 08:10  
**Approved On** : 08-Jun-2022 10:39  
**Printed On** : 16-Jun-2022 15:57

**Parameter**

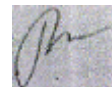
**Result**

**BLOOD GROUP & RH**

**Specimen: EDTA and Serum; Method: Haemagglutination**

ABO : 'B'  
Rh (D) : Positive

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### COMPLETE BLOOD COUNT (CBC)

SPECIMEN: EDTA BLOOD

Hemoglobin	14.9	g/dL	13.0 - 17.0
RBC Count	4.57	million/cmm	4.5 - 5.5
Hematocrit (PCV)	42.6	%	40 - 54
MCH	<b>32.6</b>	Pg	27 - 32
MCV	93.2	fL	83 - 101
MCHC	<b>35.0</b>	%	31.5 - 34.5
RDW	11.8	%	11.5 - 14.5
WBC Count	8830	/cmm	4000 - 11000

### DIFFERENTIAL WBC COUNT (Flow cytometry)

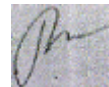
Neutrophils (%)	57	%	38 - 70
Lymphocytes (%)	40	%	20 - 40
Monocytes (%)	02	%	2 - 8
Eosinophils (%)	01	%	0 - 6
Basophils (%)	00	%	0 - 2
Neutrophils	5033	/cmm	
Lymphocytes	3532	/cmm	
Monocytes	177	/cmm	
Eosinophils	88	/cmm	
Basophils	0	/cmm	
Platelet Count (Flow cytometry)	226000	/cmm	150000 - 450000
MPV	<b>11.8</b>	fL	7.5 - 11.5

### ERYTHROCYTE SEDIMENTATION RATE

ESR (After 1 hour)	10	mm/hr	0 - 14
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*Modified Westergren Method*

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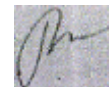
PLASMA GLUCOSE

Fasting Blood Sugar (FBS) <i>Hexokinase Method</i>	98.7	mg/dL	70 - 110
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Post Prandial Blood Sugar (PPBS) <i>Hexokinase Method</i>	128.0	mg/dL	70 - 140
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**Criteria for the diagnosis of diabetes** 1. HbA1c  $\geq$  6.5 \*  
Or  
2. Fasting plasma glucose  $>126$  gm/dL. Fasting is defined as no caloric intake at least for 8 hrs.  
Or  
3. Two hour plasma glucose  $\geq$  200mg/dL during an oral glucose tolerance test by using a glucose load containing equivalent of 75 gm anhydrous glucose dissolved in water.  
Or  
4. In a patient with classic symptoms of hyperglycemia or hyperglycemic crisis, a random plasma glucose  $\geq$  200 mg/dL.  
\*In the absence of unequivocal hyperglycemia, criteria 1-3 should be confirmed by repeat testing.  
American diabetes association. Standards of medical care in diabetes 2011. Diabetes care 2011;34;S11.

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<b>LIPID PROFILE</b>			
Cholesterol <i>(Enzymatic colorimetric)</i>	161.1	mg/dL	Desirable : < 200.0 Borderline High : 200-239 High : > 240.0
Triglyceride <i>(Enzymatic colorimetric)</i>	106.2	mg/dL	Normal : < 150.0 Borderline : 150-199 High : 200-499 Very High : > 500.0
VLDL <i>Calculated</i>	21.24	mg/dL	15 - 35
LDL CHOLESTEROL	113.86	mg/dL	Optimal : < 100.0 Near / above optimal : 100-129 Borderline High : 130-159 High : 160-189 Very High : >190.0
HDL Cholesterol <i>Homogeneous enzymatic colorimetric</i>	<b>26.0</b>	mg/dL	30 - 70
Cholesterol /HDL Ratio <i>Calculated</i>	<b>6.20</b>		0 - 5.0
LDL / HDL RATIO <i>Calculated</i>	<b>4.38</b>		0 - 3.5



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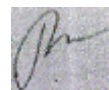
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**NEW ATP III GUIDELINES (MAY 2001), MODIFICATION OF NCEP**<?xml:namespace prefix = "o" ns = "urn:schemas-microsoft-com:office:office" />

**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
- # For test performed on specimens received or collected from non-KSHIPRA 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.  
KSHIPRA will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.  
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Table with 4 columns: Parameter, Result, Unit, Reference Interval

HEMOGLOBIN A1 C ESTIMATION

Specimen: Blood EDTA

Hb A1C 5.5 % of Total Hb
Boronate Affinity with Fluorescent Quenching
Poor Control : > 7.0 %
Good Control : 6.2-7.0 %
Non-diabetic Level : 4.3-6.2 %

Mean Blood Glucose 118.50 mg/dL
Calculated

Degree of Glucose Control Normal Range:

- Poor Control >7.0% \*
Good Control 6.0 - 7.0 %\*\*Non-diabetic level < 6.0 %
\* High risk of developing long term complication such as retinopathy, nephropathy, neuropathy, cardiopathy,etc.
\* Some danger of hypoglycemic reaction in Type I diabetics.
\* Some glucose intolerant individuals and "subclinical" diabetics may demonstrate HbA1c levels in this area.

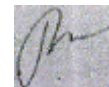
EXPLANATION :-

- \*Total haemoglobin A1 c is continuously synthesised in the red blood cell through its 120 days life span.The concentration of HBA1c in the cell reflects the average blood glucose concentration it encounters.
\*The level of HBA1c increases proportionately in patients with uncontrolled diabetes. It reflects the average blood glucose concentration over an extended time period and remains unaffected by short-term fluctuations in blood glucose levels.
\*The measurement of HbA1c can serve as a convenient test for evaluating the adequacy of diabetic control and in preventing various diabetic complications. Because the average half life of a red blood cell is sixty days,HbA1c has been accepted as a measurement which effects the mean daily blood glucose concentration, better than fasting blood glucose determination, and the degree of carbohydrate imbalance over the preceding two months.
\*It may also provide a better index of control of the diabetic patient without resorting to glucose loading procedures.

HbA1c assay Interferences:

- \*Erroneous values might be obtained from samples with abnormally elevated quantities of other Haemoglobins as a result of either their simultaneous elution with HbA1c(HbF) or differences in their glycation from that of HbA(HbS)

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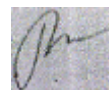
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<b>LIVER FUNCTION TEST WITH GGT</b>			
Total Bilirubin <i>Colorimetric diazo method</i>	0.52	mg/dL	0.10 - 1.0
Conjugated Bilirubin <i>Sulph acid dpl/caff-benz</i>	0.20	mg/dL	0.0 - 0.3
Unconjugated Bilirubin <i>Sulph acid dpl/caff-benz</i>	0.32	mg/dL	0.0 - 1.1
SGOT <i>(Enzymatic)</i>	25.3	U/L	0 - 37
SGPT <i>(Enzymatic)</i>	28.6	U/L	0 - 40
GGT <i>(Enzymatic colorimetric)</i>	22.4	U/L	11 - 49
Alakaline Phosphatase <i>(Colorimetric standardized method)</i>	65.9	U/L	53 - 130
<b><u>Protien with ratio</u></b>			
Total Protein <i>(Colorimetric standardized method)</i>	<b>5.6</b>	g/dL	6.5 - 8.7
Albumin <i>(Colorimetric standardized method)</i>	4.4	mg/dL	3.5 - 5.3
Globulin <i>Calculated</i>	<b>1.20</b>	g/dL	2.3 - 3.5
A/G Ratio <i>Calculated</i>	<b>3.67</b>		0.8 - 2.0

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<b>RENAL FUNCTION TEST (RFT)</b>			
UREA <i>(Urease &amp; glutamate dehydrogenase)</i>	20	mg/dL	10 - 50
Creatinine <i>(Jaffe method)</i>	0.50	mg/dL	0.5 - 1.4
Uric Acid <i>(Enzymatic colorimetric)</i>	5.2	mg/dL	2.5 - 7.0
Sodium (Na+) <i>Direct ion selective electrode</i>	138.6	mmol/L	136 - 145
Potassium (K+) <i>Direct ion selective electrode</i>	3.9	mmol/L	3.6 - 5.1
Chloride (CL-) <i>Direct ion selective electrode</i>	104.0	mmol/L	97 - 107

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<u>Parameter</u>	<u>Result</u>	<u>Unit</u>	<u>Reference Interval</u>
BUN	9.3	mg/dL	5 - 24

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**Approved by:** DR PS RAO  
MD Pathologist



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### THYROID FUNCTION TEST

T3 (Triiodothyronine) <i>Chemiluminescence</i>	<b>0.80</b>	ng/mL	0.87 - 1.81
T4 (Thyroxine) <i>Chemiluminescence</i>	6.68	µg/dL	5.89 - 14.9
TSH ( ultra sensitive ) <i>Chemiluminescence</i>	4.824	µIU/ml	0.34 - 5.6

**SUMMARY** The hypophyseal release of TSH (thyrotropic hormone) is the central regulating mechanism for the biological action of thyroid hormones. TSH is a very sensitive and specific parameter for assessing thyroid function and is particularly suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid. **LIMITATION** Presence of autoantibodies may cause unexpected high value of TSH

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### STOOL EXAMINATION

Colour	Yellow
Consistency	Semi Solid

#### CHEMICAL EXAMINATION

Occult Blood	Negative
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*Peroxidase Reaction with o-Dianisidine*

Reaction	Acidic
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*pH Strip Method*

Reducing Substance	Absent
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*Benedict's Method*

#### MICROSCOPIC EXAMINATION

Mucus	Nil
Pus Cells	1 - 2/hpf
Red Cells	Nil
Epithelial Cells	Nil
Vegetable Cells	Nil
Trophozoites	Nil
Cysts	Nil
Ova	Nil
Neutral Fat	Nil
Monilia	Nil

**Note:** Stool occult blood test is highly sensitive to peroxidase like activity of free hemoglobin.

**False negative:** False negative occult blood test may be observed in case of excess (>250mg/day) Vitamin C intake and in case of occasional unruptured RBCs.

**False positive:** False positive occult blood test may be observed in stool samples containing vegetable peroxidase (turnips, horseradish, cauliflower, broccoli, cantaloupe, parsnips) and myoglobin from food (meat diet) intake.

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### URINE ROUTINE EXAMINATION

#### PHYSICAL EXAMINATION

Quantity	20 cc
Colour	Pale Yellow
Appearance	Clear

#### CHEMICAL EXAMINATION ( BY REFLECTANCE PHOTOMETRIC METHOD)

pH	6.0	5.0 - 8.0
Sp. Gravity	1.020	1.002 - 1.03
Protein	Nil	
Glucose	Nil	
Ketone Bodies	Nil	
Urine Bile salt and Bile Pigment	Nil	
Urine Bilirubin	Nil	
Nitrite	Nil	
Leucocytes	Nil	
Blood	Nil	

#### MICROSCOPIC EXAMINATION (MANUAL BY MCIROSCOPY)

Leucocytes (Pus Cells)	Nil
Erythrocytes (Red Cells)	Nil
Epithelial Cells	1-2/hpf
Amorphous Material	Nil
Casts	Nil
Crystals	Nil
Bacteria	Nil
Monilia	Nil

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