





Patient	Mr. ANOOP SINGH			Lab No/ManualNo	4127213/	
UHIDNo/IPNO	400221221			CollectionDate	15/11/2024 9:10AM	
Age/Gender	37 Years/Male			Receiving Date	15/11/2024 10:09AM	
Bed No/Ward	OPD			Report Date	15/11/2024 2:52PM	
Referred By	PHC Department			Report Status Sample Quality	Final	
Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
	Medi	Wheel Full Body	Biochemistr	r y ensive With Vitamin Ma	ale	
<u>*SERUM CREATI</u>			I I			Serun
Serum - Creatinin	e	0.8	mg/dL	0.8 - 1.2	Enzymatic (Creat Amidohydrolase)	inine
response to dietar excreted mainly by creatinine excretio failure, urinary trac	and urinary creatinine exc y changes. The serum cre y glomerular filtration, with n can be used to estimate ct obstruction, reduced rer tration include debilitation nced malignancy.	eatinine concenti only small amo the glomerular nal blood flow, sl	ration is higher i unts due to tubu filtration rate.Se nock,dehydratio	n men than in women. S ular secretion, serum cre erum creatinine is increa n, and rhabdomyolysis.	Since urinary creatinine atinine and a 24-hour i sed in acute or chronic Causes of low serum	urine
<u>*URIC ACID (SER</u>	<u>RUM)</u>					Serun
Serum Uric Acid		4.4	mg/dL	4.0 - 8.6	Uricase	
	d product of purine metab					

υ poisoning, excessive cell destruction (e.g., following chemotherapy), hemolytic anemia, and congestive heart failure and after myocardial infarction. Uric acid is also increased in some endocrine disorders, acidosis, toxemia of pregnancy, hereditary gout, and glycogen storage disease type I. A low uric acidconcentration may be found following treatment by some drugs (e.g., lowdoseaspirin), with low dietary intake of purines, in the presence of renal tubulardefects, and in xanthinuria.

***PHOSPHORUS (SERUM)**

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

Dr. Nutan Sood MD (Pathology) Senior Consultant, Laboratory Services, Regd No: HN 012481

Prepared By MAH002502

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Page: 1 Of 15

Serum

L-Low H-High CH -Critical High CL - Critical Low

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Serum - Phosphor	us	H 4.6	mg/dL 2.7 - 4.5	Phosphomolybdate Reduction
Interpretation:-		41 h	ody. Causes of high serum phosphore	is include

<u>*GLUCOSE (PP)</u>				PLASMA(FLUORIDE)
Glucose - Post Prandial (PPBS)	122	mg/dL	70 - 140	Glucose oxidase ,hydrogen Peroxidase

Interpretation:-

Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

***LIPID PROFILE SERUM**

Serum

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Page: 2 Of 15

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	DEPARTMENT OF LABORATORY SERVICES						
Patient UHIDNo/IPNO Age/Gender Bed No/Ward Referred By	Mr. ANOOP SING 400221221 37 Years/Male OPD PHC Department	ЭH			Lab No/ManualNo CollectionDate Receiving Date Report Date Report Status Sample Quality	15/1 15/1	7213/ 1/2024 9:10AM 1/2024 10:09AM 1/2024 2:52PM I
Cholesterol			200	mg/dL	Method :Cholester oxidase, esterase, peroxidase Adults (>=20 Year		Cholesterol oxidase, esterase,peroxidase
					Desirable -200 mg Borderline200-239 mg/dL High>240 mg/dL	g/dL,	
HDL Cholesterol		Н	82	mg/dL	40 - 60		Direct measure, PTA/MgCl2
Triglycerides			85	mg/dL	Method : Enzymati Normal < 150 mg/c Borderline High 15 mg/dl, High 200-499 mg/c Very High>=500 m	dl, 50-199 dl,	Enzymatic method
Cholesterol VLDL			17	mg/dL	0 - 40		Calculated
Cholesterol / HDL	Ratio		2.44	<i>,</i>	0 400		Calculated
LDL		н	101	mg/dL	0 - 100		Calculated

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Calculated

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LDL/HDL Ratio

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Page: 3 Of 15







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NCEP Guidelines:

Lipid	Desirable	Borderline High	High	Very High
Total Cholesterol LDL Cholesterol	< 200 < 100 > 60	200-239 130-159	> 240 160-189	> 190
HDL Cholesterol Triglycerides	< 150	< 40 (Risk factor)150-199	200-499	> 500

***PROSTATIC SPECIFIC ANTIGEN(PSA)**

PSA - TOTAL	0.4	ng/mL	0.0 - 4.0	Chemiluminescence
COMMENTS				

COMMENTS

Prostate-specific antigen (PSA) is a glycoprotein that is produced by the prostate gland, the lining of the urethra, and the bulbourethral gland. Normally, very little PSA is secreted in the blood. Increases in glandular size and tissue damage caused by benign prostatic hypertrophy, prostatitis, or prostate cancer may increase circulating PSA levels. PSA exists in serum in multiple forms: complexed to alpha-1-anti-chymotrypsin (PSA-ACT complex), unbound (free PSA), and enveloped by alpha-2-macroglobulin (not detected by immunoassays). Higher total PSA levels and lower percentages of free PSA are associated with higher risks of prostate cancer

mg/dL

*BLOOD UREA

Serum - Urea

L 18

19 - 43

Urease with indicator dye

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Page: 4 Of 15

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Serum

Serum







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		Sample Quality	

Interpretation:-

The major pathway of nitrogen excretion is in the form of urea that is synthesized in the liver, released into the blood, and cleared by the kidneys. A high serum urea nitrogen occurs in glomerulonephritis, shock, urinary tract obstruction, pyelonephritis, and other causes of acute and chronic renal failure. Severe congestive heart failure, hyperalimentation, diabetic ketoacidosis, dehydration, and bleeding from the gastrointestinal tract elevate urea nitrogen. Low urea nitrogen often occurs in normal pregnancy, with decreased protein intake, in acute liver failure, and with intravenous fluid administration.

<u>*B12 VITAMIN</u>						Serum
Vit-B12	L	191	pg/mL	200 - 835	Chemiluminescence	

Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function. In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption. The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted. Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases). Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia. Pernicious anemia is a macrocytic anemia caused by vitamin B12 deficiency that is due to a lack of IF secretion by gastric mucosa. Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.

Interpretation :

A serum vitamin B12 level less than 180 pg/ml may cause megaloblastic anemia and peripheral neuropathies, Vitamin B12 levels less than 150 pg/ml is considered evidence of vitamin B12 deficiency.

***VITAMIN D 25- HYDROXY**

Vitamin D 25 Hydroxy (Total)

1 11.0 30 - 100

ng/mL

Chemiluminescence

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Page: 5 Of 15

Serum

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Reference Range

Status	25- (OH) Vitamin D
Deficient	< 20 ng/mL
Insufficient	20 - 30 ng/mL
Sufficient	30 - 100 ng/mL
Potential Toxicity	>100 ng/mL

Vitamin D is a critical nutrient to maintain strong bones. It is produced by the body in response to sunlight and occurs naturally in some foods. However, for some adults, factors such as restricted diet, frequent use of sunscreen and a sedentary lifestyle can lead to vitamin D deficiencies.

Comments

- *Decreased Levels
- · Inadequate exposure to sunlight
- · Dietary deficiency
- · Vitamin D malabsorption
- · Severe Hepatocellular disease
- · Drugs like Anticonvulsants
- · Nephrotic syndrome

* Increased levels

· Vitamin D intoxication

*GLUCOSE (FASTING).

Glucose F 81.00	mg/dL	70.00 - 100.00	Glucose oxidase ,hydrogen Peroxidase
-----------------	-------	----------------	---

Interpretation:-

Glucose is a primary cellular energy source. Fasting plasma glucose concentrations and tolerance to a dose of glucose are used to establish the diagnosis of diabetes mellitus and disorders of carbohydrate metabolism. Glucose measurements are used to monitor therapy in diabetics and in patients with dehydration, coma, hypoglycemia, insulinoma, acidosis, and ketoacidosis.

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Page: 6 Of 15

PLASMA(FLUORIDE)

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End Of Report

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Page: 7 Of 15

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	DEP	ARTMENT	OF LABOR	RATORY SERVIC	ES	
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Bed No/Ward Referred By	PHC Department		Report Date Report Status Sample Quality	15/11/2024 2:52PM Final		
Test Name		Result	Unit	Bio. Ref. Range	Method	Sample
	D HEMOGLOBIN (HBA1C) lated Hemoglobin)	•	, p	nensive With Vitamin M %	HPLC	EDTA Blood
<5.6% 5.7% to 6.4% >=6.5% <7%	ange: - Degree of Glucose contro - Normal Prediabetes Diabetes ADA Target Action Suggested	ı				

End Of Report

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Page: 8 Of 15

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Test Name			Result	Unit	Bio. Ref. Range	Method	Sample
	Ma	1:337	haal Eall Dada	Biochemis		-1-	
*LIVER FUNCTION			neel Full Body	Plus Compre	hensive With Vitamin Ma	ale	Serum
LIVER FORCHON	TEST (EFT) SENON	1					Serum
Serum -Total Proteir	ı	н	8.5	g/dL	6.3 - 8.2	Biuret Method	
Serum - Albumin			4.7	g/dL	3.5 - 5.0	BCG	
Globulin			3.8	g/dL	2 - 5	Calculated	
AG Ratio			1.24		1 - 2	Calculated	
Serum - SGOT / AS Transferase)	T (Aspartate Amino		50	U/L	17 - 59	Kinetic(leuco dye) pyridoxal 5 phosp	with hate
Serum - SGPT / ALT Transferase)	۲V (Alanine Amino	н	74	U/L	10 - 40	Reflectance spectrophotometr with pyridoxal -5- phosphate	y/ kinetic
Serum- GGT		н	116	U/L	15 - 73	L-G-glutamyl-p-nit	roanilide
Serum - Alkaline Ph	osphatase		88	U/L	38 - 126	P-nitrophenyl pho	sphate
Bilirubin Total			0.6	mg/dL	0.2 - 1.3	Diphylline,Diazoni	um Salt
Bilirubin Direct			0.4	mg/dL		Calculated	
					Calculated		
					Neonate Ref. Rang 0 - 30 Days - (0.0 - mg/dL Adult Ref. Range. >30 Days - (0.0-0.3 mg/dL	0.6)	
Bilirubin Indirect			0.2	mg/dL	0.0 - 1.1	Dual wavelength	

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Page: 9 Of 15







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Interpretation:-

Total bilirubin in serum and plasma is the sum of unconjugated bilirubin (Bu), mono- and di-glucuronide conjugated bilirubin (Bc)?, and delta bilirubin (DELB), a bilirubin fraction covalently bound to albumin. With the exception of anicteric jaundice, total serum bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.

Jaundice has been classified as unconjugated and conjugated hyperbilirubinemia. Increased plasma-unconjugated bilirubin is commonly seen in hemolytic disorders, Gilbert's syndrome, Crigler-Najjar syndrome, neonatal jaundice, and ineffective erythropoiesis and in the presence of drugs competing for glucuronide. Increased plasma-conjugated bilirubin occurs with hepatobiliary disorders, including intrahepatic and extrahepatic biliary tree obstruction, liver cell damage, Dubin-Johnson syndrome, and Rotor syndrome.Neonatal bilirubin, the sum of Bu and Bc, is increased in erythroblastosis fetalis (hemolytic disease of the newborn), which causes jaundice in the first two days of life. Other causes of neonatal jaundice include physiologic jaundice, hematoma/hemorrhage, hypothyroidism, and obstructive jaundice.

Aspartate aminotransferase is present in high activity in heart, skeletal muscle, and liver. Increased serum AST activity commonly follows myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, and drug-induced hepatitis.

Alanine aminotransferase is present in high activity in liver, skeletal muscle, heart, and kidney. Serum ALT increases rapidly in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumors, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, and myocardial infarction.

Alkaline phosphatase is present mainly in bone, liver, kidney, intestine, placenta, and lung. Serum alkaline phosphatase may be elevated in increased bone metabolism, for example, in adolescents and during the healing of a fracture; primary and secondary hyperparathyroidism; Paget's disease of bone; carcinoma metastatic to bone; osteogenic sarcoma; and Hodgkin's disease if bones are invaded. Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis increase alkaline phosphatase activity; alkaline phosphatase activity may be increased in renal infarction and failure and in the complications of pregnancy. Low alkaline phosphatase activity may occasionally be seen in hypothyroidism.

Serum proteins transport drugs and metabolites and maintain plasma osmotic pressure. Most serum proteins are synthesized in the liver, with the exception of gamma globulins. One of the most important serum proteins produced in the liver is albumin. Total serum protein concentration can be used for evaluation of nutritional status. Causes of high total serum protein concentration, Waldenstrom's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous diseases, and some tropical diseases. Total protein concentration is occasionally increased in collagen diseases, lupus erythematosus, and other instances of chronic infection or inflammation. Causes of low total serum protein concentration include pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

End Of Report

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

Dr. Nutan Sood MD (Pathology) Senior Consultant,Laboratory Services, Regd No: HN 012481

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Page: 10 Of 15

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Referred By	PHC Department			Report Status Sample Quality	Final		
Test Name		Result	Unit	Bio. Ref. Range	Method	Sample	
	Medi		linical Path	ology ehensive With Vitamin Ma	ale		
*URINE ROUTINE E		wheel Full Body I	ius compre			Urine	
Physical Examinat	ion:						
Volume		50	mL		Physical Examina	ition	
Colour		Pale Yellow		Pale Yellow	Physical Examina	ition	
Appearence:		Clear			Physical Examina	ition	
Chemical Examina	ition:						
рН		5.5		4.6 - 8.0	Indicator Test		
Specific Gravity		1.005		1.000 - 1.035	Ion Exchange		
Protein		Nil			Protein Error of Ir Sulphosalicylic A		
Glucose		Nil			Glucose Oxidase Benedict's Metho		
Ketone		Nil			Nitroprusside Rea Method	action / Rothera's	
Bilirubin		Absent			Diazonium Metho Method	d/ Fouchet's	
Urobilinogen		Normal			Ehrlich's Reaction	n/ Ehrlich's Reagent	
Nitrite:		Negative		Negative	Diazotization Rea	ction	
Blood :		Nil			Peroxidase Reac	tion	
Microscopic Exan	nination:						
Casts		Nil		Nil	Microscopy		
Epithelial cells		0-2	/HPF	0 - 1	Microscopy		
Pus Cells		0-2	/HPF	0 - 5	Microscopy		
RBC		00	/HPF	0 - 2	Microscopy		
Crystals		Nil		Nil	Microscopy		

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Wan ---

Dr. Kriti Ganguly MD,Microbiology,Consultant(Lab Services) DMC Regd No: 63478

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Page: 11 Of 15

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Interpretation:-

Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders. **Protein:** Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever. Protein reported in urine as Negative(<15 mg/dl), 1+(>=30 mg/dl), 2+(>=100 mg/dl) & 3+(>=500 mg/dl).

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications. Glucose reported in urine as Negative (<25 mg/dl), 1+(>=50 mg/dl), 2+(>=100 mg/dl), 3+(>=300 mg/dl), 4+(>=1000 mg/dl).

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or hemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high.Positive nitrite test suggestive of 105 or more organism in 1 ml of urine specimen.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetis insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia.

End Of Report

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Dr. Kriti Ganguly MD,Microbiology,Consultant(Lab Services) DMC Regd No: 63478

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Prepared By MAH002502







	Medi	Wheel Full Body	Haematol Plus Compre	Dgy Sehensive With Vitamin M	lale	
Test Name		Result	Unit	Bio. Ref. Range	e Method	Sample
Referred By	PHC Department			Report Status Sample Quality	Final	
Bed No/Ward	OPD			Report Date	15/11/2024 12:49PN	1
Age/Gender	37 Years/Male		Receiving Date	15/11/2024 10:09AN		
UHIDNo/IPNO			CollectionDate	15/11/2024 9:10AM		
Patient	Mr. ANOOP SINGH		Lab No/ManualNo	4127213/		

DEDARTMENT OF LABORATORY OF DUIDEO

Erythrocyte Sedimentation Rate (ESR)	н	18	mm/hr	0 - 15	Modified westergren
		10	111111/111	0 10	Method

Interpretation:-

Erythrocyte sedimentation rate (ESR) is a non-specific phenomena and is clinically useful in the diagnosis and monitoring of disorders associated with an increased production of acute phase reactants (e.g. pyogenic infections, inflammation and malignancies). The ESR is increased in pregnancy from about the 3rd month and returns to normal by the 4th week post-partum. ESR is influenced by age, sex, menstrual cycle and drugs (eg. corticosteroids, contraceptives). It is especially low (0 -1mm) in polycythemia, hypofibrinogenemia or congestive cardiac failure and when there are abnormalities of the red cells such as poikilocytosis, spherocytosis or sickle cells.

COMPLETE BLOOD COUNT(CBC) EDTA WHOLE BLOOD

Haemoglobin		15.3	g/dL	13.5 - 18.0	Spectrophotometry (Cyanide free method)
Hematocrit/PCV		43.5	%	42.0 - 52.0	Derived from RBC pulse hieght detection
RBC COUNT	L	4.55	10^6/µL	4.70 - 6.00	Electrical Impedance
MCV		95.6	fl	78.0 - 100.0	Calculated
МСН	н	33.7	pg	27.0 - 31.0	Calculated
MCHC	н	35.3	g/dL	31.5 - 34.5	Calculated
RDW-CV		13.4	%	11.5 - 14.0	Calculated
Platelet count		345	10^3/µL	150 - 450	Electrical Impedance
Total Leucocyte Count (TLC)		6.81	10^3/µL	4.00 - 10.50	Double Hydrodynamic Sequential System

Differential Leucocyte Count

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Lutan

Dr. Nutan Sood MD (Pathology) Senior Consultant,Laboratory Services, Regd No: HN 012481

(DHSS)

Printed at 21/11/2024 10:55



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Prepared By MAH002502

EDTA Blood







4127213/ Lab No/ManualNo Patient Mr. ANOOP SINGH UHIDNo/IPNO 400221221 CollectionDate 15/11/2024 9:10AM Age/Gender 37 Years/Male **Receiving Date** 15/11/2024 10:09AM **Bed No/Ward** OPD **Report Date** 15/11/2024 12:49PM PHC Department **Report Status** Final **Referred By** Sample Quality % 40 - 80 Flow Cytometry Neutrophils 58.7 Flow Cytometry Lymphocytes 31.9 % 20 - 40 Monocytes 8.1 % 2 - 10 Flow Cytometry Flow Cytometry 1.3 % 1 - 6 Eosinophils Basophils 0 % 0 - 1 Flow Cytometry **Absolute Leucocyte Count** Absolute Neutrophil Count 4.00 10^3/µL 1.50 - 6.60 Calculated Calculated Absolute Lymphocyte Count 10^3/µL 1.50 - 3.50 2.17 Calculated Absolute Monocyte Count 0.55 10^3/µL 0.00 - 1.00 10^3/µL Calculated Absolute Eosinophil Count 0.09 0.00 - 0.70 10^3/µL Calculated Absolute Basophil Count 0.00 0.00 - 1.00

DEPARTMENT OF LABORATORY SERVICES

End Of Report

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

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Page: 14 Of 15

L-Low H-High CH -Critical High CL - Critical Low

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DEPARTMENT OF LABORATORY SERVICES					
Patient	Mr. ANOOP SINGH	Lab No/ManualNo	4127213/		
UHIDNo/IPNO	400221221	CollectionDate	15/11/2024 9:10AM		
Age/Gender	37 Years/Male	Receiving Date	15/11/2024 10:09AM		
Bed No/Ward	OPD	Report Date	15/11/2024 12:42PM		
Referred By	PHC Department	Report Status Sample Quality	Final		

Test Name	Result	Unit	Bio. Ref. Range	Method	Sample			
Immuno-Haematology								
MediWheel Full Rody Dlus Comprehensive With Vitemin Mele								

MediWheel Full Body Plus Comprehensive With Vitamin Male

*BLOOD GROUPING

ABO GROUP 'AB' RH Type POSITIVE

Interpretation:-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same.

The test is performed by both forward as well as reverse grouping methods.

End Of Report

Note-: This report has been issued by Department of Lab Services, North East Health Care Pvt Ltd .

Nutan

Tube Agglutination Method

Dr. Nutan Sood MD (Pathology) Senior Consultant,Laboratory Services, Regd No: HN 012481

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Page: 15 Of 15

EDTA Blood

L-Low H-High CH -Critical High CL - Critical Low

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