



Lab No.	: SLK/09-03-2024/SR8845828	Lab Add.	: Newtown,Kolkata-700156
Patient Name	: ASIS GUPTA	Ref Dr.	: Dr.MEDICAL OFFICER
Age	: 35 Y 0 M 0 D	Collection Date	: 09/Mar/2024 10:34AM
Gender	: M	Report Date	: 09/Mar/2024 03:51PM



DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
SGPT/ALT , GEL SERUM (Method:Modified IFCC)	20	7-40	U/L
CREATININE, BLOOD (Method:Jaffe, alkaline picrate, kinetic)	0.87	0.7-1.3	mg/dL
BILIRUBIN (DIRECT) (Method:Vanadate oxidation)	0.10	<0.2	mg/dL
URIC ACID,BLOOD (Method:Uricase/Peroxidase)	6.90	3.5-7.2	mg/dL
UREA,BLOOD (Method:Urease with GLDH)	21.4	19-49	mg/dL
CALCIUM,BLOOD (Method:Arsenazo III)	9.30	8.7-10.4	mg/dL
POTASSIUM,BLOOD (Method:ISE INDIRECT)	4.30	3.5-5.5	mEq/L
ALKALINE PHOSPHATASE (Method:IFCC standardization)	71	46-116	U/L
BILIRUBIN (TOTAL) , GEL SERUM BILIRUBIN (TOTAL) (Method:Vanadate oxidation)	0.50	0.3-1.2	mg/dL
SODIUM,BLOOD (Method:ISE INDIRECT)	141	132 - 146	mEq/L
SGOT/AST (Method:Modified IFCC)	21	13-40	U/L
CHLORIDE,BLOOD (Method:ISE INDIRECT)	107	99-109	mEq/L
GLUCOSE,FASTING (Method:Gluc Oxidase Trinder)	88	Impaired Fasting-100-125 ~Diabetes- >= 126.~Fasting is defined as no caloric intake for at least 8 hours.	mg/dL

In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

PHOSPHORUS-INORGANIC,BLOOD (Method:Phosphomolybdate/UV)	2.7	2.4-5.1 mg/dL	mg/dL
THYROID PANEL (T3, T4, TSH) , GEL SERUM T3-TOTAL (TRI IODOTHYRONINE) (Method:CLIA)	1.25	0.60-1.81 ng/ml	ng/ml



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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
T4-TOTAL (THYROXINE) (Method:CLIA)	9.3	3.2-12.6	µg/dL
TSH (THYROID STIMULATING HORMONE) (Method:CLIA)	1.051	0.55-4.78	µIU/mL

Serum TSH levels exhibit a diurnal variation with the peak occurring during the night and the nadir, which approximates to 50% of the peak value, occurring between 1000 and 1600 hours.[1,2]

References:

- Bugalho MJ, Domingues RS, Pinto AC, Garrao A, Catarino AL, Ferreira T, Limbert E and Sobrinho L. Detection of thyroglobulin mRNA transcripts in peripheral blood of individuals with and without thyroid glands: evidence for thyroglobulin expression by blood cells. *Eur J Endocrinol* 2001;145:409-13.
- Bellantone R, Lombardi CP, Bossola M, Ferrante A,Princi P, Boscherini M et al. Validity of thyroglobulin mRNA assay in peripheral blood of postoperative thyroid carcinoma patients in predicting tumor recurrence varies according to the histologic type: results of a prospective study. *Cancer* 2001;92:2273-9.

BIOLOGICAL REFERENCE INTERVAL: [ONLY FOR PREGNANT MOTHERS]

Trimester specific TSH LEVELS during pregnancy:

FIRST TRIMESTER: 0.10 – 3.00 µ IU/mL

SECOND TRIMESTER: 0.20 -3.50 µ IU/mL

THIRD TRIMESTER : 0.30 -3.50 µ IU/mL

References:

- Erik K. Alexander, Elizabeth N. Pearce, Gregory A. Brent, Rosalind S. Brown, Herbert Chen, Chrysoula Dosiou, William A. Grobman, Peter Laurberg, John H. Lazarus, Susan J. Mandel, Robin P. Peeters, and Scott Sullivan. *Thyroid*. Mar 2017.315-389. <http://doi.org/10.1089/thy.2016.0457>
- Kalra S, Agarwal S, Aggarwal R, Ranabir S. Trimester-specific thyroid-stimulating hormone: An indian perspective. *Indian J Endocr Metab* 2018;22:1-4.

*** End Of Report ***

Dr NEEPA CHOWDHURY
MBBS MD (Biochemistry)
Consultant Biochemist
Reg No. WBMC 62456



Lab No.	: SLK/09-03-2024/SR8845828	Lab Add.	: Newtown,Kolkata-700156
Patient Name	: ASIS GUPTA	Ref Dr.	: Dr.MEDICAL OFFICER
Age	: 35 Y 0 M 0 D	Collection Date	: 09/Mar/2024 03:44PM
Gender	: M	Report Date	: 09/Mar/2024 06:50PM



DEPARTMENT OF BIOCHEMISTRY


Test Name	Result	Bio Ref. Interval	Unit
URIC ACID, URINE, SPOT URINE			
URIC ACID, SPOT URINE (Method:URICASE)	12.00	37-92 mg/dL	mg/dL
ESTIMATED TWICE			
GLUCOSE,PP			
(Method:Gluc Oxidase Trinder)	87*	Impaired Glucose Tolerance-140 to 199. Diabetes>= 200.	mg/dL

* 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 hypoglycemia, renal glycosuria, hereditary fructose intolerance and Galactosemia, the possible causes of post prandial reactive hypoglycemia (PRH) include high insulin sensitivity, exaggerated response of insulin and glucagon like peptide 1, defects in counter-regulation, very lean and /or anxious individuals, after massive weight reduction etc.

*The test should be performed as described by the WHO, using a glucose load containing the equivalent of 75-g anhydrous glucose dissolved in water.
In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate test samples.*

Reference :
ADA Standards of Medical Care in Diabetes – 2020. Diabetes Care Volume 43, Supplement 1.

*** End Of Report ***


Dr. SANCHAYAN SINHA
MBBS, MD, DNB (BIOCHEMISTRY)
CONSULTANT BIOCHEMIST
Reg No. WBMC 63214



Lab No.	: SLK/09-03-2024/SR8845828	Lab Add.	: Newtown,Kolkata-700156
Patient Name	: ASIS GUPTA	Ref Dr.	: Dr.MEDICAL OFFICER
Age	: 35 Y 0 M 0 D	Collection Date	: 09/Mar/2024 10:34AM
Gender	: M	Report Date	: 09/Mar/2024 02:55PM

**DEPARTMENT OF BIOCHEMISTRY**

Test Name	Result	Bio Ref. Interval	Unit
LIPID PROFILE , GEL SERUM			
CHOLESTEROL-TOTAL (Method:Enzymatic)	229	Desirable: < 200 mg/dL Borderline high: 200-239 mg/dL High: > or =240 mg/dL	mg/dL
TRIGLYCERIDES (Method:GPO-Trinder)	119	Normal:: < 150, BorderlineHigh::150-199, High:: 200-499, VeryHigh::>500	mg/dL
HDL CHOLESTEROL (Method:Elimination/catalase)	41	< 40 - Low 40-59- Optimum 60 - High	mg/dl
LDL CHOLESTEROL DIRECT (Method:Elimination / Catalase)	183	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	mg/dL
VLDL (Method:Calculated)	5	< 40 mg/dl	mg/dl
CHOL HDL Ratio (Method:Calculated)	5.6	LOW RISK 3.3-4.4 AVERAGE RISK 4.47-7.1 MODERATE RISK 7.1-11.0 HIGH RISK >11.0	

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.

TOTAL PROTEIN [BLOOD] ALB:GLO RATIO , .			
TOTAL PROTEIN (Method:BIURET METHOD)	7.60	5.7-8.2 g/dL	g/dL
ALBUMIN (Method:BCG Dye Binding)	4.5	3.2-4.8 g/dL	g/dL
GLOBULIN (Method:Calculated)	3.10	1.8-3.2	g/dl
AG Ratio (Method:Calculated)	1.45	1.0-2.5	

GLYCATED HAEMOGLOBIN (HBA1C) , EDTA WHOLE BLOOD			
GLYCATED HEMOGLOBIN (HBA1C)	5.5	***FOR BIOLOGICAL REFERENCE INTERVAL DETAILS , PLEASE REFER TO THE BELOW MENTIONED REMARKS/NOTE WITH ADDITIONAL CLINICAL INFORMATION ***	%
HbA1c (IFCC) (Method:HPLC)	37.0		mmol/mol

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)

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Bio Ref. Interval	Unit
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Analyzer used :- Bio-Rad-VARIANT TURBO 2.0
Method : HPLC Cation Exchange

Recommendations for glycemc targets

- Ø Patients should use self-monitoring of blood glucose (SMBG) and HbA1c levels to assess glycemc 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 glycemc control.
- Ø If a patient changes treatment plans or does not meet his or her glycemc 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.

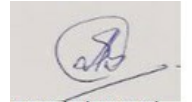
Reference: Glycated hemoglobin monitoring BMJ 2006; 333;586-8

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.

[PDF Attached](#)

***** End Of Report *****



Dr. Sudeshna Baral
M.B.B.S MD.
(Biochemistry)
(Consultant Biochemist)
Reg No. WBMC 64124



Lab No.	: SLK/09-03-2024/SR8845828	Lab Add.	: Newtown,Kolkata-700156
Patient Name	: ASIS GUPTA	Ref Dr.	: Dr.MEDICAL OFFICER
Age	: 35 Y 0 M 0 D	Collection Date	: 09/Mar/2024 10:33AM
Gender	: M	Report Date	: 09/Mar/2024 03:02PM



DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
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CBC WITH PLATELET (THROMBOCYTE) COUNT , EDTA WHOLE BLOOD			
HEMOGLOBIN (Method:PHOTOMETRIC)	13.7	13 - 17	g/dL
WBC (Method:DC detection method)	7.7	4 - 10	*10 ³ /μL
RBC (Method:DC detection method)	5.02	4.5 - 5.5	*10 ⁶ /μL
PLATELET (THROMBOCYTE) COUNT (Method:DC detection method/Microscopy)	183	150 - 450*10 ³	*10 ³ /μL
<u>DIFFERENTIAL COUNT</u>			
NEUTROPHILS (Method:Flowcytometry/Microscopy)	57	40 - 80 %	%
LYMPHOCYTES (Method:Flowcytometry/Microscopy)	35	20 - 40 %	%
MONOCYTES (Method:Flowcytometry/Microscopy)	06	2 - 10 %	%
EOSINOPHILS (Method:Flowcytometry/Microscopy)	02	1 - 6 %	%
BASOPHILS (Method:Flowcytometry/Microscopy)	00	0-0.9%	%
<u>CBC SUBGROUP</u>			
HEMATOCRIT / PCV (Method:Calculated)	41.7	40 - 50 %	%
MCV (Method:Calculated)	83.2	83 - 101 fl	fl
MCH (Method:Calculated)	27.2	27 - 32 pg	pg
MCHC (Method:Calculated)	32.7	31.5-34.5 gm/dl	gm/dl
RDW - RED CELL DISTRIBUTION WIDTH (Method:Calculated)	15.5	11.6-14%	%
PDW-PLATELET DISTRIBUTION WIDTH (Method:Calculated)	19.1	8.3 - 25 fL	fL
MPV-MEAN PLATELET VOLUME (Method:Calculated)	9.9	7.5 - 11.5 fl	

ESR (ERYTHROCYTE SEDIMENTATION RATE) , EDTA WHOLE BLOOD			
1stHour (Method:Westergren)	05	0.00 - 20.00 mm/hr	mm/hr

BLOOD GROUP ABO+RH [GEL METHOD] , EDTA WHOLE BLOOD	
ABO (Method:Gel Card)	B
RH (Method:Gel Card)	POSITIVE

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.



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Gender	: M	Report Date	: 09/Mar/2024 03:02PM



DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Bio Ref. Interval	Unit
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Historical records check not performed.

*** End Of Report ***

Kaushik Dey
 Dr. KAUSHIK DEY
 MD (PATHOLOGY)
 CONSULTANT PATHOLOGIST
 Reg No. WBMC 66405

Lab No. : SLK/09-03-2024/SR8845828
Patient Name : ASIS GUPTA
Age : 35 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date :
Report Date : 09/Mar/2024 02:53PM



DEPARTMENT OF X-RAY

DEPARTMENT OF RADIOLOGY
X-RAY REPORT OF CHEST PA

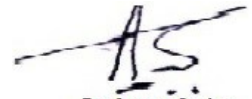
FINDINGS :

No active lung parenchymal lesion is seen.
Both the hila are normal in size, density and position.
Mediastinum is central. 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.

*** End Of Report ***


Dr. Anoop Sastry
MBBS, DMRT(CAL)
CONSULTANT RADIOLOGIST
Registration No.: WB-36628



Lab No. : SLK/09-03-2024/SR8845828	Lab Add. : Newtown,Kolkata-700156
Patient Name : ASIS GUPTA	Ref Dr. : Dr.MEDICAL OFFICER
Age : 35 Y 0 M 0 D	Collection Date : 09/Mar/2024 10:46AM
Gender : M	Report Date : 09/Mar/2024 03:10PM



DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Bio Ref. Interval	Unit
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URINE ROUTINE ALL, ALL , URINE			
<u>PHYSICAL EXAMINATION</u>			
COLOUR	PALE YELLOW		
APPEARANCE	SLIGHTLY HAZY		
<u>CHEMICAL EXAMINATION</u>			
pH (Method:Dipstick (triple indicator method))	6.0	4.6 - 8.0	
SPECIFIC GRAVITY (Method:Dipstick (ion concentration method))	1.005	1.005 - 1.030	
PROTEIN (Method:Dipstick (protein error of pH indicators)/Manual)	NOT DETECTED	NOT DETECTED	
GLUCOSE (Method:Dipstick(glucose-oxidase-peroxidase method)/Manual)	NOT DETECTED	NOT DETECTED	
KETONES (ACETOACETIC ACID, ACETONE) (Method:Dipstick (Legals test)/Manual)	NOT DETECTED	NOT DETECTED	
BLOOD (Method:Dipstick (pseudoperoxidase reaction))	NOT DETECTED	NOT DETECTED	
BILIRUBIN (Method:Dipstick (azo-diazo reaction)/Manual)	NEGATIVE	NEGATIVE	
UROBILINOGEN (Method:Dipstick (diazonium ion reaction)/Manual)	NEGATIVE	NEGATIVE	
NITRITE (Method:Dipstick (Griess test))	NEGATIVE	NEGATIVE	
LEUCOCYTE ESTERASE (Method:Dipstick (ester hydrolysis reaction))	NEGATIVE	NEGATIVE	
<u>MICROSCOPIC EXAMINATION</u>			
LEUKOCYTES (PUS CELLS) (Method:Microscopy)	0-1	0-5	/hpf
EPITHELIAL CELLS (Method:Microscopy)	0-1	0-5	/hpf
RED BLOOD CELLS (Method:Microscopy)	NOT DETECTED	0-2	/hpf
CAST (Method:Microscopy)	NOT DETECTED	NOT DETECTED	
CRYSTALS (Method:Microscopy)	NOT DETECTED	NOT DETECTED	
BACTERIA (Method:Microscopy)	NOT DETECTED	NOT DETECTED	
YEAST (Method:Microscopy)	NOT DETECTED	NOT DETECTED	

Note:

- All urine samples are checked for adequacy and suitability before examination.
- Analysis by urine analyzer of dipstick is based on reflectance photometry principle. Abnormal results of chemical examinations are confirmed by manual methods.
- The first voided morning clean-catch midstream urine sample is the specimen of choice for chemical and microscopic analysis.
- Negative nitrite test does not exclude urinary tract infections.
- Trace proteinuria can be seen in many physiological conditions like exercise, pregnancy, prolonged recumbency etc.
- 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.
- 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.
- 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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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Bio Ref. Interval	Unit
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and/or yeast in the urine.

*** End Of Report ***

Bidisha Chakraborty

Dr. Bidisha Chakraborty
Consultant Pathologist
MD, DNB (Pathology)
Dip RC Path(UK)
Reg No. WBMC 73067

Lab No. : SLK/09-03-2024/SR8845828
Patient Name : ASIS GUPTA
Age : 35 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date :
Report Date : 09/Mar/2024 04:08PM



DEPARTMENT OF CARDIOLOGY

DEPARTMENT OF CARDIOLOGY
REPORT OF E.C.G.

DATA
HEART RATE 64 Bpm
PR INTERVAL 150 Ms
QRS DURATION 74 Ms
QT INTERVAL 396 Ms
QTC INTERVAL 413 Ms

AXIS
P WAVE 39 Degree
QRS WAVE 27 Degree
T WAVE 28 Degree

IMPRESSION
: Sinus rhythm.
Right bundle branch block.

*** End Of Report ***

Dr. KUNAL BISWAS
MBBS, PG Diploma in Clinical Cardiology
Advance Echo training ,Royal Free London
Hospital, NHS, UK
Fellowship in Echocardiography
Ex. House Physician, Cardiology Department
NRS Medical College & Hospital

Lab No. : SLK/09-03-2024/SR8845828
Patient Name : ASIS GUPTA
Age : 35 Y 0 M 0 D
Gender : M

Lab Add. :
Ref Dr. : Dr.MEDICAL OFFICER
Collection Date :
Report Date : 09/Mar/2024 03:10PM



DEPARTMENT OF ULTRASONOGRAPHY

DEPARTMENT OF ULTRASONOGRAPHY
REPORT ON EXAMINATION OF WHOLE ABDOMEN

LIVER

Liver is normal in size (154 mm) and shows diffusely increased echogenicity, suggestive of grade-I fatty infiltration. No focal parenchymal lesion is evident. Intrahepatic biliary radicles are not dilated. Branches of portal veins and hepatic veins are normal.

PORTA

The appearance of porta is normal. Common Bile duct is normal (5 mm) with no intraluminal pathology (Calculi /mass) could be detected at its visualised part. Portal vein is normal (10 mm) at porta.

GALL BLADDER

Gallbladder is physiologically distended. Wall thickness appears normal. No intraluminal pathology (Calculi/mass) could be detected.

PANCREAS

Pancreas is normal in size, shape and contour. Parenchymal echogenicity is normal and homogeneous. No focal mass or calcification seen. No Calcular disease noted. Pancreatic duct is not dilated. No peri-pancreatic collection of fluid noted.

SPLEEN

Spleen is normal in size (85 mm). 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 96 mm. & Lt. kidney 99 mm). Cortical echogenicity appears normal maintaining corticomedullary differentiation. Margin is regular and cortical thickness is uniform. No calcular disease noted (**Tiny calculi may be obscured in the echogenicity of renal sinus fat**). No hydronephrotic changes detected.

URETERS

Ureters are not visualised along their entire in length due bowel gas shadowing

URINARY BLADDER

Urinary bladder is optimally distended. Wall is normal in thickness. No intraluminal calculus or mass is seen.

PROSTATE

Prostate is normal in size. Echotexture appears within normal limits. No focal alteration of its echogenicity could be detectable. It measures : 31 mm x 35 mm x 29 mm
Approximate volume could be around = 17 cc.

IMPRESSION:

Grade I fatty change of liver.

No other significant abnormality detected.

Kindly note

Ultrasound is not the modality of choice to rule out subtle bowel lesion.

Please Intimate us for any typing mistakes and send the report for correction within 7 days.

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.

The report and films are not valid for medico-legal purpose.

Patient Identity not verified.

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DEPARTMENT OF ULTRASONOGRAPHY

Subhrajit Hazra

DR. SUBHRAJIT HAZRA
DMRD, DNB (RADIODIAGNOSIS)

Patient Data

Sample ID: D02132539653
 Patient ID: SR8845828
 Name: ASIS GUPTA
 Physician:
 Sex: M
 DOB:

Analysis Data

Analysis Performed: 09/MAR/2024 14:13:23
 Injection Number: 8123
 Run Number: 103
 Rack ID:
 Tube Number: 9
 Report Generated: 09/MAR/2024 14:36:46
 Operator ID: ASIT

Comments:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.163	16269
A1b	---	1.2	0.230	19359
F	---	0.8	0.279	13850
LA1c	---	1.9	0.407	30940
A1c	5.5	---	0.515	73059
P3	---	3.6	0.789	58388
P4	---	1.2	0.869	20505
Ao	---	85.9	0.989	1412361

Total Area: 1,644,731

HbA1c (NGSP) = 5.5 % HbA1c (IFCC) = 37 mmol/mol

