LAB REPORT

NATIONALITY: Indian

Mr. DEVENDER KUMAR		Registered ON:	01/Sep/2024 02:35PM
Barcode NO:	4K620444	Sample Coll. Date:	01/Sep/2024 02:35AM
Age: 31 Y	Gender: Male	Receiving ON:	01/Sep/2024 06:56PM
ReferDoctor:	Dr. Self	Reported ON:	01/Sep/2024 09:06PM
Sample Collected AT:	HR009 PRIME HOSPITAL		

TEST NAME	RESULT	UNIT	REF. RANGE
ABO	O		
Rh Typing	POSITIVE		

Routine ABO grouping must include both cell & serum testing as each test serves as a check on the other. Clearly labeled blood samples in sterile tubes (plain & EDTA). Test should be performed on the fresh sample for best results.
Slide method is quick but not recommended since agglutination of red cells indicates presence of corresponding antigen. Results of forward grouping should always be confirmed by cell and serum grouping by tube method. Agglutination is a positive test result and indicates the presence of respective red blood cell antigens. Do not interrupts peripheral drying or fibrin strands as agglutination.
No agglutination is a negative test results and indicates the absence of red blood cell antigens.
Cord cells heavily sensitized with anti D (Rh O) may give a false negative tube test results.
All test negative with Anti D (Rh O) (Ig M) reagent (Rh negative) should be further tested for weak/partial D by D" test.
Source of errors: Drying of reaction mixture at the edges causes aggregation that may be mistaken for agglutination. Further weak reactive antigens on red cells on forward grouping and low titre of Anti A & B on reverse grouping can be missed.
False reaction seen in: Autoagglutination, Rouleaux formation, False negative results due to inactivated antisera, Age (new born and elderly may have low level of antibodies). Test results are not valid for Medicolegal purposes.

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ReferDoctor:	Dr. Self	Reported ON:	01/Sep/2024 07:46PM
Sample Collected AT:	HR009 PRIME HOSPITAL		

TEST NAME	RESULT	UNIT	REF. RANGE

WELL PROFILE 15.3

HbA1c (Glycated Haemoglobin) (HPLC METHOD)	5.9	%	4.8-6.5
ABG	122.63	mg/dl	90-140

90 - 120 mg/dl : Excellent Control
121- 150 mg/dl : Good Control
151 - 180 mg/dl :Average Control
181 - 210 mg/dl : Action Suggested
>211 mg/dl : Panic Value
(Note: Average Blood Glucose value is calculated from HBA1C value and it indicate Average Blood Sugar level over past three months.)

REMARKS
In vitro quantitative determination of HbA1c in whole blood is utilized in long term monitoring of glycemia.The HbA1c level correlates with the mean glucose concentration prevailing in the course of the patient's recent history (approx - 6-8 weeks) and therefore provides much more reliable information for glycemia monitoring than do determinations of blood glucose or urinary glucose. It is recommended that the determination of HbA1c be performed at intervals of 4-6 weeks during Diabetes Mellitus therapy. Results of HbA1c should be assessed in conjunction with the patient's medical history, clinical examinations and other findings. Below 6.0% - Normal Value 6.0% - 7.0% - Good Control 7.0% - 8.0% - Fair Control 8.0% - 10% - Unsatisfactory Control above 10% - Poor Control Method- Fully Automated H.P.L.C. Method using Bidirectional ,NGSP Certified.
Below 6.0% - Normal Value
6.0% - 7.0% - Good Control
7.0% - 8.0% - Fair Control
8.0% - 10% - Unsatisfactory Control
above 10% - Poor Control
Method- Fully Automated H.P.L.C. Method using Bidirectional ,NGSP Certified
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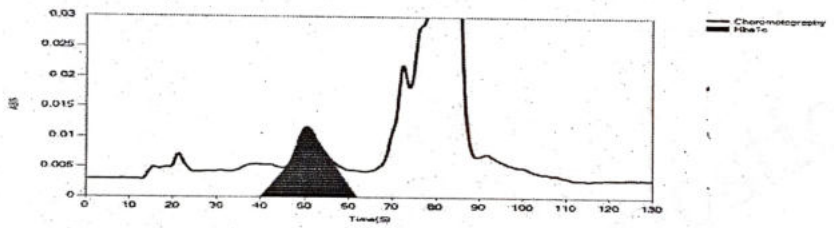
TEST NAME	RESULT	UNIT	REF. RANGE

LIFOTRONIC Graph Report

Name :	Case :	Patient Type :	Test Date : 01/09/2024 19:31:20	
Age :	Department :	Sample Type : Whole Blood EDTA	Sample Id : 4K620444	
Gender :			Total Area : 16582	

Peak Name	Retention Time(s)	Absorbance	Area	Result (Area %)
HbA0	82	3305	15047	90.1
HbA1c	51	78	837	5.9
La1c	48	65	262	1.5
HbF	34	14	134	0.8
Hba1b	26	11	88	0.5
Hba1a	21	38	214	1.2



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WELL PROFILE 15.3

TEST NAME	RESULT	UNIT	REF. RANGE
COMPLETE HAEMOGRAM (CBC, ESR)*			
Haemoglobin (Hb)	14.1	g/dl	12.0-17.0
TLC (Total Leucocyte Count)	8.64	10^3 ul	4-11
Differential Leucocyte Count			
Neutrophil (Microscopy Method)	53	%	40-80
Lymphocyte	38	%	20-40
Eosinophils	02	%	1-6
Monocytes	07	%	2-10
Basophils (Microscopy Method)	0.00	%	0-1
ABSOLUTE COUNT			
Absolute Neutrophil Count (Calculated Method)	4.6	x 10^3 /uL	2.0-7.0
Absolute Lymphocyte Count (Calculated Method)	**3.3**	x 10^3/uL	1.0-3.0
Absolute Eosinophil Count (Calculated Method)	0.17	x 10^3 cells/uL	0.02-0.5
Absolute Monocyte Count (Calculated Method)	0.6	x 10^3 cells/uL	0.2-1
RBC Count	4.62	MILLION/CMM	4.5-5.5
Packed Cell Volume	44.9	%	36-46
MCV	97.1	FL	83-101
MCH	30.6	PG	27-32
MCHC (Calculated Method)	31.5	g/dL	31.5-34.5
RDW-CV	**15.2**	%	11.6-14
Platelet Count	221	10^3 uL	150-450

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TEST NAME	RESULT	UNIT	REF. RANGE
(Electric Impedance Method)			
PCT	0.29	%	0.19-0.39
MPV	**12.90**	fL	6.5-12
PDW	**16.80**	fl	9.6-15.2
Erythrocyte Sedimentation Rate (ESR)	15	mm/h	0-15

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TEST NAME	RESULT	UNIT	REF. RANGE

WELL PROFILE 15.3

Liver Function Test (LFT) - Serum

Primary Sample Type:Serum

SERUM BILIRUBIN

Billrubin Total (DSA Method)	0.62	mg/dL	0.1-1.2
BILLIRUBIN, DIRECT (DSA Method)	0.23	mg/dL	<0.3
Billrubin,Indirect (Calculated Method)	0.39	mg/dL	0-0.9

SERUM PROTEINS

Total Protein BIURET	7.40	g/dL	5.70 - 8.20
Albumin (BCG Method)	4.41	gm/dL	3.2-5.5
Globulin (Calculated Method)	3.00	gm/dL	2.5-3.4
A:G Ratio (Calculated Method)	1.47	Ratio	0.9-2.0
SGOT (IFCC Kinetic Method)	34.71	U/L	0-46
SGPT (IFCC Kinetic Method)	48.17	U/L	0-49
Serum Alkaline Phosphatase (DGKC Method)	88.6	IU/L	30-120

MC - 5790

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TEST NAME	RESULT	UNIT	REF. RANGE
WELL PROFILE 15.3			
LIPID PROFILE			
TOTAL CHOLESTEROL CHOD-POD METHOD	**207.2**	mg/dL	NORMAL <200 mg/dL BORDERLINE HIGH 200-239 mg/dL HIGH >240mg/dL
TRIGLYCERIDES GPO-POD METHOD	**213.3**	mg/dl	0-150
HDL CHOLESTEROL - DIRECT DIRECT METHOD	50.2	mg/dL	<40 HIGH Risk factor for heart disease 40-59 mg/dL Higher,the better >60 mg/dL Considered protective against heart disease
LDL CHOLESTEROL - DIRECT Homogenous Enzymatic Assay	114.29	mg/dL	<100 mg/dL OPTIMAL 100-129 mg/dL Near optimal /above optimal 130-159 mg/dL Borderline high 160-189 High 190 mg/dL and above very high
TC/ HDL CHOLESTEROL RATIO	4.1	Ratio	3.0-5.0
LDL/HDL RATIO	2.27	Ratio	1.5-3.5
VLDL CHOLESTEROL Calculated	**42.7**	mg/dL	5-40
TOTAL LIPID	513.41	mg/dL	300-800

MC - 5790

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TEST NAME	RESULT	UNIT	REF. RANGE

WELL PROFILE 15.3

IRON DEFICIENCY *

Iron FERROZINE METHOD	55.25	ug/dL	45-158
Total Iron Binding capacity(TIBC) PHOTOMETRY	328	ug/dL	225-535
UIBC	272.75	ug/dl	160-360
% Transferrin Saturation	16.82		13-45

Comments

Useful for screening for chronic iron overload diseases, particularly hereditary hemochromatosis. Serum iron, total iron-binding capacity, and percent saturation are widely used for the diagnosis of iron deficiency. However, serum ferritin is a much more sensitive and reliable test for demonstration of iron deficiency.

Ingested iron is absorbed primarily from the intestinal tract and is temporarily stored in the mucosal cells as Fe(III)-ferritin. Ferritin provides a soluble protein shell to encapsulate a complex of insoluble ferric hydroxide-ferric phosphate. On demand, iron is released into the blood by mechanisms that are not clearly understood, to be transported as Fe(III)-transferrin.

Transferrin is the primary plasma iron transport protein, which binds iron strongly at physiological pH. Transferrin is generally only 25% to 30% saturated with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). The total iron binding capacity (TIBC) can be indirectly determined using the sum of the serum iron and UIBC. Knowing the molecular weight of the transferrin and that each molecule of transferrin can bind 2 atoms of iron, TIBC and transferrin concentration is interconvertible.

Percent saturation is usually normal or increased in persons who are iron deficient, pregnant, or are taking oral contraceptive medications. Persons with chronic inflammatory processes, hemochromatosis, or malignancies generally display low transferrin.

In hereditary hemochromatosis, serum iron is usually >150 ug/dL and percent saturation is >60%. In advanced iron overload states, the percent saturation often is >90%.

Cautions

Measurement of serum iron, iron-binding capacity, and percent saturation should not be used as a test for iron deficiency. It is often unreliable for this purpose.

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TEST NAME	RESULT	UNIT	REF. RANGE
WELL PROFILE 15.3			
Kidney Function Test (KFT) - Serum*			
Urea (GLDH METHOD)	23.84	mg/dL	15-45
Creatinine, Serum (MODIFIED JAFFE	1.18	mg/dL	0.4-1.5
Serum Uric Acid URICASE-POD METHOD	6.11	mg/dL	3.4-7.0
Sodium, Serum Indirect ISE	142.0	mmol/L	135-155
Potassium, Serum Indirect ISE	4.28	mmol/L	3.5-5.5
Chloride, serum	102	mmol/L	98-109
Calcium, Serum (Arsenazo III)IHF	8.89	mg/dL	8.2-10.6
Phosphorous (AMMONIUM MOLYBDATE)	3.62	mg/dL	2.5-4.8
Blood Urea Nitrogen (BUN) Kinetic UV Assay	11.13	mg/dL	7.9-20
BUN / Creatinine Ratio (Calculated Method)	9.43		
Urea / Creatinine Ratio (Calculated Method)	20.20		
Glomerular Filtration Rate (GFR) (Calculated Method)	76.65	mL/min/1.73 m2	>90

INTERPRETATION:
UREA- Urea is the major end product of protien metabolism impaired renal function (viz, glomerulonephritis, pyelonephritis etc.)is associated with elevated levels of urea. **Increased levels** of urea are also found during severe dehydration and massivegastrointestinal bleeding.**Decreased levels** are associated with liver damage and pregnancy.
CREATININE- Elevated levels of serum or plasma creatinine are associated with renal failure or muscular dystrophy. **Increased levels** of creatinine are also indicative of congestive heart failure, shock and mechanical obstruction of the urinary tract.
URIC ACID- Serum uric acid is the end product of purine metabolisms.Increased uric acid levels may result from leukemia, polycythemia,ingestion of foods highin nucleoproteins (e.g. liver and kidney) or impaired renal function. Gout result from the deposit of uric acid in body joints.

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ReferDoctor:	Dr. Self	Reported ON:	02/Sep/2024 08:08AM
Sample Collected AT:	HR009 PRIME HOSPITAL		

TEST NAME	RESULT	UNIT	REF. RANGE
PKG FBS*			
Blood Glucose Fasting GOD-POD METHOD	101.8	mg/dL	70.0 - 110.0

Interpretation:-

Fasting Plasma Glucose (mg/dl)	2 hr plasma Glucose (mg/dl)	Diagnosis
99 or below	140 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

*Confirm by repeating the test on a different day

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes.

IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeatig the test on another day, means a person has diabetes.

Blood Glucose Goals	For people with Diabetes
Before meal	70-110 mg/dL
2 Hours after meal	Less than 140-199 mg/dL
HbA1c	Less than 6.5%

NORMAL	Less than 5.7%
prediabetes	5.7% to 6.4%
Diabetes	6.5% or higher

Ref : American Diabetes association standards of medical care.

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TEST NAME	RESULT	UNIT	REF. RANGE
URINE ROUTINE EXAMINATION(PKG)*			
Physical Examination			
Colour (Visual)	PALE YELLOW		
Appearance (Visual)	CLEAR		
pH Double Indicators Test	6.00		7.2-7.8
Specific Gravity Refractometric	1.010		1.005-1.030
Urine Protein	NEGATIVE		NEGATIVE
Urine Sugar Oxidation Reaction	NEGATIVE		NEGATIVE
Ketones Sodium nitroprusside	NEGATIVE		NEGATIVE
Blood Peroxidase Reaction	NEGATIVE		NEGATIVE
Urobilinogen Modified Ehrlich Reaction	NEGATIVE		NEGATIVE
Urine Bilirubin Diazotisation	NEGATIVE		NEGATIVE
RBC	NIL		
Pus Cell	2-3	/HPF	Nil
Epithelial Cells	0-1	/LPF	NIL
Casts Microscopy	Nil		NIL
Yeast	NIL		NIL
Bacteria Microscopy	Nil		

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TEST NAME	RESULT	UNIT	REF. RANGE
WELL PROFILE 15.3			
Vitamin B-12 CHEMI LUMINESCENT IMMUNO ASSAY	444.5	pg/mL	211-911

CLINICAL SIGNIFICANCE :
VITAMIN B12 OR CYANOCOBALAMIN, IS A COMPLEX CORRINOID COMPOUND FOUND EXCLUSIVELY FROM ANIMAL DIETARY SOURCES, SUCH AS MEAT, EGGS AND MILK. IT IS CRITICAL IN NORMAL DNA SYNTHESIS, WHICH IN TURN AFFECTS ERYTHROCYTE MATURATION AND IN THE FORMATION OF MYELIN SHEATH. VITAMIN-B12 IS USED TO FIND OUT NEUROLOGICAL ABNORMALITIES AND IMPAIRED DNA SYNTHESIS ASSOCIATED WITH MACROCYTIC ANEMIAS. FOR DIAGNOSTIC PURPOSE, RESULTS SHOULD ALWAYS BE ASSESSED IN CONJUNCTION WITH THE PATIENTS MEDICAL HISTORY, CLINICAL EXAMINATION AND OTHER FINDINGS.
SPECIFICATIONS: INTRA ASSAY (%CV):4.0%, INTER ASSAY (%CV):4.4 %;SENSITIVITY:45 PG/ML EXTERNAL QUALITY CONTROL PROGRAM PARTICIPATION: COLLEGE OF AMERICAN PATHOLOGISTS: LIGAND ASSAY (GENERAL) SURVEY; CAP NUMBER: 7193855-01 KIT VALIDATION

REFERENCES:CHEN IW,SPERLING MI,HEMINGER IA.VITAMIN B12.IN:PESCE AJ,KALPAN LA,EDITORS.METHODS IN CLINICAL CHEMISTRY. ST.LOUIS:CV MOSBY,1987.P.569-73.

Method :FULLY AUTOMATED BIDIRECTIONALLY INTERFACED CHEMI LUMINESCENT IMMUNO ASSAY

Please correlate with clinical conditions.

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Panel Name:HR009 PRINT HOSPITAL

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Central Processing Lab:
Khasra No-1109, Main Bagga Link Road, Rithala Ind. Area, Delhi-85

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TEST NAME	RESULT	UNIT	REF. RANGE

WELL PROFILE 15.3

S.VITAMIN D TOTAL

25-OH VITAMIN D TOTAL.	**21.15**	ng/mL	30-100

Reference Range :

DEFICIENCY : <20 ng/ml
INSUFFICIENCY : 20-30 ng/ml
SUFFICIENCY : 30-100 ng/ml
TOXICITY : >100 ng/ml

Interpretation - The major circulating form of vitamin D is 25-hydroxyvitamin D (25(OH)D); thus, the total serum 25(OH)D level is currently considered the best indicator of vitamin D supply to the body from cutaneous synthesis and nutritional intake.

vitamin D insufficiency has been defined as a serum 25(OH)D level of 21-29 ng/mL (52-72 nmol/L). This is based on the observed physiological changes in calcium absorption and parathyroid hormone levels that occur with changes in vitamin D levels.

Vitamin D sufficiency: Vitamin D sufficiency has been defined as serum 25(OH)D levels of 30 ng/mL (75 nmol/L) and above based on analysis of observational studies of vitamin D and various health outcomes.

Vitamin D Total test is analyzed on Fully automated bidirectional analyser, standardized against ID-LC/MS/MS, as per Vitamin D Standardization Program (VDSP).

Method :FULLY AUTOMATED CHEMI LUMINESCENT IMMUNO ASSAY

MC - 5790

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DR ABHA SINGHAL
Consultant Pathologist
MD (PATH,MBBS)

DR SWATI NEGI
Consultant pathologist
MBBS,MD(Pathology)

DR POOJA DEVI
PhD. Biochemistry
Consultant Biochemist

LAB REPORT

NATIONALITY: Indian

Mr. DEVENDER KUMAR		Registered ON:	01/Sep/2024 02:35PM
Barcode NO:	4K620444	Sample Coll. Date:	01/Sep/2024 02:35PM
Age: 31 Y	Gender: Male	Receiving ON:	01/Sep/2024 06:56PM
ReferDoctor:	Dr. Self	Reported ON:	01/Sep/2024 08:58PM
Sample Collected AT:	HR009 PRIME HOSPITAL		

TEST NAME	RESULT	UNIT	REF. RANGE

WELL PROFILE 15.3

S.TOTAL TESTOSTERONE

S. TOTAL TESTOSTERONE	526.60	ng/dl	240-950

Interpretation

Testosterone is responsible for the development of secondary sexual characterics and thereby testosterone measurements have been very helpful in evaluating hypogondal states. Increased testosterone levels in males could be found in complete androgen resistance, while decreased levels are found in hypogonadism, orchidectomy, estrogen therapy, Klinefelter's syndrome, hypopituitarism and hepatic cirrhosis. Common causes of increased testosterone levels in females include polycystic ovaries (Stein leventhal syndrome), ovarian tumors, adrenal tumors and hyperplasia.

MC - 5790

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Print DateTime: 02/09/2024 1:53 PM

Panel Name:HR009 PRIME HOSPITAL

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WELL PROFILE 15.3

THYROID PROFILE*

T3 Total. C.L.I.A	103.30	ng/dl	60-200
T4 Total. C.L.I.A	9.63	ug/dl	4.5-12
TSH (Ultra Sensitive) C.L.I.A	2.678	ulU/ml	0.35 - 5.5

Interpretation:
TSH T3/FT3 T4/FT4 Interpretation
High Normal Normal Subclinical Hypothyroidism
Low Normal Normal Subclinical Hyperthyroidism
High High High Secondary Hyperthyroidism
Low High/Normal High/Normal Hyperthyroidism
Low Low/Normal Low/Normal Non Thyroidal Illness.

Reference Range Age related Reference Range Pregnancy.
Age TSH Pregnancy TSH

0-1 day /(Cord Blood)	1.0 - 17.4 1st Timester	0.30 - 4.50
2day - 4days	1.0 - 39.0 2st Timester	0.50 - 4.60
2wks - 20wks	1.7 - 9.1 3st Timester	0.80 - 5.20
5mths - 24mths	0.8 - 8.2	
2yrs - 7yrs	0.7 - 5.7	
8yrs - 21yrs	0.7 - 5.7	
Adults (>21 yrs)	0.35 -4.94	

TSH Levels are subjected to circadian variation, rising several hours before the onset of sleep, reaching peak levels between 11 pm and 6 am. Nadir concentrations are observed during the afternoon. Diurnal variation in TSH levels is approx 50% +/-, hence time of the day can influence the measured serum concentration.

Please Correlate with Clinical Condition.

*** End Of Report ***

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