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Reg No- CL/4018/AUG-2021
Add- 2/169, Samanwaya Nagar,
Awadhpuri, BHEL, Bhopal
Timing- Every Day 7AM TO 9PM
Call- 0755-4077288, 7470397070

TEST REPORT

Patient Name	: Mr. R.K.SHRIVASTAVA	**LAB ID**	: LAB / 3
AGE & SEX	: 63 Years Male	**Accession Date**	: 13-Apr-2023
Collected At	: UNICURE PATHOLOGY	**Report Date**	: 13-Apr-2023
Refered By	: Self	**Report Status**	: **Final**

REPORT OF HAEMATOLOGY

TESTS	RESULT	UNITS	REFERENCE RANGE
COMPLETE BLOOD COUNT (CBC) HEAMOGRAM			
Haemoglobin	: 13.6	gm%	13.5 - 18
R.B.C. Count	: 5.60	mill./cmm.	4.5 - 6.5
Packed Cell Volume	: 42.1	%	30 - 54
Total WBC Count	: 4700	/cumm	4000 - 10500
Differential Count			
Neutrophil	: 57	%	40 - 70
Lymphocytes	: 38	%	20 - 45
Monocytes	: 02	%	2 - 8
Eosinophil	: 03	%	1 - 5
RBC Indices			
MCV	: **75.4**	fl	82 - 97
MCH	: **24.3**	pg	27 - 34
MCHC	: 32.1	%	32 - 38
RDW	: **15.1**	%	11.5 - 14.5
Platelet Count	: 1.30 lacs/cumm		1.5-4.5 Lacs/cumm
Blood Group	: "B" POSITIVE		

checked by :

**********End of Report.**********

Dr Sushil Kumar Sharma
M.D. (Path)

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Referred By	: Self	**Report Status**	: **Final**

REPORT OF GLYCOSYLATED HEMOGLOBIN (HBA 1C)

Result	: 6.1
Reference Range	: 4.6% - 5.6%: indicates Normal 5.7% - 6.4%:Indicates High Risk Above 6.5% Indicates Diabetics

Checked by ;

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REPORT OF BIOCHEMISTRY

TESTS	RESULT	UNITS	REFERENCE RANGE
Blood Glucose(Fasting)	: 96.3	mg/dl	70 - 110
Blood Glucose (Post-Prandial)	: 124.6	mg/dl	70 - 140
LIVER FUNCTION TEST			
Total Bilirubin	: 0.68	mg/dl	0.3 - 1.1
Direct Bilirubin	: 0.12	mg/dl	0.1 - 0.3
Indirect Bilirubin	: 0.56	mg/dl	0.2 - 0.8
SGPT (ALT)	: 36.6	U/L	5 - 45
SGOT	: 31.3	U/L	5 - 45
Alkaline Phosphatase	: 293.7 U/L		A:<80-310 ; C: <180-1200 U/L
RENAL PROFILE			
Serum Urea	: 30.5	mg/dl	10 - 45
Serum Creatinine	: 1.23	mg/dl	0.5 - 1.4
Serum Sodium	: 141.2	m.eq./L	136 - 145
Serum Potassium	: 3.9	m.eq./L	3.5 - 5.0
Serum Uric acid	: **9.3**	mg/dl	3.5 - 7.0
Serum Calcium	: **6.5**	mg/dl	8.7 - 11.0

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REPORT OF BIOCHEMISTRY

TESTS	RESULT	UNITS	REFERENCE RANGE
Blood Glucose(Fasting)	: 96.3	mg/dl	70 - 110
LIPID PROFILE			
S. Cholesterol (Total)	: 195.8 mg/dl		Desirable Level :< 220 mg/dl Borderline level : 200-239 mg/dl High Level > 240 mg/dl
S. Triglycerides	: 98.7 mg/dl		Desirable level :< 165 mg/dl Borderline level :150 - 200 mg/dl High Level: > 200 mg/dl
HDL Cholesterol	: 41.6	mg/dl	35 - 70
LDL Cholesterol	: 134.46		Desirable Level:< 100 mg/dl Borderline level:100-180mg/dl High level: >180 mg/dl
VLDL Cholesterol	: 19.74		Desirable level:< 30 mg/dl Borderline level:30-45 mg/dl High level: > 45 mg/dl
TC/HDLC (Risk Factor 1)	: 4.71		Desirable Level : < 4.3 Borderline level : 4.4 to 11 High Level : >11
LDLC/HDLC(Risk Factor 2)	: 3.23		Desirable Level : < 3.0 Borderline level : 3.0 to 6.0 High Level : > 6.0

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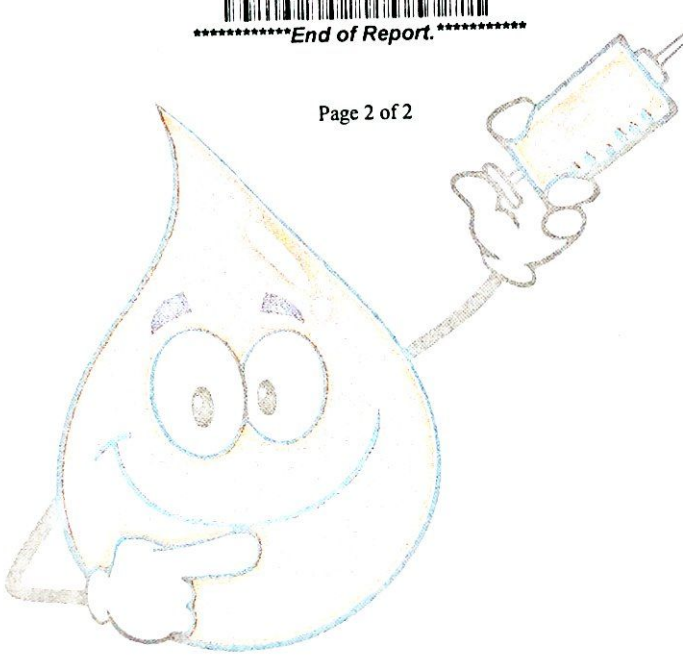

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REPORT OF SEROLOGY REPORT

HEPATITIS B SURFACE ANTIGEN

Result	: NON- REACTIVE
Method	: By IMMUNOASSAY

checked by :

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Ph:- 0755-4863650, Website:- www.sagepathlabs.com

REPORT

Name	: Mr. R.K. SHRIVASTAVA	Sample ID	: 23934880
Age/Gender	: 63 Years/Male	Reg. No	: 0382304130113
Referred by	: Dr. SELF	SPP Code	: SPL-BP-085
Referring Customer	: UNICARE PATHOLOGY LAB	Collected On	: 13-Apr-2023 04:40 PM
Primary Sample	: Whole Blood	Received On	: 13-Apr-2023 04:41 PM
Sample Tested In	: Serum	Reported On	: 13-Apr-2023 09:05 PM
Client Address	: Awadhpuri-Bhopal	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Iron Profile-I				
Iron(Fe)	96	µg/dL	65-175	Ferene
Total Iron Binding Capacity (TIBC)	379	µg/dL	250-450	Ferene
Transferrin	265.03	mg/dL	215-365	Calculated
Iron Saturation((% Transferrin Saturation)	25.33	%	20-50	Calculated
Unsaturated Iron Binding Capacity (UIBC)	283	µg/dL	110 - 370	FerroZine

Interpretation:

- Serum transferrin (and TIBC) high, serum iron low, saturation low. Usual causes of depleted iron stores include blood loss, inadequate dietary iron. RBCs in moderately severe iron deficiency are hypochromic and microcytic. Stainable marrow iron is absent. Serum ferritin decrease is the earliest indicator of iron deficiency if inflammation is absent.
- **Anemia of chronic disease:** Serum transferrin (and TIBC) low to normal, serum iron low, saturation low or normal. Transferrin decreases with many inflammatory diseases. With chronic disease there is a block in movement to and utilization of iron by marrow. This leads to low serum iron and decreased erythropoiesis. Examples include acute and chronic infections, malignancy and renal failure.
- **Sideroblastic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron normal to high, saturation high.
- **Hemolytic Anemia:** Serum transferrin (and TIBC) normal to low, serum iron high, saturation high.
- **Hemochromatosis:** Serum transferrin (and TIBC) slightly low, serum iron high, saturation very high.
- **Protein depletion:** Serum transferrin (and TIBC) may be low, serum iron normal or low (if patient also is iron deficient). This may occur as a result of malnutrition, liver disease, renal disease.
- **Liver disease:** Serum transferrin variable; with acute viral hepatitis, high along with serum iron and ferritin. With chronic liver disease (eg, cirrhosis), transferrin may be low. Patients who have cirrhosis and portacaval shunting have saturated TIBC/transferrin as well as high ferritin.

Correlate Clinically.

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DR.VIVEK KHARE
MD,PATHOLOGIST

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Referring Customer	: UNICARE PATHOLOGY LAB	Collected On	: 13-Apr-2023 04:40 PM
Primary Sample	: Whole Blood	Received On	: 13-Apr-2023 04:41 PM
Sample Tested In	: Serum	Reported On	: 13-Apr-2023 07:49 PM
Client Address	: Awadhpuri-Bhopal	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
25 - Hydroxy Vitamin D	**26.32**	ng/mL	<20.0-Deficiency 20.0-<30.0-Insufficiency 30.0-100.0-Sufficiency >100.0-Potential Intoxication	CLIA

Interpretation:

- Vitamin D helps your body absorb calcium and maintain strong bones throughout your entire life. Your body produces vitamin D when the sun's UV rays contact your skin. Other good sources of the vitamin include fish, eggs, and fortified dairy products. It's also available as a dietary supplement.
- Vitamin D must go through several processes in your body before your body can use it. The first transformation occurs in the liver. Here, your body converts vitamin D to a chemical known as 25-hydroxyvitamin D, also called calcidiol.
- The 25-hydroxy vitamin D test is the best way to monitor vitamin D levels. The amount of 25-hydroxyvitamin D in your blood is a good indication of how much vitamin D your body has. The test can determine if your vitamin D levels are too high or too low.
- .The test is also known as the 25-OH vitamin D test and the calcidiol 25-hydroxycholecalciferol test. It can be an important indicator of osteoporosis (bone weakness) and rickets (bone malformation).

Those who are at high risk of having low levels of vitamin D include:

- people who don't get much exposure to the sun
- older adults
- people with obesity.
- dietary deficiency

Increased Levels:

- Vitamin D Intoxication

Method : CLIA

Vitamin- B12 (cyanocobalamin)	307	pg/mL	211-911	CLIA

Interpretation:
This test is most often done when other blood tests suggest a condition called megaloblastic anemia. Pernicious anemia is a form of megaloblastic anemia caused by poor vitamin B12 absorption. This can occur when the stomach makes less of the substance the body needs to properly absorb vitamin B12.
Causes of vitamin B12 deficiency include:Diseases that cause malabsorption

- Lack of intrinsic factor, a protein that helps the intestine absorb vitamin B12
- Above normal heat production (for example, with hyperthyroidism)

An increased vitamin B12 level is uncommon in:

- Liver disease (such as cirrhosis or hepatitis)
- Myeloproliferative disorders (for example, polycythemia vera and chronic myelogenous leukemia)

Result rechecked and verified for abnormal cases

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Sample Tested In	: Serum	Reported On	: 13-Apr-2023 08:13 PM
Client Address	: Awadhpuri-Bhopal	Report Status	: Final Report

CLINICAL BIOCHEMISTRY

Test Name	Results	Units	Ref. Range	Method
Thyroid Profile-I(TFT)				
T3 (Triiodothyronine)	108.26	ng/dL	40-181	CLIA
T4 (Thyroxine)	11.4	µg/dL	3.2-12.6	CLIA
TSH -Thyroid Stimulating Hormone	2.44	µlU/mL	0.5-8.9	CLIA

Pregnancy & Cord Blood

T3 (Triiodothyronine):	T4 (Thyroxine)	TSH (Thyroid Stimulating Hormone)
First Trimester : 81-190 ng/dL	15 to 40 weeks:9.1-14.0 µg/dL	First Trimester : 0.24-2.99 µlU/mL
Second&Third Trimester :100-260 ng/dL		Second Trimester: 0.46-2.95 µlU/mL
		Third Trimester : 0.43-2.78 µlU/mL
Cord Blood: 30-70 ng/dL	Cord Blood: 7.4-13.0 µg/dL	Cord Blood: : 2.3-13.2 µlU/mL

Interpretation:

- Thyroid gland is a butterfly-shaped endocrine gland that is normally located in the lower front of the neck. The thyroid's job is to make thyroid hormones, which are secreted into the blood and then carried to every tissue in the body. Thyroid hormones help the body use energy, stay warm and keep the brain, heart, muscles, and other organs working as they should.
- Thyroid produces two major hormones: triiodothyronine (T3) and thyroxine (T4). If thyroid gland doesn't produce enough of these hormones, you may experience symptoms such as weight gain, lack of energy, and depression. This condition is called hypothyroidism.
- Thyroid gland produces too many hormones, you may experience weight loss, high levels of anxiety, tremors, and a sense of being on a high. This is called hyperthyroidism.
- TSH interacts with specific cell receptors on the thyroid cell surface and exerts two main actions. The first action is to stimulate cell reproduction and hypertrophy. Secondly, TSH stimulates the thyroid gland to synthesize and secrete T3 and T4.
- The ability to quantitate circulating levels of TSH is important in evaluating thyroid function. It is especially useful in the differential diagnosis of primary (thyroid) from secondary (pituitary) and tertiary (hypothalamus) hypothyroidism. In primary hypothyroidism, TSH levels are significantly elevated, while in secondary and tertiary hypothyroidism, TSH levels are low.

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