

Empowered By Quality...

Patient Name : MR. MANJUNATH SWAMY : 05/Apr/2025 08:18AM Registration Age/Gender : 56 Y O M O D /M Collected : 05/Apr/2025 11:12AM UHID/MR No : KAL.0000005189 Received : 05/Apr/2025 11:30AM

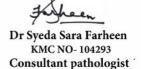
Visit ID : KAL5954 Reported : 05/Apr/2025 12:25PM Ref Doctor : SELF Status : Final Report

DEDARTMENT OF HARMATOLOGY

Barcode No : 10215714 Client Code : ECOTOWN Client Name : ECOTOWN STAFF

DEPARTMENT OF HAEMATOLOGY					
Test Name	Result	Unit	Bio. Ref.Interval		
Complete Blood Count, CBC, WHOLE BLOOD ED	ATO				
*HAEMOGLOBIN (HB)	15.20	g/dl	13.0-17.0		
Method:Photometry					
RBC COUNT(RED BLOOD CELL COUNT)	5.83	million/cmm	4.50-5.50		
Method:Coulter principle			N		
PCV/ Haematocrit	46.6	%	40-50		
Method:Calculated		a	00.101		
Mean Cell Volume (MCV)	80	fL fL	83-101		
Method:Derived from RBC Histogram	2/	na	27-32		
Mean Cell Haemoglobin (MCH) Method:Calculated	26	pg	21-32		
Mean Corpuscular Hb Concn. (MCHC)	33	g/dl	31.5-34.5		
Method:Calculated	00	9, 41	01.0 04.0		
TOTAL LEUCOCYTE COUNT (TLC)	7,870	cells/cmm	4000-11000		
Method:Coulter principle /Manual microscopy					
DIFFERENTIAL COUNT - DC (Optical impedence /manual microscopy)					
NEUTROPHIL	51.00	%	33-76		
Method:Optical Impedence					
LYMPHOCYTE	32.99	%	14-54		
Method:Optical Impedence					
MONOCYTE	6.50	%	1-10		
Method:Optical Impedence		24			
■ EOSINOPHIL	9.22	%	0-6		
Method:Optical Impedence	0.20	0/	0.1		
■ BASOPHIL	0.29	%	0-1		
Method:Optical Impedence	1.66	Lakh/cmm	1 50 4 00		
PLATELET COUNT Method:Optical Impedence	1.00	LdKII/CIIIII	1.50-4.00		
Mean Platelet Volume (MPV)	9	fL	7.0-11.0		
Method:Automated/Calculated	,	IL.	7.0-11.0		
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Page 1 of 17



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RAMAMURTHY NAGAR

#7, AVR Arcade, Opp to Shell Petrol Station, Ramamurthynagar Main Road, Bengaluru - 16.



KALYAN NAGAR





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Visit ID : KAL5954

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DEPARTMENT OF HAEMATOLOGY

Test Name Result Unit Bio. Ref.Interval

Status

ERYTHROCYTE SEDIMENTATION RATE, ESR, WHOLE BLOOD EDTA

ERYTHROCYTE SEDIMENTATION RATE

Method:Westergren

24

mm/hr

0-20

BLOOD GROUP ABO & RH, WHOLE BLOOD EDTA

Method:Slide and Tube Agglutination Method

Rh Typing

Method:Slide and Tube Agglutination Method

"B"

POSITIVE

COMMENTS:

The test will detect common blood grouping system A, B, O, AB and Rhesus (RhD). Unusual blood groups or rare subtypes will not be detected by this method. Further investigation by a blood transfusion laboratory, will be necessary to identify such groups

Disclaimer: There is no trackable record of previous ABO & RH test for this patient in this lab. Please correlate with previous blood group findings

*** End Of Report ***



Dr Syeda Sara Farheen KMC NO-104293 Consultant pathologist

Page 2 of 17



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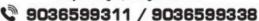
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KALYAN NAGAR

#5, AC-608, 2nd Block, 5th A Cross, HRBR, Kalyan Nagar, Bengaluru - 43





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UHID/MR No : KAL.0000005189 Received : 05/Apr/2025 11:30AM Visit ID : KAL5954 : 05/Apr/2025 01:26PM Reported

Ref Doctor : SELF Status : Final Report Barcode No Client Code : ECOTOWN

: 10215714 Client Name : ECOTOWN STAFF

DEPARTMENT OF CLINICAL PATHOLOGY

Test Name Bio. Ref.Interval Result Unit

URINE ROUTINE EXAMINATION (URE), URINE

PHYSICAL EXAMINATION

URINE VOLUME (R)	40 ml	
COLOUR	PALE YELLOW	Straw/ Pale Yellow
APPEARANCE(U)	CLEAR	Clear
CDECIFIC CDAVITY	1,020	1 010 1 025

SPECIFIC GRAVITY 1.020 1.010 - 1.025 Method:Bromothymol blue

6.0 5.0-7.0 Hq Method:Double indicator

CHEMICAL EXAMINATION ABSENT ABSENT

PROTEIN Method:Tetrabromophenol

ABSENT ABSENT SUGAR Method:Strip/Benedict

ABSENT ABSENT BILE SALT Method: Hays Sulphur Test

ABSENT BILE PIGMENTS ABSENT Method:Strip /Fouchets

ABSENT KETONE BODIES ABSENT

Method:Strip method/Rotheras **ABSENT ABSENT** BLOOD

Method:Strip/ Benzidine test

MICROSCOPIC EXAMINATION /HPF **PUS CELLS** 2-3 0-4

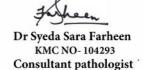
Method:Microscopy Epithelial cells 1-2 /HPF 0-4

Method:Microscopy **ABSENT** /HPF 0-2**RBCs**

Method:Microscopy

ABSENT ABSENT CRYSTALS Method:Microscopy





Page 3 of 17



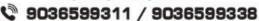
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CASTS

OTHERS

BACTERIA Method:Microscopy

Method:Microscopy

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name

Result **ABSENT** Unit

Bio. Ref.Interval

ABSENT

ABSENT

ABSENT

ABSENT

*** End Of Report ***



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Page 4 of 17



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Status : Final Report Client Code

mg/dl

: ECOTOWN

70-100

DEPARTMENT OF BIOCHEMISTRY

Test Name Bio. Ref.Interval Result Unit

PLASMA GLUCOSE- FASTING (FBS), FLOURIDE PLASMA

Plasma Glucose Fasting (FBS) Method:Hexokinase Method

INTERPRETATION (As per ADA 2022 guidelines) Fasting Plasma glucose (in mg/dl)

70-100 Normal Pre-diabetes 101-125

Diabetes Mellitus >126 Note: The Diagnosis of Diabetes requires a fasting plasma glucose of >or =126 mg/dl or a radom/2hour glucose value of >0r

=200 mg/dl on atleast 2 occasions.



Dr. Shivaraja Shetty, MBBS, MD.

KMC-75934 **Biochemist**

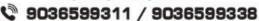
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Page 5 of 17

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Client Name . LCOTOWN STAIT			
DEF	PARTMENT OF BIOCHEM	IISTRY	
Test Name	Result	Unit	Bio. Ref.Interval
LIPID PROFILE,SERUM			
TOTAL CHOLESTEROL Method:CHE/CHO/POD	136	mg/dl	<200
H D L CHOLESTEROL Method:CHE/CHO/POD	36	mg/dl	40-60
L D L CHOLESTEROL Method:CHE/CHO/POD/CALCULATED	65	mg/dl	<100
VLDL Method:Calculated	35	mg/dl	0-40
TRIGLYCERIDES Method:GK/GPO/POD	177	mg/dl	<150
NON HDL CHOLESTEROL Method:Calculated	100	mg/dl	
T. CHOLESTEROL/ HDL RATIO Method:Calculated	3.78		<4.0
LDL / HDL RATIO Method:Calculated	1.81		0.5-3.0
ATHEROGENIC INDEX OF PLASMA (AIP) Method:Calculated	0.33		< 0.11: Low risk for CVD~ 0.11- 0.24: Intermediate risk~ for CVD~ >0.24: High risk for CVD

Note: VLDL calculation is not valid when Triglyceride value is more than 400 mg/dl as other lipoproteins are usually present.

INTERPRETATION (all in mg/dl)				
TOTAL CHOLESTEROL	LDL CHOLESTEROL	TRIGLYCERIDES		
Desirable: <200	Optimal: <100	Normal: <150		
Borderline: 200-239	Near optimal: 100-129	Borderline high: 150-199		
High: >/=240	Borderline high: 130-159	High: 200-499		
	High: 160-189	Very high: =/>500		
	Very high: >190			



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Page 6 of 17

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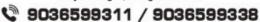


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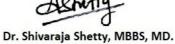
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Client Code	: ECOTOWN	

_	DEPARTMENT OF BIOCHEMISTRY			
	Test Name	Result	Unit	Bio. Ref.Interval
LI	VER FUNCTION TEST, SERUM			
\$	TOTAL PROTEIN	7.01	g/dl	6.40-8.30
MC-essa	Method:Biuret			
(43)	ALBUMIN	4.09	g/dl	3.5-5.2
	Method:BCG	0.00		0.0.5
(43)	GLOBULIN	2.92	g/dl	2.3-3.5
	Method:Calculated	1.4		1.0-1.8
(88)	A/G RATIO Method:Calculated	1.4		1.0-1.0
23	TOTAL BILIRUBIN	0.79	mg/dl	0.3-1.2
W. 400	Method:DPD			
\$	CONJUGATED/DIRECT Bilirubin	0.16	mg/dl	0.00-0.20
MC-4644	Method:DPD			
(4)	UNCONJUGATED/INDIRECT Bilirubin	0.63	mg/dl	0.1-1.0
MC-8888	Method:Calculated			
**	ALKALINE PHOSPHATASE Method:IFCC	68	U/L	30-120
₩.	Aspartate Transaminase (AST/ SGOT)	19	U/L	<50
M:	Method:IFCC			
\$3	Alanine Aminotransferase (ALT/ SGPT) Method:IFCC	31	U/L	<50
E	GGT, Gamma Glutamyl transferase Method:IFCC	20	U/L	<55





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Page 7 of 17



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: ECOTOWN STAFF Client Name

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mg/dl

8.8-10.6

DEPARTMENT OF BIOCHEMISTRY

Test Name Result Unit Bio. Ref.Interval

9.2

Registration

Collected

Received

TOTAL CALCIUM, SERUM

SERUM TOTAL CALCIUM Method:Arsenazo III

INTERPRETATION:

- -Calcium level is increased in patients with hyperparathyroidism, Vitamin D intoxication, metastatic bone tumor, milk-alkali syndrome, multiple myeloma, Paget's disease.
- Calcium level is decreased in patients with hemodialysis, hypoparathyroidism (primary, secondary), vitamin D deficiency, acute pancreatitis, diabetic Keto-acidosis, sepsis, acute myocardial infarction (AMI), malabsorption, osteomalacia, renal failure, rickets.

SERUM MAGNESIUM, SERUM

SERUM MAGNESIUM

Method:Xylidyl blue

1.84

mg/dl

1.8 - 2.6

COMMENTS:

-Magnesium is primarily an intracellular ion associated with gastrointestinal (GI) absorption and renal excretion. It is the fourth most abundant cation in the body and is second to potassium within cell. It is stored in bones, skeletal muscles and other cells and only a part in

extracellular fluid. Mg²⁺ is a cofactor of many enzyme system concerned with cell respiration, glycolysis, transmembrane transport of other cations such as calcium and sodium. The activity of Na-K-ATPase pump depends on magnesium.

-Assessment of magnesium level is used for the diagnosis and monitoring of hypomagnesemia or hypermagnesemia.

-Magnesium deficiency leads to impairment of neuromuscular functions resulting in hyperirritability, tetany, convulsion or electrocardiographic changes. It is also associated with cardiovascular diseases such as hypertension, myocardial infarction, cardiac dysrhythmias, coronary vasonasm & premature atherosclerosic. Dishatic katagidadic changes alreadyling magnetic leadable magnetic l dysrhythmias, coronary vasopasm & premature atherosclerosis. Diabetic ketoacidosis, chronic alcoholism, malnutrition, lactation malabsorption are other conditions linked with it

-Increased serum magnesium concentration has been observed in dehydration, Addison's disease, rhabdomyolysis or acute or chronic renal



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Page 8 of 17



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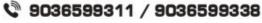
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DEPARTMENT OF BIOCHEMISTRY

Test Name SERUM PHOSPHORUS, SERUM

PHOSPHOROUS

Ref Doctor

Method: Molybdate-UV/ Endpoint Method

Result Unit Bio. Ref.Interval

4.00 mg/dl

2.4-4.4

INTERPRETATION:

-Approximately 80% of the phosphorus in the human body is found in the calcium phosphate salts which make up the inorganic substance of bone. The remainder is involved in the esterification of carbohydrate metabolism intermediaries and is also found as component of phospholipids. Phosphoproteins, nucleic acids and nucleotides.

-Hypophosphatemia can be caused by shift of phosphate from extracellular to intracellular spaces, increased renal loss (renal tubular defects, hyperparathyroidism) or gastrointestinal loss (diarrhea, vomiting) and decreased intestinal absorption.

LIMITATIONS:

-Interferences: bilirubin (up to 20 mg/dL) hemolysis (haemoglobin up to 1000 mg/dL) and lipemia (triglycerides up to 1000 mg/dL) do not interface. Other drugs and substances may interface.

-Clinical diagnosis should no be made on the findings of a single test result, but should integrate both clinical laboratory data



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Page 9 of 17



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DEPARTMENT OF BIOCHEMISTRY

Test Name Result Unit Bio. Ref.Interval

Registration

HbA1C-Glycosylated Hemoglobin, WHOLE BLOOD EDTA

Glycosylated Hemoglobin- HbA1C

Method:HPLC

Estimated Average Glucose (eAG)

5.80

120

mg/dl

4 - 5.6

Method:Calculated

INTERPRETATION

American Diabetes Association (ADA) 2023 Criteria

HbA1c in % Non diabetic adults

< 5.7 5.7 - 6.4 At risk (Prediabetes) -

Diagnosing Diabetes -6.5 & above

American Diabetes Association (ADA) is recommending the use of a new term in diabetes management, estimated average

glucose/eAG. The relationship between HbA1c and eAG is described by the formula 28.7 X HbA1c % - 46.7 = eAG.

2. The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCT assay.

3. Low glycated haemoglobin in a non diabetic individual are often associated with systemic inflammatory diseases, chronic anaemia (especially severe iron deficiency and haemolytic), chronic renal failure and liver diseases. Clinical correlation suggested.

4. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control.

Excellent control-6-7 %
Fair to Good control - 7-8 %

Unsatisfactory control – 8 to 10 % Poor Control – More than 10 %

INCREASED IN (Other than DM)

- Chronic renal failure with or without hemodialysis
- Iron deficiency anemia. Increased serum triglycerides
- Alcohol
- Salicylate treatment.

DECREÁSED IN

- 1. Shortened RBC life span (hemolytic anemia, blood loss), Pregnancy
- Ingestion of large amounts (>1g/day) of vitamin C or E.
 Hemoglobinopathies (e.g.: spherocytes) produce variable increase or decrease.
- Results of %HbA1c are not reliable in patients with chronic blood loss and consequent variable erythrocyte life span.



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Page 10 of 17



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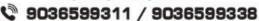
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DEPARTMENT OF BIOCHEMISTRY			
Test Name	Result	Unit	Bio. Ref.Interval
RENAL FUNCTION TEST 1,SERUM			
SERUM UREA	21	mg/dl	17-43
Method:Urease GLDH			
BLOOD UREA NITROGEN (BUN)	9.81	mg/dl	6-20
Method:Calculated			
SERUM CREATININE	1.18	mg/dl	0.70-1.18
Method:Enzymatic			
SERUM URIC ACID	6.8	mg/dl	3.5-7.2
Method:URICASE			
SERUM SODIUM	138.7	mmol/L	135-155
Method:Direct ISE			
SERUM POTASSIUM	3.93	mmol/L	3.5-5.0
Method:Direct ISE			
SERUM CHLORIDE	98.6	mmol/L	94-110
Method:Direct ISE			





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Page 11 of 17

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KALYAN NAGAR





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μg/dL

Client Code : ECOTOWN

70-180

DEPARTMENT OF BIOCHEMISTRY

79.00

Test Name Result Unit Bio. Ref.Interval

SERUM IRON, SERUM

SERUM IRON

Method:TPTZ Colorimetric

INTERPRETATION:

Serum iron test is used in differential diagnosis of anaemia and diagnosis of acute iron toxicity especially in children.

INCREASED IN:

- -Hemosiderosis of excessive iron intake (e.g. repeated blood transfusion, iron therapy, iron containing vitamins).
- -Decreased formation of RBCs (thalassemia, pyridoxal deficiency anaemia)
- -Increased destruction of RBCs (hemolytic anaemia)
- -Acute liver damage
- -Progesteronal birth control pills & pregnancy
- -Premenstrual elevation
- -Acute iron toxicity

DECREASED IN:

- -Iron deficiency anaemia
- -Normochromic anaemia of infections & chronic diseases
- -Nephrosis
- -Menstruation
- -Diurnal variation: Normal in mid morning, low values in mid afternoon, and very low values near midnight.

*** End Of Report ***



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Page 12 of 17

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Patient Name : MR. MANJUNATH SWAMY : 05/Apr/2025 08:18AM Registration Age/Gender : 56 Y O M O D /M Collected : 05/Apr/2025 11:12AM UHID/MR No : KAL.0000005189 Received : 05/Apr/2025 11:30AM

Visit ID : KAL5954 Reported : 05/Apr/2025 02:28PM

Ref Doctor : SELF Status : Final Report Barcode No Client Code : ECOTOWN : 10215714 Client Name : ECOTOWN STAFF

DEPARTMENT OF HORMONE ASSAYS

	Test Name	Result	Unit	Bio. Ref.Interval
Т	HYROID PROFILE TOTAL (T3,T4,TSH),SERUM			
(Z)	T3- TRI-IODOTHYRONINE TOTAL	0.95	ng/mL	0.60-1.81
MC-8888	Method:CLIA			
*	T4 - THYROXINE TOTAL	11.56	μg/dL	5.48-14.28
MC-8888	Method:CLIA			
**	Thyroid Stimulating Hormone (TSH)	4.75	μIU/mL	0.50-8.90
MC-8888	Method:CLIA			

INTERPRETATION:

- Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
- 2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.

 3. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
- Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism)
- 5. Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.

7. REFERENCE RANGE:

PREGNANCY	TSH in ul U/mL	
1st Trimester	0.10 - 2.50	
2nd Trimester	0.20 - 3.00	
3rd Trimester	0.30 - 3.00	

Age	TSH in uI U/mL
0 - 4 Days	1.00 - 39.00
2 Weeks to 5 Months	1.70 - 9.10
5 Months to 20 Yrs.	0.70 - 6.40
21 Yrs. to 54 years	0.40 - 4.20
>55 Yrs.	0.50 - 8.90

(References range recommended by the American Thyroid Association)

Comments

During pregnancy, Free thyroid profile (FT3, FT4 & Ultra-TSH) is recommended.

TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations



Dr. Shivaraja Shetty, MBBS, MD. KMC-75934 **Biochemist**

Page 13 of 17

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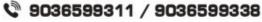
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KALYAN NAGAR





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DEPARTMENT OF HORMONE ASSAYS

Test Name Result Unit Bio. Ref.Interval

25 HYDROXY VITAMIN D, SERUM

ng/ml 30-100 VITAMIN D 18.73 Method:CLIA

INTERPRETATION:

LEVEL	REFERENCE RANGE
Deficient	< 20 ng/ml
Insufficient	20-<30 ng/ml
Sufficient (adequate)	30-100 ng/ml
Toxicity	> 100 ng/ml

DECREASED LEVELS:

- -Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany.
- -Inadequate exposure to sunlight.
- -Dietary deficiency.
- -Vitamin D malabsorption.
- -Severe Hepatocellular disease.
- -Drugs like Anticonvulsants.
- -Nephrotic syndrome.

COMMENTS:

-Vitamin D (Cholecalciferol) promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1, 25 Dihydronxy vitamin D (5-8 hrs).

-The assay measures D3 (Cholecaciferol) metabolites of vitamin D.

- -25 (OH) D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
- -Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
 -It shows seasonal variation, with values being 40-50% lower in winter than in summer.
- -Levels vary with age and are increased in pregnancy
- -This is the recommended test for evaluation of vitamin D intoxication.



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Page 14 of 17



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: SELF

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DEPARTMENT OF HORMONE ASSAYS

Test Name Result Unit Bio. Ref.Interval

Status

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL, SERUM

PROSTATE SPECIFIC ANTIGEN Method:CLIA

4.66

ng/mL

0-4

NOTE:Rechecked.

Ref Doctor

INTERPRETATION:

Raised Total PSA levels may indicate prostate cancer, benign prostate hypertation (BPH), or inflammation of the prostate. Prostate manipulation by biopsy or rigorous physical activity may temporarily elevate PSA levels. The blood test should be done before surgery or six weeks after manipulation. The total PSA may be ordered at regular intervals during treatment of men who have been diagnosed with Prostate cancer and in prostatic cancer cases under observation.



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Page 15 of 17

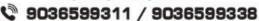
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DEPARTMENT OF HORMONE ASSAYS

Test Name Result Unit Bio. Ref.Interval

VITAMIN B12, SERUM

VITAMIN B12 Method:CLIA

Age/Gender

259 pg/mL 75-807

Vitamin B12, also known as cyanocobalamin, is a water soluble vitamin that is required for the maturation of erythrocytes and coenzyme form for more than 12 different enzyme systems. Groupsat risk for vitamin B12 deficiency include those (1) older than 65 years of age (2) with malabsorption (3) who are vegetarians (4) with autoimmune disorders(5) taking prescribed medication known to interfere with vitamin absorption or metabolism, including nitrous oxide, phenytoin, dihydrofolate reductase inhibitors, metformin,

and proton pump inhibitors (6) infants with suspected metabolic disorders.

The most common cause of Vitamin B12 deficiency is pernicious anemia. Deficiency of Vitamin B12 is associated with megaloblastic anemia and neuropathy. Excess Vitamin B12 is excreted in urine. No adverse effects have been associated with excess vitamin B12 intake from food or supplements in healthy people

Results may differ between laboratories due to variation in population and test method. Vitamin B12 is implicated in the formation of myelin, and along with Folate is required for DNA synthesis. The most prominent source of B12 for humans is meat while untreated fresh water can also be a source.

Megaloblastic anaemia has been found to be due to B12 deficiency, a major cause being Pernicious anemia due to poor B12 uptake resulting in below normal serum levels. Other conditions related to low B12 levels include iron deficiency anemia, pregnancy, vegetarianism, partial gastrectomy, ileal damage, oral contraceptives, parasitic infestations, pancreatic deficiency, treated epilepsy and advancing age. The correlation of serum B12 levels and Megaloblastic anemia however is not always clear - some patients with high MCV may have normal B12 levels, while some individuals with B12 deficiency may not have megaloblastic anemia. Disorders renal failure, liver diseases and myeloproliferative diseases may have elevated vitamin B12 levels.

LIMITATIONS:

For diagnostic purposes, the B12 results should be used in conjunction with other data; e.g.; symptoms results of other testing, clinical impressions, etc.

If the B12 level is inconsistent with clinical evidence, additional testing is suggested to confirm the result.



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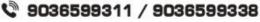
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Page 16 of 17



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DEPARTMENT OF HORMONE ASSAYS

Test Name Result Unit Bio. Ref.Interval

FOLIC ACID, SERUM

FOLIC ACID 3.42 ng/ml 3.1-20.5

Method:CMIA

INTERPRETATION:

Decreased levels of folic acid are seen in megaloblastic anemia, malnutrition, alcoholism, and inadequate dietary intake. Decreased levels are associated with a higher risk of fetal malformations during pregnancy.

In patients taking methotrexate therapy, antibodies formed may interfere with the assay.

*** End Of Report ***



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Working Hours : Mon - Sat 6.30 AM - 9.00 PM, Sunday : 6.30 AM - 3.00 PM 💿 enquiry@ecotowndiagnostics.com 📵 www.ecotowndiagnostics.com

Page 17 of 17