Allianz Medical Services
- 252, Nazar Singh Place, G-5, Sant Nagar, East of Kailash, New Delhi-65
- 325A, Ashoka Enclave Main, Sector-34, Faridabad.
- 1, M.D. Road, New Delhi.

PatientName	: **Mr.SAHIL**		
Age/Gender	: 22 Y/M	Collected	: 10/Jul/2025 03:58PM
Barcode No	: 4K005380	Received	: 10/Jul/2025 04:13PM
Visit ID	: GEN13851	Reported	: 10/Jul/2025 07:35PM
Ref. By	: SELF	Status	: Final Report
Client Code	: GENE1097	Panel Name	: ALLIANZ MEDICAL SERVICES
UHID	: GEN.0000013851	Customer Ref.	: SELF

DEPARTMENT OF HAEMATOLOGY

GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
HBA1C				
Glycosylated Hemoglobin (HPLC METHOD)	4.5	N	%	Normal Glucose tolerance (non-diabetic): <5.6% Pre-diabetic: 5.7-6.4% Diabetic Mellitus: >6.5%
ESTIMATED AVG. GLUCOSE	82.45	N	mg/dl	62.30-142.72

INTERPRATION:
HbA1c result is suggestive of non diabetic adults (>=18 years)/well controlled Diabetes in a known Diabetic.
HbA1c ia used to monitor fluctuations in blood glucose conncentration in the past 8-12 weeks period.

Interprtation as per American Diabetes Association (ADA) Guidelines

Reference Group	Non diabetic adults >=18 years	At risk (prediabetes)	Diagnosing Diabetes	Therapeutic goals for glycemic control
HbA1c in %	4.0 - 5.6	5.7-6.4	>=6.5	<7.0

Therapeutic Glycemic targets:-
Pregnant Diabetic Patients - Less than 6.5%
Children with type 1 Diabetes - Less than 7.0 %
Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1C result does not correlate with the patient's blood glucose levels.

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Test Name	Result	flag	Unit	Bio. Ref. Range
CBC+ESR(COMPLETE BLOOD COUNT WITH ESR)				
HAEMOGLOBIN (HB) Non-Cyanmethemoglobin	13.7	N	g/dL	12.0-18.0
TOTAL LEUCOCYTE COUNT (TLC) Flow cytometry	4.8	N	10^3/uL	4.0-12.0
Differential Count (Fluorescent Flow Cytometry)				
NEUTROPHIL	55	N	%	40-80
LYMPHOCYTE	35	N	%	20-40
EOSINOPHIL	4	N	%	0-6.0
MONOCYTE	6	N	%	2-10.0
BASOPHIL	00	N	%	0.0-1.0
ABSOLUTE NEUTROPHIL COUNT Automated Calculated	2.64	N	10^3/uL	2.0-7.0
ABSOLUTE LYMPHOCYTE COUNT Automated Calculated	1.68	N	10^3/uL	0.40-4.0
ABSOLUTE EOSINOPHIL COUNT Automated Calculated	0.19	N	10^3/uL	0.02-0.50
ABSOLUTE MONOCYTE COUNT Automated Calculated	0.29	N	10^3/uL	0.12-1.20
RBC COUNT(RED BLOOD CELL COUNT) Optical Flowcytometry	4.60	N	10^6/µL	4.0-5.50
PCV/HAEMATOCRIT RBC pulse height detection	42.6	N	%	40-54
MCV Automated/Calculated	92.61	N	fL	80-100
MCH Automated/Calculated	29.4	N	pg	27-34

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
MCHC Automated/Calculated	32.1	N	%	32-36
PLATELET COUNT Optical Flowcytometry	155	N	10^3/µL	150-450
PCT	0.21	N	%	0.108-0.282
RDW-CV Automatic Calculated	13.60	N	%	11.0-16.0
RDW-SD	53.40	N	fl	35.0-56.0
MPV Calculated	**13.3**	H	fL	6.5-12.0
PDW Calculated	**20.1**	H	fL	15.0-17.0
ERYTHROCYTE SEDIMENTATION RATE Westergren	9	N	mm/1st hr	0-20

CBC:

The non cynhemoglobin is most accurate method for estimation of Hemoglobin.If Anaemia is suspected it is prudent to measure PCV & RBC count along with hemoglobin concentration. This will be useful in assessing the correctness of Hemoglobin value and in calculation of Red cell indices (for morphological classification of Anaemia). Hb may decrease in Various Anaemias, blood loss, autoimmune disorders malignancy etc. it may also be decreased in recumbent position, excess squeezing during finger puncture, presence of clot in adequate mixing of blood with anticoagulant, and spurious anaemia (increased plasma volume in pregnancy, pooling of red cell in spleenomegaly, fluid retention in congestive cardiac failure and in paraproteinemias. Increased hemoglobin is seen in Sternous excersice, at high altitude, in hemoconcentration, prolonged application of tourriquet during venupuncture and in Polycythemia. The purpose of carrying out TLC is to detect increase or decrease in the total no. of WBC i.e leucocytosis or leucopenia respectively. TLC is carried out in investigation of any fever, inflammation allergic or hematologic disorder, malignancy and or follow up of chemotherapy or radiotherapy. Source of error in counts are – prolonged or tight application of tourniquet leads to stasis and false elvevation of all count, exercise, excessive squeezing of finger puncture, inadequate or non mixing of blood with anticoagulants leads to formation of clots cause falsely low count. Platelet count is usually obtained if there is a suspicion of a bleeding disorder. Automated hematology analyser more precisely count platelets. Significance : causes of raised platelet counts are primary ; chronic myeloproliferative disorder like CML, ET, MF and PCV. Reactive or secondry causes are: Disseminated malignancy, hemorrhage, spleenomegaly, chronic inflammation, Iron deficiency anaemia with bleeding. False elevation of platelet count can result from the presence of fragments of red/white cells, microspherocytes or cryoglobulins. Cause of pseudothrombocytopenia are clumping of platelets in EDTA dependant platelet antibody in some patients which is active only in vitro, platelet satellitism, platelet clumping due to the presence of giant platelets (which are not counted as platelets by electronic cell analyser). •Test results released pertain to the specimen submitted. All test results are dependent on the quality of the samples received by the lab. Lab investigations are only a tool to facilitating in arriving at a diagnosis and should be clinically correlated by the referring physician. Report dispatch may be delayed due to unforeseen circumstances. Inconvenience is regretted. Test results may show inter laboratory variations.Test results are not valid for Medicolegal purposes.

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
LFT(LIVER FUNCTION TEST)				
Billrubin Total (DSA Method)	0.62	N	mg/dL	0.20-1.20 mg/dL
BILLIRUBIN, DIRECT (DSA Method)	0.28	N	mg/dL	0.00-0.30 mg/dL
Billrubin,Indirect (Calculated Method)	0.34	N	mg/dL	0.0-0.9 mg/dL
TOTAL PROTEINS BIURET	6.60	N	g/dL	6.6-8.3 g/dL
ALBUMIN (BCG Method)	4.00	N	g/dL	3.5-5.3 g/dL
GLOBULIN (Calculated Method)	2.60	N	g /dL	2.0-3.5 g/dL
SGOT (IFCC Kinetic Method)	26.10	N	U/L	0-40
SGPT (IFCC Kinetic Method)	40.60	N	U/L	0-49
Serum Alkaline Phosphatase (DGKC Method)	89.88	N	U/L	30-120 U/L
A/G RATIO Calculated	1.54	N	%	1.0-2.1
GGT	26.65	N	mg/dL	11.0-61.0

COMMENTS:
Please Correlate with Clinical Condition.

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
LIPID PROFILE				
TOTAL CHOLESTEROL CHOD-POD METHOD	172.20	N	mg/dL	NORMAL <200 mg/dL~BORDERLINE HIGH 200-~239 mg/dL~HIGH >240mg/dL
TRIGLYCERIDES GPO-POD METHOD	107.00	N	mg/dL	Normal(150 mg/dl)~Borderline high(150.0-199.0 mg/dl)~High(200-499)~Very High(500 mg/dl)
H D L CHOLESTEROL Homogenous Direct Method	44.64	N	mg/dL	<40 HIGH Risk factorfor~heart disease~40-59 mg/dL Higher,the~better~>60 mg/dL Considered~protective againstheart~disease
L D L CHOLESTEROL Homogenous Enzymatic Assay	106.16	N	mg/dL	<100 mg/dL OPTIMAL~100-129 mg/dL Near optimal~/above optimal~130-159 mg/dLBorderline~high~160-189 High~190 mg/dL andabove high
VLDL Calculated	21.40	N	mg/dL	15-30

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
T. CHOLESTEROL/ HDL RATIO Calculated	2.38		Ratio	Low Risk: 3.3-4.4 Average Risk: 4.5-7.0 Moderate Risk: 7.1-11.0 High Risk: >=11.0
LDL / HDL RATIO Calculated	0.42	N	%	0-3.5

Lipid Profle Test	Lipid Profle Test	Borderline High	High
Total cholesterol	<200 mg/dL	200-239 mg/dL	≥240 mg/dL
Triglycerides	<150 mg/dL	150-199 mg/dL	≥200 mg/dL
HDL cholesterol	≥60 mg/dL	40-59 mg/dL	<40 mg/dL
LDL cholesterol	<100 mg/dL	130-159 mg/dL	≥160 mg/dL

Desirable levels of cholesterol and triglycerides are associated with a lower risk of heart disease, while high levels increase the risk

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
KFT(Kidney Function Test)				
SERUM UREA (GLDH METHOD)	43.90	N	mg/dL	15-45 mg/dL
SERUM CREATININE (MODIFIED JAFFE	0.71	N	mg/dL	0.45-1.50 mg/dL
SERUM URIC ACID URICASE-POD METHOD	5.80	N	mg/dL	2.6-6.0 mg/dL
SERUM SODIUM Indirect ISE	145	N	mmol/L	136.0-145.0 mmol/L
SERUM POTASSIUM Indirect ISE	4.56	N	mmol/L	3.4-4.7 mmol/L
SERUM CHLORIDE Indirect ISE	104.5	N	mmol/L	98.0-108.0 mmol/L
CALCIUM (Arsenazo III)IHF	9.10	N	mg/dl	8.1-10.4
PHOSPHOROUS (AMMONIUM MOLYBDATE)	3.57	N	mg/dl	2.5-4.8
Blood Urea Nitrogen (BUN) Kinetic UV Assay	20.51	N	mg/dL	5-25
BUN/CREATININE RATIO (Calculated Method)	**28.89**	H		10-20
Urea Creatinine Ratio (Calculated Method)	61.83		Ratio	
Estimated Glomerular Filtration Rate (eGFR) (Calculated Method)	147.45		mL/min/1.73m2	

Interpretation:
Blood urea nitrogen (BUN) and creatinine are waste products that are fltered out of the blood by the kidneys. Elevated levels of BUN and creatinine in the blood can indicate decreased kidney function. The glomerular fltration rate (GFR) is a measure of how well your kidneys are fltering waste products from your blood. A low GFR can indicate decreased kidney function. The urine albumin-to-creatinine ratio (ACR) is a measure of the amount of albumin (a type of protein) in your urine relative to the amount of creatinine. Elevated levels of ACR can indicate damage to the kidneys.

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GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
IRON PROFILE-I				
SERUM IRON COLORIMETRIC	101.50	N	ug/dL	45-158 ug/dL
TOTAL IRON BINDING CAPACITY Calculations	348.00	N	ug/dL	225-535 ug/dL
UIBC Ferrozine	246.50	N	ug/d	160-360 ug/dl
TRANSFERRIN SATURATION	29.17	N	%	13-45

INTERPRETATION:

SERUM IRON INCREASED IN:

-Hemosiderosis of excessive iron intake (e.g. repeated blood transfusion, iron therapy, iron containing vitamins)
-Increased destruction of RBCs (hemolytic anaemia)
-Acute liver damage
-Acute iron toxicity
-Thalassemia

SERUM IRON DECREASED IN:

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

TIBC/UIBC INCREASED IN:

-Iron deficiency anemia
-Acute & Chronic blood loss
-Acute liver damage
-Progesterone birth control pills

TIBC/UIBC DECREASED IN:

-Hemochromatosis
-Cirrhosis of the liver
-Thalassemia
-Anemia of infective & chronic disease
-Nephrosis

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	flag	Unit	Bio. Ref. Range
PKG FBS				
Plasma Glucose Fasting Glucose Oxidase/Peroxidase	76.0	N	mg/dL	70-100 mg/dL

Interpretation:-

(In accordance with the American diabetes association guidelines): ·

- A fasting plasma glucose level below 100 mg/dL is considered normal. ·
- A fasting plasma glucose level between 100-126 mg/dL is considered as glucose intolerant or pre diabetic. A fasting and post-prandial blood sugar test (after consumption of 75 gm of glucose) is recommended for all such patients. ·
- A fasting plasma glucose level of above 126 mg/dL is highly suggestive of a diabetic state. A repeat fasting test is strongly recommended for all such patients. A fasting plasma glucose level in excess of 126 mg/dL on both the occasions is confirmatory of a diabetic state.

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DEPARTMENT OF HORMONE ASSAYS

GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
THYROID PROFILE*				
T3 Total. C.L.I.A	178.00	N	ng/dl	60-200
T4 Total. C.L.I.A	9.71	N	ug/dl	4.50-12.0
Ultrasensitive TSH C.L.I.A	3.20	N	uIU/mL	0.55-4.78

INTERPRETATION:
1. 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.
4. Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propanolol and propylthiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
6. 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. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.

REFERENCE RANGE:

PREGNANCY	TSH in µIU/mL
1st Trimester	0.25 - 4.33 **µIU/mL**
2nd Trimester	0.43 - 6.61 **µIU/mL**
3rd Trimester	0.38 – 6.22 **µIU/mL**

Age	TSH in µIU/mL
1 – 3 years	0.76 - 10.00 **µIU/mL**
3 - 6 years	0.79 – 5.54 **µIU/mL**
6 - 12 years	0.49 – 5.83 **µIU/mL**
12 - 18 years	0.59 - 6.93 **µIU/mL**
>18 years	0.30 - 4.50 **µIU/mL**

(References range recommended by the American Thyroid Association)

COMMENTS:
1. During pregnancy, Free thyroid profile (FT3, FT4 & Ultra-TSH) is recommended.
2. 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.

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DEPARTMENT OF HORMONE ASSAYS

GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
B12				
VITAMIN B12	257.00	N	pg/mL	183-822 pg/mL
CLIA				

COMMENTS:
Vitamin B12 belongs to the family of cobalamins and serves as a cofactor for two important reactions in humans. As methylcobalamin, it is a cofactor for methionine synthetase in the conversion of homocysteine to methionine, and as adenosylcobalamin for the conversion of methylmalonyl-coenzyme A (CoA) to succinyl-CoA. All vitamin B12 comes from diet and is present in all foods of animal origin. Severe prolonged vitamin B12 deficiency may cause megaloblastic anemia and/or neurological degeneration.

- Causes of vitamin B12 deficiency
- Dietary deficiency (strict vegetarians)
- Decreased production of intrinsic factor
- Helicobacter pylori infection
- Competition for vitamin 812 in gut
- Blind loop syndrome
- Decreased ileal absorption of vitamin 812
- Pancreatic insufficiency
- Surgical resection

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DEPARTMENT OF HORMONE ASSAYS

GENEHXIS HELATH 1.3

Test Name	Result	flag	Unit	Bio. Ref. Range
VITD				
25-OH Vitamin D (TOTAL)	37.00	N	ng/dl	30-100
CLIA				

Reference Range :

DEFICIENCY : 100 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

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

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