

# DIAGNOSTIC REPORT



CLIENT CODE : C000119167

CLIENT'S NAME AND ADDRESS :  
SRL PSC GORAKHPUR (HOME COLLECTION)  
AKSHAYBAR SINGH BHAWAN, CIVIL LINES, 7 PARK ROAD,  
GORAKHPUR  
GORAKHPUR 273001  
UTTAR PRADESH INDIA  
8601366999 9311426484

SRL LIMITED  
45-M, Betlahata, Hanuman Mandir Road,  
Gorakhpur, 273001  
UTTAR PRADESH, INDIA  
Tel : 9111591115, Fax : CIN - U74899PB1995PLC045956

PATIENT NAME : AJAI SRIVASATAV

PATIENT ID : AJAIM211053185

ACCESSION NO : 0185UE001597

AGE : 67 Years

SEX : Male

DATE OF BIRTH : 21/10/1953

DRAWN : 13/05/2021 10:45

RECEIVED : 13/05/2021 11:44

REPORTED : 13/05/2021 15:01

REFERRING DOCTOR : SELF

CLIENT PATIENT ID :

Test Report Status	Results	Biological Reference Interval	Units
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## COMPLETE CARE ESSENTIAL

### BLOOD COUNTS

HEMOGLOBIN	16.6	13.0 - 17.0	g/dL
RED BLOOD CELL COUNT	6.08	High 4.5 - 5.5	mil/ $\mu$ L
WHITE BLOOD CELL COUNT	8.2	4.0 - 10.0	thou/ $\mu$ L
PLATELET COUNT	110	Low 150 - 410	thou/ $\mu$ L

### RBC AND PLATELET INDICES

HEMATOCRIT	49.6	40 - 50	%
MEAN CORPUSCULAR VOLUME	82.0	Low 83 - 101	fL
MEAN CORPUSCULAR HEMOGLOBIN	27.3	27.0 - 32.0	pg
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION	33.4	31.5 - 34.5	g/dL
RED CELL DISTRIBUTION WIDTH	15.8	High 11.6 - 14.0	%
MEAN PLATELET VOLUME	13.6	High 6.8 - 10.9	fL

### WBC DIFFERENTIAL COUNT - NLR

NEUTROPHILS	61	40 - 80	%
ABSOLUTE NEUTROPHIL COUNT	5.00	2.0 - 7.0	thou/ $\mu$ L
LYMPHOCYTES	35	20 - 40	%
ABSOLUTE LYMPHOCYTE COUNT	2.87	1.0 - 3.0	thou/ $\mu$ L
EOSINOPHILS	02	1 - 6	%
ABSOLUTE EOSINOPHIL COUNT	0.16	0.02 - 0.50	thou/ $\mu$ L
MONOCYTES	02	2 - 10	%
ABSOLUTE MONOCYTE COUNT	0.16	Low 0.2 - 1.0	thou/ $\mu$ L
BASOPHILS	0	0 - 2	%
ABSOLUTE BASOPHIL COUNT	0.00	Low 0.02 - 0.10	thou/ $\mu$ L

DIFFERENTIAL COUNT PERFORMED ON: EDTA SMEAR

### ALANINE AMINOTRANSFERASE, SERUM

ALANINE AMINOTRANSFERASE (ALT/SGPT)	47	High < 45.0	U/L
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### ASPARTATE AMINOTRANSFERASE, SERUM

ASPARTATE AMINOTRANSFERASE (AST/SGOT)	29	15 - 37	U/L
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### BILIRUBIN, TOTAL, SERUM

BILIRUBIN, TOTAL	1.30	High 0.2 - 1.0	mg/dL
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### TSH 3RD GENERATION ULTRA( TSH3 - UL), SERUM

TSH 3RD GENERATION	3.410	0.27 - 4.20	$\mu$ IU/mL
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### GLUCOSE, FASTING, PLASMA



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GLUCOSE, FASTING, PLASMA	115	High 82 - 99	mg/dL
URINALYSIS			
COLOR	YELLOWISH		
APPEARANCE	CLEAR		
PH	5.5	4.7 - 7.5	
SPECIFIC GRAVITY	1.025	1.003 - 1.035	
GLUCOSE	DETECTED ( + + + )	NOT DETECTED	
PROTEIN	NOT DETECTED	NOT DETECTED	
KETONES	NOT DETECTED	NOT DETECTED	
BLOOD	NOT DETECTED	NOT DETECTED	
BILIRUBIN	NOT DETECTED	NOT DETECTED	
UROBILINOGEN	NORMAL	NORMAL	
NITRITE	NOT DETECTED	NOT DETECTED	
WBC	1-2	0-5	/HPF
EPITHELIAL CELLS	1-2	0-5	/HPF
RED BLOOD CELLS	NOT DETECTED	NOT DETECTED	/HPF
CASTS	NOT DETECTED		
CRYSTALS	CALCIUM OXALATE SEEN.		
BACTERIA	NOT DETECTED	NOT DETECTED	
CORONARY RISK PROFILE (LIPID PROFILE), SERUM			
CHOLESTEROL	118	< 200 Desirable 200 - 239 Borderline High > / = 240 High	mg/dL
TRIGLYCERIDES	67	< 150 Normal 150 - 199 Borderline High 200 - 499 High > / = 500 Very High	mg/dL
HDL CHOLESTEROL	50	< 40 Low > / = 60 High	mg/dL
DIRECT LDL CHOLESTEROL	70	< 100 Optimal 100 - 129 Near or above optimal 130 - 159 Borderline High 160 - 189 High > / = 190 Very High	mg/dL
NON HDL CHOLESTEROL	68	Desirable: Less than 130 Above Desirable: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very high: > or = 220	mg/dL



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CHOL/HDL RATIO		2.4	Low 3.3 - 4.4 Low Risk 4.5 - 7.0 Average Risk 7.1 - 11.0 Moderate Risk > 11.0 High Risk	
LDL/HDL RATIO		1.4	0.5 - 3.0 Desirable/Low Risk 3.1 - 6.0 Borderline/Moderate Risk > 6.0 High Risk	
VERY LOW DENSITY LIPOPROTEIN		13.4	< /= 30.0	mg/dL
SERUM BLOOD UREA NITROGEN				
BLOOD UREA NITROGEN		11	8 - 23	mg/dL
CREATININE, SERUM				
CREATININE		0.89	0.80 - 1.30	mg/dL
BUN/CREAT RATIO				
BUN/CREAT RATIO		12.36	5.00 - 15.00	
URIC ACID, SERUM				
URIC ACID		3.1	Low 3.5 - 7.2	mg/dL

## Interpretation(s)

WBC DIFFERENTIAL COUNT - NLR-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR < 3.3, COVID-19 patients tend to show mild disease.

(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients A.-P. Yang, et al. International Immunopharmacology 84 (2020) 106504 This ratio element is a calculated parameter and out of NABL scope.

ALANINE AMINOTRANSFERASE, SERUM-Alanine aminotransferase (ALT) test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ASPARTATE AMINOTRANSFERASE, SERUM-Aminotransferase (AST) is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. BILIRUBIN, TOTAL, SERUM-Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels results from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice).

An elevated bilirubin level in a newborn may be temporary and resolve itself within a few days to two weeks. However, if the bilirubin level is above a critical threshold or rapidly increases, an investigation of the cause is needed so appropriate treatment can be initiated.

Source: Wallach's Interpretation of Diagnostic tests, 9th ed2) Wallach's interpretation of diagnostic tests, 9th ed

TSH 3RD GENERATION ULTRA( TSH3 - UL), SERUM-Comment: The Biological Reference Interval of TSH-3rd Generation Ultra [TSH3-UL] is not established for age less than 2 years.

Below mentioned are the guidelines for Pregnancy related reference ranges for TSH.

Levels in Pregnancy	TSH (µIU/mL)
First Trimester	0.1 - 2.5
2nd Trimester	0.2 - 3.0
3rd Trimester	0.3 - 3.0

GLUCOSE, FASTING, PLASMA-ADA 2012 guidelines for adults as follows:

Pre-diabetics: 100 - 125 mg/dL

Diabetic: > or = 126 mg/dL



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(Ref: Tietz 4th Edition & ADA 2012 Guidelines)

URINALYSIS-Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of hemolytic anemia

CORONARY RISK PROFILE (LIPID PROFILE), SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease. This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Recommendations:

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

SERUM BLOOD UREA NITROGEN-Causes of Increased levels

Pre renal

- High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal
- Renal Failure

Post Renal

- Malignancy, Nephrolithiasis, Prostatism

Causes of decreased levels

- Liver disease
- SIADH.

CREATININE, SERUM-Higher than normal level may be due to:

- Blockage in the urinary tract
- Kidney problems, such as kidney damage or failure, infection, or reduced blood flow
- Loss of body fluid (dehydration)
- Muscle problems, such as breakdown of muscle fibers
- Problems during pregnancy, such as seizures (eclampsia), or high blood pressure caused by pregnancy (preeclampsia)

Lower than normal level may be due to:

- Myasthenia Gravis
- Muscular dystrophy

URIC ACID, SERUM-Causes of Increased levels

Dietary

- High Protein Intake.
- Prolonged Fasting,



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• Rapid weight loss.  
Gout  
Lesch nyhan syndrome.  
Type 2 DM.  
Metabolic syndrome.

Causes of decreased levels  
• Low Zinc Intake  
• OCP's  
• Multiple Sclerosis

Nutritional tips to manage increased Uric acid levels  
• Drink plenty of fluids  
• Limit animal proteins  
• High Fibre foods  
• Vit C Intake  
• Antioxidant rich foods

## SPECIALISED CHEMISTRY - ANEMIA

### FERRITIN, SERUM

FERRITIN	7.8	Low 30 - 400	ng/mL
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#### Interpretation(s)

FERRITIN, SERUM-Ferritin is a high-molecular-weight protein that contains approximately 20% iron. It occurs normally in almost all tissues of the body but especially in hepatocytes and reticuloendothelial cells, where it serves as an iron reserve. When needed, the iron molecules are released from the apoferritin shell and bind to transferrin, the circulating plasma protein that transports iron to the erythropoietic cells.

A low serum ferritin value is thought to be the best laboratory indicator of iron depletion. Virtually all patients with low serum iron and low ferritin have iron deficiency. Serum Ferritin concentration, when considered with other factors such as serum iron, iron-binding capacity and tissue iron stores is valuable in the diagnosis of iron deficiency anemia, anemia of chronic infection and conditions such as thalassemia and hemochromatosis that are associated with iron overload. It is particularly useful in distinguishing between iron-deficiency anemia (serum ferritin levels diminished) and "anemia of chronic disease" (serum ferritin levels usually normal or elevated).

Ferritin is an acute phase reactant. It can be found to be elevated in the following conditions and do not reflect actual body iron stores: 1.Inflammation 2.Significant tissue destruction 3.Liver diseases 4.Malignancies such as acute leukemia and Hodgkin's disease 5.Therapy with iron supplements.

#### Interferences:

Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or to animal serum products can be prone to this interference and anomalous values may be observed.

\*\*End Of Report\*\*

Please visit [www.srlworld.com](http://www.srlworld.com) for related Test Information for this accession

Dr. Ajay Kumar Dwivedi  
Lab Head



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