Ms HEENA KUMARI

41 Year(s)/Female

Ref. by : -

Partner : Getvisit TPA

Report Ref. ID : DEL2580108

Patient ID : OHPJD2CV1529643

Collected : 03/08/2025 07:35 AM

Received : 03/08/2025 11:07 AM

Reported : 03/08/2025 12:49 PM

Test	Results	Units	Biological Reference
BIOCHEMISTRY			
Glycated Hemoglobin (HbA1C) Whole Blood			
Glycated Hemoglobin (HbA1C) High-Performance Liquid Chromatography (HPLC)	4.8	%	Normal: < 5.7 Pre-Diabetes: 5.7-6.4 Diabetes: ⇒ 6.5
Mean Blood Glucose Calculated	91.00	mg/dL	< 117

HbA1C is used to monitor fluctuations in blood glucose concentration in the past 8 to 12 week's period.
The reference interval defined as per American Diabetes Association guidelines 2016:

- Less than 5.7%: Non Diabetic
- 5.7 to 6.4%: at increased risk of developing diabetes in the future
- More than 6.5%: Diabetic
- Therapeutic glycemic target
  - Adults: less than 7%
  - Children with Type 1 diabetes: less than 7%
- Pregnant diabetic patients: less than 6.5%

Note: Targets may be individualized based on: Age/life expectancy, Comorbid conditions, Diabetes duration, Hypoglycemia status, Individual patient considerations

Reference: American Diabetes Association. Standards of medical care in diabetes - 2021.

Mean Blood Glucose is average Blood glucose which directly correlates with A1C, reported in the same units as blood sugar levels (mg/dl). Thus it reflects the average glucose concentration in the past 8 to 12 weeks period. This should not be compared with Fasting or Post prandial or random blood sugar which measures glucose concentration at that point of time of testing.

Lipid Profile Serum			
Cholesterol, Total Cholesterol Esterase/Cholesterol Oxidase/Peroxidase	169	mg/dL	< 200
Triglycerides Cholesterol Oxidase	**169**	mg/dL	< 150

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Test	Results	Units	Biological Reference
High-Density Lipoprotein (HDL) Cholesterol Cholesterol Esterase/Cholesterol Oxidase/Peroxidase	**42**	mg/dL	> 50
Non-High Density Lipoprotein (Non-HDL) Cholesterol Calculated	127	mg/dL	< 130
Low-Density Lipoprotein (LDL) Cholesterol Calculated	93.2	mg/dL	< 100
Very Low-Density Lipoprotein (VLDL) Cholesterol Calculated	**33.8**	mg/dL	< 30
Cholesterol/High Density Lipoprotein (HDL) Ratio Calculated	4.0		3.3 - 4.4
Low-Density Lipoprotein/High-Density Lipoprotein (LDL/HDL) Ratio Calculated	2.2		0.5 - 3
High-Density Lipoprotein/Low-Density Lipoprotein (HDL/LDL) Ratio Calculated	0.5		> 0.4

Remarks	Total Cholesterol (mg/dL)	Triglycerides (mg/dL)	LDL Cholesterol (mg/dL)
Optimal	<200	<150	<100
Above Optimal	-	-	100-129
Borderline	200-239	150-199	130-159
High	≥ 240	200-499	160-189
Very High	-	≥ 500	≥ 190

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Test	Results	Units	Biological Reference

Lipid profile is a group test consisting of various lipids. Lipid profiles are generally collected with overnight fasting. However, recent guidelines have recommended non fasting samples for lipid profile for assessment of cardiovascular risk. The details for the study can be checked at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2733560

In certain instances measurements in the same patient can show physiological and analytical variations. In such cases three serial samples at an interval of 1 week each are recommended for Total cholesterol, TG, HDL and LDL.

Cholesterol levels are increased in primary hypercholesterolemia; secondary hyperlipoproteinemia, including nephrotic syndrome; primary biliary cirrhosis; hypothyroidism; and in some cases, diabetes mellitus. Low cholesterol levels may be found in malnutrition, malabsorption, advanced malignancy, and hyperthyroidism.

Triglyceride levels are used in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, or various endocrine disorders.

High Density Lipoprotein (HDL) cholesterol levels is used to evaluate the risk of developing coronary heart disease (CHD). The risk of CHD increases with lower HDL cholesterol concentrations.

LDL (low-density lipoprotein) cholesterol level, sometimes called "bad" cholesterol, makes up most of our body's cholesterol. High levels of LDL cholesterol raise your risk for heart disease and stroke.

Very-low-density lipoprotein (VLDL) cholesterol is produced in the liver and released into the bloodstream to supply body tissues with triglycerides. High levels of VLDL cholesterol have been associated with the development of plaque deposits on artery walls, which narrow the passage and restrict blood flow.

Liver Function Test (LFT)

Serum

Test	Results	Units	Biological Reference
Bilirubin, Total Diazo Method	1.16	mg/dL	0.2 - 1.3
Bilirubin, Direct Calculated	0.18	mg/dL	0 - 0.3
Bilirubin, Indirect Reflectance Spectrophotometry	0.98	mg/dL	0.1 - 1.1
Aspartate Aminotransferase (AST) Multipoint-Rate/UV with Pyridoxal-5-Phosphate (P-5-P)	33	U/L	14 - 36
Alanine Transaminase (ALT) LDH, UV Kinetic	30	U/L	<50

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Test	Results	Units	Biological Reference
Aspartate Aminotransferase/Alanine Transaminase (AST/ALT) Ratio Calculated	1.1		0.7 - 1.4
Alkaline Phosphatase (ALP) Multipoint-Rate/UV with Pyridoxal-5-Phosphate (P-5-P)	95	U/L	38 - 126
Gamma-Glutamyl Transpeptidase (GGT) SZAZ Carboxylated Substrate	23	U/L	12 - 43
Protein Biuret	7.6	g/dL	6 - 8.3
Albumin Bromo-Cresol Green	4.3	g/dL	3.5 - 5
Globulin Calculated	3.3	g/dL	2.3 - 3.5
Albumin/Globulin (A/G) Ratio Calculated	1.3		0.8 - 2

In certain individuals, **total bilirubin** up to 2.0 mg/dl is considered normal. High bilirubin values can be due to jaundice.

Total bilirubin is invariably increased in jaundice. Causes of jaundice are prehepatic, resulting from various hemolytic diseases; hepatic, resulting from hepatocellular injury or obstruction; and posthepatic, resulting from obstruction of the hepatic or common bile ducts.

Increased **direct bilirubin** levels can occur in hepatobiliary disorders, including intrahepatic and extrahepatic biliary tree obstruction, liver cell damage, Dubin-Johnson syndrome, and Rotor syndrome.

High **indirect bilirubin** levels can occur in hemolytic disorders, Gilbert's syndrome, Crigler-Najjar syndrome, neonatal jaundice, and ineffective erythropoiesis.

High **Aspartate Aminotransferase** values can occur in Myocardial infarction, pulmonary emboli, skeletal muscle trauma, alcoholic cirrhosis, viral hepatitis, or drug-induced hepatitis.

Elevated **Alanine Aminotransferase** levels are seen in liver cell necrosis, hepatitis, hepatic cirrhosis, liver tumours, obstructive jaundice, Reye's syndrome, extensive trauma to skeletal muscle, myositis, myocarditis, or myocardial infarction.

High **alkaline phosphatase** levels can be be due to primary and secondary hyperparathyroidism, Paget's disease of bone, carcinoma metastatic to the bone, osteogenic sarcoma, Hodgkin's disease, Hepatobiliary diseases involving cholestasis, inflammation, or cirrhosis.
ALP levels can also be elevated in fever and increased bone metabolism(e.g., in adolescents and during the healing of a fracture), in renal

Test	Results	Units	Biological Reference

infarction and failure and in pregnancy complications.
Low **ALP** levels may occasionally be seen in hypothyroidism.

Gamma-glutamyl transferase (GGT) is a sensitive indicator of hepatobiliary disease. It is useful in the diagnosis of obstructive jaundice and chronic alcoholic liver disease, in the follow-up of chronic alcoholics undergoing treatment, and in the detection of hepatotoxicity. GGT is more responsive to biliary obstruction than AST, ALT, or ALP.

Total **protein** levels can be used to evaluate nutritional status.
High **protein** concentrations can be due to dehydration, Waldenström's macroglobulinemia, multiple myeloma, hyperglobulinemia, granulomatous, and some tropical diseases.
Low **protein** concentrations can be due to pregnancy, excessive intravenous fluid administration, cirrhosis or other liver diseases, chronic alcoholism, heart failure, nephrotic syndrome, glomerulonephritis, neoplasia, protein-losing enteropathies, malabsorption, and severe malnutrition.

Increased **albumin** levels may indicate dehydration or hyperinfusion with albumin.
Decreased **albumin** levels are found in rapid or over-hydration, severe malnutrition and malabsorption, severe diffuse liver necrosis, chronic active hepatitis, and neoplasia.
Albumin is commonly reduced in chronic alcoholism, pregnancy, renal protein loss, thyroid dysfunction, peptic ulcer disease, and chronic inflammatory diseases.

Globulin includes carrier proteins, enzymes, complement, and immunoglobulins. Most of these are synthesised in the liver, although immunoglobulins are synthesised by plasma cells.
Increased **globulin** level usually results from an increase in immunoglobulins.
Malnutrition and congenital immune deficiency can decrease **globulin** levels due to decreased synthesis. Nephrotic syndrome can cause decreased globulin levels due to protein loss through the kidney.

AST/ALT Ratio > 2:1 (AST is two times higher than ALT) is indicative of alcoholic liver disease.
AST/ALT Ratio < 1:1 (ALT is higher than AST) indicates non-alcoholic fatty liver disease.

Kidney Function Test (KFT) Mini

Serum

Test	Results	Units	Biological Reference
Urea Urease	24	mg/dL	15 - 36
Creatinine Twopoint-Rate-Creatinine Aminohydrolase	0.61	mg/dL	0.52 - 1.04
Blood Urea Nitrogen (BUN) Calculated	11.2	mg/dL	6 - 20
Blood Urea Nitrogen (BUN)/Creatinine Ratio Calculated	18.36	Ratio	10 - 20

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Test	Results	Units	Biological Reference
Uric Acid Uricase	4.6	mg/dL	2.5 - 6.2
Calcium Arsenazo Method	10.0	mg/dL	8.4 - 10.2
Estimated Glomerular Filtration Rate (eGFR) Twopoint-Rate-Creatinine Aminohydrolase/Calculation	115	ml/min/1.73m²	Normal: ⇒ 90 Mild decrease: 60-89 Mild moderate decrease: 45-59 Severe decrease: 15-29 End stage kidney disease: < 15

High **urea** and **BUN** levels are suggestive of poor kidney function due to acute or chronic kidney diseases, decreased blood flow to the kidneys as in congestive heart failure, shock, stress, recent heart attack or severe burns, bleeding from the gastrointestinal tract, conditions that obstruct urine flow or dehydration.
Low **urea** and **BUN** levels are uncommon and are not usually a cause for concern. They can be seen in severe liver disease or malnutrition but are not used to diagnose or monitor these conditions. Low urea levels are also seen in normal pregnancy.

Creatinine is elevated in kidney disease, damage, infection, urinary tract obstruction, reduced blood flow to the kidneys in case of shock, congestive heart failure, complications of diabetes.

High levels of **uric acid** are seen in kidney disease, pre-eclampsia, purine-rich food, alcoholism, and side effects of cancer treatment.

Low **calcium** levels may be due to hypoparathyroidism, kidney failure, pancreatitis, malnutrition, or a disorder in calcium absorption.
High **calcium** levels may be due to hyperparathyroidism, hyperthyroidism, sarcoidosis, drugs like diuretics, and excessive calcium supplementation.

High **phosphorus** levels can be due to dehydration, hypoparathyroidism, hypervitaminosis D, metastases to bone, sarcoidosis, pulmonary embolism, renal failure, or diabetes mellitus with ketosis.
Low **phosphorus** levels can be caused by hyperparathyroidism, high calcium levels, sepsis, vitamin D deficiency, renal tubular disorders, chronic hemodialysis, vomiting, or occasionally decreased dietary phosphate intake.

Chronic Kidney Disease often has no symptoms until the later stages. So, reliable estimates of GFR are important for identifying the disease as early as possible.
Factors that can affect **eGFR** include pregnancy, being over the age of 70, unusual muscle mass, cirrhosis, nephrotic syndrome, a past solid organ transplant, and some medications.

Glucose, Fasting Fluoride Plasma,Glucose Oxidase-Peroxidase (GOD-POD)	**118**	mg/dL	70 - 99

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Test	Results	Units	Biological Reference

Approved By

Dr. Vinay Yadav
MBBS, MD (Pathology)
Pathologist

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Test	Results	Units	Biological Reference
HAEMATOLOGY			
Complete Blood Count (CBC) with ESR Whole Blood			
Red Blood Cells (RBC) Count DC Impedance Method	3.86	mill/mm³	3.8 - 4.8
Hemoglobin (Hb) Cyanide-free SLS method	**9.3**	g/dL	12 - 15
Comments Kindly correlate clinically and with iron studies for further evaluation.			
Hematocrit (HCT) | Packed Cell Volume (PCV) Calculated	**30.9**	%	36 - 46
Mean Corpuscular Volume (MCV) Calculated	**80.0**	fL	83 - 101
Mean Corpuscular Hemoglobin (MCH) Calculated	**24.0**	pg	27 - 32
Mean Corpuscular Hemoglobin Concentration (MCHC) Calculated	**30.1**	g/dL	31.5 - 34.5
Red Cell Distribution Width (RDW) CV Calculated	**18.5**	%	11.6 - 14
Mentzer Index Calculated	21		Beta Thalassemia trait: < 14 Iron deficiency anemia: >= 14
Sehgal Index Calculated	1658.0		Beta Thalassemia trait: < 972 Iron deficiency anaemia: >= 972
Total White Blood Cell Count (TC) Flow Cytometry	5160	cells/mm³	4000 - 10000
Differential Count			

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Test	Results	Units	Biological Reference
Neutrophils Flow Cytometry	61.7	%	40 - 80
Lymphocytes Flow Cytometry	31.3	%	20 - 40
Monocytes Flow Cytometry	5.0	%	2 - 10
Eosinophils Flow Cytometry	1.5	%	1 - 6
Basophils Flow Cytometry	0.5	%	0 - 2
Absolute Neutrophil Count (ANC) Calculated	3184	/mm³	2000 - 7000
Absolute Lymphocyte Count (ALC) Calculated	1615	/mm³	1000 - 3000
Absolute Monocyte Count (AMC) Calculated	258	/mm³	200 - 1000
Absolute Eosinophil Count (AEC) Calculated	77	/mm³	20 - 500
Absolute Basophil Count (ABC) Calculated	26	/mm³	0 - 100
Neutrophil Lymphocyte Ratio (NLR) Calculated	2.0		1 - 3
Platelet Count DC Impedance Method	**120**	10^3/µL	150 - 450

Comments Manually confirmed. No clumps seen. Large platelets seen. Kindly correlate clinically and advise follow up

Platelet Hematocrit Calculated	**0.181**	%	0.2 - 0.5
Mean Platelet Volume (MPV) Calculated	**15.0**	fL	7 - 13

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Test	Results	Units	Biological Reference
Erythrocyte Sedimentation Rate (ESR) Quantitative Capillary Photometry	**36**	mm/h	0 - 20

- Reference Ranges are in accordance with Dacie & Lewis Practical Hematology International Edition (12th)
- As per International Council for Standardization in Hematology's recommendations Differential Leucocyte counts are additionally reported in Absolute numbers in each cell per unit volume of blood.

Approved By

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Test	Results	Units	Biological Reference
IMMUNOLOGY			
Thyroid Stimulating Hormone (TSH) Serum,Chemiluminescent Immunoassay	1.969	µIU/mL	0.4 - 4.049

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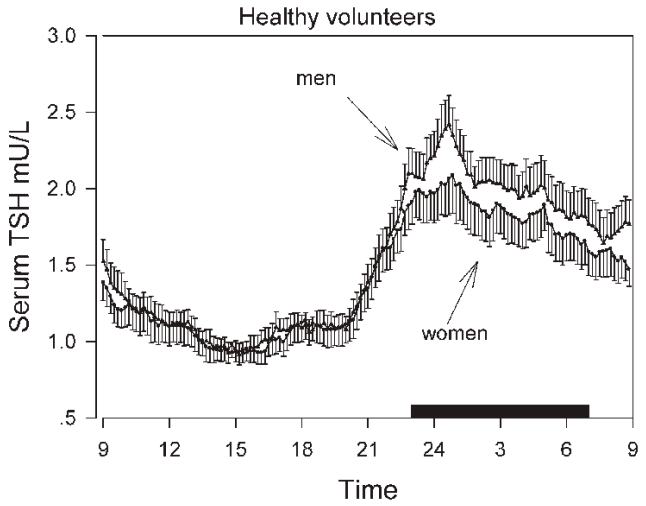
Test	Results	Units	Biological Reference

Clinical Significance:

Thyroid Stimulating Hormone (TSH), also called Thyrotropin is a hormone secreted into the blood by the Pituitary gland (a gland present in the brain). It signals the thyroid gland to make and release the thyroid hormones (T3 & T4) into the blood.
High TSH level indicates that the thyroid gland is not making enough thyroid hormone (primary hypothyroidism). Low TSH level usually indicates that the thyroid is producing too much thyroid hormone (hyperthyroidism).



Factors influencing TSH levels

- **TSH level** shows a significant decline after meal intake in comparison to fasting values. If the patient is taking any thyroid medication different times each day, they may sometimes be taking the thyroid hormone on an empty stomach, and sometimes with or after having food. This may have clinical implications in the diagnosis and management of hypothyroidism, especially Subclinical hypothyroidism.
- **Circadian Rhythm:** TSH levels follow a circadian variation, reaching peak levels between Morning 2 - 4 am and at a minimum between Evening 6-10 pm. The above graph considers a sleep window of 11:00 PM to 7:30 AM. The variation is of the order of 50%. There are studies which quote variations up to 70 % depending on when the sample is drawn during which time of the day. Hence time of sample collection during a day can significantly influence on the measured serum TSH concentrations.
- **Other Factors:** It is important to recognize that TSH is a labile hormone and is subject to non-thyroidal pituitary influences (glucocorticoids, somatostatin, dopamine etc.), stress, activity, that can disrupt the TSH/FT4 relationship. Genetics, Poisonous substances and radiation exposure, Inflammation of the thyroid gland, Deficiency or excess of iodine in the diet, Pregnancy, Certain medications – antidepressants, cholesterol lowering drugs, chemotherapy drugs, steroids, Thyroid cancer.

In **pregnant females** the reference range of TSH differs. Please refer the table below for the same:-

PREGNANCY	TSH REFERENCE RANGE (µIU/mL)
1st Trimester	0.100-2.500
2nd Trimester	0.200-3.00

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Test	Results	Units	Biological Reference
3rd Trimester	0.300-3.00		

References:

- Indian Journal of Endocrinology and Metabolism 18(5):p 705-707, Sep-Oct 2014.
- http://www.pnei-it.com/1/upload/thyrotropin_secretion_patterns_in_health_and_disease.pdf

Test	Results	Units	Biological Reference
Vitamin D, 25-Hydroxy Serum,Chemiluminescent Immunoassay	33.7	ng/mL	Deficient: < 20 Insufficient: 20-30 Sufficient: 30-100 Toxicity: > 100

Clinical Significance:

For the diagnosis of vitamin D deficiency, it is recommended that there be a clinical correlation with serum 25(OH)vitamin D, calcium, parathyroid hormone, and alkaline phosphatase.
While monitoring oral vitamin D therapy, serum 25(OH)vitamin D should be tested after 3 months of treatment. However, the required dosage of vitamin D supplements and time to achieve target vitamin D levels show seasonal and individual variability depending on age, body fat, sun exposure, physical activity, genetic factors (especially variable vitamin D receptor responses), associated liver or renal disease, malabsorption syndromes, and calcium or magnesium deficiency influencing the metabolism of vitamin D.

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MC-3278

Test	Results	Units	Biological Reference
CLINICAL PATHOLOGY			
Urine Routine Analysis Urine			
Urine, Physical Examination			
Volume Manual	20	mL	
Colour Manual	Pale Yellow		Pale yellow
Appearance RGB Sensor Technology	Clear		Clear
Urine, Chemical Examination			
pH Double Indicator Method	6.0		5 - 8
Specific Gravity Bromo Thymol Blue Indicato	**1.000**		1.001 - 1.035
Protein Protein Error of pH Indicator	Nil		Nil
Glucose Enzyme Method Glucose Oxidase-Peroxidase (GOD-POD)	Nil		Nil
Ketones Nitroprusside Method/Dipstick	Nil		Nil
Bilirubin Azo Coupling Method	Nil		Nil
Blood Peroxidase Activity	Negative		Negative
Urobilinogen Azo Coupling Method	Normal		Normal

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Test	Results	Units	Biological Reference
Leucocyte Esterase Granulocyte Esterase Method	Negative		Negative
Nitrites Griess Method	Negative		Negative

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Test	Results	Units	Biological Reference

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CONDITIONS OF LABORATORY TESTING & REPORTING

- Tests marked with NABL symbol are accredited by NABL vide certificate no MC-3278
- It is presumed that the test sample belongs to the patient named or identified in the test requisition form. Test results released pertain to the specimen submitted.
- Laboratory investigations are only a tool to facilitate arriving at a diagnosis and should be clinically correlated by the Referring Physician.
- All tests are performed and reported as per the turnaround time stated in the Orange Health Labs Directory of Services (DOS).
- Orange Health Labs confirms that all tests have been performed or assayed with the highest quality standards, clinical safety & technical integrity.
- All test results are dependent on the quality of the sample received by the Laboratory and the assay technology.
- Report delivery may be delayed due to unforeseen circumstances. Inconvenience is regretted.
- A requested test might not be performed if:
    - The specimen received is insufficient or inappropriate, or the specimen quality is unsatisfactory
    - Incorrect specimen type
    - Request for testing is withdrawn by the ordering doctor or patient
    - There is a discrepancy between the label on the specimen container and the name on the test requisition form
- Test results may show interlaboratory variations.
- Test results are not valid for medico-legal purposes.
- This is a computer-generated medical diagnostic report that has been validated by an Authorized Medical Practitioner/Doctor. The report does not need a physical signature.

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