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Mail Id : care@1mglabs.com
Phone No. : 0124-4166666
CIN : U85100HR2015PTC057368

REGISTERED OFFICE :
5th Floor, Tower- B,
The Presidency Building, 46/4,
Mehrauli Gurgaon Road, Sector 14
Gurgaon - 122 001

ISO 9001:2015

Name:	**Prateek Raj**	Order ID:	2344540
Age/Gender:	33 Y/Male	Registration Date:	19/Jan/2021 01:19PM
Patient ID:	032101190059	Collection Date:	19/Jan/2021 11:26AM
Barcode ID:	A3002975	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Whole Blood	Report Date:	19/Jan/2021 04:01PM

HAEMATOLOGY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Complete Blood Count				
Hemoglobin	14.8	g/dL	13.0 - 17.0	Cyanide-free SLS-Hemoglobin
RBC	**4.44**	mili/cu.mm	4.5-5.5	DC Impedence Method
PCV	42.4	%	40 - 54	Calculated
MCV	95.5	fL	83 - 101	Calculated
MCH	**33.4**	pg	27 - 32	Calculated
MCHC	35.00	g/dL	32 - 35	Calculated
RDW-SD	**46.20**	fL	39 - 46	Electronic Impendance
RDW-CV	**11.40**	%	11.6 - 14.0	Calculated
Total Leucocyte Count	5.7	10^3/µl	4 - 10	Flowcytometery/Microscopic
Differential Leucocyte Count				
Neutrophils	46	%	40 - 80	Flowcytometery/Microscopic
Lymphocytes	**42**	%	20 - 40	Flowcytometery/Microscopic
Monocytes	6	%	2 - 10	Flowcytometery/Microscopic
Eosinophils	5	%	1 - 6	Flowcytometery/Microscopic
Basophils	1	%	0 - 2	Flowcytometery/Microscopic
Immature Granulocyte Count	-	%		Flowcytometery/Microscopic
Absolute Leucocyte Count				
Absolute Neutrophil Count	2.62	10^3/µl	2.0 - 7.0	Calculated
Absolute Lymphocyte Count	2.39	10^3/µl	1.0 - 3.0	Calculated
Absolute Monocyte Count	0.34	10^3/µl	0.2 - 1.0	Calculated
Absolute Eosinophil Count	0.28	10^3/µl	0.02 - 0.50	Calculated
Absolute Basophil Count	0	10^3/µl	0.0 - 0.10	Calculated
Absolute Immature Granulocyte Count	-	10^3/µl		Calculated
Platelet Count	216	10^3/µl	150 - 410	Microscopic
MPV	10.8	fL		Calculated
PDW	18.40	fL		Calculated

Kindly correlate clinically

Dr. Naziya B Maner
DCP, DNB (Pathology)

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Barcode ID:	A3002975	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	HEM2	Report Date:	19/Jan/2021 05:39PM

HAEMATOLOGY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Erythrocyte Sedimentation Rate	**18**	mm/hour	<=10	Modified Westergren at 18°C

ESR measurement by the conventional method of Westergren, suggested by the International Committee for Standardization in Hematology as the standard procedure, provides an index of progress of the disease and is widely used in clinical practice as an indicator of inflammation, infection, trauma, or malignant diseases. ESR is specifically indicated for certain conditions: to monitor rheumatoid arthritis, tuberculosis, and systemic lupus erythematosis; and to diagnose and monitor giant cell arteritis and polymyalgia rheumatica. An elevated ESR may also be associated with many other conditions, including autoimmune disease, anemia, infection, and malignancy. Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors, In polycythemia, the mass of the red blood cells increases which cause the decrease of ESR. In Anemia, the mass of the red cells decreases which cause the increase of ESR. In other words, Erythrocyte Sedimentation Rate is indirectly proportional to ratio between mass of the red cells and plasma.The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, a1-antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
Technical Issues: Elevation in room temperature also affects the Erythrocyte Sedimentation Rate. Moving tube in sloping position, length and calibre of the tube also affect Erythrocyte Sedimentation Rate.
Drugs that may cause increase ESR levels include: dextran, methyldopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

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SampleType:	Whole Blood	Report Date:	19/Jan/2021 04:01PM

HAEMATOLOGY

Comprehensive Full Body Check

Peripheral Smear Examination

RBC- Predominantly normocytic normochromic.

TLC - Within normal limits

PLATELETS - Adequate on the smear.

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Patient ID:	032101190059	Collection Date:	19/Jan/2021 11:26AM
Barcode ID:	A3002976	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Plasma	Report Date:	19/Jan/2021 03:29PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Microalbumin/Creatinine Ratio.				
Microalbumin	1.00	mg/L	< 20	Turbidimetric
Urinary Creatinine	0.57	g/L	-	Enzymatic
Microalbumin/Creatinine Ratio	1.75	ug/mg	Normal<30 Microalbuminia 30-300 Clinical albuminuria>300	Calculated
Glucose - Fasting Blood	93	mg/dl	70-105	Hexokinase/G-6-PDH

American Diabetes associations reference range,

Normal	<100 mg/dl
Impaired Fasting	100-125 mg/dl
Diabetes	>=126 mg/dl

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Referred By:	Self	Report Status:	Final
SampleType:	Whole Blood	Report Date:	19/Jan/2021 04:18PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Glycosylated Hemoglobin (HbA1c)	4.9	%	4 - 6	HPLC - Cation Exchange

As per American Diabetes Association (ADA)

Reference Group	HbA1c in %
Non diabetic adults >=18 years	<5.7
At risk (Prediabetes)	5.7 - 6.4
Diagnosing Diabetes	>=6.5
Therapeutic goals for glycemic control	Age> 19 years Goal of therapy: <7.0 Action suggested: >8.0 Age <19 years Goal of therapy: <7.5

Note:

1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate.

Average Blood Glucose	93.93	mg/dl	Mentioned below	Calculated

Range for Average Blood Glucose:

Excellent Control	90 – 120 mg/dl
Good Control	121 – 150 mg/dl
Average	151 – 180 mg/dl
Action Suggested	181 – 210 mg/dl
Panic Value	>=211 mg/dl

Average Blood Glucose is a calculated parameter from HbA1c value and it indicates average glucose over the past 3 months.

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Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 04:18PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Iron Deficiency Profile				
Iron Serum	**180.0**	ug/dl	65-175	Ferrozine
Total Iron Binding Capacity (TIBC)	302.00	ug/dl	250 - 400	Caculated
Transferrin	**198.6**	mg/dl	200 - 360	Calculated
Transferrin Saturation	**59.60**	%	16 - 50	Calculated

Serum iron measures the amount of ferric iron (Fe3+) bound mainly to serum transferrin but does not include the divalent iron contained in serum as hemoglobin. Serum iron concentration is decreased in people with iron-deficiency anemia and chronic inflammatory disorders. Elevated concentrations of serum iron occur in iron-loading disorders such as hemochromatosis. Serum iron alone is unreliable due to considerable physiologic diurnal variation in the results with highest values in the morning and lowest values in the evening as well as variation in response to iron therapy. Therefore, serum iron results should always be interpreted in the context of other studies.

TIBC is a measurement of serum transferrin after saturation of all available binding sites with iron. TIBC quantitatively measures serum transferrin and can be useful in diagnosis of iron deficiency anemia, iron overload and chronic inflammatory disorders. Increased levels of TIBC suggest that total iron body stores are low, increased concentrations may be a sign of iron deficiency anemia, polycythemia vera, and may occur during the third trimester of pregnancy. Decreased levels of TIBC may indicate anemia of chronic disease such as hemolytic anemia, hemochromatosis, chronic liver disease, hypoproteinemia, malnutrition, pernicious anemia, and sickle cell anemia.

Transferrin, a β-globulin, synthesized in liver, is the principal protein responsible for iron transport. Transferrin transports ferric ions from the iron stores of intracellular or mucosal ferritin to bone marrow where erythrocyte precursors and other cells have transferrin surface receptors.Transferrin is responsible for 50% to 70% of the iron binding capacity of serum. Since other proteins may bind iron, transferrin concentration correlates with, but is not identical to TIBC.
Indications for transferrin quantitation include: screening for nutritional status; differential diagnosis of anemia; and monitoring anemia treatment. Iron deficiency and iron overload are best diagnosed using a combination of iron, transferrin, and ferritin determinations. Decreased levels of transferrin are associated with conditions involving chronic liver disease, malnutrition, nephrotic syndrome, protein-losing enteropathies, iron overload or hereditary hemochromatosis, and congenital atransferrinemia. Elevated levels of transferrin are associated with iron deficiency anemia where elevated transferrin often precedes the appearance of anemia by days to months. Transferrin levels are also elevated with increased estrogen due to pregnancy, oral contraceptives, etc.

Kindly correlate clinically

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Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 04:18PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Lipid Profile				
Cholesterol	**239**	mg/dl	Desirable <200, Borderline High 200 - 239, High >=240	Enzymatic
Triglycerides	**266**	mg/dl	Normal: <150, Borderline: 150 - 199, High:200-499, Very High>=500	GPO-POD(Enzymatic)
HDL Cholesterol	**35**	mg/dl	45 - 65	Accelerator Selective Detergent
LDL Cholesterol	**151**	mg/dl	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Liquid Selective Detergent
VLDL Cholesterol	**53**	mg/dl	10 - 30	Calculated
Cholesterol : HDL Cholesterol	6.8	Ratio		Calculated
HDL/LDL Ratio	0.23	Ratio		Calculated
LDL/HDL Ratio	4.31	Ratio		Calculated
Non-HDL Cholesterol	**204.00**	mg/dl	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219, Very High: >= 220	Calculated

In all adults (>=20 years of age), a fasting lipoprotein profile should be obtained at least every 5 years. The measurement and monitoring of atherogenic cholesterol levels remain an important part of a comprehensive ASCVD prevention strategy. An elevated level of cholesterol carried by circulating apolipoprotein B-containing lipoproteins (non–high-density lipoprotein cholesterol and low-density lipoprotein cholesterol [LDL-C], termed atherogenic cholesterol) is a root cause of atherosclerosis, the key underlying process contributing to most clinical atherosclerotic cardiovascular disease (ASCVD) events.

Reducing elevated levels of atherogenic cholesterol will lower ASCVD risk in proportion to the extent that atherogenic cholesterol is reduced. This benefit is presumed to result from atherogenic cholesterol lowering through multiple modalities, including lifestyle and drug therapies.

Atherosclerosis is a process that often begins early in life and progresses for decades before resulting a clinical ASCVD event. Therefore, both intermediate-term and long-term or lifetime risk should be considered when assessing the potential benefits and hazards of risk-reduction therapies.

Nonlipid ASCVD risk factors should also be managed appropriately, particularly high blood pressure, cigarette smoking, and diabetes mellitus.

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Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 04:18PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Liver Function Test				
Bilirubin-Total	1.0	mg/dl	0.2 - 1.2	Diazonium salt
Bilirubin-Direct	0.3	mg/dl	0 - 0.5	Diazo
Bilirubin-Indirect	0.7	mg/dl	0 - 0.8	Calculated
Protein, Total	7.6	g/dl	6.4 - 8.3	Biuret, End Point
Albumin	4.5	g//dl	3.5-5.2	Bromcresol Green
Globulin	3.1	g/dl	1.8 - 3.6	Calculated
A/G Ratio	1.4	Ratio		Calculated
Aspartate Aminotransferase (SGOT)	24	U/L	0 - 34	NADH (Without P-5-P)
Alanine Transaminase (SGPT)	27	U/L	0 - 55	NADH (Without P-5-P)
SGOT/SGPT	0.89	Ratio		Calculated
Alkaline Phosphatase	106	U/L	40-150	Para-Nitrophenyl Phosphate
Gamma Glutamyltransferase (GGT)	36	U/L	12-64	L-G-G-3-C-4-N Substrate

LFTS are based upon measurements of substances released from damaged hepatic cells into the blood that gives idea of the Existence, Extent and Type of Liver damage.
- Acute Hepatocellular damage: ALT & AST levels are sensitive index of hepatocellular damage
- Obstruction to the biliary tract,Cholestasis and blockage of bile flow:
1) Serum Total Bilirubin concentration 2) Serum Alkaline Phosphatase (ALP) activity 3) Gamma Glutamyl Transpeptidase (GGTP) 4) 5`-Nucleotidase
- Chronic liver disease: Serum Albumin concentration
Bilirubin results from the enzymatic breakdown of heme. Jaundice is a yellowish discoloration of the skin and mucous membranes caused by hyperbilirubinemia.
Pre-hepatic or hemolytic jaundice - Abnormal red cells, antibodies,drugs and toxins,Hemoglobinopathies, Gilbert's syndrome, Crigler-Najjar syndrome
Hepatic or Hepatocellular jaundice-Viral hepatitis,toxic hepatitis, intrahepatic cholestasis
Post-hepatic jaundice -Extrahepatic cholestasis, gallstones, tumors of the bile duct, carcinoma of pancreas
In viral hepatitis and other forms of liver disease associated with acute hepatic necrosis, serum AST and ALT concentrations are elevated even before the clinical signs and symptoms of disease appear. ALT is the more liver-specific enzyme and elevations of ALT activity persist longer than AST activity. Peak values of aminotransferase activity occur between the seventh and twelfth days. Activities then gradually decrease, reaching normal activities by the third to fifth week. Peak activities bear no relationship to prognosis and may fall with worsening of the patient's condition.
Aminotransferase activities observed in cirrhosis vary with the status of the cirrhotic process and range from the upper reference limit to four to five times higher, with an AST/ALT ratio greater than 1. The ratio's elevation can reflect the grade of fibrosis in these patients. Slight or moderate elevations of both AST and ALT activities have been observed after administration of various medications and chronic hepatic injury such as (1) hemochromatosis, (2) Wilson disease, (3) autoimmune hepatitis, (4) primary biliary cirrhosis, (5) sclerosing cholangitis, and (6) a1-antitrypsin deficiency. AST activity also is increased in acute myocardial infarction, progressive muscular dystrophy and dermatomyositis, reaching concentrations up to eight times the upper reference limit.Slight to moderate AST elevations are noted in hemolytic disease.
GGT is a sensitive indicator of the presence of hepatobiliary disease, being elevated in most subjects with liver disease regardless of cause. Increased concentrations of the enzyme are also found in serum of subjects receiving anticonvulsant drugs, such as phenytoin and phenobarbital.

Kindly correlate clinically

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Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 04:18PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Sodium	**132**	mmol/L	136 - 145	Indirect ISE

Kindly correlate clinically

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Patient ID:	032101190059	Collection Date:	19/Jan/2021 11:26AM
Barcode ID:	A3002977	Sample Receive Date:	19/Jan/2021 02:50PM
Referred By:	Self	Report Status:	Final
SampleType:	Urine	Report Date:	19/Jan/2021 03:29PM

BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Urine Sodium	47	mmol/L	40 - 220	Indirect ISE
Urine Potassium	35.30	mmol/L	25 - 125	Indirect ISE
Urine Chloride	**77.00**	mmol/L	100 - 250	Indirect ISE

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BIOCHEMISTRY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Amylase				
Amylase	49	U/L	25-125	CMPG3 Substrate
Chloride	99	mmol/L	98 - 107	Indirect ISE
Kidney Panel				
Blood Urea Nitrogen	**8.00**	mg/dl	8.9 - 20.6	Urease
Creatinine	0.82	mg/dl	0.72-1.25	Kinetic Alkaline Picrate
BUN/Creatinine Ratio	9.8	Ratio		Calculated
Calcium	8.9	mg/dl	8.4 - 10.2	Arsenazo
Uric Acid	**7.4**	mg/dl	3.5 - 7.2	Uricase

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Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 06:02PM

Immunology

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Thyroid Profile				
T3, Total	0.93	ng/ml	0.58 - 1.59	CMIA
T4, Total	7.2	µg/dl	4.87 - 11.72	CMIA
Thyroid Stimulating Hormone - ULTRA	**11.22**	uIU/ml	0.35 – 4.94	CMIA

Thyroid dysfunction is common in the general population and Laboratory tests are essential for the accurate diagnosis and cost-effective monitoring of thyroid dysfunction. TSH is now firmly established as the first-line thyroid function test to assess thyroid status for most clinical conditions. Interpretation of the results of thyroid function tests is facilitated by an understanding of thyroid hormone physiology, especially the normal inverse relationship between free $T_4$and TSH concentrations.Changes in thyroid status are normally associated with concordant changes in T3,T4 and TSH concentrations (e.g. raised T4 and T3 with suppressed TSH in thyrotoxicosis; low T4 and T3 with elevated TSH in hypothyroidism). An abnormal TSH requires further investigation, including measurement of free T_4. In most clinical situations involving discordant FT4 and TSH results, the TSH test usually yields the most diagnostically reliable result, provided that the patient is not receiving medications that directly inhibit TSH secretion, and there are no conditions affecting the pituitary-thyroid axis.. Using TSH as a single criterion has been shown to accurately classify the thyroid state of a patient in over 95% of cases. Non-thyroidal illness (NTI), pituitary disease and various drugs can all affect the axis and cause discrepancies between TSH levels, thyroid hormone levels and the clinical state. Measurement of the TSH level is indicated for patients with symptoms suggestive of thyroid dysfunction, reduced bone mineral density, dyslipidaemia, depression, or atrial fibrillation.

Total T4 measures the total amount of thyroxine circulating in the bloodstream. Indications:Used to make diagnosis of underactive or overactive thyroid when TSH is abnormal • Used with TSH for monitoring patients with Graves' disease • Newborn screening test for hypothyroidism • Fairly accurate in patients with no protein abnormalities and not pregnant Free T4 measures the available, unbound amount of thyroxine in the bloodstream.

Free T4 is critical for evaluating patients with hypothalamic-pituitary disease. It is also useful for evaluating the response to levothyroxine in cases of poor compliance and in the first months of treating patients with chronic, severe hypothyroidism.

The total T3 test measures the total amount of triiodothyronine circulating in the bloodstream. Free T3 measures the free, unbound levels of the hormone triiodothyronine available for use by the body.Total T3 measurements, however, should be performedIn patients suspected of having T3 thyrotoxicosis and in patients taking drugs that inhibit the peripheral conversion of T4 to T3 (such as dexamethasone, propranolol, propylthiouracil, amiodarone, and iodine-containing contrast media)

Maternal hypothyroidism causes adverse effects on fetal psychomotor development, highlighting the significance of evaluating thyroid function during pregnancy.Tests should be performed pre-pregnancy or in the first trimester with TSH tests that can detect mild thyroid failure. During pregnancy, the total levels of T3 and T4 are high because of increased TBG, and free T4 levels may slightly increase during the first trimester but will subsequently decline in the second and third trimesters.

In addition to the pre-analytical factors, potential analytical factors that interfere with the thyroid function tests assays such as heterophilic antibodies and autoantibodies, may lead to discordant thyroid function test results. The optimal use of thyroid function tests should be patient-specific and depends on the patient's specific thyroid disease, the stage of the disease and co-existing medical conditions. Results should be interpreted in the appropriate clinical context of the individual patient with good communication between clinicians and the requesting test laboratory.

Kindly correlate clinically

Dr. Naziya B Maner
DCP, DNB (Pathology)

Name:	**Prateek Raj**	Order ID:	2344540
Age/Gender:	33 Y/Male	Registration Date:	19/Jan/2021 01:19PM
Patient ID:	032101190059	Collection Date:	19/Jan/2021 11:26AM
Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 06:02PM

Immunology

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Vitamin D (25-OH)	**6.9**	ng/ml	Deficiency:< 20, Insufficiency:20-29, Sufficiency:30 - 100, Toxicity possible:> 100	CMIA

Vitamin D may be acquired by exposure of skin to sunlight or ingestion of foods containing vitamin D or its metabolites. Vitamin D levels are best determined by measurement of 25 Hydroxy Vitamin D, as it is the major circulating form in blood and has longer half life (2-3 weeks) than 1,25 Dihydroxy Vitamin D (5-8 hrs).
Decreased Vitamin D 25(OH)D are due to:
1. Inadequate exposure to sunlight
2. Inadequate dietary Vitamin D
3. Severe hepatocellular disease
4. Vitamin D Malabsorption
5. Drugs (anticonvulsants)
6. Nephrotic syndrome (increased loss)

Vitamin D deficiency results in abnormalities in calcium, phosphorus, and bone metabolism, producing rickets in children and osteomalacia in adults. Insufficient levels of Vitamin D leads to an increased risk of developing non-skeletal pathologies such as cardiovascular disease, cancer, diabetes, autoimmune diseases and infectious diseases.

Vitamin B12	< 83	pg/ml	187 - 883	CMIA

Serum vitamin B-12 concentrations are measured to assess its deficiency in patients presenting with haematolological, neurological, and neuropsychiatric abnormalities.Early diagnosis of vitamin B12 deficiency is advisable because neurological symptoms may be irreversible and often occur before or without hematological manifestations.
A low intake of vitamin B12, malabsorption, pernicious anemia, gastrointestinal disorders and certain medicines should be considered in the diagnosis of vitamin B12 deficiency.
Most common cause of vitamin B12 deficiency is pernicious anemia, an autoimmune disease in which chronic atrophic gastritis results from antibodies to gastric parietal cells and Intrinsic Factor, directed against gastric parietal cell H+/K+ATPase. Pernicious anemia may also occur in children because of either failure of IF secretion or secretion of biologically inactive IF.
Laboratory evaluation of Vitamin B12 deficiency includes : measurement of serum vitamin B12 (cobalamin) concentrations, measurement of methylmalonic acid and homocysteine in patients with low normal vitamin B12 levels, and antibodies to intrinsic factor for the diagnosis of pernicious anemia. In patients with anemia, the peripheral blood smear should be examined for macrocytic red blood cells (MCV >100 fl) and hypersegmented neutrophils. Serum vitamin B12 concentrations commonly fall during pregnancy, but these patients do not exhibit hematologic evidence of deficiency.
High levels of intrinsic factor blocking antibodies may cause spuriously high values for vitamin B12 with some immunoassays. Testing for the presence of IF-blocking antibodies is recommended if vitamin B12 results do not support clinical impression. Serum concentrations of homocysteine and methylmalonic acid are elevated in functional vitamin B12 deficiency due to a decreased rate of metabolism.

Kindly correlate clinically

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Barcode ID:	A3002974	Sample Receive Date:	19/Jan/2021 02:44PM
Referred By:	Self	Report Status:	Final
SampleType:	Serum	Report Date:	19/Jan/2021 03:57PM

SEROLOGY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Hepatitis Bs (Surface) Antigen	NON REACTIVE		Non - Reactive	Immunochromatographic

Infection with HBV results in a wide spectrum of acute and chronic liver diseases that may lead to cirrhosis and hepatocellular carcinoma. Hepatitis B surface antigen (HBsAg), derived from the viral envelope, is the first antigen to appear following infection and can be detected serologically as an aid in the laboratory diagnosis of acute HBV infection. Rapid tests are qualitative tests based on immunochromatographic techniques for lateral association of monoclonal and polyclonal antibodies specific for HBsAg

Note: This is a screening test. If positive, further Confirmation by HBsAg Quantitative is advised

Rheumatoid Factor-Qualitative	NON REACTIVE	Non Reactive	Latex Agglutination

Rheumatoid Factor are autoantibodies directed against the Fc fragment of the human IgG.The formation of immune complex in the joint space leads to the activation of complement and destructive inflammation, causing rheumatoid arthritis.The determination of Rheumatoid Factor is most commonly used not only for the screening of rheumatoid arthritis but also assists in the prognosis of the disease and in the monitoring of therapeutic response.

Note: This is a screening test. If positive, further Confirmation by rheumatoid factor quantitative is advised.

C-Reactive Protein (Qualitative)	NON REACTIVE	Non-Reactive	Latex Agglutination

C-reactive protein (CRP) is an acute-phase protein synthesized in the liver that serves as an early marker of inflammation or infection making it a useful marker for monitoring disease activity.Small increases in serum levels of CRP can often be detected before any clinical features become apparent.
During infectious or inflammatory disease states, CRP levels rise rapidly within the first 6 to 8 hours and peak reaches after 48 hours.
CRP levels are unaffected by anaemia, protein levels, red blood cell shape or patient age or sex.
However, in women, CRP concentrations tend to be higher late in pregnancy.
Concentrations in plasma usually rise dramatically after
(1) myocardial infarction (2) stress (3) trauma (4) infection (5) inflammation (6) surgery
(7) neoplastic proliferation.
Determination of CRP is clinically useful for
(1) screening for organic disease;
(2) assessment of the activity of inflammatory disease;
(3) detection of intercurrent infections in systemic lupus erythematosus (SLE), in leukemia, or after surgery (secondary rise in plasma concentration)
(4) management of neonatal septicemia and meningitis, when specimen collections for bacteriological investigations may be difficult.
The utility of measuring CRP as a risk factor for cardiovascular disease has led to the development of high-sensitivity CRP (hs-CRP) assays sensitive to 0.5–10 mg/L to detect lower levels of CRP.
CRP is a more sensitive and more reliable indicator of acute inflammatory processes than the erythrocyte sedimentation rate (ESR) and leukocyte count. Blood CRP levels rise more rapidly than ESR and after the disease has subsided, CRP values rapidly fall and reach within normal limits often days before ESR has returned to normal.

Note: This is a screening test. If positive, further Confirmation by CRP quantitative is advised.

Kindly correlate clinically

Dr. Naziya B Maner
DCP, DNB (Pathology)

LFS Healthcare Pvt Ltd (1mglabs)
LABORATORY : Unit No 1, Ground floor, Sub-divided Plot no. EL-15, Bhosari MIDC, Pune - 411 026
Website : www.1mglabs.com
Mail Id : care@1mglabs.com
Phone No. : 0124-4166666
CIN : U85100HR2015PTC057368

REGISTERED OFFICE :
5th Floor, Tower- B,
The Presidency Building, 46/4,
Mehrauli Gurgaon Road, Sector 14
Gurgaon - 122 001

ISO 9001:2015

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Age/Gender:	33 Y/Male	Registration Date:	19/Jan/2021 01:19PM
Patient ID:	032101190059	Collection Date:	19/Jan/2021 11:26AM
Barcode ID:	A3002977	Sample Receive Date:	19/Jan/2021 02:50PM
Referred By:	Self	Report Status:	Final
SampleType:	Urine	Report Date:	19/Jan/2021 04:17PM

CLINICAL PATHOLOGY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Urine Albumin	NEGATIVE		Negative	Acid Base Indicator

Kindly correlate clinically

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Barcode ID:	A3002977	Sample Receive Date:	19/Jan/2021 02:50PM
Referred By:	Self	Report Status:	Final
SampleType:	Urine	Report Date:	19/Jan/2021 04:17PM

CLINICAL PATHOLOGY

Comprehensive Full Body Check

Test Name	Result	Unit	Bio Ref.Interval	Method
Urine Routine & Microscopy				
Colour	Pale yellow		Pale Yellow	Manual
Specific gravity	1.015		1.005 - 1.030	pKa change
Appearance	CLEAR		Clear	Manual
Ph	6.00		5.0 - 8.5	Double Indicator
Urobilinogen	Normal		Normal	Azo Dye
Leucocytes	Negative		Negative	Microscopy
Urine protein	Negative		Negative	Acid Base Indicator
Ketones	Negative		Negative	Acetoacetic Acid
Nitrite	Negative		Negative	Sulbhanilamide Diazo
Urine Glucose	Negative		Negative	Benedict test
Bile pigments	Negative		Negative	Fouchet Reagent
Blood	Negative		Negative	Microscopy
Bile salts	Negative		Negative	Hays sulphur
Epithelial cells	1 - 2		0 - 5/HPF	Microscopy
Urine RBC	Absent		Nil	Microscopy
Pus cells	1 - 2		0 - 5/HPF	Microscopy
Casts	Absent		Nil	Microscopy
Crystals	Absent		Nil	Microscopy
Budding yeast cells	Absent		Nil	Microscopy
Bacteria	Absent		Nil	Microscopy

*** End Of Report ***

Kindly correlate clinically

Dr. Naziya B Maner
DCP, DNB (Pathology)

Why Do Preventive Test?

Reality Check

60%
deaths are due to preventable diseases

50%
are at risk of heart disease

59
The mean age of heart failure patients in India

68%
Urban Indians do not practice preventive healthcare

20%
Population suffers from one of the preventable diseases

50 million
people in India suffer from diabetes, making it the Diabetes Capital of the World.

Average cost per case of hospitalisation in urban India is **₹26,455**

How much does it cost you to avoid getting sick?

₹ 1 spent on prevention saves **₹ 133** on absenteeism cost and **₹6.62** in healthcare costs.

Prevent illness instead of treating them!

Comprehensive Full Body Check-up

(105 tests)

Contains tests of Liver, Kidney, Heart, Vitamins, Diabetes, etc.

Women Wellness Package

(35 tests)

Contains tests of thyroid, hormones, Iron studies etc.