



## LABORATORY REPORT - FINAL

Name : Mr K P SHRAVAN	Gender : Male	Lab ID : 50641000301
Age : 40 Years	Mob. No. : 9035707662	Pt. ID : 6186848
B2B :	Ref. By : VIKRAM KAMATH	Pt. Loc :
Reg Date and Time : 29-Jun-2025 06:37	Report Date and Time :	Ref Id1 :
Sample Received at : KA-Bannergatta Road		Ref Id2 :
Sample Collected at :		

## Abnormal Result(s) Summary

Test Name	Result Value	Unit	Reference Range
<b>Calcium</b>			
Adjusted Calcium	8.1	mg/dL	8.8 - 10.4
<b>Kidney Function Test</b>			
Chloride	109	mEq/L	98 - 107
<b>Lipid Profile</b>			
LDL Cholesterol (Direct)	32	mg/dL	<100 - Optimal 100-129 - near optimal 130 - 159 - Borderline high 160 -189 - High More than 190 - Very high
Active - B12	> 256.0	pmol/L	25.1 - 165.0

Abnormal Result(s) Summary End



MC-6072

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Reg Date and Time : 29-Jun-2025 06:37	Report Date and Time : 29-Jun-2025 11:11	Ref Id1 :
Sample Received at : KA-Bannerghatta Road		Ref Id2 :
Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
Homocysteine	7.02	µmol/L	6.6 - 14.8	

CMIA

Serum Coll. Time:29-Jun-2025 06:42

**INTERPRETATIONS:**

Useful as An aid for screening patients suspected of having an inherited disorder of methionine metabolism. Homocysteine concentrations >13 mcmol/L are considered abnormal in patients evaluated for suspected nutritional deficiencies (B12, folate) and inborn errors of metabolism. Measurement of methylmalonic acid (MMA) distinguishes between B12 (cobalamin) and folate deficiencies, as MMA is only elevated in B12 deficiency. Response to dietary treatment can be evaluated by monitoring plasma homocysteine concentrations over time. Homocysteine concentrations < or =10 mcmol/L are desirable when utilized for cardiovascular risk.

**CAUTIONS:**

A fasting specimen is recommended; however, nonfasting homocysteine concentrations produce slightly higher, but likely clinically insignificant changes. Other factors that may influence and increase plasma homocysteine include Age, Smoking, Poor diet/cofactor deficiencies, Chronic kidney disease/renal disease, Hypothyroidism

Medications that may increase homocysteine concentrations include methotrexate, azuridine, nitrous oxide, phenytoin, carbamazepine, oral contraceptive. S. adenocyl methionin is an antidepressant whose molecular form is similar to S adenosyl – homocysteine. These drug may interfere with the architect homocysteine assay.

Approved By: DR Prajwal A  
Released by: Neuberg Anand Reference Laboratory

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh,A-Abnormal,HC- High Critical,LC-Low Critical,C-Critical)

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**DR Prajwal A**Consultant Biochemist  
DLH 2018 0000588 KTK

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Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>Complete Blood Count</b>				
<u><b>HB AND INDICES</b></u>				
Haemoglobin	14.5	g/dL	13.5 - 16.5	
SLS				
PCV	44.80	%	39 - 54	
Calculated				
RBC (Electrical Impedance)	5.31	million/cmm	4.2 - 6.5	
<i>Sheath flow DC detection</i>				
Mean Corpuscular Volume	84.4	fL	75 - 95	
Calculated				
Mean Corpuscular Hemoglobin	27.3	pg	26 - 32	
Calculated				
Mean Corpuscular Hb Concentration	32.4	g/dL	30 - 35	
Calculated				
Red Cell Distribution Width (RDW)	13.30	%	11 - 16	
Calculated				
<u><b>TOTAL AND DIFFERENTIAL WBC COUNT (Flowcytometry)</b></u>				
Total WBC Count	7000	Cells/cmm	4000 - 11000	
<i>Flow Cytometry</i>				
Neutrophil	60.7	%	40 - 75	
<i>Flowcytometry</i>				
Lymphocyte	28.9	%	20 - 45	
<i>Flow Cytometry</i>				

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**Dr Pradeep Kumar V**

Pathologist

KMC NO. - 97304

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Eosinophil 2.1 % 1 - 6

*Flow Cytometry*

Monocytes 7.7 % 1 - 10

*Flow Cytometry*

Basophil 0.6 % 0 - 1

*Flow Cytometry*

**PLATELET COUNT (Optical)**

Platelet Count 335000 Cells/cmm 150000 - 450000  
*Sheath flow DC detection*

Mean Platelet Volume (MPV) 8.30 fL 6.5 - 12

Whole Blood EDTA Coll. Time:29-Jun-2025 06:42

Approved By: Dr Pradeep Kumar V  
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TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
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**LIPID PROFILE STANDARD**

Cholesterol <i>Enzymatic</i>	118	mg/dL	Desirable : <200 Borderline High : 200-239 High : >239
Triglyceride <i>Glycerol Phosphate Oxidase</i>	154	mg/dL	<150 mg/dL - Normal 150-199 mg/dL - Borderline high 200-499 mg/dL - High > 500 mg/dL - Very high
HDL Cholesterol <i>Accelerator Selective Detergent</i>	45.0	mg/dL	No risk - > 55 Moderate risk - 35 -55 High risk - < 35
LDL Cholesterol (Direct) <i>Enzymatic assay using selective clearance with a detergent</i>	L 32	mg/dL	<100 - Optimal 100-129 - near optimal 130 - 159 - Borderline high 160 -189 - High More than 190 - Very high
LDL CHOL/HDL CHOL RATIO <i>Calculated</i>	0.7		<3.5
Chol/HDL <i>Calculated</i>	2.6		<4.5

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**DR Prajwal A**

Consultant Biochemist  
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Sample Collected at :

NON HDL Cholesterol <i>Calculated</i>	73.0	mg/dL	CHD and CHD risk equivalent (10-year risk for CHD >20%) : <130 Multiple (2+) risk factors and 10-year risk =20% : < 160 0-1 risk factor : < 190
--	------	-------	---

Note: Ref range are only approximate guide lines. Risk assessment should take both LDLc and other risk factors to derive overall 10yrs risk of CAD.

**Free T4** 1.10 ng/dL Adults: 0.70 - 1.48  
*CMIA*

TSH 1.45 µIU/mL 0.35 - 4.94  
CMIA  
Serum Coll. Time:29-Jun-2025 06:42

## **C- Reactive Protein**

C- Reactive Protein                    0.20                    mg/dL            <0.5  
*Turbidimetric*

## **TOTAL CALCIUM**

Calcium	8.50	mg/dL	8.4 - 10.2
<i>Arsenazo III</i>			
Albumin	4.44	g/dL	3.5 - 5.0
<i>Colorimetric</i>			
Adjusted Calcium	L	8.1	mg/dL
<i>Calculated</i>			8.8 - 10.4

Approved By: DR Prajwal A

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*Dhruva*

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Reg Date and Time : 29-Jun-2025 06:37	Report Date and Time : 29-Jun-2025 11:35	Ref Id1 :
Sample Received at : KA-Bannerghatta Road		Ref Id2 :
Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>Glycated Haemoglobin Estimation</b>				
HbA1C <i>Capillary Electrophoresis</i>	5.5	%	</= 5.6 % - NORMAL 5.7 - 6.4 % - PREDIABETES >/= 6.5 % - DIABETES (By the ADA Recommendation - Jan 2012)	
Estimated Avg Glucose (3 Mths) <i>Calculated</i>	111.15	mg/dL	Not available	

**Interpretation :**

HbA1C level reflects the mean glucose concentration over previous 8-12 weeks and provides better indication of long term glycemic control.

Levels of HbA1C may be low as result of shortened RBC life span in case of hemolytic anemia.

Increased HbA1C values may be found in patients with polycythemia or post splenectomy patients.

Patients with Homozygous forms of rare variant Hb(CC,SS,EE,SC) HbA1c can not be quantitated as there is no HbA.

In such circumstances glycemic control can be monitored using plasma glucose levels or serum Fructosamine.

The A1c target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, risk of hypoglycemia or adverse consequences from hypoglycemia, patient motivation and adherence.

Approved By : Dr Pradeep Kumar V

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Pathologist

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Reg Date and Time : 29-Jun-2025 06:37	Report Date and Time : 29-Jun-2025 10:58	Ref Id1 :
Sample Received at : KA-Bannerghatta Road		Ref Id2 :
Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>LIVER FUNCTION TEST STANDARD</b>				
Cholesterol <i>Enzymatic</i>	118	mg/dL	Desirable : <200 Borderline High : 200-239 High : >239	
Proteins (Total) <i>Biuret</i>	6.84	g/dL	6.4 - 8.3	
Albumin <i>Colorimetric</i>	4.44	g/dL	3.5 - 5.0	
Globulin <i>Calculated</i>	2.40	g/dL	2-3	
Albumin / Globulin RATIO <i>Calculated</i>	1.85		1.5-2.5	
S.G.P.T. <i>IFCC</i>	30	U/L	0 - 55	
S.G.O.T. <i>IFCC</i>	27	U/L	5 - 34	
Alkaline Phosphatase <i>PNPP-AMP Buffer</i>	97.0	U/L	50 - 116	
Gamma Glutamyl Transferase <i>G-glutamyl-carboxy-nitroanilide</i>	15.0	U/L	<55	
Bilirubin Total <i>Diazonium Salt</i>	0.80	mg/dL	0.3 - 1.2	
Bilirubin-Direct <i>DIAZO REACTION</i>	0.31	mg/dL	0.0 - 0.5	

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DR Prajwal A

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Bilirubin Indirect 0.49 mg/dL 0-0.8

Calculated

Serum Coll. Time:29-Jun-2025 06:42

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Sample Received at : KA-Bannerghatta Road		Ref Id2 :
Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>Renal Function Test - Standard</b>				
Urea <i>Calculated</i>	31.24	mg/dL	<42.8	
Creatinine <i>Enzymatic</i>	1.11	mg/dL	0.6 - 1.3	
Uric Acid <i>Uricase-Peroxidase method</i>	5.0	mg/dL	3.7 - 7.7	
Sodium <i>ISE, Indirect</i>	140	mEq/L	136 - 145	
Potassium <i>ISE, Indirect</i>	4.36	mEq/L	3.5 - 5.1	
Chloride <i>ISE, Indirect</i>	H 109	mEq/L	98 - 107	
BUN <i>Urease</i>	14.56	mg/dL	< 20 mg/dL	
Serum	Coll. Time:29-Jun-2025 06:42			
Blood Glucose Levels <i>Hexokinase</i>	96.00	mg/dL	Fasting >/= 126 mg/dl - Diabetes. Random >/= 200 - Diabetes. (By the ADA Recommendations -Jan 2012)	
Plasma Fluoride F	Coll. Time:29-Jun-2025 06:42			

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Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>VITAMIN D</b>				
Vitamin D (Total)	35.00	ng/mL	Less than 20 ng/ml : Deficient 21 - 29 ng/ml : Borderline Insufficient > 30 ng/ml : Optimal > 100 ng/ml - Toxicity	
Serum	Coll. Time:29-Jun-2025 06:42			

25-OH-VitD plays a primary role in the maintenance of calcium homeostasis. It promotes intestinal calcium absorption and, in concert with PTH, skeletal calcium deposition, or less commonly, calcium mobilization. Modest 25-OH-VitD deficiency is common; in institutionalised elderly, its prevalence may be >50%. Although much less common, severe deficiency is not rare either. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, a particular problem in Northern latitudes during winter; inadequate intake; malabsorption (e.g. due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. Hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

**INTERPRETATION**

Levels <10 ng/mL may be associated with more severe abnormalities and can lead to inadequate mineralization of newly formed osteoid, resulting in rickets in children and osteomalacia in adults. In these individuals, serum calcium levels may be marginally low, and parathyroid hormone (PTH) and serum alkaline phosphatase are usually elevated. Definitive diagnosis rests on the typical radiographic findings or bone biopsy/histomorphometry.

Patients who present with hypercalcemia, hyperphosphatemia, and low PTH may suffer either from ectopic, unregulated conversion of 25-OH-VitD to 1,25 (OH)2-VitD, as can occur in granulomatous diseases, particularly sarcoidosis, or from nutritionally-induced hypervitaminosis D. Serum 1,25 (OH)2-VitD levels will be high in both groups, but only patients with hypervitaminosis D will have serum 25-OH-VitD concentrations of >80 ng/mL, typically >150 ng/mL.

Patients with CKD have an exceptionally high rate of severe vitamin D deficiency that is further exacerbated by the reduced ability to convert 25-OH-VitD into the active form, 1,25 (OH)2-VitD. Emerging evidence also suggests that the progression of CKD & many of the cardiovascular complications may be linked to hypovitaminosis D. Approximately half of Stage 2 and 3 CKD patients are nutritional vitamin D deficient (25-OH-VitD, less than 30 ng/mL), and this deficiency is more common among stage 4 CKD patients. Additionally, calcitriol (1,25 (OH)2-VitD) levels are also overtly low (less than 22 pg/mL) in CKD patients. Similarly, vast majority of dialysis patients are found to be deficient in nutritional vitamin D and have low calcitriol levels. Recent data suggest an elevated PTH is a poor indicator of deficiencies of nutritional vitamin D and calcitriol in CKD patients. CAUTIONS Long term use of anticonvulsant medications may result in vitamin D deficiency that could lead to bone disease; the anticonvulsants most implicated are phenytoin, phenobarbital, carbamazepine, and valproic acid.

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MC-6072

**LABORATORY REPORT - FINAL**



Name : Mr K P SHRAVAN	Gender : Male	Lab ID : 50641000301
Age : 40 Years	Mob. No. : 9035707662	Pt. ID : 6186848
B2B :	Ref. By : VIKRAM KAMATH	Pt. Loc :
Reg Date and Time : 29-Jun-2025 06:37	Report Date and Time : 29-Jun-2025 12:22	Ref Id1 :
Sample Received at : KA-Bannerghatta Road		Ref Id2 :
Sample Collected at :		

TEST	RESULTS	UNIT	BIOLOGICAL REF RANGE	REMARKS
<b>Active - B12 ( Holotranscobalamin)</b>				

**Active - B12** H > 256.0 pmol/L 25.1 - 165.0

CMIA

Serum Coll. Time:29-Jun-2025 06:42

Note:  
Active B12 test measures the amount of B12 bound to Holo Transcobalamin whereas the serum Vit B12 measure both Transcobalamin (TC) and Haptocorrin (HC) fractions as total Vit B12. It is more sensitive. If the serum vitamin B12 level is < 300 pg/mL, the levels of Active Vit B12 alone or in combination with serum total Vit B12 levels is/are useful in unmasking the deficiency state. Holo TC level of < 32 pmol/L indicates Vit B12 deficiency.

Measurement of Active Vit B12 is found to be more sensitive in detecting Vit B12 deficiency.

Holo Transcobalamin level of < 32 pmol/L has been suggested as cut off to identify the Vit B12 deficiency. Active Vitamin B12 levels will remain unchanged in pregnancy.

High titres of Intrinsic factor blocking auto antibodies (IF Ab) can lead to spuriously normal or high Vitamin B12 values.

Ref: Tietz Textbook of Clinical Chemistry and Molecular Diagnostics;6th Edition; P: 669-674.

Approved By: DR Prajwal A  
Released by: Neuberg Anand Reference Laboratory

----- End Of Report -----

# For test performed on specimens received or collected from non-NARL locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request and such verification has been carried out at the point generation of the said specimen by the sender. NARL will be responsible Only for the analytical part of test carried out. All other responsibility will be of referring Laboratory.

Note:(LL-VeryLow,L-Low,H-High,HH-VeryHigh,A-Abnormal,HC- High Critical,LC-Low Critical,C-Critical)

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**DR Prajwal A**

Consultant Biochemist  
DLH 2018 0000588 KTK

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**Neuberg Anand Reference Laboratory - A Unit of Neuberg Diagnostics Private Limited**

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