

Patient Name	: Mr.ROHIT SHARMA	Barcode	: E00738142
Age/Gender	: 36 Y O M O D/M	Sample Collected On	: 10/Jun/2021 09:18AM
Order Id	: 8894272	Sample Received On	: 10/Jun/2021 04:19PM
Referred By	:	Report Generated On	: 10/Jun/2021 08:22PM
Sample Type	: WHOLE BLOOD EDTA	Sample Temperature	: Maintained
Visit No.	: MED002.160699	Rate Type	: MEDLIFE LABS DELHI INTERFACE

DEPARTMENT OF HEMATOLOGY
MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
COMPLETE BLOOD COUNT (CBC) , WHOLE BLOOD EDTA			
HAEMOGLOBIN Spectrophotometer	15.7	g/dL	13-17
RBC COUNT Electrical Impedance	5.43	Million/cu.mm	4.5-5.5
PCV Electronic pulse & Calculation	46.50	%	40-50
MCV Calculated	86	fL	83-101
MCH Calculated	28.9	pg	27-32
MCHC Calculated	33.8	g/dL	31.5-34.5
R.D.W-CV Calculated	14.7	%	11.6-14
R.D.W-SD Calculated	46.00	fl	37.0 - 54.0
PLATELET COUNT Electrical impedance	158000	Cells/cu.mm	150000-410000
TOTAL WBC COUNT Electrical Impedance	7,400	Cells/cu.mm	4000-10000
DIFFERENTIAL LEUCOCYTIC COUNT (DLC) Electrical Impedance			
NEUTROPHILS %	40.0	%	40-80
LYMPHOCYTES %	46.2	%	20-40
EOSINOPHILS %	6.0	%	1-6
MONOCYTES %	5.8	%	2-10
BASOPHILS %	2.0	%	0-2
ABSOLUTE LEUCOCYTE COUNT Calculated			
NEUTROPHILS	2960	Cells/cu.mm	2000-7000
LYMPHOCYTES	3418.8	Cells/cu.mm	1000-3000
EOSINOPHILS	444	Cells/cu.mm	20-500
MONOCYTES	429.2	Cells/cu.mm	200-1000
BASOPHILS	148	Cells/cu.mm	0-100

Saakshi
DR. SAAKSHI MITTAL
MD PATHOLOGY
CONSULTANT PATHOLOGIST



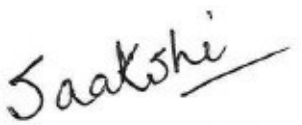
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ERYTHROCYTE SEDIMENTATION RATE (ESR) , WHOLE BLOOD EDTA

ESR Westergren	15	mm at the end of 1 hour	0-15
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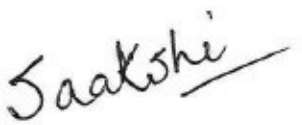
PERIPHERAL SMEAR , WHOLE BLOOD EDTA**PERIPHERAL SMEAR**

RBCs ARE NORMOCYTIC NORMOCHROMIC.

TLC IS NORMAL , DLC SHOWS LYMPHOCYTOSIS. NO IMMATURE CELLS SEEN.

PLATELET ARE ADEQUATE.

NO HEMOPARASITES SEEN


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Referred By	:	Report Generated On	: 10/Jun/2021 07:06PM
Sample Type	: NAF PLASMA	Sample Temperature	: Maintained
Visit No.	: MED002.160699	Rate Type	: MEDLIFE LABS DELHI INTERFACE

DEPARTMENT OF BIOCHEMISTRY

MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
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GLUCOSE, FASTING, NAF PLASMA

GLUCOSE, FASTING GOD - POD	88	mg/dL	70 - 100
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Americal Diabetes Association (ADA) guideliness Blood Sugar Levels for diagnosing Diabetes and Prediabetes

Condition	Fasting Blood Glucose
Normal	<100
Pre-Diabetes	100-125
Diabetes	More than 126*

* A confirmatory test of either a fasting blood sugar, OGTT or random blood sugar with symptoms must be done on another day (Except in the case of unequivocal hyperglycemia with metabloic decompensation)

*Atleast 8-10 hours fasting is mandatory for Fasting Blood Glucose/Sugar. If not, values might fluctuate.

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DEPARTMENT OF BIOCHEMISTRY
MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
HbA1c; GLYCOSYLATED HEMOGLOBIN , WHOLE BLOOD EDTA			
HbA1c, GLYCATED HEMOGLOBIN HPLC	5.5	%	
ESTIMATED AVERAGE GLUCOSE (eAG) Calculated	111	mg/dL	

General Information's
REFERENCE GROUP

NON DIABETIC ADULTS >18 YEARS

AT RISK (PREDIABETES)

DIAGNOSING DIABETES

DIABETICS

EXCELLENT CONTROL

FAIR TO GOOD CONTROL

UNSATISFACTORY CONTROL

POOR CONTROL

HbA1c IN %

<5.7

5.7 – 6.4

>= 6.5

6 – 7

7 – 8

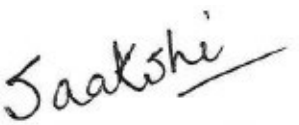
8 – 10

>10

Reference Range as per American Diabetes Association (ADA)

Note: Dietary preparation or fasting is not required.

1. A1C test should be performed at least two times a year in patients who are meeting treatment goals (and who have stable glycemic control).
2. Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. When mean annual HbA1c is <1.1 times ULN (upper limit of normal), renal and retinal complications are rare, but complications occur in >70% of cases when HbA1c is >1.7 times ULN.
3. Falsely low HbA1c (below 4%) may be observed in patients with clinical conditions that shorten erythrocyte life span or decrease mean erythrocyte age. HbA1c may not accurately reflect glycemic control when clinical conditions that affect erythrocyte survival are present. Fructosamine may be used as an alternate measurement of glycemic control.
(Note: Average Blood Glucose value is calculated from HbA1c value and it indicates Average Blood Sugar level over past three months.)
Method :Derived from HbA1c values


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MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
LIPID PROFILE (7 PARAMETERS) , SERUM			
TOTAL CHOLESTEROL CHE/CHO/POD	179	mg/dL	Desirable:<200 Borderline High:200-239 High:>240
TRIGLYCERIDES Enzymatic	259	mg/dL	Normal:<150 Borderline High:151-199 High:200-499 Very High:>500
HDL CHOLESTEROL CHE/CHO/POD	39	mg/dL	High (Desirable):>60 Acceptable:40-59 Low:<39
NON-HDL CHOLESTEROL Calculated	140.00	mg/dl	Optimal:<130 Near&Above optimal: 131-159 Borderline High:160-189 High: 190-219 Very high: >220
LDL CHOLESTEROL Calculated	88.2	mg/dL	Optimal:<100 Near Optimal:101-129 Borderline High:130-159 High:160-189 Very High:>190
VLDL CHOLESTEROL Calculated	51.8	mg/dL	<30
CHOL / HDL RATIO Calculated	4.59	Ratio	0-4.97

General Information's: LDL & VLDL are calculated values by using Friedewald's equation. The value of LDL and VLDL will not be reported in the following circumstances as the value should not be considered/used in such cases as per the limitation of Friedewald's equation. A) When chylomicrons are present, B) When plasma/serum triglyceride (TGL) concentration exceeds 400 mg/dl, C) In patients with dysbetalipoproteinemia (type III lipoproteinemia) Also, If TGL value exceeds 400 mg/dl it is suggested to go for Direct LDL method for getting an actual value and for further evaluation. *REFERENCE RANGES AS PER NCEP ATP III GUIDELINES: *10-12 hours fasting is mandatory for lipid parameters. If not, values might fluctuate.

Saakshi
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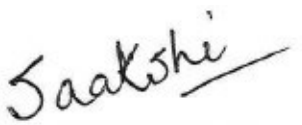
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Test Name	Result	Unit	Bio. Ref. Interval
RENAL PROFILE (6 PARAMETERS) , SERUM			
UREA Urease	30.00	mg/dL	19.0-43.0
BLOOD UREA NITROGEN Calculated	14.0	mg/dL	9.0 - 20.0
CREATININE Amidohydrolase	0.90	mg/dL	0.66 - 1.25
UREA/CREATININE RATIO Calculated	33.33	Ratio	
BUN / CREATININE RATIO Calculated	15.56	Ratio	
URIC ACID Uricase	5.70	mg/dL	3.5-8.5

General Information:

Preanalytical issues such as high-protein intake and increased muscle bulk may lead to elevated creatinine levels not representative of actual renal function in an individual. Likewise, serum creatinine as a marker of renal function is often unreliable in the those with decreased muscle bulk such as the elderly, amputees and is individuals affected by muscular dystrophy.


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Test Name	Result	Unit	Bio. Ref. Interval
LIVER FUNCTION TEST (11 PARAMETERS), SERUM			
BILIRUBIN-TOTAL Diazonium salt	0.90	mg/dL	0.20 - 1.20
BILIRUBIN-DIRECT Spectrophotometric	0.30	mg/dL	0.0-0.3
BILIRUBIN-INDIRECT Direct measure	0.60	mg/dL	0.0-1.10
ALKALINE PHOSPHATASE PNP	166.00	U/L	38-126
AST/SGOT UV with P-5-P	43.0	U/L	17-59
ALT/SGPT UV with P-5-P	50.0	U/L	<50.0
AST:ALT RATIO Calculated	0.86	Ratio	Upto 1.3
PROTEIN, TOTAL Biuret	7.90	g/dL	6.3-8.2
ALBUMIN Bromocresol Green	4.90	g/dL	3.5 - 5.0
GLOBULIN Calculated	3.00	g/dL	2.0-3.5
A/G RATIO Calculated	1.63		0.8-2.0

Genral Information:

High coffee consumption and heavy smoking were both associated with low total protein and albumin levels. High coffee consumption lowered serum AST levels, independently. Because smoking, coffee and alcohol drinking habits showed strong interactions among each other, the association of those habits and LFTs should be carefully analyzed and interpreted.

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MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
IRON PROFILE , SERUM			
IRON	112.0	µg/dL	49-181
Ferene			
TIBC - d	407	µg/dL	261-462
Dye Binding			
% OF SATURATION	27.52	%	14-50
Calculated			
UIBC - c	295.00	µg/dL	135 - 392
Calculated			

Transferrin is the primary plasma iron transport protein, which binds iron strongly at physiological pH. Transferrin is generally only 25% to 30% saturated with iron. The additional amount of iron that can be bound is the unsaturated iron-binding capacity (UIBC). Diurnal variation is seen in serum iron levels—normal values in midmorning, low values in midafternoon, very low values (approximately 10 µg/dL) near midnight.

TIBC measures the blood's capacity to bind iron with transferrin (TRF). Estrogens and oral contraceptives increase TIBC levels. Asparaginase, chloramphenicol, corticotropin, cortisone, and testosterone decrease the TIBC levels.

% saturation represents the amount of iron-binding sites that are occupied. Iron saturation is a better index of iron stores than serum iron alone. % saturation is decreased in iron deficiency anemia (usually <10% in established deficiency).

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Test Name	Result	Unit	Bio. Ref. Interval
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EGFR - ESTIMATED GLOMERULAR FILTRATION RATE , SERUM

CREATININE Amidohydrolase	0.90	mg/dL	0.66 - 1.25
EGFR - CREATININE AND GLOMERULAR FILTRATION RATE CKD-EPI FORMULA	109.49	mL/min/1.73m ²	

Stage e-GFR	Description
1 90+	Normal kidney function but urine findings or structural abnormalities or genetic trait point to kidney disease
2 60 to 89	Mildly reduced kidney function and other findings (as for stage 1) point to kidney disease
3A 45 to 59	Moderate reduced kidney function
3B 30 to 44	Moderate reduced kidney function
4 15 to 29	Severely reduced kidney function
5 <15 or on dialysis	Very severe or end stage kidney failure

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DEPARTMENT OF IMMUNOLOGY

MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
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THYROID PROFILE (TOTAL T3, TOTAL T4, TSH) , SERUM

TRI-iodothyronine (T3, TOTAL) ECLIA	1.66	ng/mL	0.97-1.80
Thyroxine (T4, TOTAL) ECLIA	12.60	µg/dL	5.53-14.00
TSH ECLIA	3.220	µIU/mL	0.46-4.68

TSH is a glycoprotein hormone secreted by the anterior pituitary. TSH is a labile hormone & is secreted in a pulsatile manner throughout the day and is subject to several non-thyroidal pituitary influences. TSH levels are influenced by circadian rhythm, reaches peak level between 2 to 4 am and at its minimum between 6 to 10pm. hence time of the day significantly affects serum TSH concentrations.

Important note for the people with borderline TSH levels (4.0 to 10 mIU/L).

People with borderline TSH level while have no or mild to moderate sign & symptoms of thyroid issues, are considered to have **Sub-Clinical Hypothyroidism (SCH)**. Some time it could be a temporary fluctuation due to many reasons like age factor, circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies, and a retest (after 3 or 4 weeks) may be needed along with the test **Free T4** for further evaluation and confirmation.

For pregnant females	Bio Ref Range for TSH in uIU/ml (As per American Thyroid Association)
First trimester	0.1 - 2.5
Second trimester	0.2 – 3.0
Third trimester	0.3 – 3.0

References:

American Thyroid Association (ATA) & European Thyroid Association (ETA)

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DEPARTMENT OF IMMUNOLOGY

MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
VITAMIN D (25 OH)-TOTAL , SERUM			
VITAMIN D (25 - OH VITAMIN D) ECLIA	36.9	ng/mL	Deficient : < 20 Insufficient : 20 - 30 Sufficient : 30 - 100 Potential Toxicity : > 100

The assay measures both D2 (Ergocalciferol) and D3 (Cholecalciferol) metabolites of vitamin D. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1,25 Dihydroxy vitamin D (5-8 hrs). The reference ranges discussed in the preceding are related to total 25-OHD; as long as the combined total is 30 ng/mL or more, the patient has sufficient vitamin D Levels needed to prevent rickets and osteomalacia (15 ng/mL) are lower than those that dramatically suppress parathyroid hormone levels (20–30 ng/mL). In turn, those levels are lower than levels needed to optimize intestinal calcium absorption (34 ng/mL). Neuromuscular peak performance is associated with levels approximately 38 ng/mL.

Saakshi
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MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
VITAMIN B12 , SERUM			
VITAMIN B12 ECLIA	176	pg/ml	239-931

Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. A significant increase in RBC MCV may be an important indicator of vitamin B12 deficiency.

Patients taking vitamin B12 supplementation may have misleading results. A normal serum concentration of B12 does not rule out tissue deficiency of vitamin B12 . The most sensitive test for B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum B12 concentrations are normal.

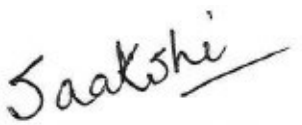
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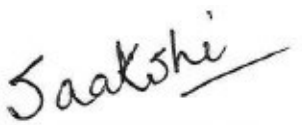
Test Name	Result	Unit	Bio. Ref. Interval
PROSTATIC SPECIFIC ANTIGEN (PSA TOTAL) , SERUM			
TOTAL PROSTATIC SPECIFIC ANTIGEN (tPSA) ECLIA	0.900	ng/mL	0.0-4.0


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DEPARTMENT OF SEROLOGY**MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)**

Test Name	Result	Unit	Bio. Ref. Interval
RHEUMATOID FACTOR (RA) -(LATEX AGGLUTINATION) , SERUM			
RHEUMATOID FACTOR (RA) LATEX AGGLUTINATION	NEGATIVE		NEGATIVE


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DEPARTMENT OF CLINICAL PATHOLOGY
MASTER CHECKUP WITH CANCER & ARTHRITIS SCREENING (MALE)

Test Name	Result	Unit	Bio. Ref. Interval
COMPLETE URINE EXAMINATION, URINE			
PHYSICAL EXAMINATION			
VOLUME	30.00	mL	
COLOUR	Pale Yellow		PALE YELLOW
Visual			
TRANSPARENCY	Clear		CLEAR
Visual			
pH	6.0		5-7.5
Dipstick			
SP. GRAVITY	1.020		1.002-1.030
Dipstick			
BIOCHEMICAL EXAMINATION			
Dipstick/Benedicts Test			
URINE PROTEIN	Negative		NEGATIVE
GLUCOSE	Negative		NEGATIVE
URINE BILIRUBIN	Negative		NEGATIVE
KETONES	Negative		NEGATIVE
UROBILINOGEN	Normal		NORMAL
BLOOD	Negative		NEGATIVE
NITRITE	Negative		NEGATIVE
MICROSCOPIC EXAMINATION			
PUS CELLS	2-4	/hpf	0-5
EPITHELIAL CELLS	1-2	/hpf	<10
RBC	Absent	/hpf	ABSENT
CASTS	Absent		ABSENT
CRYSTALS	Absent		ABSENT
BACTERIA	Absent		
YEAST	Absent		
PARASITES	Absent		
OTHERS	Nil		

*** End Of Report ***

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Saakshi
DR. SAAKSHI MITTAL
MD PATHOLOGY
CONSULTANT PATHOLOGIST



Medlife International Private Limited

Regd. Office: Room # 101A, Zubaida Complex, Exhibition Road, Patna, Bihar - 800 001
Lab Address: H.No. B-192, First Floor, Naraina Industrial Estate Phase-1, New Delhi-110028.
CIN: U24230BR2014PTC023149 | ☎ 7022000900 | ✉ labs@medlife.com | 🌐 labs.medlife.com