Patient NAME	: Ms.GITA RANI SINGH	Barcode NO	: 13133717
Age/Gender	: 57 Y/Female	Registration ON	: 09/Oct/2024
LabNo	: 012410090867	Sample Collected ON	: 09/Oct/2024
Referred BY	:Dr. S GUHA	Sample Received ON	: 09/Oct/2024
CLIENT CODE	:WBCL/NAPP/LIH	Report Generated ON	: 09/Oct/2024
Refer Lab/Hosp	:	Sample STATUS	: Final Approved
Lab Address	:AS 130, Block-H, R M Road, Kol: 157	Other Info	:

DEPARTMENT OF BIOCHEMISTRY

Test Name	Value	Unit	Bio Ref.Interval
Urea (Method:Urease - GLDH) (Sample:Serum)	24.0	mg/dL	17 - 43 New born :8.4-25.8 Infant:10.8-38.4

Please clinically correlate. Partial reproduction of test reports is strictly prohibited.
The reports are strictly for the use of medical practitioners and are not medical diagnosis.

Comments:

1. Urea is synthesized in the liver as a by-product of the deamination of amino acids.
2. Urea is measured to monitor patients undergoing dialysis and evaluate renal and metabolic function.
3. Higher than normal levels of urea indicate problems with kidney function however levels are increased as a result of congestive heart failure, heart attack, shock, and dehydration.
4. Lower than normal levels are not usually of clinical significance, however, has been associated with pregnancy and liver disease.

Creatinine (Method:MODIFIED JAFFE) (Sample:Serum)	0.71	mg/dl	Male-0.67- 1.17 Female-0.51– 0.95 Neonate- 0.31- 0.98 Infants-0.16-0.39 Child- 0.26 – 0.77

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Comments:
Creatinine is a catabolic end product of creatine. The amount produced each day is related to muscle mass. Creatinine is freely filtered by the glomerulus,(small amounts are reabsorbed and secreted by renal tubules). Creatinine is measured for the assessment of kidney function(impaired renal perfusion, loss of functioning nephrons) and in monitoring renal dialysis. The method commonly used for estimating Creatinine makes use of Jaffe's reaction with an alkaline picrate reagent.

Dr Sanghamitra Mukherjee
Reg. No - WBMC 62049
M.B.B.S. M.D. (Pathology)
Consultant Pathologist
Approved By

Dr. Rinini Dastidar
Ph.D.Biochemistry (C.U.)
Senior Consultant Biochemist
Approved By

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Value	Unit	Bio Ref.Interval
Lipid Profile Basic			
Cholesterol Total (Method:CHOD POD) (Sample:Serum)	135	mg/dL	Desirable< 200 Borderline High-200-239 High- 240
Cholesterol HDL (Method:Enzymatic Immunoinhibition) (Sample:Serum)	42	mg/dL	Low-HDL Cholesterol <40 High HDL Cholesterol >60
Cholesterol VLDL (Method:Calculated) (Sample:Serum)	29	mg/dL	7 - 40
Cholesterol LDL (Method:Calculated) (Sample:Serum)	64	mg/dL	Optimal : < 100 Near optimal : 100-129 Borderline High : 130-159 High : 160-189 Very high : >= 190
Triglycerides (Method:GPO-POD) (Sample:Serum)	143	mg/dL	Normal: < 150 Borderline: 150-199 High: >200 Very High:>500
Cholesterol Total / HDL Ratio (Method:Calculated) (Sample:Serum)	3.2		0 - 4.0
Cholesterol LDL / HDL Ratio (Method:Calculated) (Sample:Serum)	1.5		0 - 3.5

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Note:
1. Measurements in the same patient can show physiological& analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL& LDL Cholesterol.
2. As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.
3. Low HDL levels are associated with increased risk forAtherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
4. NLA-2014identifies Non HDL Cholesterol(an indicator of all atherogeniclipoproteins such as LDL , VLDL, IDL, Lpa, Chylomicron remnants)along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non HDL.
5. Apolipoprotein B is an optional, secondary lipid target for treatment once LDL & Non HDL goals have been achieved.
6. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement.
7. For calculation of CHD risk, history of smoking, any medication for hypertension & current blood pressure levels are required.

Dr Sanghamitra Mukherjee
Reg. No - WBMC 62049
M.B.B.S. M.D. (Pathology)
Consultant Pathologist
Approved By

Dr. Rinini Dastidar
Ph.D.Biochemistry (C.U.)
Senior Consultant Biochemist
Approved By

MC-6206

Patient NAME	: Ms.GITA RANI SINGH	Barcode NO	: 13133717
Age/Gender	: 57 Y/Female	Registration ON	: 09/Oct/2024
LabNo	: 012410090867	Sample Collected ON	: 09/Oct/2024
Referred BY	:Dr. S GUHA	Sample Received ON	: 09/Oct/2024
CLIENT CODE	:WBCL/NAPP/LIH	Report Generated ON	: 09/Oct/2024
Refer Lab/Hosp	:	Sample STATUS	: Final Approved
Lab Address	:AS 130, Block-H, R M Road, Kol: 157	Other Info	:

DEPARTMENT OF CHROMATOGRAPHY

Test Name	Value	Unit	Bio Ref.Interval
Glycosylated Hemoglobin (HbA1c) (Method:HPLC) (Sample:EDTA Whole Blood)	**6.6**	%	Non-diabetic : 4 – 5.7 Pre-diabetic : 5.7 - 6.4 Diabetic : ≥ 6.5
Estimated Average Glucose (eAG) (Method:Calculated) (Sample:EDTA Whole Blood)	143	mg/dL	Excellent Control : 90-120 Good Control : 121-150 Average Control : 151-180 Action Suggested : 181-210 Panic Value : > 210

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Comments:

1. HbA1c is used for monitoring diabetic control. It reflects the estimated average glucose (eAG).
2. HbA1c has been endorsed by clinical groups & ADA (American Diabetes Association) guidelines 2017, for diagnosis of diabetes using a cut-off point of 6.5%.
3. Trends in HbA1c are a better indicator of diabetic control than a solitary test.
4. Reduced HbA1c levels may result due to Hemolysis, Hemoglobinopathies, Acute blood loss, Hypertriglyceridemia, Chronic hepatic disorder, Excessive diet control, Prolong high dose anti-diabetic drugs intake. In some cases, hemolytic anemia and hemorrhage may also cause of low HbA1c Value.
5. Elevated HbA1c levels may result due to Iron deficiency, Vit-B12 deficiency, Alcoholism, Uremia, Hyperbilirubinemia.
6. To estimate the eAG from the HbA1C value, the following equation is used: eAG (mg/dl) = 28.7 x HbA1c - 46.7
7. Interference of haemoglobinopathies in HbA1c estimation:
a. For HbF > 25%, an alternate platform (Fructosamine) is recommended for testing of HbA1c.
b. Homozygous haemoglobinopathy is detected, fructosamine is recommended for monitoring diabetic status.
8. In known diabetic patients, following values can be considered as a tool for monitoring the glycemic control. Excellent Control – 6 to 7 %, Fair to Good Control - 7 to 8 %, Unsatisfactory Control - 8 to 10 % and Poor Control - More than 10 %.

***Note**: Hemoglobin electrophoresis (HPLC method) is recommended for detecting haemoglobinopathy.*

Sample: O.S.S

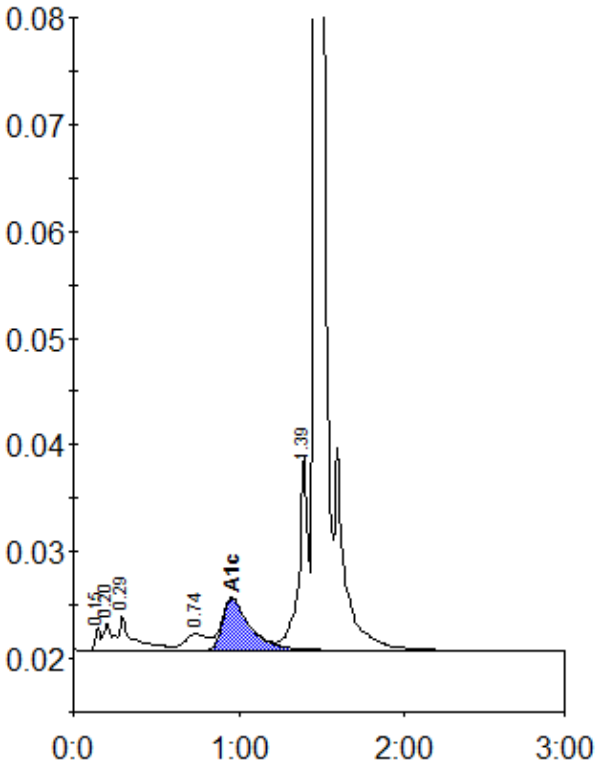
*** End Of Report ***

Dr. Rinini Dastidar
Ph.D.Biochemistry (C.U.)
Senior Consultant Biochemist
Approved By

Dr. Niranjan Mondal
Reg. No - WBMC 64023
MD (Biochemistry)
Consultant Biochemist
Approved By

Patient report

Bio-Rad	DATE: 09/10/2024
D-10	TIME: 18:36
S/N: #DJ8K412704	Software version: 4.30-2
Sample ID:	13133717
Injection date	09/10/2024 18:24
Injection #: 45	Method: HbA1c
Rack #: ---	Rack position: 5



Peak table - ID: 13133717

Peak	R.time	Height	Area	Area %
Unknown	0.15	2161	4523	0.4
A1a	0.20	2491	6992	0.6
A1b	0.29	3219	21232	1.9
LA1c/CHb-1	0.74	1525	15197	1.4
A1c	0.96	4823	55411	6.6
P3	1.39	18224	70486	6.4
A0	1.47	325527	927606	84.2
Total Area:	1101448			

Concentration:	%	mmol/mol
A1c	6.6	48