



PO No :PO1806014095-625



Name	: Ms.CHARU SINGH	Client Name	: TATA 1MG PUNE
Age/Gender	: 27/Female	Registration Date	: 07-Feb-24 11:39 AM
Patient ID	: MGP367993	Collection Date	: 07/Feb/2024 09:31AM
Barcode ID/Order ID	: D7436667 / 8899052	Sample Receive Date	: 07/Feb/2024 12:32PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: WHOLE BLOOD-EDTA	Report Date	: 07/Feb/2024 01:14PM

HAEMATOLOGY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glycosylated Hemoglobin (HbA1c)	5.4	%	4 - 5.6	HPLC (NGSP certified)
Estimated average glucose (eAG)	108.28	mg/dL		Calculated

Comment:

Interpretation: HbA1c%

≤5.6	Normal
5.7-6.4	At Risk For Diabetes
≥6.5	Diabetes

Adapted from American Diabetes Association.

Comments:

A 3 to 6 monthly monitoring is recommended in diabetics. People with diabetes should get the test done more often if their blood sugar stays too high or if their healthcare provider makes any change in the treatment plan. HbA1c concentration represent the integrated values for blood glucose over the preceding 8-12 weeks and is not affected by daily glucose fluctuation, exercise & recent food intake.

Please note, Glycemic goal should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness, and individual patient considerations.

Factors that interfere with HbA1c Measurement: Hemoglobin variants, elevated fetal hemoglobin (HbF) and chemically modified derivatives of hemoglobin (e.g. carbamylated Hb in patients with renal failure) can affect the accuracy of HbA1c measurements.

Factors that affect interpretation of HbA1c Measurement: Any condition that shortens erythrocyte survival or decrease mean erythrocyte age (e. g., recovery from acute blood loss, hemolytic anemia, HbSS, HbCC, and HbSC) will falsely lower HbA1c test results regardless of the assay method used. Iron deficiency anemia is associated with higher HbA1c.

Note: Presence of Hemoglobin variants and/or conditions that affect red cell turnover must be considered, particularly when the HbA1c result does not correlate with the patient's blood glucose levels.

- HPLC - High performance liquid chromatography

NABL certificate
and scope

This test has been performed at

TATA 1MG PUNE

Address: Teerth Business Center, Ground Floor,
Unit No 1, Sub-Divided Plot No EL-15, Bhosari
MIDC, Pune - 411026

A. Mandvekar

Dr. Aparna Mandvekar
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 2008/05/2160

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: EDTA	Report Date	: 07/Feb/2024 05:28PM

HAEMATOLOGY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Complete Blood Count				
Hemoglobin	12.7	g/dL	12.0 - 15.0	Spectrophotometry:Cynide free SLS
RBC	4.47	mili/cu.mm	3.8-4.8	Electrical Impedence
HCT	38.4	%	36-46	RBC Pulse height detection
MCV	85.8	fL	83 - 101	RBC Pulse measurement
MCH	28.3	pg	27 - 32	Calculated
MCHC	33.0	g/dL	31.5 - 34.5	Calculated
RDW-CV	15.1	%	11.5-14	Calculated
Total Leucocyte Count	8.21	10 ³ /μI	4 - 10	Double hydrodynamic sequential system/Microscopy
Differential Leucocyte Count				
Neutrophils	61	%	40-80	Double hydrodynamic sequential system/Microscopy
Lymphocytes	30	%	20-40	Double hydrodynamic sequential system/Microscopy
Monocytes	5	%	2-10	Double hydrodynamic sequential system/Microscopy
Eosinophils	4	%	1-6	Double hydrodynamic sequential system/Microscopy
Basophils	0	%	0-2	Double hydrodynamic sequential system/Microscopy
Absolute Leucocyte Count				
Absolute Neutrophil Count	5.01	10 ³ /μI	2 - 7	Calculated
Absolute Lymphocyte Count	2.46	10 ³ /μI	1.0 - 3.0	Calculated
Absolute Monocyte Count	0.41	10 ³ /μI	0.2 - 1	Calculated



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Test Name	Result	Unit	Bio. Ref. Interval	Method
Absolute Eosinophil Count	0.33	$10^3/\mu\text{I}$	0.02 - 0.5	Calculated
Absolute Basophil Count	0	$10^3/\mu\text{I}$	0.02 - 0.1	Calculated
Platelet Count	341	$10^3/\mu\text{I}$	150-410	Electrical Impedence/ Microscopy
MPV	8.3	fL	7.5-12	Calculated
PDW	16	fL	11-22	Calculated

Comment:

- As per the recommendation of International council for Standardization in Hematology, the differential leucocyte counts are additionally being reported as absolute numbers of each cell in per unit volume of blood.

Erythrocyte Sedimentation Rate

Erythrocyte Sedimentation Rate	10	mm/hr	0-12	Modified Westergren
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Comment:

- ESR provides an index of progress of the disease and is widely used as an indicator of inflammation, infection, trauma, or malignant diseases. Changes are more significant than a single abnormal test
- It is specifically indicated to monitor the course or response to the treatment of diseases like rheumatoid arthritis, tuberculosis bacterial endocarditis, acute rheumatic fever, Hodgkins disease, temporal arthritis, and systemic lupus erythematosus; 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, malignancy, pregnancy, multiple myeloma, menstruation, and hypothyroidism.
- Although a normal ESR cannot be taken to exclude the presence of organic disease, its rate is dependent on various physiologic and pathologic factors.
- The most important component influencing ESR is the composition of plasma. High level of C-Reactive Protein, fibrinogen, haptoglobin, alpha-1 antitrypsin, ceruloplasmin and immunoglobulins causes the elevation of Erythrocyte Sedimentation Rate.
- Drugs that may cause increase ESR levels include: dextran, methyl dopa, oral contraceptives, penicillamine, procainamide, theophylline, and Vitamin A. Drugs that may cause decrease levels include: aspirin, cortisone, and quinine

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Test Name	Result	Unit	Bio. Ref. Interval	Method
"Test conducted on Whole Blood - EDTA "				



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Barcode ID/Order ID	: D7436666 / 8899052	Sample Receive Date	: 07/Feb/2024 12:31PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Fluoride Plasma F	Report Date	: 07/Feb/2024 03:11PM

BIOCHEMISTRY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Glucose - Fasting				
Glucose - Fasting	74	mg/dL	70-99	Hexokinase/ G-6-PDH

Fasting Plasma Glucose (mg/dL)	2 hr plasma Glucose (mg/dL)	Diagnosis
99 or below	139 or below	Normal
100 to 125	140 to 199	Pre-Diabetes (IGT)
126 or above	200 or above	Diabetes

Reference : American Diabetes Association

Comment:

Impaired glucose tolerance (IGT) fasting, means a person has an increased risk of developing type 2 diabetes but does not have it yet. A level of 126 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes. IGT (2 hrs Post meal), means a person has an increased risk of developing type 2 diabetes but does not have it yet. A 2-hour glucose level of 200 mg/dL or above, confirmed by repeating the test on another day, means a person has diabetes

Plasma Glucose Goals	For people with Diabetes
Before meal	70-130 mg/dL
2 Hours after meal	Less than 180 mg/dL
HbA1c	Less than 7%

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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 07/Feb/2024 03:12PM

BIOCHEMISTRY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Lipid Profile				
Cholesterol - Total	128	mg/dL	Age>20 years : Desirable <200, Border Line 200 to 239, High >240, Normal: <150,	Enzymatic
Triglycerides	59	mg/dL	Borderline: 150 - 199, High:200-499, Very High>=500	Glycerol Phosphate Oxidase
Cholesterol - HDL	39	mg/dl	40 - 60	Accelerator Selective Detergent
Cholesterol - LDL	77	mg/dl	Desirable: <100 Above desirable: 100 - 129 Borderline high : 130 - 159 High : 160 - 189 Very high : >=190	Calculated
Cholesterol- VLDL	12	mg/dl	10 - 30	Calculated
Cholesterol : HDL Cholesterol	3.3	Ratio	Desirable : 3.0-4.0 High risk : >4	Calculated
LDL : HDL Cholesterol	2.00	Ratio	Desirable : 2.0-2.5 High risk : >3.0	Calculated
Non HDL Cholesterol	89	mg/dl	Desirable:< 130, Above Desirable:130 - 159, Borderline High:160 - 189, High:190 - 219, Very High: >= 220	Calculated

Comment:



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Test Name	Result	Unit	Bio. Ref. Interval	Method
<p>●Lipid profile measurements in the same patient can show physiological & analytical variations. It is recommended that 3 serial samples 1 week apart may be tested.</p> <p>●Indians are at a high risk of developing atherosclerotic cardiovascular disease (ASCVD); at a much earlier age and more severe with high mortality. Dyslipidemia (abnormal lipid profile) is the major risk factor and found in almost 80% Indians.</p> <p>●Total cholesterol is the total amount of cholesterol in blood comprising of HDL, LDL-C, and VLDL.</p> <p>●LDL Cholesterol (LDL-C) or "bad" cholesterol contributes most significantly to atherosclerosis leading to heart disease or stroke and is the primary target for reducing risk for cardiovascular disease.</p> <p>●High-density lipoprotein (HDL) or "good" cholesterol can lower risk of heart disease and stroke.</p> <p>●Triglyceride (TG) level also plays a major role in CVD. Indians are more prone to Atherogenic dyslipidemia, a condition associated with high TG, low HDL-C and high LDL-C; this is associated with diabetes, metabolic syndrome and insulin resistance. Hence high triglyceride levels also need to be treated.</p> <p>●Non-HDL-Cholesterol (Non-HDLC) measures all plaque forming lipoproteins (e.g. remnants, LDL-C, VLDL, Lp(a), Apo-B). Monitoring of Non-HDLC is important in patients with high TG (e.g. diabetics, obese persons) and those already on statin therapy.</p> <p>●Lipid Association of India (LAI-2020) recommends:-</p> <ul style="list-style-type: none"> Screening of all Indians above the age of 20 years for CVD risk factors, esp. lipid profile. Identification of Risk factors: Age (male ≥ 45 years, female ≥ 55 years); Family h/o heart disease at younger age (<55 yrs in males, <65 yrs in female), Smoking/tobacco use, High blood pressure, Low HDL (males <40 mg/dl and females <50mg/dl). Fasting lipid profile is not mandatory for screening. Both fasting and non-fasting lipid profiles are equally important for managing Indian patients. Non-HDLC should be calculated in every subject. LAI recommends LDL-C as the primary target and Non-HDLC as the co-primary target for initiating drug therapy. Lifestyle modifications are of first and foremost importance for management and prevention of dyslipidemia. Among low risk groups, treatment is started only after 3 months of lifestyle changes. Testing for Apolipoprotein B, hsCRP, Lp(a) should be considered for patients in moderate risk group. Newer treatment goals based on Risk Groups and values of LDL-C and Non-HDLC 				

New treatment goals by Lipid Association of India (2020)

	CONSIDER THERAPY (cut-off level)		TREATMENT GOALS	
Risk groups	LDL-C (mg/dL)	Non-HDLC (mg/dL)	LDL-C (mg/dL)	Non-HDLC (mg/dL)
Extreme Risk Gp Cat. A	≥ 50	≥ 80	<50 (Optional ≤ 30)	<80 (Optional ≤ 60)
Extreme Risk Gp Cat. B	>30	>60	≤ 30	≤ 60
Very High Risk	≥ 50	≥ 80	<50	<80
High Risk	≥ 70	≥ 100	<70	<100
Moderate Risk	≥ 100	≥ 130	<100	<130
Low risk	$\geq 130^*$	$\geq 160^*$	<100	<130

*After an adequate non-pharmacological intervention for at least 3 months

●As per NCEP Expert Panel (2011) guidelines, universal screening for dyslipidemia is recommended for children between 9 - 11 yrs (repeat at 17-21 yrs). Screening is not recommended before the age of 2yrs. Above the age of 2 yrs, selective screening is done in children with family history of premature CVD or risk factors like obesity, diabetes, and hypertension.

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BIOCHEMISTRY

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Test Name	Result	Unit	Bio. Ref. Interval	Method
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Note: Reference Interval as per National Cholesterol Education Program (NCEP) Report.



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Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 07/Feb/2024 02:53PM

BIOCHEMISTRY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Liver Function Test				
Bilirubin-Total	0.35	mg/dL	0.2-1.2	Diazonium Salt
Bilirubin-Direct	0.13	mg/dL	0.0-0.5	Diazo Reaction
Bilirubin-Indirect	0.22	mg/dL	0 - 0.8	Calculated
Protein, Total	7.45	g/dL	6.4 - 8.3	Biuret, End Point
Albumin	4.21	g/dL	3.5-5.0	Bromcresol Green
Globulin	3.2	g/dl	1.8 - 3.6	Calculated
A/G Ratio	1.30	Ratio		Calculated
Aspartate Transaminase (SGOT)	27	U/L	11 - 34	NADH (Without P-5-P)
Alanine Transaminase (SGPT)	10	U/L	0-34	NADH (Without P-5-P)
SGOT/SGPT	2.70	Ratio		Calculated
Alkaline Phosphatase	94	U/L	40-150	Para-Nitrophenyl Phosphate
Gamma Glutamyltransferase (GGT)	16	U/L	9 - 38	L-G-G-3-C-4-N Substrate

Comment:

- 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) α 1-antitrypsin deficiency.

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•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.				

Kidney Function Test.

Blood Urea Nitrogen	7	mg/dL	8-23	Urease
Urea	15.69	mg/dl	17.5 – 49.22	Calculated
Creatinine	0.62	mg/dl	0.5-1.0	Kinetic Alkaline Picrate
Uric Acid	3.8	mg/dL	2.5 - 6.2	Uricase
Sodium	138	mmol/L	136 - 145	Indirect ISE
Potassium	4.58	mmol/L	3.5-5.1	Indirect ISE
Chloride	106.0	mmol/L	98 - 107	Indirect
BUN/Creatinine Ratio	11.8	Ratio	12:1 - 20:1	Calculated

Comment:

BUN is directly related to protein intake and nitrogen metabolism and inversely related to the rate of excretion of urea. Blood urea nitrogen (BUN) levels reflect the balance between the production and excretion of urea. Increased levels are seen in renal failure (acute or chronic), urinary tract obstruction, dehydration, shock, burns, CHF, GI bleeding, nephrotoxic drugs. Decreased levels are seen in hepatic failure, nephrotic syndrome, cachexia (low-protein and high-carbohydrate diets).

Urea is a non-proteinous nitrogen compound formed in the liver from ammonia as an end product of protein metabolism. Urea diffuses freely into extracellular and intracellular fluid and is ultimately excreted by the kidneys. Increased levels are found in acute renal failure, chronic glomerulonephritis, congestive heart failure, decreased renal perfusion, diabetes, excessive protein ingestion, gastrointestinal (GI) bleeding, hyperalimentation, hypovolemia, ketoacidosis, muscle wasting from starvation, neoplasms, pyelonephritis, shock, urinary tract obstruction, nephrotoxic drugs. Decreased levels are seen in inadequate dietary protein, low-protein/high-carbohydrate diet, malabsorption syndromes, pregnancy, severe liver disease, certain drugs.

Creatinine is catabolic product of creatinine phosphate, which is excreted by filtration through the glomerulus and by tubular secretion. Creatinine clearance is an acceptable clinical measure of glomerular filtration rate (GFR). Increased levels are seen in acute/chronic renal failure, urinary tract obstruction, hypothyroidism, nephrotoxic drugs, shock, dehydration, congestive heart failure, diabetes. Decreased levels are found in muscular dystrophy.

BUN/Creatinine ratio (normally 12:1–20:1) is decreased in acute tubular necrosis, advanced liver disease, low protein intake, and following hemodialysis. BUN/Creatinine ratio is increased in dehydration, GI bleeding, and increased catabolism.

Uric acid levels show diurnal variation. The level is usually higher in the morning and lower in the evening. Increased levels are seen in starvation, strenuous exercise, malnutrition, or lead poisoning, gout, renal disorders, increased breakdown of body cells in some cancers (including leukemia, lymphoma, and multiple myeloma) or cancer treatments, hemolytic anemia, sickle cell anemia, or heart failure, pre-eclampsia, liver disease (cirrhosis), obesity, psoriasis, hypothyroidism, low blood levels of parathyroid hormone (PTH), certain drugs, foods that are very high in purines - such as organ meats, red meats, some seafood and beer. Decreased levels are seen in liver disease, Wilson's disease, Syndrome of inappropriate antidiuretic hormone (SIADH), certain drugs.

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Age/Gender	: 27/Female	Registration Date	: 07-Feb-24 11:39 AM
Patient ID	: MGP367993	Collection Date	: 07/Feb/2024 09:31AM
Barcode ID/Order ID	: D7436665 / 8899052	Sample Receive Date	: 07/Feb/2024 12:34PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Serum	Report Date	: 07/Feb/2024 05:28PM

Immunology

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Thyroid Stimulating Hormone, Ultrasensitive				
Thyroid Stimulating Hormone - Ultra Sensitive	2.874	uIU/ml	0.35 – 4.94	CMIA

Comment:

Pregnancy	Reference ranges for TSH (μ IU/ml) [As per American thyroid Association]
1st trimester	0.1-2.5
2nd trimester	0.2-3.0
3rd trimester	0.3-3.0

- TSH levels are subject to circadian variation, reaching peak levels between 2 - 4 a.m. and at a minimum between 6-10 pm.
- The variation is of the order of 50%, hence time of the day has influence on the measured serum TSH concentrations.
- TSH is secreted in a dual fashion: Intermittent pulses constitute 60-70% of total amount, background continuous secretion is 30-40%. These pulses occur regularly every 1-3 hrs.
- TSH is a very sensitive and specific parameter for assessing thyroid function and is particularly suitable for early detection or exclusion of disorders in the central regulating circuit between the hypothalamus, pituitary and thyroid.
- Changes in thyroid status are typically associated with concordant changes in T3, T4 and TSH levels.
- For the diagnosis of hypothyroidism and hyperthyroidism, sole dependence on TSH should not be done and assay needs to be interpreted with the clinical condition & other investigations.
- Serum TSH level changes significantly in response to even minor changes in thyroid hormones.
- Transient increase in TSH level or an abnormal TSH levels can be seen in various nonthyroidal diseases.
- Unexpectedly abnormal or discordant thyroid test values may be seen with some rare, but clinically significant conditions such as central hypothyroidism, TSH-secreting pituitary tumors, thyroid hormone resistance, or the presence of heterophilic antibodies (HAMA) or thyroid hormone autoantibodies.

NABL certificate
and scope

This test has been performed at

TATA 1MG PUNEAddress: Teerth Business Center, Ground Floor,
Unit No 1, Sub-Divided Plot No EL-15, Bhosari
MIDC, Pune - 411026

AAMandvekar

Dr. Aparna Mandvekar
MBBS, MD (Pathology)
Consultant Pathologist
Reg No: 2008/05/2160Scan for
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Immunology

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name Result Unit Bio. Ref. Interval Method

TSH	T3	T4	Interpretation
High	Normal	Normal	Subclinical Hypothyroidism
Low	Normal	Normal	Subclinical Hyperthyroidism
High	High	High	Secondary Hyperthyroidism
Low	High/Normal	High/Normal	Hyperthyroidism
Low	Low	Low	Non thyroidal illness / Secondary Hypothyroidism



NABL certificate and scope



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Age/Gender	: 27/Female	Registration Date	: 07-Feb-24 11:39 AM
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Barcode ID/Order ID	: D7436654 / 8899052	Sample Receive Date	: 07/Feb/2024 12:34PM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Urine	Report Date	: 07/Feb/2024 03:47PM

CLINICAL PATHOLOGY

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Urine Routine & Microscopy				
Colour	PALE YELLOW		Pale Yellow	Visual
Appearance	CLEAR		Clear	Visual
Specific gravity	1.015		1.003 - 1.035	pKa change
pH	6.0		4.6-8.0	Double Indicator
Glucose	Negative		Negative	GOD-POD
Protein	Negative		Negative	Protein- error principle
Ketones	Negative		Negative	Nitroprusside
Blood	Negative		Negative	Visual
Bilirubin	Negative		Negative	Diazonium
Urobilinogen	Normal		Normal	Azo Dye
Leucocyte Esterase	Negative		Negative	Pyrrole
Nitrite	Negative		Negative	Sulphanilamide Diazo
Pus cells	1-2	/hpf	0-5	Microscopy
Red Blood Cells	NIL	/hpf	0-2	Microscopy
Epithelial cells	1-2	/hpf	Few	Microscopy
Casts	Nil	/hpf	Nil	Microscopy
Crystals	Nil		Nil	Microscopy
Yeast	Nil		Nil	Microscopy
Bacteria	Nil		Nil	Microscopy

Comment:

•Note: Pre-test condition to be observed while submitting the sample-first void, mid stream urine, collected in a clean, dry, sterile container is recommended for routine urine analysis, avoid contamination with any discharge from vaginal, urethra, perineum, Avoid prolonged transit time & undue exposure to sunlight.

•During interpretation, points to be considered are Negative nitrite test does not exclude the urinary tract infections. Trace proteinuria can be seen with many physiological conditions like prolonged recumbency, exercise, high protein diet. False positive reactions for bile pigments, proteins, glucose and nitrites can be caused by peroxidase like activity by disinfectants, therapeutic dyes, ascorbic acid and certain drugs. • Urine microscopy is done in centrifuged urine specimens

NABL certificate
and scope

This test has been performed at

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Patient ID	: MGP367993	Collection Date	: 07/Feb/2024 09:31AM
Barcode ID/Order ID	: Z8899052 / 8899052	Sample Receive Date	: 01/Jan/0001 12:01AM
Referred By	: Dr.	Report Status	: Final Report
Sample Type	: Human Subject	Report Date	: 07/Feb/2024 03:42PM

CLINICAL WELLNESS

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
Blood Pressure (BP)				
Blood Pressure	107/65	mm Hg		Oscillometric

Comment:

Classification	Systolic/Diastolic
Normal BP	<130/80
High normal BP	systolic BP of 130-139 mm Hg & diastolic of 80-89 mm Hg
High normal/hypertension	BP > 140 mm Hg systolic and/or greater than 90 mm Hg diastolic
Hypertension	BP of >160 mm Hg systolic and/or greater than 100 mm Hg diastolic

- Reference: Hypertension, Ministry of Health & Family Welfare Government of India (2016).
- This is measured by a Phlebotomist and the same has been entered.

Body Mass Index (BMI)

Height	156.00	cm	
Weight	56	kg	
Body Mass Index	23.22	kg/m2	Calculated

Comment:

- BMI is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2).
- World Health Organization (WHO) defines overweight and obesity as abnormal or excessive fat accumulation that presents a risk to health.
- Obesity classification according to Asia-Pacific guidelines:

Classification	BMI
Under-weight	<18.5
Normal	18.5 - 22.9
Overweight	23-24.9
Obese	≥25

NABL certificate and scope



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CLINICAL WELLNESS

TCS WELLNESS PACKAGE PATHOLOGY HOME VISIT

Test Name	Result	Unit	Bio. Ref. Interval	Method
<ul style="list-style-type: none">Reference: Asia Pacific Guidelines.This is calculated by a Phlebotomist and the same has been entered.				

*** End Of Report ***

Conditions of Laboratory Testing & Reporting:
Test results released pertain to the sample, as received. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the interpreting clinician. Result delays may happen because of unforeseen or uncontrollable circumstances. Test report may vary depending on the assay method used. Test results may show inter-laboratory variations. Test results are not valid for medico-legal purposes. Please mail your queries related to test results to Customer Care mail ID cs.labs@1mg.com

Disclaimer: Results relate only to the sample received. Test results marked "BOLD" indicate abnormal results i.e. higher or lower than normal. All lab test results are subject to clinical interpretation by a qualified medical professional. This report cannot be used for any medico-legal purposes. Partial reproduction of the test results is not permitted. Also, TATA 1mg Labs is not responsible for any misinterpretation or misuse of the information. The test reports alone may not be conclusive of the disease/condition, hence clinical correlation is necessary. Reports should be vetted by a qualified doctor only.

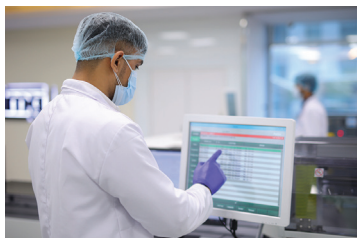


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