Patient Name	: Mr.SRIKANTH B	Collected	: 11/Feb/2018 11:25AM
Age/Gender	: 23 Y 0 M 0 D /M	Received	: 11/Feb/2018 02:55PM
UHID/MR No	: DLBN.0000000260	Reported	: 11/Feb/2018 03:28PM
Visit ID	: DLBNOPV441	Status	: Final Report
Ref Doctor	: Dr.MOUNIKA	Client Name	: PCC LB NAGAR
IP/OP NO	:	Client Code	: PCC0128

DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
COMPLETE BLOOD COUNT (CBC) , *WHOLE BLOOD EDTA*				
HAEMOGLOBIN	15.8	g/dL	13-17	Cyanmethemoglobin
PCV	44.50	%	40-50	Electronic pulse & Calculation
RBC COUNT	4.98	Million/cu.mm	4.5-5.5	Electrical Impedence
MCV	89	fL	83-101	VCS
MCH	31.7	pg	27-32	Calculated
MCHC	**35.5**	g/dL	31.5-34.5	Calculated
R.D.W	**11**	%	11.6-14	Calculated
TOTAL LEUCOCYTE COUNT (TLC)	7,900	cells/cu.mm	4000-10000	Electrical Impedence
DIFFERENTIAL LEUCOCYTIC COUNT (DLC)				
NEUTROPHILS	60.4	%	40-80	Microscopic
LYMPHOCYTES	32.8	%	20-40	Microscopic
EOSINOPHILS	2.9	%	1-6	Microscopic
MONOCYTES	3.5	%	2-10	Microscopic
BASOPHILS	0.4	%	<1-2	Microscopic
ABSOLUTE LEUCOCYTE COUNT				
NEUTROPHILS	4771.6	Cells/cu.mm	2000-7000	
LYMPHOCYTES	2591.2	Cells/cu.mm	1000-3000	
EOSINOPHILS	229.1	Cells/cu.mm	20-500	
MONOCYTES	276.5	Cells/cu.mm	200-1000	
BASOPHILS	31.6	Cells/cu.mm	20-100	
PLATELET COUNT	278000	cells/cu.mm	150000-410000	Electrical impedence

SIN No:HA00155510

This test has been performed at Apollo Health and Lifestyle Ltd/National Reference Lab, Hyderabad.

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Patient Name	: Mr.SRIKANTH B	Collected	: 11/Feb/2018 11:25AM
Age/Gender	: 23 Y 0 M 0 D /M	Received	: 11/Feb/2018 03:21PM
UHID/MR No	: DLBN.0000000260	Reported	: 11/Feb/2018 04:19PM
Visit ID	: DLBNOPV441	Status	: Final Report
Ref Doctor	: Dr.MOUNIKA	Client Name	: PCC LB NAGAR
IP/OP NO	:	Client Code	: PCC0128

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
GLUCOSE, RANDOM , *SODIUM FLUORIDE PLASMA*	**68**	mg/dL	70 - 140	Glucose oxidase

SIN No:BI00385622

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Patient Name	: Mr.SRIKANTH B	Collected	: 11/Feb/2018 11:25AM
Age/Gender	: 23 Y 0 M 0 D /M	Received	: 11/Feb/2018 02:49PM
UHID/MR No	: DLBN.0000000260	Reported	: 11/Feb/2018 03:44PM
Visit ID	: DLBNOPV441	Status	: Final Report
Ref Doctor	: Dr.MOUNIKA	Client Name	: PCC LB NAGAR
IP/OP NO	:	Client Code	: PCC0128

DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID STIMULATING HORMONE (TSH) , *SERUM*	1.49	µIU/mL	0.35-5.5	CLIA

Comments:-

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.Significant variations in TSH can occur with circadian rhythm, hormonal status, stress, sleep deprivation, caloric intake, medication & circulating antibodies.

It is important to confirm any TSH abnormality in a fresh specimen drawn after ~ 3 weeks before assigning a diagnosis, as the cause of an isolated TSH abnormality.

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

VITAMIN D (25 - OH VITAMIN D) , *SERUM*	9.57	ng/mL		CLIA

Comment:

BIOLOGICAL REFERENCE RANGES

VITAMIN D STATUS	VITAMIN D 25 HYDROXY (ng/mL)
DEFICIENCY	<10
INSUFFICIENCY	10 – 30
SUFFICIENCY	30 – 100
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.

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DEPARTMENT OF IMMUNOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12 , *SERUM*	**131**	pg/mL	180-914	CLIA

Comment:

TEST RESULT (in pg/mL)	INTERPRETATION
180- 914	NORMAL
145 - 180	INDETERMINATE
<145	DEFICIENT

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.

FERRITIN , *SERUM*	112.5	ng/mL	23.9-336.2	CLIA

Comment:

- Ferritin estimation is useful in the diagnosis of iron deficiency anemia and iron overload.
- Increased levels seen in hemachromatosis, frequent blood transfusions with packed RBCs and alcoholic liver disease.
- Decreased levels seen in heavy menstrual bleeding, poor absorption of iron, iron deficiency anaemia and long term GI bleed.
- Ferritin is an acute phase reactant and thus may be increased with inflammation, chronic infection, liver disease, auto-immune disorders and some type of cancers. Ferritin is not used to detect or monitor these conditions.

SIN No:IM00126858
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Patient Name	: Mr.SRIKANTH B	Collected	: 11/Feb/2018 11:25AM
Age/Gender	: 23 Y 0 M 0 D /M	Received	: 11/Feb/2018 03:58PM
UHID/MR No	: DLBN.0000000260	Reported	: 12/Feb/2018 04:41PM
Visit ID	: DLBNOPV441	Status	: Final Report
Ref Doctor	: Dr.MOUNIKA	Client Name	: PCC LB NAGAR
IP/OP NO	:	Client Code	: PCC0128

DEPARTMENT OF SEROLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
HCV Tri Dot , *SERUM*	NEGATIVE		NEGATIVE	ICT

Comment:

The 4th Generation HCV TRI-DOT is a rapid, sensitive and qualitative in vitro diagnostic test for the detection of antibodies to Hepatitis C Virus in test specimen. It utilizes a unique combination of modified HCV antigens from the putative core, NS3, NS4 & NS5 regions of the virus to selectively identify all subtypes of Hepatitis C

Virus in human serum/plasma with a high degree of sensitivity and specificity.

This is only a screening test and all reactive samples should be confirmed by HCV RNA PCR. The presence of anti-HCV does not imply a Hepatitis C infection but may be indicative of recent and / or past infection by HCV.

HIV I AND II ANTIBODIES , *SERUM*	0.72	S/C UNITS		ECLIA

Comment:

RESULTS IN S/C UNITS	INTERPRETATION
< 0.9	NON-REACTIVE
0.9 - 1.1	EQUIVOCAL
> 1.1	REACTIVE

This test uses 4 recombinant antigens derived from HIV-1 core (p24), HIV-1 envelope (env 10 and env13) and HIV-2 envelope (env Al). These antigens detect antibodies to HIV-1 and antibodies to HIV-2 in the same test.

Reactive results suggest the presence of HIV-1 and/or HIV-2 infection, but it is not diagnostic for HIV infection and should be considered preliminary. The results from this or any other diagnostic kit should be used and interpreted only in the context of the overall clinical picture.

A negative test result does not exclude the possibility of exposure to or infection with HIV. Levels of HIV antibodies may be undetectable in the early stages of infection

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DEPARTMENT OF SEROLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
HBsAg , *SERUM*	1.0	S/C UNITS		ECLIA

Corelate clinically repeat sample if clinicaly indicated.

Comment:

VALUE IN S/C UNITS	INTERPRETATION
<0.90	NEGATIVE
0.90 - 1.00	INDETERMINATE
> 1.00	POSITIVE

This assay detects the first serological marker of Hepatitis B as early as 4-16 weeks after exposure. It persists during acute illness and disappears 12-20 weeks after onset of symptoms. The titers rise rapidly during the period of viral replication and is frequently associated with infectivity. Persistence of HBsAg for more than 6 months indicates development of carrier state or chronic liver disease.

It is recommended that a positive result of HBsAg must be be confirmed using a different enzyme immunoassay kit or by using a confirmatory assay based on neutralisation with human anti hepatitis B surface antibody.

Based upon clinical history it may become necessary to test for presence of other markers of hepatitis B virus infection.

***** End Of Report *****

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M.B.B.S MD
Consultant Microbiologist

DR. K. RAMA KRISHNA REDDY
M.B.B.S, M.D
CONSULTANT PATHOLOGIST

SIN No:SE00053436

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