LABORATORY REPORT

Redcliffe labs

Patient NAME			
DOB/Age/Gender		Report STATUS	
Patient ID / UHID		Barcode NO	
Referred BY		Sample Type	
Sample Collected		Report Date	

Test Description	Value(s)	Unit(s)	Reference Range
Fit India Full Body checkup with Vitamin Screening			
Complete Blood Count (CBC)			
RBC Parameters			
Hemoglobin *Cyanide free spectrophotometry*	**11.7 L***	g/dL	12.0 - 15.0
RBC Count *Electrical impedance*	4.2	10^6/µl	3.8 - 4.8
PCV *Calculated*	36.1	%	36 - 46
MCV *Calculated*	85.2	fl	83 - 101
MCH *Calculated*	27.7	pg	27 - 32
MCHC *Calculated*	32.5	g/dL	31.5 - 34.5
RDW (CV) *Calculated*	**16.2 H***	%	11.6 - 14.0
RDW-SD *Calculated*	**46.1 H***	fl	35.1 - 43.9
WBC Parameters			
TLC *Electrical impedance and microscopy*	7.3	10^3/µl	4 - 10
Differential Leucocyte Count			
Neutrophils *Flow-cytometry DHSS*	64.2	%	40 - 80
Lymphocytes *Flow-cytometry DHSS*	25.9	%	20 - 40
Monocytes *Flow-cytometry DHSS*	6.4	%	2 - 10
Eosinophils *Flow-cytometry DHSS*	2.9	%	1 - 6
Basophils *Flow-cytometry DHSS*	0.6	%	0 - 2
Absolute Leukocyte Counts			
Neutrophils. *Calculated*	4.69	10^3/µl	2 - 7
Lymphocytes. *Calculated*	1.89	10^3/µl	1 - 3
Monocytes. *Calculated*	0.47	10^3/µl	0.2 - 1.0
Eosinophils. *Calculated*	0.21	10^3/µl	0.02 - 0.5
Basophils.	0.04	10^3/µl	0.02 - 0.1

Note :- (H* - High , L* - Low ,CL* - Critical Low,CH* - Critical High)

Dr. Neha Prabhakar
MBBS, MD(Pathology)

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Test Description	Value(s)	Unit(s)	Reference Range
Calculated			
Platelet Parameters			
Platelet Count *Electrical impedance and microscopy*	188	10^3/µl	150 - 410
Mean Platelet Volume (MPV) *Calculated*	**12.7 H***	fL	9.3 - 12.1
PCT *Calculated*	0.2	%	0.17 - 0.32
PDW *Calculated*	**26.5 H***	fL	8.3 - 25.0
P-LCR *Calculated*	**57.5 H***	%	18 - 50
P-LCC *Calculated*	108	10^9/L	44 - 140
Mentzer Index *Calculated*	20.29	%	> 13

Interpretation:
CBC provides information about red cells, white cells and platelets. Results are useful in the diagnosis of anemia, infections, leukemias, clotting disorders and many other medical conditions.

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Test Description	Value(s)	Unit(s)	Reference Range
Erythrocyte Sedimentation Rate (ESR)			
ESR - Erythrocyte Sedimentation Rate *MODIFIED WESTERGREN*	**19 H***	mm/hr	0 - 12

Interpretation:
ESR is also known as Erythrocyte Sedimentation Rate. An ESR test is used to assess inflammation in the body. Many conditions can cause an abnormal ESR, so an ESR test is typically used with other tests to diagnose and monitor different diseases. An elevated ESR may occur in inflammatory conditions including infection, rheumatoid arthritis ,systemic vasculitis, anemia, multiple myeloma , etc. Low levels are typically seen in congestive heart failure, polycythemia ,sickle cell anemia, hypo fibrinogenemia , etc.

Reference- Dacie and lewis practical hematology

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Dr Meenal Garg
MBBS, MD(Pathology)
Registration number-MCI-48034

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Test Description	Value(s)	Unit(s)	Reference Range

HbA1C (Glycosylated Haemoglobin)

Glycosylated Hemoglobin (HbA1c) *HPLC*	5.2	%	<5.7
Estimated Average Glucose	102.54	mg/dl	Refer Table Below

Interpretation:
Interpretation For HbA1c% As per American Diabetes Association (ADA)

Reference Group	HbA1c in %
Non diabetic adults >=18 years	<5.7
At risk (Prediabetes)	5.7 - 6.4
Diagnosing Diabetes	>= 6.5
Therapeutic goals for glycemic control	Age > 19 years Goal of therapy: < 7.0 Age < 19 years Goal of therapy: <7.5

Note:
1. Since HbA1c reflects long term fluctuations in the blood glucose concentration, a diabetic patient who is recently under good control may still have a high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled. 2. Target goals of < 7.0 % may be beneficial in patients with short duration of diabetes, long life expectancy and no significant cardiovascular disease. In patients with significant complications of diabetes, limited life expectancy or extensive co-morbid conditions, targeting a goal of < 7.0 % may not be appropriate

Comments :
HbA1c provides an index of average blood glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations ADA criteria for correlation between HbA1c & Mean plasma glucose levels.

HbA1c(%)	Mean Plasma Glucose (mg/dL)	HbA1c(%)	Mean Plasma Glucose (mg/dL)
6	126	12	298
8	183	14	355
10	240	16	413

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Glucose Fasting

Glucose Fasting *Hexokinase*	78.3	mg/dL	70 - 100

Interpretation:

Status	Fasting plasma glucose in mg/dL
Normal	70 - 100
Impaired fasting glucose	101 - 125
Diabetes	≥126

Reference : American Diabetes Association

Comment :
Blood glucose determinations in commonly used as an aid in the diagnosis and treatment of diabetes. Elevated glucose levels (hyperglycemia) may also occur with pancreatic neoplasm, hyperthyroidism, and adrenal cortical hyper function as well as other disorders. Decreased glucose levels (hypoglycemia) may result from excessive insulin therapy insulinoma, or various liver diseases.

Note
1.The diagnosis of Diabetes requires a fasting plasma glucose of > or = 126 mg/dL or a random / 2 hour plasma glucose value of > or = 200 mg/dL with symptoms of diabetes mellitus.
2.Very high glucose levels (>450 mg/dL in adults) may result in Diabetic Ketoacidosis.

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MC-5280

Test Description	Value(s)	Unit(s)	Reference Range
Liver Function Test (LFT)			
Bilirubin Total *Diazonium Salt*	0.2	mg/dL	0.2 - 1.2
Bilirubin Direct *Diazo Reaction*	0.1	mg/dL	0.0 - 0.5
Bilirubin Indirect *Calculated*	0.1	mg/dL	0.1 - 1.0
SGOT/AST *Enzymatic [NADH (without P-5-P)]*	21.1	U/L	11 - 34
SGPT/ALT *Enzymatic [NADH (without P-5-P)]*	16.8	U/L	< 34
SGOT/SGPT Ratio	**1.26 H***	Ratio	<1.00
Alkaline Phosphatase *Para-nitrophenyl phosphate (p-NPP)*	62	U/L	46 – 122
Total Protein *Biuret*	7.44	g/dL	6.4 - 8.3
Albumin *Colorimetric BCG*	4.17	g/dL	3.5 - 5.2
Globulin *Calculated*	3.27	g/dL	2.3 - 3.5
Albumin :Globulin Ratio *Calculated*	**1.28 L***	Ratio	1.3 - 2.1
Gamma Glutamyl Transferase (GGT) *L-Gamma-Glutamyl-3-Carboxy-4-Nitroanalide*	11.5	U/L	< 38

Interpretation:
The liver filters blood, metabolizes nutrients, detoxifies harmful substances, and produces blood clotting proteins. Liver cells contain enzymes that facilitate these functions. When cells are damaged, enzymes leak into the blood, detectable through blood tests.

Key enzymes tested:

1. **AST (SGOT):** may indicate tissue injury / damage in muscles or liver.
2. **ALT (SGPT):** Primarily in the liver. Elevated ALT and AST suggest liver damage.
3. **Alkaline Phosphatase & GGT:** Linked to bile production and flow. Elevated levels may indicate bile flow issues related to the liver, gallbladder, or bile ducts.

Blood proteins, **albumin and globulin**, are essential for growth, development, and health.

1. **Low protein:** May indicate bleeding, liver disorders, malnutrition, or agammaglobulinemia.
2. **High protein (Hyperproteinemia):** Often due to dehydration or increased protein production.
3. **Low albumin:** Caused by poor diet, kidney, or liver disease.
4. **High albumin:** Usually due to severe dehydration.

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Dr. Poulami Sarkar
MBBS,MD (Biochemistry)
Consultant Biochemist
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MC-5280

Test Description	Value(s)	Unit(s)	Reference Range
Kidney Function Test (KFT)			
Blood Urea *Urease*	15.17	mg/dL	15 - 40
Bun *Calculated*	7.09	mg/dL	7.0 - 18.7
Creatinine *Kinetic Alkaline Picrate*	0.59	mg/dL	0.5 - 1.2
eGFR (CKD-EPI)	115.30	ml/min/1.73 sq m	Normal Or High: >= 90 Mild Or Decrease: 60-89 Mild To Moderate Decrease: 45-59 Mild To Severe Decrease: 30-44 Severe Decrease: 15-29 Kidney Failure: < 15
Bun/Creatinine Ratio *Calculated*	12.02		12 - 20
Urea / Creatinine Ratio *Calculated*	25.71		25.68- 42.8
Uric Acid *Uricase*	3.84	mg/dL	2.5 - 6.2
Calcium Serum *Arsenazo III*	**8.2 L***	mg/dL	8.4 - 10.2
Phosphorus *Phosphomolybdate*	4.5	mg/dL	2.3 - 4.7
Sodium *ISE-Indirect*	139	mmol/L	136 - 145
Potassium *ISE-Indirect*	5.07	mmol/L	3.5 - 5.1
Chloride *ISE-Indirect*	**109.82 H***	mmol/L	98 - 107

Interpretation:
Kidney function tests is a collective term for a variety of individual tests and procedures that can be done to evaluate how well the kidneys are functioning. Many conditions can affect the ability of the kidneys to carry out their vital functions. Some lead to a rapid (acute) decline in kidney function others lead to a gradual (chronic) decline in function. Both result in a buildup of toxic waste substances done on urine samples, as well as on blood samples. A number of symptoms may indicate a problem with your kidneys. These include : high blood pressure, blood in urine, frequent urges to urinate, difficulty beginning urination, painful urination, swelling in the hands and feet due to a buildup of fluids in the body. A single symptom may not mean something serious. However, when occurring simultaneously, these symptoms suggest that your kidneys are not working properly. Kidney function tests can help determine the reason. Ionized calcium this test if you have signs of kidney or parathyroid disease. The test may also be done to monitor progress and treatment of these diseases."**eGFR test is applicable for patients aged 18 years or more."**

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Test Description	Value(s)	Unit(s)	Reference Range
Lipid Profile			
Total Cholesterol *Enzymatic*	181	mg/dL	<200
Triglycerides *Glycerol phosphate oxidase*	126	mg/dL	<150
HDL Cholesterol *Accelerator Selective Detergent*	52	mg/dL	> 40
Non HDL Cholesterol *Calculated*	129	mg/dL	<130
LDL Cholesterol *Calculated*	**103.8 H***	mg/dL	<100
V.L.D.L Cholesterol *Calculated*	25.2	mg/dL	< 30
Chol/HDL Ratio *Calculated*	3.48	Ratio	-
HDL/ LDL Ratio *Calculated*	0.5	Ratio	-
LDL/HDL Ratio *Calculated*	2	Ratio	-

Interpretation:
Lipid level assessments must be made following 9 to 12 hours of fasting, otherwise assay results might lead to erroneous interpretation. NCEP recommends of 3 different samples to be drawn at intervals of 1 week for harmonizing biological variables that might be encountered in single assays.

National Lipid Association Recommendations (NLA-2014)	Total Cholesterol (mg/dL)	Triglyceride (mg/dL)	LDL Cholesterol (mg/dL)	Non HDL Cholesterol (mg/dL)
Optimal	<200	<150	<100	<130
Above Optimal			100-129	130 - 159
Borderline High	200-239	150-199	130-159	160 - 189
High	>=240	200-499	160-189	190 - 219
Very High	-	>=500	>=190	>=220

HDL Cholesterol	
Low	**High**
<40	>=60

Risk Stratification for ASCVD (Atherosclerotic Cardiovascular Disease) by Lipid Association of India.

Risk Category	A. CAD with > 1 feature of high risk group
Extreme risk group	B. CAD with >1 feature of very high risk group of recurrent ACS (within 1 year) despite LDL-C <or = 50 mg/dl or poly vascular disease
Very High Risk	1.Established ASCVD 2.Diabetes with 2 major risk factors of evidence of end organ damage 3. Familial Homozygous Hypercholesterolemia

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High Risk	1. Three major ASCVD risk factors 2. Diabetes with 1 major risk factor or no evidence of end organ damage 3. CHD stage 3B or 4. 4 LDL >190 mg/dl 5. Extreme of a single risk factor 6. Coronary Artery Calcium - CAC > 300 AU 7. Lipoprotein a >/= 50 mg/dl 8. Non stenotic carotid plaque
Moderate Risk	2 major ASCVD risk factors
Low Risk	0-1 major ASCVD risk factors
Major ASCVD (Atherosclerotic cardiovascular disease) Risk Factors	
1. Age >/=45 years in Males & >/= 55 years in Females	3. Current Cigarette smoking or tobacco use
2. Family history of premature ASCVD	4. High blood pressure
5. Low HDL	

Newer treatment goals and statin initiation thresholds based on the risk categories proposed by Lipid Association of India in 2020.

Risk Group	**Treatment Goals**		**Consider Drug Therapy**	
	LDL-C (mg/dl)	**Non-HDL (mg/dl)**	**LDL-C (mg/dl)**	**Non-HDL (mg/dl)**
Extreme Risk Group Category A	<50 (Optional goal <OR = 30)	<80 (Optional goal <OR = 60)	>OR = 50	>OR = 80
Extreme Risk Group Category B	>OR = 30	>OR = 60	> 30	> 60
Very High Risk	<50	<80	>OR = 50	>OR = 80
High Risk	<70	<100	>OR = 70	>OR = 100
Moderate Risk	<100	<130	>OR = 100	>OR = 130
Low Risk	<100	<130	>OR = 130*	>OR = 160

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

References : Management of Dyslipidaemia for the Prevention of Stroke : Clinical practice Recommendations from the Lipid Association of India. Current Vascular Pharmacology,2022,20,134-155.

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Test Description	Value(s)	Unit(s)	Reference Range
Vitamin B12 / Cyanocobalamin			
Vitamin - B12 *CMIA*	**172 L***	pg/mL	187 - 883

Interpretation:
Low Values are a sign of a vitamin B12 deficiency. People with this deficiency are likely to have or develop symptoms. Causes of vitamin B12 deficiency include:Not enough vitamin B12 in diet (rare except with a strict vegetarian diet), Diseases that cause malabsorption (for example, celiac disease and Crohn's disease), Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy. Increased vitamin B12 levels are uncommon. Usually excess vitamin B12 is removed in the urine. Conditions that can increase B12 levels include: Liver disease (such as cirrhosis or hepatitis), Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia). Vitamin B12: Low Levels can cause malabsorption, Lack of intrinsic factor, Above normal heat production (for example, with hyperthyroidism), Pregnancy.High Level Liver disease, Myeloproliferative disorders (for example, polycythemia vera and chronic myelocytic leukemia). 1. Out of 140 healthy indian population, 91% of Vitamin B 12 concentrations was at lower level: 59.00 pg/ml and upper level: 700.00 pg/ml

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Vitamin D 25 Hydroxy

Vitamin D 25 - Hydroxy *CMIA*	**10.3 L***	ng/mL	Deficient <20 Insufficient 21 - 29 Sufficient 30 - 100

Interpretation:
25-Hydroxy vitamin D represents the main body reservoir and transport form. Mild to moderate deficiency is associated with Osteoporosis / Secondary Hyperparathyroidism while severe deficiency causes Rickets in children and Osteomalacia in adults. Prevalence of Vitamin D deficiency is approximately >50% specially in the elderly. This assay is useful for diagnosis of vitamin D deficiency and Hypervitaminosis D. It is also used for differential diagnosis of causes of Rickets & Osteomalacia and for monitoring Vitamin D replacement therapy.

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Thyroid Profile Total

Triiodothyronine (T3) *CMIA*	52.21	ng/dL	35 - 193
Total Thyroxine (T4) *CMIA*	**4.19 L***	µg/dL	4.87 - 11.72
Thyroid Stimulating Hormone (Ultrasensitive) *CMIA*	1.4312	µlU/mL	0.35 - 4.94

Interpretation:

Pragnancy	Refrence Range TSH
1st Trimester	0 .1 - 2.5
2nd Trimester	0.2 - 3.0
3rd Trimester	0.3 - 3.0

Clinical Use:
1. Diagnose Hypothyroidism & Hyperthyroidism
2. Monitor T4 therapy
3. Measure subnormal TSH levels

Increased TSH: Primary hypothyroidism, Subclinical hypothyroidism, TSH-dependent hyperthyroidism, Thyroid hormone resistance
Decreased TSH: Graves' disease, Autonomous thyroid hormone secretion, TSH deficiency

Thyroid malfunction (hyper or hypo) affects T3 & T4 levels. Pituitary or hypothalamic issues also influence thyroid activity.

1. Primary Hypothyroidism: High TSH levels.
2. Secondary/Tertiary Hypothyroidism: Low TSH levels.
3. Euthyroid Sick Syndrome: Abnormal thyroid test results due to non-thyroidal illnesses (NTI).

TBG levels are stable in healthy individuals but may be altered by pregnancy, estrogens, androgens, steroids, or glucocorticoids, causing inaccurate T3 & T4 readings.

TSH	T4	T3	Interpretation
High	Normal	Normal	Mild (subclinical) hypothyroidism
High	Low	Low Or Nomral	Hypothyroidism
Low	Normal	Normal	Mild (subclinical) hyperthyroidism
Low	High Or Normal	High Or Normal	Hyperthyroidism
Low	Low Or Normal	Low Or Normal	Nonthyroidal illness; pituitary (secondary) hypothyroidism
Normal	High	High	Thyroid hormone resistance syndrome (a mutation in the thyroid hormone receptor decreases thyroid hormone function)

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Test Description	Value(s)	Unit(s)	Reference Range
Urine Routine and Microscopic Examination			
Physical Examination			
Volume	20	mL	-
Colour	Pale yellow	-	Pale yellow
Transparency	Clear	-	Clear
Deposit	Absent	-	Absent
Chemical Examination			
Reaction (pH) *Double Indicator*	5.5	-	4.5 - 8.0
Specific Gravity *Ion Exchange*	1.015	-	1.010 - 1.030
Urine Glucose (sugar) *Oxidase / Peroxidase*	Negative	-	Negative
Urine Protein (Albumin) *Acid / Base Colour Excahnge*	Negative	-	Negative
Urine Ketones (Acetone) *Legals Test*	Negative	-	Negative
Blood *Peroxidase Hemoglobin*	Negative	-	Negative
Leucocyte esterase *Enzymatic Reaction*	Negative	-	Negative
Bilirubin Urine *Coupling Reaction*	Negative	-	Negative
Nitrite *Griless Test*	Negative	-	Negative
Urobilinogen *Ehrlichs Test*	Normal	-	Normal
Microscopic Examination			
Pus Cells (WBCs)	1-2	/hpf	0 - 5
Epithelial Cells	1-2	/hpf	0 - 4
Red blood Cells	Absent	/hpf	0 - 2
Crystals	Absent	-	Absent
Cast	Absent	-	Absent
Yeast Cells	Absent	-	Absent
Amorphous deposits	Absent	-	Absent
Bacteria	Absent	-	Absent
Protozoa	Absent	-	Absent

Interpretation:
URINALYSIS- Routine urine analysis assists in screening and diagnosis of various metabolic, urological, kidney and liver disorders.

Protein: Elevated proteins can be an early sign of kidney disease. Urinary protein excretion can also be temporarily elevated by strenuous exercise, orthostatic proteinuria, dehydration, urinary tract infections and acute illness with fever

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Glucose: Uncontrolled diabetes mellitus can lead to presence of glucose in urine. Other causes include pregnancy, hormonal disturbances, liver disease and certain medications.

Ketones: Uncontrolled diabetes mellitus can lead to presence of ketones in urine. Ketones can also be seen in starvation, frequent vomiting, pregnancy and strenuous exercise.

Blood: Occult blood can occur in urine as intact erythrocytes or haemoglobin, which can occur in various urological, nephrological and bleeding disorders.

Leukocytes: An increase in leukocytes is an indication of inflammation in urinary tract or kidneys. Most common cause is bacterial urinary tract infection.

Nitrite: Many bacteria give positive results when their number is high. Nitrite concentration during infection increases with length of time the urine specimen is retained in bladder prior to collection.

pH: The kidneys play an important role in maintaining acid base balance of the body. Conditions of the body producing acidosis/ alkalosis or ingestion of certain type of food can affect the pH of urine.

Specific gravity: Specific gravity gives an indication of how concentrated the urine is. Increased specific gravity is seen in conditions like dehydration, glycosuria and proteinuria while decreased specific gravity is seen in excessive fluid intake, renal failure and diabetes insipidus.

Bilirubin: In certain liver diseases such as biliary obstruction or hepatitis, bilirubin gets excreted in urine.

Urobilinogen: Positive results are seen in liver diseases like hepatitis and cirrhosis and in cases of haemolytic anaemia.

*** End Of Report ***

Dr. Neha Prabhakar
MBBS, MD(Pathology)

Bio-Rad CDM System
VII Inst. #1.

Patient Data

Sample ID:
Patient ID:
Name:
Physician:
Sex:
DOB:

Comments:

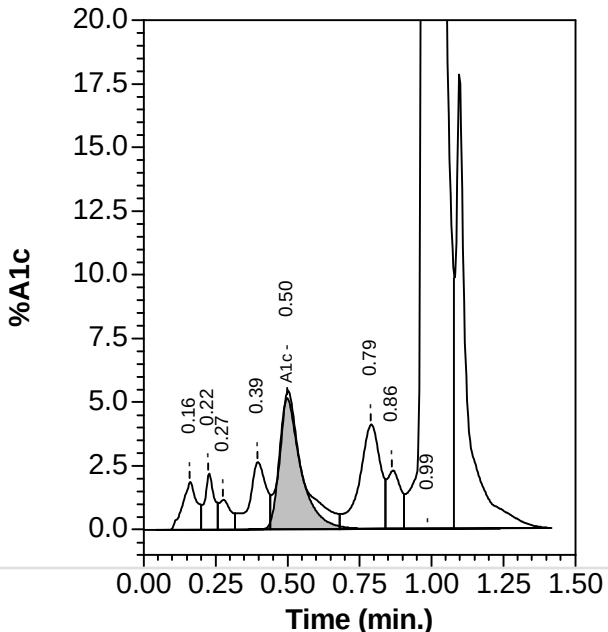
Analysis Data

Analysis Performed:
Injection Number:
Run Number:
Rack ID:
Tube Number:
Report Generated:
Operator ID:

Peak Name	NGSP %	Area %	Retention Time (min)	Peak Area
A1a	---	1.0	0.158	28174
A1b	---	0.8	0.223	21395
F	---	0.5	0.274	14120
LA1c	---	1.6	0.395	42915
A1c	5.2	---	0.498	117078
P3	---	3.2	0.787	87701
P4	---	1.2	0.862	31905
Ao	---	87.4	0.987	2385143

Total Area: 2,728,431

HbA1c (NGSP) = 5.2 %



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2. It is to be presumed that the tests performed pertain to the specimen/sample attributed to the Customer's name or identification. It is presumed that the verification particulars have been cleared out by the customer or his/her representation at the point of generation of said specimen / sample. It is hereby clarified that the reports furnished are restricted solely to the given specimen only.

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