Redcliffe labs

Healthy India Ki Trusted Lab

smart Health Report

An Insightful Health Analytics Report for Easier Understanding

Prepared For

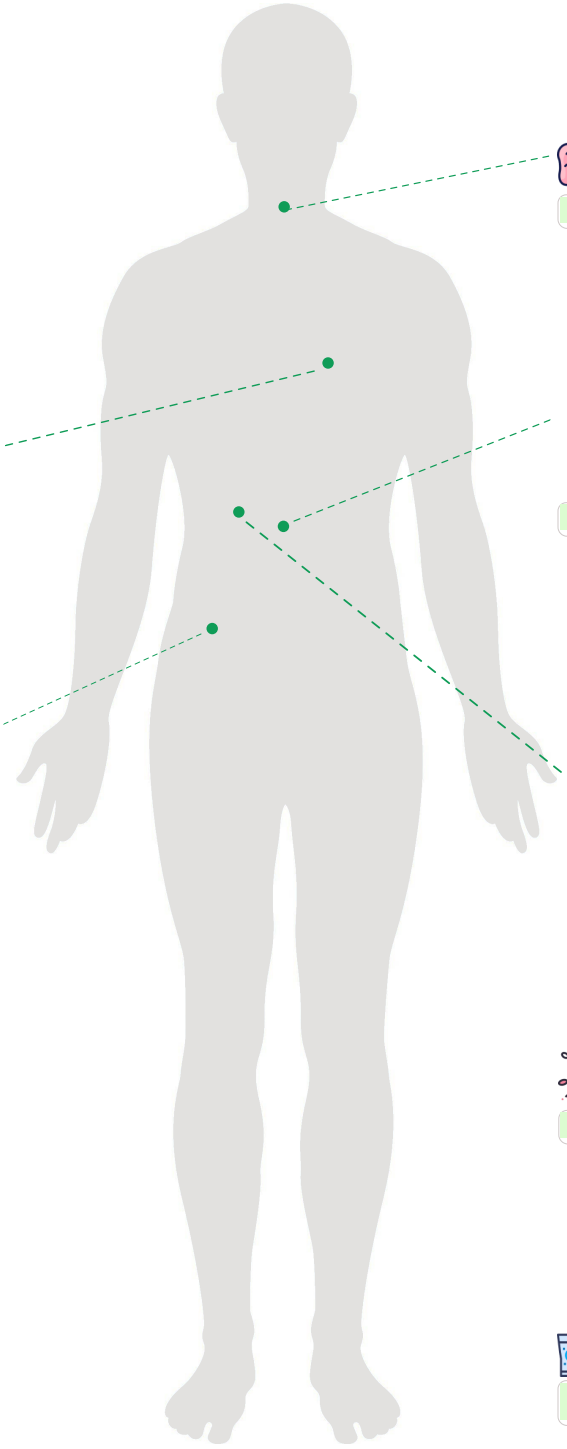
Mr Dummy-PL263C

M 50

SMART HEALTH REPORT

Name	Patient ID	Gender	Age
Mr Dummy-PL263C	11050417	M	50

Health Summary



THYROID PROFILE
Everything looks good

LIPID PROFILE
Everything looks good

DIABETES MONITORING
Everything looks good

KIDNEY PROFILE
Everything looks good

LIVER PROFILE
Everything looks good

ANEMIA STUDIES
Everything looks good

VITAMIN PROFILE
Everything looks good

MINERAL PROFILE
Everything looks good

LABORATORY REPORT

Redcliffe labs

Patient NAME	**: Mr Dummy-PL263C**		
DOB/Age/Gender	: 50 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 11050417/OF11050417	Barcode NO	: HR133017
Referred BY	: Self	Sample Type	: Whole blood EDTA
Sample Collected	: Jan 13, 2025, 11:44 AM	Report Date	: Jan 13, 2025, 01:32 PM.

MC-5280

Test Description	Value(s)	Unit(s)	Reference Range
Full Body Package with Thyroid Panel- Comprehensive			
Complete Blood Count (CBC)			
RBC Parameters			
Hemoglobin *Cyanide free spectrophotometry*	13.5	g/dL	13.0 - 17.0
RBC Count *Electrical impedance*	4.7	10^6/µl	4.5 - 5.5
PCV *Calculated*	40.2	%	40 - 50
MCV *Calculated*	89.1	fl	83 - 101
MCH *Calculated*	29	pg	27 - 32
MCHC *Calculated*	32.5	g/dL	31.5 - 34.5
RDW (CV) *Calculated*	13.5	%	11.6 - 14.0
RDW-SD *Calculated*	41.1	fl	35.1 - 43.9
WBC Parameters			
TLC *Electrical impedance and microscopy*	4.8	10^3/µl	4 - 10
Differential Leucocyte Count			
Neutrophils *Flow-cytometry DHSS*	57.1	%	40 - 80
Lymphocytes *Flow-cytometry DHSS*	29.6	%	25 - 35
Monocytes *Flow-cytometry DHSS*	9.1	%	2 - 10
Eosinophils *Flow-cytometry DHSS*	3.7	%	0 - 5
Basophils *Flow-cytometry DHSS*	0.5	%	0 - 1
Absolute Leukocyte Counts ***Calculated***			
Neutrophils. *Calculated*	2.74	10^3/µl	2 - 7
Lymphocytes. *Calculated*	1.42	10^3/µl	1 - 3
Monocytes. *Calculated*	0.44	10^3/µl	0.2 - 1.0
Eosinophils. *Calculated*	0.18	10^3/µl	0.02 - 0.5

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Test Description	Value(s)	Unit(s)	Reference Range
Basophils. *Calculated*	0.02	10^3/µl	0.02 - 0.5
Platelet Parameters			
Platelet Count *Electrical impedance and microscopy*	198	10^3/µl	150 - 410
Mean Platelet Volume (MPV) *Calculated*	10	fL	9.3 - 12.1
PCT *Calculated*	0.2	%	0.17 - 0.32
PDW *Calculated*	18.8	fL	8.3 - 25.0
P-LCR *Calculated*	35	%	18 - 50
P-LCC *Calculated*	69	10^9/L	44 - 140
Mentzer Index *Calculated*	18.96	%	> 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

HbA1C (Glycosylated Haemoglobin)

Glycosylated Hemoglobin (HbA1c) *HPLC*	4.8	%	< 5.7
Estimated Average Glucose *Calculated*	91.06	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

Patient NAME	**: Mr Dummy-PL263C**		
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Patient ID / UHID	: 11050417/OF11050417	Barcode NO	: ZH055896
Referred BY	: Self	Sample Type	: FLUORIDE F
Sample Collected	: Jan 13, 2025, 11:44 AM	Report Date	: Jan 13, 2025, 01:33 PM.

MC-5280

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

Glucose Fasting

Glucose Fasting *Hexokinase*	94.0	mg/dL	70 - 100

Interpretation:

Status	Fasting plasma glucose in mg/dL
Normal	<100
Impaired fasting glucose	100 - 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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Referred BY	: Self	Sample Type	: Serum
Sample Collected	: Jan 13, 2025, 11:44 AM	Report Date	: Jan 13, 2025, 01:38 PM.

MC-5280

Liver Function Test (LFT)

Test Description	Value(s)	Unit(s)	Reference Range
Bilirubin Total *Colorimetric Diazo*	1.2	mg/dL	0 - 1.2
Bilirubin Direct *Diazo*	0.2	mg/dL	0 - 0.20
Bilirubin Indirect *Calculated*	1	mg/dL	0.1 - 1.0
SGOT/AST *IFCC without P5P*	38.5	U/L	up to 40
SGPT/ALT *IFCC without P5P*	40	U/L	up to 41
SGOT/SGPT Ratio	0.96	%	-
Alkaline Phosphatase *IFCC*	76.3	U/L	40 - 129
Total Protein *Biuret*	6.98	g/dL	6.6 - 8.7
Albumin *BCG Colorimetric*	4.71	g/dL	3.5 - 5.2
Globulin *Calculated*	**2.27**	g/dL	2.3 - 3.5
Albumin :Globulin Ratio *Calculated*	2.07	-	1.3 - 2.1
Gamma Glutamyl Transferase (GGT) *IFCC*	24.1	U/L	10 - 71

Interpretation:
The liver filters and processes blood as it circulates through the body. It metabolizes nutrients, detoxifies harmful substances, makes blood clotting proteins, and performs many other vital functions. The cells in the liver contain proteins called enzymes that drive these chemical reactions. When liver cells are damaged or destroyed, the enzymes in the cells leak out into the blood, where they can be measured by blood tests Liver tests check the blood for two main liver enzymes. Aspartate aminotransferase (AST),SGOT: The AST enzyme is also found in muscles and many other tissues besides the liver. Alanine aminotransferase (ALT), SGPT: ALT is almost exclusively found in the liver. If ALT and AST are found together in elevated amounts in the blood, liver damage is most likely present. Alkaline Phosphatase and GGT: Another of the liver's key functions is the production of bile, which helps digest fat. Bile flows through the liver in a system of small tubes (ducts), and is eventually stored in the gallbladder, under the liver. When bile flow is slow or blocked, blood levels of certain liver enzymes rise: Alkaline phosphatase Gamma-utamyl transpeptidase (GGT) Liver tests may check for any or all of these enzymes in the blood. Alkaline phosphatase is by far the most commonly tested of the three. If alkaline phosphatase and GGT are elevated, a problem with bile flow is most likely present. Bile flow problems can be due to a problem in the liver, the gallbladder, or the tubes connecting them. Proteins are important building blocks of all cells and tissues. Proteins are necessary for your body's growth, development, and health. Blood contains two classes of protein, albumin and globulin. Albumin proteins keep fluid from leaking out of blood vessels. Globulin proteins play an important role in your immune system. Low total protein may

Indicate:
1.Bleeding
2.Liver disorder
3.Malnutrition
4.Agammaglobulinemia High Protein levels 'Hyperproteinemia: May be seen in dehydration due to inadequate water intake or to excessive water loss (eg, severe vomiting, diarrhea, Addison's disease and diabetic acidosis) or as a result of increased production of proteins Low albumin levels may be

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MC-5280

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

Caused by:
1.A poor diet (malnutrition).
2.Kidney disease.
3.Liver disease. High albumin levels may be caused by: Severe dehydration.

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MC-5280

Kidney Function Test (KFT)

Test Description	Value(s)	Unit(s)	Reference Range
Blood Urea *Urease*	26	mg/dL	16.6 - 48.5
Bun *Urease*	12.15	mg/dL	6 - 20
Creatinine *Jaffe*	0.85	mg/dL	0.70 - 1.20
eGFR (CKD-EPI)	105.84	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*	14.29		12 - 20
Urea / Creatinine Ratio	30.59		
Uric Acid *Enzymatic colorimetric*	5.1	mg/dL	3.4 - 7.0
Calcium Serum *BAPTA*	9.48	mg/dL	8.6 - 10.0
Phosphorus *Molybdate UV*	3.93	mg/dL	2.5 - 4.5
Sodium *ISE-Indirect*	142.69	mmol/L	136 - 145
Potassium *ISE-Indirect*	5.1	mmol/L	3.5 - 5.1
Chloride *ISE-Indirect*	104.3	mmol/L	98 - 107

Interpretation:
Kidney function tests is a collective term for a variety of individual tests and proceduresthat can be done toevaluate how well the kidneys are functioning. Many conditions can affect the ability of the kidneys to carryout their vital functions. Somelead to a rapid (acute) decline in kidney functionothers lead to a gradual (chronic) declineinfunction. Both result in a buildup of toxic waste subst 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. Electrolytes are present in the human body and the balancing act of the electrolytes in our bodies is essential for normal function of our cells and organs. There has to be a balance.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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Lipid Profile

Test Description	Value(s)	Unit(s)	Reference Range
Total Cholesterol *Enzymatic - Cholesterol Oxidase*	190.5	mg/dL	<200
Triglycerides *Glycerol phosphate oxidase*	140	mg/dL	<150
HDL Cholesterol *Enzymatic colorimetric*	67	mg/dL	> 40
Non HDL Cholesterol *Calculated*	123.5	mg/dL	<130
LDL Cholesterol *Calculated*	95.5	mg/dL	<100
V.L.D.L Cholesterol *Calculated*	28	mg/dL	< 30
Chol/HDL Ratio *Calculated*	2.84	Ratio	-
HDL/ LDL Ratio *Calculated*	0.7	Ratio	-
LDL/HDL Ratio *Calculated*	1.43	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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MC-5280

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

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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MC-5280

Iron Studies

Test Description	Value(s)	Unit(s)	Reference Range
Iron *FerroZine*	146.3	µg/dL	33 - 193
TIBC,(Total Iron Binding Capacity) *Method :Spectrophotometric Assay*	373.7	µg/dL	250 - 450
UIBC *FerroZine*	227.4	µg/dL	125 - 345
Transferrin Saturation *Method :Derived from IRON and TIBC values*	39.15	%	-

Interpretation:
Increased levels due to iron ingestion or ineffective erythropoiesis.Decreased levels due to infection, inflammation, malignancy, menstruation and Fe deficiency.Needs to be taken into consideration with TIBC. Transferrin Saturation:- Low level Transferrin Saturation can indicate iron deficiency, erythropoiesis, infection, or inflammation. High level Transferrin Saturation can indicate recent ingestion of dietary iron,ineffective erythropoiesis,haemochromatosis or liver disease.High TIBC, UIBC, or transferrin usually indicates iron deficiency, but they are also increased in pregnancy and with the use of oral contraceptives. Low TIBC, UIBC, or transferrin may occur if someone has:Hemochromatosis, Certain types of anemia due to accumulated iron,Malnutrition,kidney disease that causes a loss of protein in urine.

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MC-5280

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

Vitamin B12 / Cyanocobalamin

Vitamin - B12 *ECLIA*	256	pg/mL	197 - 771

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

"Patients on Biotin supplement may have interference in some immunoassays. Ref: Arch Pathol Lab Med—Vol 141, November 2017. With individuals taking high dose Biotin (more than 5 mg per day) supplements, at least 8-hour wait time before blood draw is recommended."

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MC-5280

Test Description	Value(s)	Unit(s)	Reference Range
Vitamin D 25 Hydroxy			
Vitamin D 25 - Hydroxy *ECLIA*	40	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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Test Description	Value(s)	Unit(s)	Reference Range

FT3 (Free Triiodothyronine 3)

T3, Free *ECLIA*	3.1	pg/mL	2.0 - 4.4 Pregnancy : 2.0 - 3.8

Interpretation:
1. Triiodothyronine (T3) is one of the two primary thyroid hormones the thyroid gland produces, along with thyroxine (T4). T3 regulates metabolism, energy production, growth, and development throughout the body.

2. Free T3 refers to the portion of T3 that is unbound to proteins in the blood and is considered the active form of the hormone. It represents the fraction of T3 available for cellular uptake and metabolic activity.

3. The free T3 blood test assesses thyroid function and diagnoses thyroid disorders, such as hyperthyroidism (overactive thyroid) or hypothyroidism (underactive thyroid). It provides valuable information about the body's metabolic rate and thyroid hormone status.

FT4 (Free Thyroxine 4)

T4, Free *ECLIA*	0.95	ng/dL	0.93 - 1.7

Interpretation:
1. Free T4 is the unbound and active form of thyroxine, a hormone produced by the thyroid gland that helps regulate metabolism, energy production, and overall growth and development. Interpreting free T4 levels helps diagnose thyroid function disorders.

2. Low free T4 levels, indicative of hypothyroidism, can result from several causes. Primary hypothyroidism occurs when the thyroid gland itself is underactive, often due to Hashimoto's thyroiditis, iodine deficiency, or thyroid surgery. Secondary hypothyroidism arises when the pituitary gland fails to produce sufficient thyroid-stimulating hormone (TSH) to activate the thyroid, commonly due to pituitary disorders. Tertiary hypothyroidism is caused by the hypothalamus failing to produce enough thyrotropin-releasing hormone (TRH), which leads to decreased production of TSH and subsequently T4.

3. High free T4 levels, indicative of hyperthyroidism, can be caused by various conditions. Graves' disease, an autoimmune disorder, overstimulates the thyroid gland, leading to excessive hormone production. Overactive thyroid nodules can also contribute to high free T4 levels by producing excess hormone independently. Thyroiditis, an inflammation of the thyroid, can release stored hormones into the bloodstream, causing elevated levels. Overmedication with thyroid hormone replacement can also result in high free T4 levels.

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MC-5280

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

TSH 3rd Generation

Thyroid Stimulating Hormone (Ultrasensitive) *ECLIA*	2.31	µlU/mL	0.35 - 4.94

Interpretation:

Pregnancy	Reference ranges TSH
1 st Trimester	0.1 - 2.5
2 ed Trimester	0.2 - 3.0
3 rd Trimester	0.3 - 3.0

Note:
TSH levels are subject to circadian variation, reaching peak levels between 2-4 am. and at a minimum between 6-10 pm. The variation is of 50 %, hence time of the day has influence on the measured serum TSH concentrations.

Clinical Use:
- Diagnose Hypothyroidism and Hyperthyroidism
- Monitor T4 replacement or T4 suppressive therapy
- Qunatify TSH levels in the subnormal range

Increased Levels : Primary hypothyroidism, Subclinical hypothyroidis, TSH dependent Hyperthyroidism, Thyroid hormone resistance
Decreased Levels: Grace disease, Autonomous thyroid hormone secretion, TSH deficiency

Patient NAME	**: Mr Dummy-PL263C**		
DOB/Age/Gender	: 50 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 11050417/OF11050417	Barcode NO	: YB647999
Referred BY	: Self	Sample Type	: Spot Urine
Sample Collected	: Jan 13, 2025, 11:44 AM	Report Date	: Jan 13, 2025, 01:32 PM.

MC-5280

Urine Routine and Microscopic Examination

Test Description	Value(s)	Unit(s)	Reference Range
Physical Examination			
Volume *visual*	20	ml	-
Colour *visual*	Pale yellow	-	Pale yellow
Transparency *visual*	Clear	-	Clear
Deposit *visual*	Absent	-	Absent
Chemical Examination			
Reaction (pH) *Double Indicator*	6.5	-	4.5 - 8.0
Specific Gravity *Ion Exchange*	1.010	-	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	Absent
Crystals	Absent	-	Absent
Cast	Absent	-	Absent
Yeast Cells	Absent	-	Absent
Amorphous deposits	Absent	-	Absent
Bacteria	Absent	-	Absent
Protozoa	Absent	-	Absent

Interpretation:

Booking Centre :- REDCLIFFE - ILC NOIDA
Processing Lab :- Redcliffe Lifetech Pvt. Ltd., H-55, Sector-63, Noida, Uttar Pradesh - 201301

Patient NAME	**: Mr Dummy-PL263C**		
DOB/Age/Gender	: 50 Y/Male	Report STATUS	: Final Report
Patient ID / UHID	: 11050417/OF11050417	Barcode NO	: YB647999
Referred BY	: Self	Sample Type	: Spot Urine
Sample Collected	: Jan 13, 2025, 11:44 AM	Report Date	: Jan 13, 2025, 01:32 PM.

MC-5280

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

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

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 ***

Terms and Conditions of Reporting

1. The presented findings in the Reports are intended solely for informational and interpretational purposes by the referring physician or other qualified medical professionals possessing a comprehensive understanding of reporting units, reference ranges, and technological limitations. The laboratory shall not be held liable for any interpretation or misinterpretation of the results, nor for any consequential or incidental damages arising from such interpretation.

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.

3. It is to be noted that variations in results may occur between different laboratories and over time, even for the same parameter for the same Customer. The assays are performed and conducted in accordance with standard procedures, and the reported outcomes are contingent on the specific individual assay methods and equipment(s) used, as well as the quality of the received specimen.

4. This report shall not be deemed valid or admissible for any medico-legal purposes.

5. The Customers assume full responsibility for apprising the Company of any factors that may impact the test finding. These factors, among others, includes dietary intake, alcohol, or medication / drug(s) consumption, or fasting. This list of factors is only representative and not exhaustive.

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