Barcode No	**13818085**	Lab No	00012507011770
Patient Name	**Mr.ANIL;**	Reg Date	01/Jul/2025 03:15PM
Age/Sex	54 YRS/Male	Sample Coll. Date	01/Jul/2025 02:22 PM
Refered By	DR. SUDHIR JAIN	Sample Rec.Date	01/Jul/2025 03:49 PM
Client Code/Name	AP010003 A.S.P.C.		
Ref. Lab/Hosp		Report Date	01/Jul/2025 04:43PM
Panel Address	WASIM SAIFI (9654617487)		

Nirogyam Accuprobe Profile II

HAEMATOLOGY

Test Name With Methodology	Result	Unit	Biological Ref.Interval
Complete Blood Count (CBC EXT)			
Haemoglobin Whole Blood EDTA, Cyanide free	16.0	gm/dl	13.0-17.0
TLC (Total Leucocyte Count) /(WBC) Whole Blood EDTA, Flow Cytometry	5.37	th/cumm	4.0-10.0
DIFFERENTIAL LEUCOCYTE COUNT			
Polymorphs Whole Blood EDTA Flowcytometry	49	%	40-80
Lymphocytes Flowcytometry	**40.2**	%	20-40
Eosinophils Flowcytometry	1.5	%	1-6
Monocytes Whole Blood EDTA Flowcytometry	8.5	%	2-10
Basophils Whole Blood EDTA Flowcytometry	0.8	%	0-1
Absolute Neutrophil Count Whole Blood EDTA, Flowcytometry	2,631	/cumm	2000-7000
Absolute Lymphocyte Count. Whole Blood EDTA, Flowcytometry	2,159	/µL	1000.0 - 3000.0
Absolute Eosinophil Count Whole Blood EDTA, Flowcytometry	81	/cumm	20-500
Absolute Monocyte Count Whole Blood EDTA, Flowcytometry	456	/cumm	20-1000
Absolute Basophils Count Whole Blood EDTA, Flowcytometry	43	/cumm	20-100
RBC Whole Blood EDTA, Impedance	**5.61**	millions/cmm	4.5-5.5
HCT Whole Blood EDTA, Calculated	49	%	40-50
MCV Whole Blood EDTA, Calculated	87.34	fl	83-101
MCH	28.52	pg	27-32

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Whole Blood EDTA, Calculated			
MCHC	32.65	g/dl	31.5-34.5
Whole Blood EDTA, Calculated			
Platelet Count	205	thou/µL	150-410
Whole Blood EDTA, Impedance			
MPV	**12.9**	fl	7.4-10.4
Calculated			
RDW- CV	**14.1**	%	11.6-14.0
CALCULATED			
Whole Blood EDTA, Flowcytometry			
RDW- SD	43.6	fl	35-56
CALCULATED			
Whole Blood EDTA, Flowcytometry			
PCT	0.26	%	0.10-0.28
Whole Blood EDTA, Flow Cytometry			
PDW	16.1	fl	9.0-17.0
CALCULATED			
Whole Blood EDTA, Calculated			
Mentzer Index	15.57	Ratio	
RDWI	219.52		
Green and King	67.22		
Neutrophil - Lymphocyte Ratio (NLR)	1.22	Ratio	
Calculated			
Lymphocyte - Monocyte Ratio (LMR)	4.73	Ratio	
Calculated			
Platelet - Lymphocyte Ratio (PLR)	94.96	Ratio	
Calculated			
ESR [Westergren]	13	mm/ 1 hr	0 -15
Modified Westergren			

Kindly correlate clinically. Advise for recheck from fresh sample in case, it is not correlation clinically, to rule out any pre-analytical error.

Referrance range according to Practical Haematology, Dacie & Lewis, 12th edition, 2012.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval

.IMMUNO BIOCHEMISTRY-1

Glucose Fasting (Blood Glucose Fasting)

Blood Sugar Fasting Plasma Fluoride, Hexokinase	**249**	mg/dL	70-100

COMMENTS:
Fasting Blood Sugar/Glucose test. A blood sample will be taken after an overnight fast. A fasting blood sugar level less than 100 mg/dL is normal. A fasting blood sugar level from 100 to 125 mg/dL is considered prediabetes. If it's 126 mg/dL or higher on two separate tests, you have diabetes. (***American Diabetes Association***)

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
	HAEMATOLOGY		
HbA1c (Glycated hemoglobin)			
Glycosylated Hb (HbA1c) EDTA, HPLC	**8.0**	%	4.2-6.5
Average Glucose Calculated.	**183**	mg/dl	73-140

Ref Range for HBA1c

Non Diabetic: < 5.7 %
Pre-Diabetic: 5.7 - 6.5 %
Diabetic: > 6.5 %

Remark: Hemoglobin A1c criteria for diagnosing diabetes have not been established for patients who are <18 years of age.

HbA1c goals in treatment of diabetes:

Ages 0-6 years: 7.6% - 8.4%
Ages 6-12 years: <8%
Ages 13-19 years: <7.5%
Adults: <7%

COMMENT:

The Glycosylated Hemoglobin (HbA1c or A1c) test evaluates the average amount of glucose in the blood over the last 2 to 3 months. This test is used to monitor treatment in someone who has been diagnosed with diabetes. It helps to evaluate how well the person's glucose levels have been controlled by treatment over time. This test may be used to screen for and diagnose diabetes or risk of developing diabetes. Depending on the type of diabetes that a person has, how well their diabetes is controlled, and on doctor recommendations, the HbA1c test may be measured 2 to 4 times each year. The American Diabetes Association recommends HbA1c testing in diabetics at least twice a year. When someone is first diagnosed with diabetes or if control is not good, HbA1c may be ordered more frequently.

Note: If a person has anemia, few type of hemoglobinopathy, hemolysis, or heavy bleeding, HbA1c test results may be falsely low. If someone is iron-deficient, the HbA1c level may be increased. If a person has had a recent blood transfusion, the HbA1c may be inaccurate and may not accurately reflect glucose control for 2 to 3 months..

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.IMMUNO BIOCHEMISTRY-1

Iron Panel Basic

Test Name With Methodology	Result	Unit	Biological Ref.Interval
Iron Serum, FerroZine without deproteinization	107.0	ug/dl	33-193
UIBC Direct determination with FerroZine	224	ug/dL	63 - 433
TIBC Serum, Calculated	330.55	ug/dL	250 - 400
Transferrin Saturation Calculated	32.37	%	15-55

COMMENT:

Serum iron measures the amount of circulating iron that is bound to transferrin. Clinicians order this laboratory test when they are concerned about iron deficiency, which can cause anemia and other problems.
Total iron-binding capacity The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood. Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anemia, iron deficiency or iron deficiency anemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
Kidney Panel-2			
Blood Urea Serum, Urease, GLDH	31.2	mg/dL	21-40.0
Serum Creatinine. Serum, Jaffes	0.90	mg/dL	0.7-1.2
Uric Acid Enzymatic colorimetry	5.95	mg/dL	3.4 - 7.0
Sodium Serum, Ion Selective Electrode	**134.3**	mmol/L	136-145
Potassium Serum, Ion Selective Electrode	4.34	mmol/L	3.7-5.5
Chloride Serum, Ion Selective Electrode	98.60	mmol/L	98-107
Calcium. Serum, NM-BAPTA	9.68	mg/dL	8.6-10.0
Phosphorus Serum Serum, Molybdate UV	**2.45**	mg/dl	2.5-4.5
BUN (Blood Urea Nitrogen) Serum, Calculated	14.58	mg/dL	6.0-20.0
BUN/Creatinine Ratio Calculated	16.2	Ratio	10-20
Urea/Creatinine Ratio Calculated	34.67	Ratio	
eGFR (estimated Glomerular Filtration Rate) Calculated	93.61	mL/min/1.73 m2	>60

The National Kidney Foundation recommends using the Estimated GFR using MDRD Creatinine Equation (2021) to estimate GFR. (http://surl.li/lwaub)

Kindly correlate clinically. Advise for recheck from fresh sample in case, it is not correlation clinically, to rule out any pre-analytical error.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
Lipid Profile			
Cholesterol Serum, CHOD-PAP Enzymatic	**241.0**	mg/dL	<200
Triglyceride Serum, GPO, Colorimetric	**191.0**	mg/dL	<150
HDL-Cholesterol Serum, Homogeneous Enz.Colorimetric	43.6	mg/dL	40-60
LDL Cholesterol Serum, Calculated	**159.2**	mg/dl	0-100
VLDL Cholesterol Serum, Calculated	38.2	mg/dl	5 - 40
LDL / HDL Ratio Serum, Calculated	**3.65**	Ratio	0 - 3.55
HDL / LDL Ratio Serum, Calculated	0.27	Ratio	>0.3
Chol / HDL Ratio Serum, Calculated	**5.53**	Ratio	0 - 4.97
Non-HDL Cholesterol Serum, Calculated	**197.4**	mg/dl	<130

Lipids are a group of fats and fat-like substances that are important constituents of cells and sources of energy. The lipid profile is used as part of a cardiac risk assessment to help determine an individual's risk of heart disease. It is recommended that healthy adults with no other risk factors for heart disease be tested with a fasting lipid profile once every four to six years. If other risk factors are present or if previous testing revealed a high cholesterol level in the past, more frequent testing is recommended.

TOTAL CHOLESTEROL	(mg/dl)	HDL	(mg/dl)	LDL	(mg/dl)	TRIGLYCERIDES	(mg/dl)
DESIRABLE	<200	LOW	<40	OPTIMAL	<100	NORMAL	<150
BORDERLINE HIGH	200-239	HIGH	>60	NEAR OPTIMAL	100-129	BORDERLINE HIGH	150-199
HIGH	>240			BORDERLINE HIGH	130-159	HIGH	200-499
				HIGH	160-189	VERY HIGH	>500
				VERY HIGH	>190		

*REFERENCE RANGES AS PER NCEP ATP III GUIDELINES

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
Liver Panel (LFT)			
Total Bilirubin. Serum, DCA	0.62	mg/dl	0.0-1.2
Conjugated Bilirubin Serum, DCA	0.26	mg/dl	0.0-0.3
Unconjugated Bilirubin Serum, Calculated	0.36	mg/dL	0.2-0.7
SGOT (AST) Serum, Optimized UV test with IFCC	27.20	IU/L	0 -40
SGPT (ALT) Serum, Optimized UV test with IFCC	**44.50**	IU/L	0-41
Alk.Phosphatase Serum, Kinetic, IFCC	69.20	IU/L	40-129
T.Protein Serum, Biuret	7.18	gm/dl	6.4-8.3
Albumin.. Serum, Bromocresol Green	4.47	gm/dL	3.5-5.2
Globulin Serum, Calculated	2.71	gm/dl	2.3- 3.5
A/G Ratio Serum, Calculated	1.65	Ratio	1.30 - 1.70
Gamma G.T. Serum, Kinetic with IFCC	24.40	IU/L	<60
SGOT/SGPT Ratio Serum, Calculated	0.61	Ratio	0-5

Comment:

A liver panel (Liver function test) or one or more of its component tests may be used to help diagnose liver disease if a person has symptoms that indicate possible liver dysfunction. If a person has a known condition or liver disease, testing may be performed at intervals to monitor liver status and to evaluate the effectiveness of any treatments.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
Thyroid Profile-I [T3,T4,TSH]			
T3 (Triiodothyronine) Serum, Chemi Luminescent Immuno Assay	135.3	ng/dl	60-181
T4 (Thyroxine) Serum, Chemi Luminescent Immuno Assay	6.51	ug/dl	4.5-12.6
TSH (Ultrasensitive) Serum, Electro Chemi Luminescent Immuno Assay	2.99	uIU/mL	0.13-6.33

Comments:

- Our reference range applies the central 95th interval (2.5th – 97.5th quantile) according to the CLSI/IFCC guidelines EP28-A3c.
- A circadian variation in serum TSH in healthy subjects is well documented. TSH level is reaching peak levels between 2-4 am 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 value of TSH.
- TSH levels between 6.3 and 15.0 may represent subclinical or compensated hypothyroidism or show considerable physiological & seasonal variation, suggest clinical correlation or repeat testing with fresh sample.
- TSH levels may be transiently altered because of non-thyroid illness, like severe infection, renal disease, liver disease, heart disease, severe burns, trauma, surgery etc. Few drugs also altered the TSH values.
- A high TSH result often means an underactive thyroid gland caused by failure of the gland (hypothyroidism). A low TSH result can indicate an overactive thyroid gland (hyperthyroidism) or damage to the pituitary gland that prevents it from producing TSH.
- Resistance to thyroid hormone (RTH) and central hyperthyroidism (TSH-oma) are rare conditions associated with elevated TSH, T4 and T3 levels.

Below mentioned are the guidelines for age reference ranges for T3,T4 and TSH results:

Age	Total T3 (ng/dl)	Total T4 (µg/dl)	TSH (µlU/ml)
1 - 6 days	73 - 288	5.04 - 18.5	0.7 - 15.0
6 days - 3 months	80 - 275	5.41 - 17.0	0.72 - 11.0
4 - 12 months	86 - 265	5.67 - 16.0	0.73 - 8.35
1 - 6 years	92 - 248	5.95 - 14.7	0.70 - 5.97
7 - 11 years	93 - 231	5.99 - 13.8	0.60 - 5.84
12 - 20 years	91 - 218	5.91 - 13.2	0.51 - 6.50
>20 years	60 - 181	4.50 - 12.6	0.13 - 6.33

TSH Level in pregnancy

First Trimester	0.10 – 2.5 µlU/ml
Second Trimester	0.20 – 3.0 µlU/ml
Third Trimester	0.30 – 3.0 µlU

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CLINICAL PATHOLOGY

Urine R/M (Urine Analysis)

Test Name With Methodology	Result	Unit	Biological Ref.Interval
PHYSICAL EXAMINATION			
Color Urine, Visual	Pale Yellow		
Transparency Visual	S. Hazy		Clear
pH Double indicator	6.0		4.7-7.5
Specific Gravity Urine, Hydrogenous ionogen reaction	1.010		1.005-1.035
CHEMICAL EXAMINATION			
Urine Glucose Urine, Oxidation reaction	Negative		Negative
Urine Protein. Urine, Protein ionization	Negative		Negative
Urine Bilirubin Urine, Azo- coupling reaction	Negative		Negative
Ketones Urine, Acetoacetate and nitroprusside reaction	Negative		Negative
Urobilinogen Urine, p-aminobenzoic acid and phenazopyridine reaction	Normal		Normal
Nitrate Urine, Diazotized reaction	Negative		Negative
Blood Urine, perroxiase reaction	Negative		Negative
Leukocytes Est Urine, Esterases	Trace		Negative
MICROSCOPIC EXAMINATION			
Pus Cells. Urine, Manual Microscopic	5-7	/hpf	0-5
Epithelial Cells Urine, Manual Microscopic	2-3	/hpf	0-5
R.B.C. Manual Microscopic	Not Seen	/hpf	Not Seen
Crystals	Not Seen	/hpf	Not Seen

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Urine, Manual Microscopic Casts	Not Seen	/lpf	Not Seen
Urine, Manual Microscopic Bacteria	Not Detected		Not Detected

Manual Microscopic

.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval

.IMMUNO BIOCHEMISTRY-1

Vitamin B12 (Cynocobalamin)

Vitamin B12 Level Serum, Electro Chemi Luminescent Immuno Assay	330.0	pg/ml	197-711

Comment:

Vitamin B12 (cobalamin) is an important water-soluble vitamin. In contrast to other water-soluble vitamins it is not excreted quickly in the urine, but rather accumulates and is stored in the liver, kidney and other body tissues. Humans obtain Vitamin B12 exclusively from animal dietary sources, such as meat, eggs and milk. As a result, a vitamin B12 deficiency may not manifest itself until after 5 or 6 years of a diet supplying inadequate amounts. Vitamin B12 functions as a methyl donor and works with folic acid in the synthesis of DNA and red blood cells and is vitally important in maintaining the health of the insulation sheath (myelin sheath) that surrounds nerve cells. Preservatives such as fluorides & ascorbic acid interfere with this assay. Excessive exposure of the specimen to light may alter Vitamin B12 result.

Kindly correlate with clinical conditions.

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Test Name With Methodology	Result	Unit	Biological Ref.Interval
Vitamin D (25 Hydroxyvitamin D)			
Vitamin D, 25 Hydroxy Serum, Electro Chemi Luminescent Immuno Assay	73.30	ng/mL	Deficiency: <20.0 Insufficient: 21-29 Sufficient: 30-100

Comments:
This test is used to determine the levels of Total 25-hydroxy-vitamin D and is used to determine if bone weakness, bone malformation, or abnormal metabolism of calcium is occurring as a result of a deficiency or excess of vitamin D. Since vitamin D is a fat-soluble vitamin and is absorbed from the intestine like a fat, vitamin D is also s used to monitor individuals with diseases that interfere with fat absorption, such as cystic fibrosis and Crohn's disease, and in patients who have had gastric bypass surgery and may not be able to absorb enough Vitamin D. Vitamin D is also used to determine effectiveness of treatment when vitamin D, calcium, phosphorus, and/or magnesium supplementation is prescribed. Reasons for suboptimal 25-OH-VitD levels include lack of sunshine exposure, inadequate intake; malabsorption eg, due to Celiac disease); depressed hepatic vitamin D 25-hydroxylase activity, secondary to advanced liver disease; and enzyme-inducing drugs, in particular many antiepileptic drugs, including phenytoin, phenobarbital, and carbamazepine, that increase 25-OH-VitD metabolism. In contrast to the high prevalence of 25-OH-VitD deficiency, hypervitaminosis D is rare, and is only seen after prolonged exposure to extremely high doses of vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.
For diagnostic purposes, the results should always be assessed in conjunction with the patient's medical history, clinical examination and other findings.

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Terms & Conditions

- The reported results are for the information of the referring doctor and should be correlated to clinical diagnosis.
- In case of insufficient quantity or poor quality of specimen test will not be performed. In such cases it is expected that fresh specimen is sent for reporting of the same parameter.
- There may be circumstances beyond our control that can delay results, e.g., invalid assay run.
- The results of a laboratory test are dependent on the quality of the sample as well as the assay procedure.
- The report is to be interpreted and used by medical personnel only.
- This reports is not intended for medico-legal purpose.
- Assays are performed in accordance with standard procedures. Results may vary from time to time and from lab to lab for the same parameter for the same patient. The reported results are dependent on individual assay method or equipments used and quality of specimen(s) received. Investigations have their limitations and isolated laboratory investigations may not confirm the final diagnosis of disease. They only assist in arriving at diagnosis in conjunction with clinical presentation and other related investigations.
- For the test performed on specimens received or collected from different locations, it is presumed that the specimen belongs to the patient named or identified as labeled on the container/test request form and such verification has been carried out at the point of generation of the said specimen by the sender.
- Accuprobe will be responsible only for the analytical part of the test carried out. All other responsibility will be of referring Laboratory.
- If any dispute arising in future party can file the suit in the court of law with the jurisdiction within Delhi jurisdiction only.

---------- End of Report ----------

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