



	Dr. Vinay Chopr MD (Pathology & Mic Chairman & Consulta	robiology)	MI	m Chopra D (Pathology) ht Pathologist
NAME	: Mrs. SARWAN KAUR			
AGE/ GENDER	: 70 YRS/FEMALE		PATIENT ID	: 1567276
COLLECTED BY	: SURJESH		REG. NO./LAB NO.	: 012408010019
REFERRED BY	•		REGISTRATION DATE	: 01/Aug/2024 10:32 AM
BARCODE NO.	: 01514235		COLLECTION DATE	: 01/Aug/2024 10:44AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		REPORTING DATE	: 01/Aug/2024 10:55AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMB	ALA CANT		. 01/ hug/ 2024 10.00/hit
Test Name		Value	Unit	Biological Reference interval
	SWAS	THYA W	ELLNESS PANEL: 1.0	
	CON	/IPLETE BI	LOOD COUNT (CBC)	
RED BLOOD CELLS (F	RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB)		11.8 ^L	gm/dL	12.0 - 16.0
RED BLOOD CELL (RE	BC) COUNT FOCUSING, ELECTRICAL IMPEDENCE	4.01	Millions	/cmm 3.50 - 5.00
PACKED CELL VOLUN		36.3 ^L	%	37.0 - 50.0
MEAN CORPUSCULA		90.7	fL	80.0 - 100.0
MEAN CORPUSCULA	R HAEMOGLOBIN (MCH) AUTOMATED HEMATOLOGY ANALYZER	29.6	pg	27.0 - 34.0
MEAN CORPUSCULA	R HEMOGLOBIN CONC. (MCHC)	32.6	g/dL	32.0 - 36.0
RED CELL DISTRIBUT	TON WIDTH (RDW-CV)	13.1	%	11.00 - 16.00
RED CELL DISTRIBUT	TON WIDTH (RDW-SD) AUTOMATED HEMATOLOGY ANALYZER	44.5	fL	35.0 - 56.0
MENTZERS INDEX		22.62	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDE	X	29.8	RATIO	BETA THALASSEMIA TRAIT: < = 65.0 IRON DEFICIENCY ANEMIA: > 65.0
WHITE BLOOD CELLS	S (WBCS)			INCO DELICIENCI ANEMIA. 2 03.0
TOTAL LEUCOCYTE C		6490	/cmm	4000 - 11000
NUCLEATED RED BLO		NIL		0.00 - 20.00
	DOD CELLS (nRBCS) % NUTOMATED HEMATOLOGY ANALYZER &	NIL	%	< 10 %

KOS Diagnostic Lab (A Unit of KOS Healthcare)



DR.VINAY CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY)



TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.





EXCELLENCE IN HEALTHCARE & DIAGNOSTICS

Dr. Yugam Chopra

MD (Pathology & Microbiology) MD (Pathology) Chairman & Consultant Pathologist **CEO & Consultant Pathologist** NAME : Mrs. SARWAN KAUR **PATIENT ID AGE/ GENDER** : 70 YRS/FEMALE :1567276 **COLLECTED BY** : SURJESH :012408010019 REG. NO./LAB NO. **REFERRED BY** :01/Aug/2024 10:32 AM : **REGISTRATION DATE BARCODE NO.** :01514235 **COLLECTION DATE** :01/Aug/2024 10:44AM **CLIENT CODE.** : KOS DIAGNOSTIC LAB **REPORTING DATE** :01/Aug/2024 10:55AM **CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit **Biological Reference interval NEUTROPHILS** 72^H % 50 - 70 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY

Dr. Vinay Chopra

LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	20	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6	%	2 - 12
BASOPHILS by flow cytometry by SF cube & microscopy ABSOLUTE LEUKOCYTES (WBC) COUNT	0	%	0 - 1
ABSOLUTE NEUTROPHIL COUNT by flow cytometry by SF cube & microscopy	4673	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by flow cytometry by SF cube & microscopy	1298	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by flow cytometry by sf cube & microscopy	130	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	389	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by flow cytometry by SF cube & microscopy	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE MARKE	<u>RS.</u>		
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	236000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.27	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by hydro dynamic focusing, electrical impedence	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by hydro dynamic focusing, electrical impedence	85000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	35.9	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) by hydro dynamic focusing, electrical impedence NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD	16.4	%	15.0 - 17.0



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Chairman & Consultant Pathologist		Pathology) Pathologist
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6349/1, NICHOLSON ROAD, AMBALA CANTT		
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7 5 0 K	O YRS/FEMALE URJESH 11514235 COS DIAGNOSTIC LAB	20 YRS/FEMALE PATIENT ID URJESH REG. NO./LAB NO. REGISTRATION DATE 01514235 COLLECTION DATE COS DIAGNOSTIC LAB REPORTING DATE 0349/1, NICHOLSON ROAD, AMBALA CANTT





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ERYTHROCYTE SEDIMENTATION RATE (ESR) INPUT SEDIMENTATION RATE (ESR) by MODIFIED WESTERGREN AUTOMATED METHOD INTERPRETATION: • SSR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer mmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other is C-reactive protein This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others ystemic lupus erythematosus ONDITION WITH LOW ESR Now ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (leucocytosis) , and some protein abnormalities. Some changes in red cell si s is ckle cells in sickle cell anaemia) also lower the ESR. OTE: • ESR and C - reactive protein (C-RP) are both markers of inflammation. • GRP is not affected by as many other factors as is ESR, making it a better marker of inflammation. • CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation. • CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation. • CRP is not affected by as many other factors as is ESR, making it a bet	T ADDRESS	6349/1, NICHOLSON ROAD, A	AMBALA CANTI		
RYTHROCYTE SEDIMENTATION RATE (ESR) 10 mm/1st hr 0 - 20 by MODIFIED WESTERGREN AUTOMATED METHOD NTERPRETATION: . ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer mmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. . An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other s C-reactive protein . This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others ystemic lupus erythematosus CONDITION WITH LOW ESR I ow ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell si s sickle cells in sickle cell anaemia) also lower the ESR. IDTE: . ESR and C - reactive protein (C-RP) are both markers of inflammation. . Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves. . CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation . . If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen. . Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. . Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR	lame		Value	Unit	Biological Reference interval
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	eactive protein test may also be inc lupus erythem TION WITH LOW ESR can be seen wy thaemia), signifi le cells in sickle of and C - reactive p erally, ESR does r is not affected by e ESR is elevated nen tend to have as such as dextra	used to monitor disease activi natosus ESR with conditions that inhibit the cantly high white blood cell co cell anaemia) also lower the ES protein (C-RP) are both markers not change as rapidly as does C r as many other factors as is ESF , it is typically a result of two ty a higher ESR, and menstruation n, methyldopa, oral contracent	ty and response normal sedime unt (leucocytos SR. of inflammation RP, either at the R, making it a be ypes of proteins n and pregnancy	e to therapy in both of the a ntation of red blood cells, s is) , and some protein abno n. e start of inflammation or a tter marker of inflammatio , globulins or fibrinogen. (can cause temporary eleva	bove diseases as well as some others, such as uch as a high red blood cell count rmalities. Some changes in red cell shape (such s it resolves. 1.



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Test Name		Value	Unit	Biological Reference interval
				-
	PR		/IE STUDIES (PT/INR)	
PT TEST (PATIENT) by PHOTO OPTICAL C		OTHROMBIN TIN 13.1	NE STUDIES (PT/INR) Secs	11.5 - 14.5
by PHOTO OPTICAL C	CLOT DETECTION			
by PHOTO OPTICAL C PT (CONTROL) by PHOTO OPTICAL C	CLOT DETECTION	13.1	SECS	
РТ (CONTROL) by photo optical c ISI by photo optical c	CLOT DETECTION CLOT DETECTION CLOT DETECTION DRMALISED RATIO (INR)	13.1 12	SECS	

INTERPRETATION:-

1.INR is the parameter of choice in monitoring adequacy of oral anti-coagulant therapy. Appropriate therapeutic range varies with the disease and treatment intensity.

2. Prolonged INR suggests potential bleeding disorder /bleeding complications

3. Results should be clinically correlated.

4. Test conducted on Citrated Plasma

RECOMMENDED THERAPEUTIC RANGE FOR	ORAL ANTI-CO	AGULANT THI	ERAPY (INR)
INDICATION		INTERNATIO	NAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis			
Treatment of pulmonary embolism			
Prevention of systemic embolism in tissue heart valves			
Valvular heart disease	Low Intensity		2.0 - 3.0
Acute myocardial infarction			
Atrial fibrillation			
Bileaflet mechanical valve in aortic position			
Recurrent embolism			
Mechanical heart valve	High Intensity		2.5 - 3.5
Antiphospholipid antibodies ⁺			
COMMENTS:			

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Test Name		Value Unit	Biological Reference interval

The prothrombin time (PT) and its derived measures of prothrombin ratio (PR) and international normalized ratio (INR) are measures of the efficacy of the extrinsic pathway of coagulation. PT test reflects the adequacy of factors I (fibrinogen), II (prothrombin), V, VII, and X. It is used in conjunction with the activated partial thromboplastin time (aPTT) which measures the intrinsic pathway. The common causes of prolonged prothrombin time are :

1.Oral Anticoagulant therapy.

2.Liver disease.

3.Vit K. deficiency.

4.Disseminated intra vascular coagulation. 5.Factor 5, 7, 10 or Prothrombin dificiency



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Test Name		Value	Unit	Biological Reference interval
	CL	INICAL CHEMIS	TRY/BIOCHEMISTR	Y
		GLUCOSE	FASTING (F)	
GLUCOSE FASTING (I by glucose oxidas	F): PLASMA e - peroxidase (god-pod)	96.48	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0

KOS Diagnostic Lab (A Unit of KOS Healthcare)

A fasting plasma glucose level below 100 mg/dl is considered normal.
 A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.
 A fasting plasma glucose level of above 125 mg/dl is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients.
 A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.



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Test Name		Value	Unit	Biological Reference interval
		LIPID PROFILE :	BASIC	
CHOLESTEROL TOTA	L: SERUM	167.5	mg/dL	OPTIMAL: < 200.0
by CHOLESTEROL OX			3	BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SER		122.38	mg/dL	OPTIMAL: < 150.0
by GLYCEROL PHOSP	PHATE OXIDASE (ENZYMATIC)			BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0
				VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (67.05	mg/dL	LOW HDL: < 30.0
by SELECTIVE INHIBIT	TON			BORDERLINE HIGH HDL: 30.0 -
				60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: S	SERUM	75.97	mg/dL	OPTIMAL: < 100.0
by CALCULATED, SPE			<u>J</u>	ABOVE OPTIMAL: 100.0 - 129.0
				BORDERLINE HIGH: 130.0 - 159.0
				HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTE	ROL: SERUM	100.45	mg/dL	OPTIMAL: < 130.0
by CALCULATED, SPE		100110		ABOVE OPTIMAL: 130.0 - 159.0
				BORDERLINE HIGH: 160.0 - 189.0
				HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL	SFRUM	24.48	mg/dL	0.00 - 45.00
by CALCULATED, SPE	ECTROPHOTOMETRY	21110	°.	0.00 10.00
TOTAL LIPIDS: SERU		457.38	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL		2.5	RATIO	LOW RISK: 3.30 - 4.40
by CALCULATED, SPE				AVERAGE RISK: 4.50 - 7.0
				MODERATE RISK: 7.10 - 11.0
LDL/HDL RATIO: SER		1.13	RATIO	HIGH RISK: > 11.0 LOW RISK: 0.50 - 3.0
by CALCULATED, SPE		1.15	NATIO	MODERATE RISK: 3.10 - 6.0
				HIGH RISK: > 6.0

KOS Diagnostic Lab (A Unit of KOS Healthcare)

DR.VINAY CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS , MD (PATHOLOGY)

KOS Central Lab:6349/1, Nicholson Road, Ambala Cantt -133 001, HaryanaKOS Molecular Lab:IInd Floor, Parry Hotel, Staff Road, Opp. GPO, Ambala Cantt -133 001, Haryana0171-2643898, +91 99910 43898care@koshealthcare.comwww.koshealthcare.comwww.koshealthcare.com



TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.





		Chopra y & Microbiology) Consultant Pathologist	Dr. Yugam MD CEO & Consultant	(Pathology)
NAME	: Mrs. SARWAN KAUR			
AGE/ GENDER	: 70 YRS/FEMALE	PATI	ENT ID	: 1567276
COLLECTED BY	: SURJESH	REG. I	NO./LAB NO.	: 012408010019
REFERRED BY	:	REGIS	TRATION DATE	: 01/Aug/2024 10:32 AM
BARCODE NO.	: 01514235	COLLI	ECTION DATE	: 01/Aug/2024 10:44AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPO	RTING DATE	: 01/Aug/2024 12:06PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROA	D, AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
TRIGLYCERIDES/HD		1.83 ^L	RATIO	3.00 - 5.00

INTERPRETATION:

1. Measurements in the same patient can show physiological & analytical variations. Three serial samples 1 week apart are recommended for Total Cholesterol, Triglycerides, HDL & LDL Cholesterol.

2. As per NLA-2014 guidelines, all adults above the age of 20 years should be screened for lipid status. Selective screening of children above the age of 2 years with a family history of premature cardiovascular disease or those with at least one parent with high total cholesterol is recommended.

 Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.
 NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL, VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co- primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL & Non HDL

5. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement





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	Dr. Vinay Cho MD (Pathology & M Chairman & Consu	1icrobiology)		(Pathology)
NAME	: Mrs. SARWAN KAUR			
AGE/ GENDER	: 70 YRS/FEMALE		PATIENT ID	: 1567276
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AM			. 017 Hug, 202 1 12.001 M
	. 0040/1, MonoLSON Rond, M	VIDITEIT OTTIVIT		
Test Name		Value	Unit	Biological Reference interval
	LIV	ER FUNCTIO	N TEST (COMPLETE)	
BILIRUBIN TOTAL: SI by DIAZOTIZATION, SF	ERUM PECTROPHOTOMETRY	0.41	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
	CONJUGATED): SERUM	0.14	mg/dL	0.00 - 0.40
-	(UNCONJUGATED): SERUM	0.27	mg/dL	0.10 - 1.00
SGOT/AST: SERUM	RIDOXAL PHOSPHATE	20.81	U/L	7.00 - 45.00
SGPT/ALT: SERUM	RIDOXAL PHOSPHATE	19.92	U/L	0.00 - 49.00
AST/ALT RATIO: SER by CALCULATED, SPE	UM	1.04	RATIO	0.00 - 46.00
ALKALINE PHOSPHA by para nitrophen propanol	TASE: SERUM YL PHOSPHATASE BY AMINO METHYL	69.62	U/L	40.0 - 130.0
GAMMA GLUTAMYL by SZASZ, SPECTROF	. TRANSFERASE (GGT): SERUM PHTOMETRY	12.53	U/L	0.00 - 55.0
TOTAL PROTEINS: SE by BIURET, SPECTRO	ERUM	7.27	gm/dL	6.20 - 8.00
ALBUMIN: SERUM		3.99	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPE		3.28	gm/dL	2.30 - 3.50
A : G RATIO: SERUM by CALCULATED, SPE		1.22	RATIO	1.00 - 2.00

<u>INTERPRETATION</u> NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Referance Range.

USE:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

INCREASED:

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5





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	Dr. Vinay Chop MD (Pathology & M Chairman & Consult	icrobiology)	Dr. Yugam MD CEO & Consultant	(Pathology)	
NAME	: Mrs. SARWAN KAUR				
AGE/ GENDER	: 70 YRS/FEMALE	PATI	ENT ID	: 1567276	
COLLECTED BY	: SURJESH	REG.	NO./LAB NO.	:012408010019	
REFERRED BY	:	REGIS	STRATION DATE	:01/Aug/2024 10:32	AM
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AM	IBALA CANTT			
Test Name		Value	Unit	Biological R	eference interval
HEPATOCELLULAR C	ARCINOMA & CHRONIC HEPATITIS		> 1.3 (Slightly Inc	reased)	

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)

2. Extra Hepatic cholestatis: 0.8 (normal or slightly decreased).

NORMAL	< 0.65
GOOD PROGNOSTIC SIGN	0.3 - 0.6
POOR PROGNOSTIC SIGN	1.2 - 1.6



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		nopra & Microbiology) nsultant Pathologist	Dr. Yugam Chopra MD (Pathology) CEO & Consultant Pathologist	
NAME AGE/ GENDER	: Mrs. SARWAN KAUR : 70 YRS/FEMALE	 D	ATIENT ID	: 1567276
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD,	AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
	кі	DNEY FUNCTION	I TEST (COMPLETE)	
UREA: SERUM		42.68	mg/dL	10.00 - 50.00
by UREASE - GLUTAN CREATININE: SERUN	/ATE DEHYDROGENASE (GLDH) /	1.06	mg/dL	0.40 - 1.20
by ENZYMATIC, SPEC		1.00	Thy/de	0.40 - 1.20
	DGEN (BUN): SERUM ECTROPHOTOMETRY	19.94	mg/dL	7.0 - 25.0
-	GEN (BUN)/CREATININE	18.81	RATIO	10.0 - 20.0
RATIO: SERUM				
by CALCULATED, SPE UREA/CREATININE F	ECTROPHOTOMETRY RATIO: SERLIM	40.26	RATIO	
	ECTROPHOTOMETRY	40.20	KATIO	
URIC ACID: SERUM by URICASE - OXIDAS		3.33	mg/dL	2.50 - 6.80
CALCIUM: SERUM	SE PERUXIDASE	8.78	mg/dL	8.50 - 10.60
by ARSENAZO III, SPE				
PHOSPHOROUS: SEF	RUM DATE, SPECTROPHOTOMETRY	3.06	mg/dL	2.30 - 4.70
ELECTROLYTES				
SODIUM: SERUM		136.7	mmol/L	135.0 - 150.0
by ISE (ION SELECTIV		2.02	mmal //	2 50 5 00
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE) CHLORIDE: SERUM		3.83	mmol/L	3.50 - 5.00
		102.53	mmol/L	90.0 - 110.0
by ISE (ION SELECTIV	,			
	RULAR FILTERATION RATE	F / F		
estimated glome (eGFR): SERUM by calculated	RULAR FILTERATION RATE	56.5		

INTERPRETATION:

To differentiate between pre- and post renal azotemia.

INCREASED RATIO (>20:1) WITH NORMAL CREATININE:

1. Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate.

2. Catabolic states with increased tissue breakdown.



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	MD	Vinay Chopra (Pathology & Microbio rman & Consultant Pa	ology)	Yugam (MD (P onsultant Pa	Pathology)			
NAME	: Mrs. SARWAN K	AUR						
AGE/ GENDER	: 70 YRS/FEMALE		PATIENT ID		: 1567276			
COLLECTED BY	: SURJESH		REG. NO./LAB N	n	:0124080100	19		
REFERRED BY	. Setwebit		REGISTRATION					
					: 01/Aug/2024			
BARCODE NO.	:01514235		COLLECTION DA		:01/Aug/2024 1			
CLIENT CODE.	: KOS DIAGNOSTIO		REPORTING DAT	ГЕ	:01/Aug/20241	12:06PM		
CLIENT ADDRESS	: 6349/1, NICHOL	SON ROAD, AMBALA	CANTT					
Test Name	_	Val	lue U	nit	Biologi	ical Refer	ence inter	val
burns, surgery, cache 7. Urine reabsorption 3. Reduced muscle m 9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal azotemia 2. Prerenal azotemia	kia, high fever). (e.g. ureter colostor ass (subnormal crea tetracycline, glucocc D:1) WITH ELEVATED (BUN rises dispropo superimposed on re	ny) tinine production) orticoids) CREATININE LEVELS: rtionately more than nal disease.	: infection, GI bleeding, th creatinine) (e.g. obstructi			Irome, hig	sh protein o	diet,
burns, surgery, cache 7. Urine reabsorption 3. Reduced muscle m 9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal azotemia 2. Prerenal azotemia DECREASED RATIO (<1 1. Acute tubular necro 2. Low protein diet ar 3. Severe liver disease 4. Other causes of de 5. Repeated dialysis (6. Inherited hyperam 7. SIADH (syndrome c 8. Pregnancy. DECREASED RATIO (<1 1. Phenacimide thera 2. Rhabdomyolysis (ru 3. Muscular patients 5. Muscular patients 5. Muscular patients 6. Joiabetic ketoacido 5. Should produce an inu 2. Cephalosporin ther ESTIMATED GLOMERU	kia, high fever). (e.g. ureter colostor ass (subnormal crea tetracycline, glucoco D:1) WITH ELEVATED (BUN rises dispropo superimposed on re D:1) WITH DECREASE Disis. d starvation. creased urea synthe urea rather than crea monemias (urea is v f inappropiate antid D:1) WITH INCREASE Dy (accelerates conv eleases muscle creat who develop renal fa- sis (acetoacetate cat creased BUN/creatir apy (interferes with LAR FILTERATION RA	ny) tinine production) orticoids) CREATININE LEVELS: rtionately more than nal disease. D BUN : sis. atinine diffuses out o irtually absent in bloc iuretic harmone) due D CREATININE: ersion of creatine to o inine). ailure. uses false increase in ine ratio). creatinine measuremo TE:	creatinine) (e.g. obstruction of extracellular fluid). od). to tubular secretion of une creatinine). creatinine with certain me ent).	ve uropath ea.	iy). es,resulting in no	ormal ratio		
2. Urine reabsorption 3. Reduced muscle m 4. Certain drugs (e.g. NCREASED RATIO (>2 4. Postrenal azotemia DECREASED RATIO (<1 4. Acute tubular necro 5. Low protein diet ar 6. Severe liver disease 6. Other causes of de 6. Repeated dialysis (6. Inherited hyperam 7. SIADH (syndrome c 8. Pregnancy. DECREASED RATIO (<1 9. Phenacimide thera 8. Rabdomyolysis (ro 8. Muscular patients 9. Muscular pa	kia, high fever). (e.g. ureter colostor ass (subnormal crea tetracycline, glucocc D:1) WITH ELEVATED (BUN rises dispropo superimposed on re D:1) WITH DECREASE D:3: d starvation. creased urea synthe urea rather than crea monemias (urea is v f inappropiate antid D:1) WITH INCREASE Dy (accelerates conv eleases muscle creating who develop renal factors is (acetoacetate can creased BUN/creating apy (interferes with LAR FILTERATION RA	ny) tinine production) orticoids) CREATININE LEVELS: rtionately more than nal disease. D BUN : sis. atinine diffuses out o irtually absent in bloc iuretic harmone) due D CREATININE: ersion of creatine to o inine). ailure. uses false increase in nine ratio). creatinine measurement TE:	creatinine) (e.g. obstruction of extracellular fluid). od). to tubular secretion of ure creatinine). creatinine with certain me ent). GFR (mL/min/1.73m2)	ve uropath ea. ethodologi	es,resulting in no	ormal ratio		
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DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY)







	Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Patholog		(Pathology)
NAME	: Mrs. SARWAN KAUR		
AGE/ GENDER	: 70 YRS/FEMALE	PATIENT ID	: 1567276
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REFERRED BY	:	REGISTRATION DATE	: 01/Aug/2024 10:32 AM
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CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 01/Aug/2024 12:06PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANT	ſT	
Test Name	Value	Unit	Biological Reference interval

COMMENTS:

Estimated Glomerular filtration rate (eGFR) is the sum of filtration rates in all functioning nephrons and so an estimation of the GFR provides a measure of functioning nephrons of the kidney.
 eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
 In patients, with eGFR creatinine between 45-59 ml/min/1.73 m2 (G3) and without any marker of Kidney damage, It is recommended to measure of CFD with the commended to measure

3. In patients, with eGFR cleaning between 45-59 minimit 1.73 m2 (G3) and without any marker of Kidney damage, it is recommended to measure eGFR with Cystatin C for confirmation of CKD
4. eGFR category G1 OR G2 does not fulfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).

ADVICE:

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated





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	Dr. Vinay Ch MD (Pathology & Chairman & Cons		Dr. Yugan MD CEO & Consultant	(Pathology)
NAME	: Mrs. SARWAN KAUR			
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CLIENT CODE.	: KOS DIAGNOSTIC LAB	REP	ORTING DATE	: 01/Aug/2024 11:26AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, A	AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
		CLINICAL PA	THOLOGY	
		OUTINE & MICRO	SCOPIC EXAMINAT	ΓΙΟΝ
PHYSICAL EXAMINA				
OUANTITY RECIEVE		10	ml	
	U CTANCE SPECTROPHOTOMETRY	10	ml	
COLOUR		PALE YELLOW		PALE YELLOW
	CTANCE SPECTROPHOTOMETRY			
TRANSPARANCY		CLEAR		CLEAR
	CTANCE SPECTROPHOTOMETRY	1.00		1 000 1 000
SPECIFIC GRAVITY	CTANCE SPECTROPHOTOMETRY	1.02		1.002 - 1.030
CHEMICAL EXAMIN				
REACTION	men	ACIDIC		
	CTANCE SPECTROPHOTOMETRY	ACIDIC		
PROTEIN		Trace		NEGATIVE (-ve)
by DIP STICK/REFLEC	CTANCE SPECTROPHOTOMETRY			(
SUGAR		Negative		NEGATIVE (-ve)
	CTANCE SPECTROPHOTOMETRY			
pH by DIP STICK/REELEC	CTANCE SPECTROPHOTOMETRY	6.5		5.0 - 7.5
BILIRUBIN		Negative		NEGATIVE (-ve)
	CTANCE SPECTROPHOTOMETRY			
NITRITE		Negative		NEGATIVE (-ve)
	CTANCE SPECTROPHOTOMETRY.	Norreal		0.2 1.0
UROBILINOGEN	CTANCE SPECTROPHOTOMETRY	Normal	EU/dL	0.2 - 1.0
KETONE BODIES		Negative		NEGATIVE (-ve)
	CTANCE SPECTROPHOTOMETRY	insgativo		
BLOOD		Negative		NEGATIVE (-ve)
	CTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID		NEGATIVE (-ve)	NEGATIVE (-ve)
by DIF STICKKEFLEC	CTANCE SPECTROPHOTOMETRY			

MICROSCOPIC EXAMINATION



DR.VINAY CHOPRA CONSULTANT PATHOLOGIST MBBS, MD (PATHOLOGY & MICROBIOLOGY)

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST MBBS , MD (PATHOLOGY)







Dr. Vinay Chopra

MD (Pathology & Microbiology) Chairman & Consultant Pathologist



Dr. Yugam Chopra MD (Pathology) CEO & Consultant Pathologist

NAME	: Mrs. SARWAN KAUR				
AGE/ GENDER	: 70 YRS/FEMALE	PATIEN	ΓID	: 1567276	
COLLECTED BY	: SURJESH	REG. NO	./LAB NO.	: 012408010019	
REFERRED BY	:	REGIST	RATION DATE	: 01/Aug/2024 10:32 AM	
BARCODE NO.	: 01514235		FION DATE	: 01/Aug/2024 10:44AM	
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORT	ING DATE	: 01/Aug/2024 11:26AM	
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AM		MBALA CANTT			
Test Name		Value	Unit	Biological Reference interval	
				, end and end of the second se	
RED BLOOD CELLS (F by MICROSCOPY ON ((BCS) CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)	/HPF	0 - 3	
PUS CELLS by MICROSCOPY ON (CENTRIFUGED URINARY SEDIMENT	2-3	/HPF	0 - 5	
EPITHELIAL CELLS by MICROSCOPY ON (CENTRIFUGED URINARY SEDIMENT	3-5	/HPF	ABSENT	

NEGATIVE (-ve) CRYSTALS NEGATIVE (-ve) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT CASTS NEGATIVE (-ve) NEGATIVE (-ve) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT BACTERIA NEGATIVE (-ve) NEGATIVE (-ve) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT NEGATIVE (-ve) NEGATIVE (-ve) OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT TRICHOMONAS VAGINALIS (PROTOZOA) ABSENT ABSENT

by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT

*** End Of Report ***



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