

Dr. Vinay Chopra  
MD (Pathology & Microbiology)  
Chairman & Consultant Pathologist

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

NAME : Mr. A.K GUPTA  
AGE/ GENDER : 75 YRS/MALE  
COLLECTED BY : SURJESH  
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)  
BARCODE NO. : 01517594  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1623473  
REG. NO./LAB NO. : 012409240015  
REGISTRATION DATE : 24/Sep/2024 10:01 AM  
COLLECTION DATE : 24/Sep/2024 10:11 AM  
REPORTING DATE : 24/Sep/2024 10:33 AM

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

SWASTHYA WELLNESS PANEL: Y  
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	11.9 <sup>L</sup>	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.2	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	37.6 <sup>L</sup>	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	89.6	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.3	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.6 <sup>L</sup>	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	14.2	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	47.4	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	21.33	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	30.26	RATIO	BETA THALASSEMIA TRAIT: <= 65.0 IRON DEFICIENCY ANEMIA: > 65.0

WHITE BLOOD CELLS (WBCS)

TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	7170	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by AUTOMATED 6 PART HEMATOLOGY ANALYZER	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) % by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	NIL	%	< 10 %

DIFFERENTIAL LEUCOCYTE COUNT (DLC)

NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	54	%	50 - 70
--	----	---	---------



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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 10:33AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	30	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	8 <sup>H</sup>	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	8	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	%	0 - 1
<b>ABSOLUTE LEUKOCYTES (WBC) COUNT</b>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	3872	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	2151	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	574 <sup>H</sup>	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	574	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE &amp; MICROSCOPY</i>	0	/cmm	0 - 110
<b>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</b>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	185000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.21	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	11	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	66000	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	35.9	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.5	%	15.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11 AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 02:30 PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

#### GLYCOSYLATED HAEMOGLOBIN (HbA1c)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)	gH	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)	182.9H	mg/dL	60.00 - 140.00

#### INTERPRETATION:

#### AS PER AMERICAN DIABETES ASSOCIATION (ADA):

REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (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	<b>Age &gt; 19 Years</b>
	Goals of Therapy:
	< 7.0
	Actions Suggested:
	>8.0
	<b>Age &lt; 19 Years</b>
	Goal of therapy:
	<7.5

#### COMMENTS:

- Glycosylated hemoglobin (HbA1c) test is three monthly monitoring done to assess compliance with therapeutic regimen in diabetic patients.
- Since Hb1c reflects long term fluctuations in blood glucose concentration, a diabetic patient who has recently under good control may still have high concentration of HbA1c. Converse is true for a diabetic previously under good control but now poorly controlled.
- 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.
- High HbA1c (>9.0 -9.5 %) is strongly associated with risk of development and rapid progression of microvascular and nerve complications
- Any condition that shortens RBC life span like acute blood loss, hemolytic anemia falsely lowers HbA1c results.
- HbA1c results from patients with HbSS, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirement that adversely impact HbA1c as a marker of long-term glycemic control.
- Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.



  
 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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 10:54AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

### ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	10	mm/1st hr	0 - 20
--------------------------------------	----	-----------	--------

by RED CELL AGGREGATION BY CAPILLARY PHOTOMETRY

#### INTERPRETATION:

1. ESR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and auto-immune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
3. 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, such as systemic lupus erythematosus

#### CONDITION WITH LOW ESR

A low 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 shape (such as sickle cells in sickle cell anaemia) also lower the ESR.

#### NOTE:

1. ESR and C - reactive protein (C-RP) are both markers of inflammation.
2. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
3. **CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.**
4. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen.
5. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations.
6. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while aspirin, cortisone, and quinine may decrease it



  
 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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:00AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

#### PROTHROMBIN TIME STUDIES (PT/INR)

PT TEST (PATIENT) by PHOTO OPTICAL CLOT DETECTION	12.8	SECS	11.5 - 14.5
PT (CONTROL) by PHOTO OPTICAL CLOT DETECTION	12	SECS	
ISI by PHOTO OPTICAL CLOT DETECTION	1.1		
INTERNATIONAL NORMALISED RATIO (INR) by PHOTO OPTICAL CLOT DETECTION	1.07		0.80 - 1.20
PT INDEX by PHOTO OPTICAL CLOT DETECTION	93.75	%	

#### 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-COAGULANT THERAPY (INR)

INDICATION	INTERNATIONAL NORMALIZED RATIO (INR)
Treatment of venous thrombosis	2.0 - 3.0
Treatment of pulmonary embolism	
Prevention of systemic embolism in tissue heart valves	
Valvular heart disease	
Acute myocardial infarction	
Atrial fibrillation	
Bileaflet mechanical valve in aortic position	
Recurrent embolism	2.5 - 3.5
Mechanical heart valve	
Antiphospholipid antibodies <sup>+</sup>	

COMMENTS:



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:00AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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 deficiency





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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 12:57PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

### CLINICAL CHEMISTRY/BIOCHEMISTRY

#### GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	122.53 <sup>H</sup>	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > OR = 126.0
--	---------------------	-------	---


#### INTERPRETATION

##### IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.
2. 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.
3. 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.



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
<b>LIPID PROFILE : BASIC</b>			
CHOLESTEROL TOTAL: SERUM <i>by CHOLESTEROL OXIDASE PAP</i>	110.19	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM <i>by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)</i>	116.55	mg/dL	OPTIMAL: < 150.0 BORDERLINE HIGH: 150.0 - 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (DIRECT): SERUM <i>by SELECTIVE INHIBITION</i>	36.84	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	50.04	mg/dL	OPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 - 129.0 BORDERLINE HIGH: 130.0 - 159.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	73.35	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.0 BORDERLINE HIGH: 160.0 - 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	23.31	mg/dL	0.00 - 45.00
<b>TOTAL LIPIDS: SERUM</b> <i>by CALCULATED, SPECTROPHOTOMETRY</i>	<b>336.93<sup>L</sup></b>	<b>mg/dL</b>	<b>350.00 - 700.00</b>
CHOLESTEROL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.99	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0
LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.36	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0





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

<b>NAME</b>	: Mr. A.K GUPTA		
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>PATIENT ID</b>	: 1623473
<b>COLLECTED BY</b>	: SURJESH	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>BARCODE NO.</b>	: 01517594	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
TRIGLYCERIDES/HDL RATIO: SERUM	3.16	RATIO	3.00 - 5.00


by CALCULATED, SPECTROPHOTOMETRY

**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.
3. 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.
4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogenic lipoproteins such as LDL, VLDL, IDL, Lp(a), 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



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

### LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM <i>by DIAZOTIZATION, SPECTROPHOTOMETRY</i>	0.57	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.19	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.38	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	18.73	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	18.45	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.02	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	92.96	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	36.56	U/L	0.00 - 55.0
<b>TOTAL PROTEINS: SERUM</b> <i>by BIURET, SPECTROPHOTOMETRY</i>	<b>6.04<sup>L</sup></b>	<b>gm/dL</b>	<b>6.20 - 8.00</b>
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	3.53	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.51	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.41	RATIO	1.00 - 2.00

#### INTERPRETATION

**NOTE:-** To be correlated in individuals having SGOT and SGPT values higher than Normal Reference 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
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

**DECREASED:**

1. Acute Hepatitis due to virus, drugs, toxins (with AST increased 3 to 10 times upper limit of normal)
2. Extra Hepatic cholestasis: 0.8 (normal or slightly decreased).

**PROGNOSTIC SIGNIFICANCE:**

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



  
**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 : Mr. A.K GUPTA  
AGE/ GENDER : 75 YRS/MALE  
COLLECTED BY : SURJESH  
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)  
BARCODE NO. : 01517594  
CLIENT CODE. : KOS DIAGNOSTIC LAB  
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1623473  
REG. NO./LAB NO. : 012409240015  
REGISTRATION DATE : 24/Sep/2024 10:01 AM  
COLLECTION DATE : 24/Sep/2024 10:11AM  
REPORTING DATE : 24/Sep/2024 12:20PM

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)	51.65 <sup>H</sup>	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETRY	1.76 <sup>H</sup>	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	24.14	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	13.72	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	29.35	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	4.11	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	8.88	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.05	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	138.8	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.44	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	104.1	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM by CALCULATED	39.8
--	------

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.



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

<b>NAME</b>	: Mr. A.K GUPTA		
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>PATIENT ID</b>	: 1623473
<b>COLLECTED BY</b>	: SURJESH	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>BARCODE NO.</b>	: 01517594	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB	<b>REPORTING DATE</b>	: 24/Sep/2024 12:20PM
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

3. GI haemorrhage.
4. High protein intake.
5. Impaired renal function plus
6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
7. Urine reabsorption (e.g. ureter colostomy)
8. Reduced muscle mass (subnormal creatinine production)
9. Certain drugs (e.g. tetracycline, glucocorticoids)

**INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:**

1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy).
2. Prerenal azotemia superimposed on renal disease.

**DECREASED RATIO (<10:1) WITH DECREASED BUN :**

1. Acute tubular necrosis.
2. Low protein diet and starvation.
3. Severe liver disease.
4. Other causes of decreased urea synthesis.
5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
6. Inherited hyperammonemias (urea is virtually absent in blood).
7. SIADH (syndrome of inappropriate antidiuretic hormone) due to tubular secretion of urea.
8. Pregnancy.

**DECREASED RATIO (<10:1) WITH INCREASED CREATININE:**

1. Phenacimide therapy (accelerates conversion of creatine to creatinine).
2. Rhabdomyolysis (releases muscle creatinine).
3. Muscular patients who develop renal failure.

**INAPPROPRIATE RATIO:**

1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
2. Cephalosporin therapy (interferes with creatinine measurement).

**ESTIMATED GLOMERULAR FILTRATION RATE:**

CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m <sup>2</sup> )	ASSOCIATED FINDINGS
G1	Normal kidney function	>90	No proteinuria
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine
G3a	Mild decrease in GFR	60 -89	
G3b	Moderate decrease in GFR	30-59	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	



*[Signature]*

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

*[Signature]*

**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

<b>NAME</b>	: Mr. A.K GUPTA		
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>PATIENT ID</b>	: 1623473
<b>COLLECTED BY</b>	: SURJESH	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>BARCODE NO.</b>	: 01517594	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB	<b>REPORTING DATE</b>	: 24/Sep/2024 12:20PM
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

**COMMENTS:**

1. 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.
2. eGFR calculated using the 2009 CKD-EPI creatinine equation and GFR category reported as per KDIGO guideline 2012
3. In patients, with eGFR creatinine between 45-59 ml/min/1.73 m<sup>2</sup> (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



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

#### IRON PROFILE

<b>IRON: SERUM</b> <i>by FERROZINE, SPECTROPHOTOMETRY</i>	35 <sup>L</sup>	µg/dL	59.0 - 158.0
UNSATURATED IRON BINDING CAPACITY (UIBC) :SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	319.29	µg/dL	150.0 - 336.0
TOTAL IRON BINDING CAPACITY (TIBC) :SERUM <i>by SPECTROPHOTOMETRY</i>	354.29	µg/dL	230 - 430
<b>%TRANSFERRIN SATURATION: SERUM</b> <i>by CALCULATED, SPECTROPHOTOMETRY (FERENE)</i>	9.88 <sup>L</sup>	%	15.0 - 50.0
TRANSFERRIN: SERUM <i>by SPECTROPHOTOMETRY (FERENE)</i>	251.55	mg/dL	200.0 - 350.0

#### INTERPRETATION:-

VARIABLES	ANEMIA OF CHRONIC DISEASE	IRON DEFICIENCY ANEMIA	THALASSEMIA α/β TRAIT
SERUM IRON:	Normal to Reduced	Reduced	Normal
TOTAL IRON BINDING CAPACITY:	Decreased	Increased	Normal
% TRANSFERRIN SATURATION:	Decreased	Decreased < 12-15 %	Normal
SERUM FERRITIN:	Normal to Increased	Decreased	Normal or Increased

#### IRON:

1. Serum iron studies is recommended for differential diagnosis of microcytic hypochromic anemia.i.e iron deficiency anemia, zinc deficiency anemia, anemia of chronic disease and thalassemia syndromes.

2. It is essential to isolate iron deficiency anemia from Beta thalassemia syndromes because during iron replacement which is therapeutic for iron deficiency anemia, is severely contra-indicated in Thalassemia.

#### TOTAL IRON BINDING CAPACITY (TIBC):

1. It is a direct measure of protein transferrin which transports iron from the gut to storage sites in the bone marrow.

#### % TRANSFERRIN SATURATION:

1. Occurs in idiopathic hemochromatosis and transfusional hemosiderosis where no unsaturated iron binding capacity is available for iron mobilization. Similar condition is seen in congenital deficiency of transferrin.



  
 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

<b>NAME</b>	<b>: Mr. A.K GUPTA</b>		
<b>AGE/ GENDER</b>	<b>: 75 YRS/MALE</b>	<b>PATIENT ID</b>	<b>: 1623473</b>
<b>COLLECTED BY</b>	<b>: SURJESH</b>	<b>REG. NO./LAB NO.</b>	<b>: 012409240015</b>
<b>REFERRED BY</b>	<b>: CENTRAL PHOENIX CLUB (AMBALA CANTT)</b>	<b>REGISTRATION DATE</b>	<b>: 24/Sep/2024 10:01 AM</b>
<b>BARCODE NO.</b>	<b>: 01517594</b>	<b>COLLECTION DATE</b>	<b>: 24/Sep/2024 10:11AM</b>
<b>CLIENT CODE.</b>	<b>: KOS DIAGNOSTIC LAB</b>	<b>REPORTING DATE</b>	<b>: 24/Sep/2024 11:36AM</b>
<b>CLIENT ADDRESS</b>	<b>: 6349/1, NICHOLSON ROAD, AMBALA CANTT</b>		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

## ENDOCRINOLOGY

### THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM	0.526	ng/mL	0.35 - 1.93
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
THYROXINE (T4): SERUM	4.98	µgm/dL	4.87 - 12.60
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
THYROID STIMULATING HORMONE (TSH): SERUM	1.372	µIU/mL	0.35 - 5.50
by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			

3rd GENERATION, ULTRA SENSITIVE

#### INTERPRETATION:

TSH levels are subject to circadian variation, reaching peak levels between 2-4 a.m 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 measured serum TSH concentrations. TSH stimulates the production and secretion of the metabolically active hormones, thyroxine (T4) and triiodothyronine (T3). Failure at any level of regulation of the hypothalamic-pituitary-thyroid axis will result in either underproduction (hypothyroidism) or overproduction (hyperthyroidism) of T4 and/or T3.

CLINICAL CONDITION	T3	T4	TSH
Primary Hypothyroidism:	Reduced	Reduced	Increased (Significantly)
Subclinical Hypothyroidism:	Normal or Low Normal	Normal or Low Normal	High
Primary Hyperthyroidism:	Increased	Increased	Reduced (at times undetectable)
Subclinical Hyperthyroidism:	Normal or High Normal	Normal or High Normal	Reduced

#### LIMITATIONS:-

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.
2. Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (eg: phenytoin, salicylates).
3. Serum T4 levels in neonates and infants are higher than values in the normal adult, due to the increased concentration of TBG in neonate serum.
4. TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROXINE (T4)		THYROID STIMULATING HORMONE (TSH)	
Age	Refferance Range (ng/mL)	Age	Refferance Range (µg/dL)	Age	Reference Range (µIU/mL)
0 - 7 Days	0.20 - 2.65	0 - 7 Days	5.90 - 18.58	0 - 7 Days	2.43 - 24.3
7 Days - 3 Months	0.36 - 2.59	7 Days - 3 Months	6.39 - 17.66	7 Days - 3 Months	0.58 - 11.00
3 - 6 Months	0.51 - 2.52	3 - 6 Months	6.75 - 17.04	3 Days - 6 Months	0.70 - 8.40



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60
RECOMMENDATIONS OF TSH LEVELS DURING PREGNANCY ( $\mu$ U/mL)			
1st Trimester	0.10 - 2.50		
2nd Trimester	0.20 - 3.00		
3rd Trimester	0.30 - 4.10		

#### INCREASED TSH LEVELS:

- 1.Primary or untreated hypothyroidism may vary from 3 times to more than 100 times normal depending upon degree of hypofunction.
- 2.Hypothyroid patients receiving insufficient thyroid replacement therapy.
- 3.Hashimotos thyroiditis
- 4.DRUGS: Amphetamines, idonie containing agents & dopamine antagonist.
- 5.Neonatal period, increase in 1st 2-3 days of life due to post-natal surge

#### DECREASED TSH LEVELS:

- 1.Toxic multi-nodular goitre & Thyroiditis.
- 2.Over replacement of thyroid hormone in treatment of hypothyroidism.
- 3.Autonomously functioning Thyroid adenoma
- 4.Secondary pituitary or hypothalamic hypothyroidism
- 5.Acute psychiatric illness
- 6.Severe dehydration.
- 7.DRUGS: Glucocorticoids, Dopamine, Levodopa, T4 replacement therapy, Anti-thyroid drugs for thyrotoxicosis.
- 8.Pregnancy: 1st and 2nd Trimester



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

## VITAMINS

### VITAMIN D/25 HYDROXY VITAMIN D3

VITAMIN D (25-HYDROXY VITAMIN D3): SERUM by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)	40.5	ng/mL	DEFICIENCY: < 20.0 INSUFFICIENCY: 20.0 - 30.0 SUFFICIENCY: 30.0 - 100.0 TOXICITY: > 100.0
---	------	-------	--

#### INTERPRETATION:

DEFICIENT:	< 20	ng/mL
INSUFFICIENT:	21 - 29	ng/mL
PREFERRED RANGE:	30 - 100	ng/mL
INTOXICATION:	> 100	ng/mL

- Vitamin D compounds are derived from dietary ergocalciferol (from plants, Vitamin D2), or cholecalciferol (from animals, Vitamin D3), or by conversion of 7- dihydrocholecalciferol to Vitamin D3 in the skin upon Ultraviolet exposure.
- 25-OH--Vitamin D represents the main body reservoir and transport form of Vitamin D and transport form of Vitamin D, being stored in adipose tissue and tightly bound by a transport protein while in circulation.
- Vitamin D plays a primary role in the maintenance of calcium homeostasis. It promotes calcium absorption, renal calcium absorption and phosphate reabsorption, skeletal calcium deposition, calcium mobilization, mainly regulated by parathyroid hormone (PTH).
- Severe deficiency may lead to failure to mineralize newly formed osteoid in bone, resulting in rickets in children and osteomalacia in adults.

#### DECREASED:

- Lack of sunshine exposure.
- Inadequate intake, malabsorption (celiac disease)
- Depressed Hepatic Vitamin D 25- hydroxylase activity
- Secondary to advanced Liver disease
- Osteoporosis and Secondary Hyperparathyroidism (Mild to Moderate deficiency)
- Enzyme Inducing drugs: anti-epileptic drugs like phenytoin, phenobarbital and carbamazepine, that increases Vitamin D metabolism.

#### INCREASED:

- Hypervitaminosis D is Rare, and is seen only after prolonged exposure to extremely high doses of Vitamin D. When it occurs, it can result in severe hypercalcemia and hyperphosphatemia.

**CAUTION:** Replacement therapy in deficient individuals must be monitored by periodic assessment of Vitamin D levels in order to prevent hypervitaminosis D

**NOTE:-** Dark coloured individuals as compare to whites, is at higher risk of developing Vitamin D deficiency due to excess of melanin pigment which interfere with Vitamin D absorption.



  
 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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

**VITAMIN B12/COBALAMIN**

**VITAMIN B12/COBALAMIN: SERUM**
172<sup>L</sup>
pg/mL
190.0 - 890.0

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

**INTERPRETATION:-**

INCREASED VITAMIN B12	DECREASED VITAMIN B12
1.Ingestion of Vitamin C	1.Pregnancy
2.Ingestion of Estrogen	2.DRUGS:Aspirin, Anti-convulsants, Colchicine
3.Ingestion of Vitamin A	3.Ethanol lgestion
4.Hepatocellular injury	4. Contraceptive Harmones
5.Myeloproliferative disorder	5.Haemodialysis
6.Uremia	6. Multiple Myeloma

1.Vitamin B12 (cobalamin) is necessary for hematopoiesis and normal neuronal function.  
 2.In humans, it is obtained only from animal proteins and requires intrinsic factor (IF) for absorption.  
 3.The body uses its vitamin B12 stores very economically, reabsorbing vitamin B12 from the ileum and returning it to the liver; very little is excreted.  
 4.Vitamin B12 deficiency may be due to lack of IF secretion by gastric mucosa (eg, gastrectomy, gastric atrophy) or intestinal malabsorption (eg, ileal resection, small intestinal diseases).  
 5.Vitamin B12 deficiency frequently causes macrocytic anemia, glossitis, peripheral neuropathy, weakness, hyperreflexia, ataxia, loss of proprioception, poor coordination, and affective behavioral changes. These manifestations may occur in any combination; many patients have the neurologic defects without macrocytic anemia.  
 6.Serum methylmalonic acid and homocysteine levels are also elevated in vitamin B12 deficiency states.  
 7.Follow-up testing for antibodies to intrinsic factor (IF) is recommended to identify this potential cause of vitamin B12 malabsorption.  
**NOTE:**A normal serum concentration of vitamin B12 does not rule out tissue deficiency of vitamin B12. The most sensitive test for vitamin B12 deficiency at the cellular level is the assay for MMA. If clinical symptoms suggest deficiency, measurement of MMA and homocysteine should be considered, even if serum vitamin B12 concentrations are normal.



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

### TUMOUR MARKER

#### PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL

PROSTATE SPECIFIC ANTIGEN (PSA) - TOTAL:	0.86	ng/mL	0.0 - 4.0
--	------	-------	-----------

SERUM

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

#### INTERPRETATION:

##### NOTE:

1. This is a recommended test for detection of prostate cancer along with Digital Rectal Examination (DRE) in males above 50 years of age.
2. False negative / positive results are observed in patients receiving mouse monoclonal antibodies for diagnosis or therapy
3. PSA levels may appear consistently elevated / depressed due to the interference by heterophilic antibodies & nonspecific protein binding
4. Immediate PSA testing following digital rectal examination, ejaculation, prostatic massage, indwelling catheterization, ultrasonography and needle biopsy of prostate is not recommended as they falsely elevate levels
5. PSA values regardless of levels should not be interpreted as absolute evidence of the presence or absence of disease. All values should be correlated with clinical findings and results of other investigations
6. Sites of Non-prostatic PSA production are breast epithelium, salivary glands, peri-urethral & anal glands, cells of male urethra & breast milk
7. Physiological decrease in PSA level by 18% has been observed in hospitalized / sedentary patients either due to supine position or suspended sexual activity
8. The concentration of PSA in a given specimen, determined with assays from different manufacturers, may not be comparable due to differences in assay methods, calibration, and reagent specificity.

#### RECOMMENDED TESTING INTERVALS

1. Preoperatively (Baseline)
2. 2-4 Days Post operatively
3. Prior to discharge from hospital
4. Monthly Follow Up if levels are high and showing a rising trend

POST SURGERY	FREQUENCY OF TESTING
1st Year	Every 3 Months
2nd Year	Every 4 Months
3rd Year Onwards	Every 6 Months

#### CLINICAL USE:

1. An aid in the early detection of Prostate cancer when used in conjunction with Digital rectal examination in males more than 50 years of age and in those with two or more affected first degree relatives.
2. Followup and management of Prostate cancer patients.
3. Detect metastatic or persistent disease in patients following surgical or medical treatment of Prostate cancer

#### INCREASED LEVEL:

1. Prostate cancer
2. Benign Prostatic Hyperplasia
3. Prostatitis





**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


<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 11:36AM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

4. Genitourinary infections



  
**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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 05:04PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
-----------	-------	------	-------------------------------

## CLINICAL PATHOLOGY

### URINE ROUTINE & MICROSCOPIC EXAMINATION

#### PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	AMBER YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	HAZY		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	1.01		1.002 - 1.030
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			

#### CHEMICAL EXAMINATION

REACTION	ACIDIC		
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
PROTEIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SUGAR	1+		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
pH	6		5.0 - 7.5
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BILIRUBIN	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
NITRITE	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.			
UROBILINOGEN	Normal	EU/dL	0.2 - 1.0
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
KETONE BODIES	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
BLOOD	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
ASCORBIC ACID	NEGATIVE (-ve)		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE 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

<b>NAME</b>	: Mr. A.K GUPTA	<b>PATIENT ID</b>	: 1623473
<b>AGE/ GENDER</b>	: 75 YRS/MALE	<b>REG. NO./LAB NO.</b>	: 012409240015
<b>COLLECTED BY</b>	: SURJESH	<b>REGISTRATION DATE</b>	: 24/Sep/2024 10:01 AM
<b>REFERRED BY</b>	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	<b>COLLECTION DATE</b>	: 24/Sep/2024 10:11AM
<b>BARCODE NO.</b>	: 01517594	<b>REPORTING DATE</b>	: 24/Sep/2024 05:04PM
<b>CLIENT CODE.</b>	: KOS DIAGNOSTIC LAB		
<b>CLIENT ADDRESS</b>	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	2-4	/HPF	0 - 5
EPITHELIAL CELLS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	1-3	/HPF	ABSENT
CRYSTALS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
CASTS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
BACTERIA <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
OTHERS <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	NEGATIVE (-ve)		NEGATIVE (-ve)
TRICHOMONAS VAGINALIS (PROTOZOA) <i>by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT</i>	ABSENT		ABSENT

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



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

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

