

(A Unit of KOS Healthcare)



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

NAME : Mr. HARMINDER PAL SINGH

AGE/ GENDER : 27 YRS/MALE PATIENT ID : 1484558

COLLECTED BY : REG. NO./LAB NO. : 012411060069

 REFERRED BY
 : 06/Nov/2024 08:52 PM

 BARCODE NO.
 : 01520257
 COLLECTION DATE
 : 06/Nov/2024 08:58 PM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 06/Nov/2024 09:44 PM

**CLIENT ADDRESS**: 6349/1, NICHOLSON ROAD, AMBALA CANTT

Test Name Value Unit Biological Reference interval

### SWASTHYA WELLNESS PANEL: 1.0 COMPLETE BLOOD COUNT (CBC)

### RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	15.8	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	5.87 <sup>H</sup>	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	52.3	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	89	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	26.9 <sup>L</sup>	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	30.2 <sup>L</sup>	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	15.7	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	52.7	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	15.16	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	23.79	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	8050	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by automated 6 part hematology analyzer	NIL		0.00 - 20.00
NUCLEATED RED BLOOD CELLS (nRBCS) %	NIL	%	< 10 %



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by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER





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DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
NEUTROPHILS	87 <sup>H</sup>	%	50 - 70
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			0.0 10
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	$\mathbf{6^{L}}$	%	20 - 40
EOSINOPHILS	1	%	1 - 6
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
MONOCYTES	6	%	2 - 12
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	0/	0 1
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT	7004	/cmm	2000 - 7500
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY		, 011111	2000 1000
ABSOLUTE LYMPHOCYTE COUNT	483 <sup>L</sup>	/cmm	800 - 4900
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE EOSINOPHIL COUNT	80	/cmm	40 - 440
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY			
ABSOLUTE MONOCYTE COUNT	483	/cmm	80 - 880
by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/	0 110
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIVE	MARKERS.		
PLATELET COUNT (PLT)	184000	/cmm	150000 - 450000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	101000	, 011111	100000 100000
PLATELETCRIT (PCT)	0.26	%	0.10 - 0.36
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE			
MEAN PLATELET VOLUME (MPV)	14 <sup>H</sup>	fL	6.50 - 12.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	_/ /		
PLATELET LARGE CELL COUNT (P-LCC)	97000 <sup>H</sup>	/cmm	30000 - 90000
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE		0/	110 450
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	52.8 <sup>H</sup>	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW)	16.9	%	15.0 - 17.0
by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	10.0	70	10.0 - 17.0
NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD			



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**Test Name Value** Unit **Biological Reference interval** 



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### **ERYTHROCYTE SEDIMENTATION RATE (ESR)**

ERYTHROCYTE SEDIMENTATION RATE (ESR)

mm/1st hr 23H

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:

- 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.
   Prings such as doubt as mathyldona, oral contracentives, popicillamino procesingmide, the onbylling, and vital.

- 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



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### **CLINICAL CHEMISTRY/BIOCHEMISTRY GLUCOSE FASTING (F)**

GLUCOSE FASTING (F): PLASMA NORMAL: < 100.0 227.65<sup>H</sup> mg/dL

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 100.0 - 125.0

DIABETIC: > 0R = 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.



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	LIPID PROFILE	: BASIC	
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	137.28	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	155.97 <sup>H</sup>	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 by SELECTIVE INHIBITION	33.63	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	72.46	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 by CALCULATED, SPECTROPHOTOMETRY	103.65	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 by CALCULATED, SPECTROPHOTOMETRY	31.19	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY	430.53	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	4.08	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0



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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.15	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED. SPECTROPHOTOMETRY	4.64	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.

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 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

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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### **LIVER FUNCTION TEST (COMPLETE)**

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.69	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY	0.18	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY	0.51	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	20.45	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	18.84	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.09	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL	162.92 <sup>H</sup>	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY	54.13	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY	7.77	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	4.28	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.49	gm/dL	2.30 - 3.50
A: GRATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.23	RATIO	1.00 - 2.00

#### INTERPRETATION

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
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



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#### **DECREASED:**

CLIENT CODE.

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).

#### PROGNOSTIC SIGNIFICANCE:

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



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Test Name	Value	Unit	Biological Reference interval
	KIDNEY FUNCTION TE	ST (COMPLETE)	
UREA: SERUM by UREASE - GLUTAMATE DEHYDROGENASE (G	34.49	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECTROPHOTOMETERY	1.88 <sup>H</sup>	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM by CALCULATED, SPECTROPHOTOMETRY	16.12	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREAT RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	ININE 8.57 <sup>L</sup>	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	18.35	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	7.88 <sup>H</sup>	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPECTROPHOTOMETRY	10.26	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM by PHOSPHOMOLYBDATE, SPECTROPHOTOME	2.43 TRY	mg/dL	2.30 - 4.70
<b>ELECTROLYTES</b>			
SODIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	150	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.57	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE ELECTRODE)	112.5 <sup>H</sup>	mmol/L	90.0 - 110.0
ESTIMATED GLOMERULAR FILTERATI	ON RATE		
ESTIMATED GLOMERULAR FILTERATIO (eGFR): SERUM	N RATE 49.6		

by CALCULATED

NOTE 2 RESULT RECHECKED TWICE **ADVICE** KINDLY CORRELATE CLINICALLY

**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



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**Test Name Value** Unit **Biological Reference interval** 

glomerular filtration rate.

- 2. Catabolic states with increased tissue breakdown.
- 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 inappropiate antidiuretic harmone) 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.

### **INAPPROPIATE 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 FILTERATION RATE:

STIIVIATED GEOWIERGEART	THINATED GEOMEROEAR TETERATION RATE.			
CKD STAGE	DESCRIPTION	GFR ( mL/min/1.73m2 )	ASSOCIATED FINDINGS	
G1	Normal kidney function	>90	No proteinuria	
G2	Kidney damage with	>90	Presence of Protein,	
	normal or high GFR		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	Kidnev failure	<15		



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

KOS Central Lab: 6349/1, Nicholson Road, Ambala Cantt -133 001, Haryana



### **KOS Diagnostic Lab** (A Unit of KOS Healthcare)



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

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

**NAME** : Mr. HARMINDER PAL SINGH

AGE/ GENDER : 27 YRS/MALE **PATIENT ID** : 1484558

COLLECTED BY REG. NO./LAB NO. :012411060069

REFERRED BY **REGISTRATION DATE** : 06/Nov/2024 08:52 PM BARCODE NO. **COLLECTION DATE** : 06/Nov/2024 08:58PM :01520257 CLIENT CODE. : KOS DIAGNOSTIC LAB REPORTING DATE :08/Nov/2024 09:13AM

**CLIENT ADDRESS** : 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 creating between 45-59 ml/min/1.73 m2 (G3) and without any marker of Kidney damage, It is recommended to measure

4. eGFR category G1 OR G2 does not fullfill 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).

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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**CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT

**Value** Unit **Biological Reference interval Test Name** 

### **CLINICAL PATHOLOGY URINE ROUTINE & MICROSCOPIC EXAMINATION**

#### PHYSICAL EXAMINATION

QUANTITY RECIEVED	10	ml
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY		

PALE YELLOW PALE YELLOW

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

TRANSPARANCY HAZY **CLEAR** 

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY SPECIFIC GRAVITY 1.02 1.002 - 1.030

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**CHEMICAL EXAMINATION** 

**ACIDIC** REACTION

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY 3+ **NEGATIVE (-ve)** 

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**SUGAR** 2+ **NEGATIVE (-ve)** 

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY рΗ 5.5 5.0 - 7.5

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

NEGATIVE (-ve) **BILIRUBIN** Negative by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

Negative NEGATIVE (-ve) NITRITE

EU/dL UROBILINOGEN Normal 0.2 - 1.0

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

KETONE BODIES Negative NEGATIVE (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY NEGATIVE (-ve)

**Negative** by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

ASCORBIC ACID NEGATIVE (-ve) NEGATIVE (-ve)

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

**MICROSCOPIC EXAMINATION** 

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY.

/HPF RED BLOOD CELLS (RBCs) NEGATIVE (-ve) 0 - 3by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT

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(A Unit of KOS Healthcare)



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

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

NAME : Mr. HARMINDER PAL SINGH

**AGE/ GENDER** : 27 YRS/MALE **PATIENT ID** : 1484558

COLLECTED BY : REG. NO./LAB NO. : 012411060069

 REFERRED BY
 : 06/Nov/2024 08:52 PM

 BARCODE NO.
 : 01520257
 COLLECTION DATE
 : 06/Nov/2024 08:58 PM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 07/Nov/2024 04:34 AM

**CLIENT ADDRESS**: 6349/1, NICHOLSON ROAD, AMBALA CANTT

PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  CRYSTALS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  BACTERIA by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  TRICHOMONAS VAGINALIS (PROTOZOA) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  TRICHOMONAS VAGINALIS (PROTOZOA) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT  ABSENT  BEGATIVE (-ve)  NEGATIVE (-ve)				
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by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT TRICHOMONAS VAGINALIS (PROTOZOA) ABSENT ABSENT		NEGATIVE (-ve)		NEGATIVE (-ve)
· ·	5	NEGATIVE (-ve)		NEGATIVE (-ve)
		ABSENT		ABSENT

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



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