



	Dr. Vinay Chc MD (Pathology & I Chairman & Const	Microbiology)	icrobiology) MD (Pathology)			
NAME : N	Ars. ASHU					
AGE/ GENDER : 4	6 YRS/FEMALE	P	ATIENT ID	: 1564280		
COLLECTED BY :		R	EG. NO./LAB NO.	: 012411140059		
REFERRED BY :		R	EGISTRATION DATE	: 14/Nov/2024 06:43 PM		
BARCODE NO. : 0	1520813	C	OLLECTION DATE	: 14/Nov/2024 07:33PM		
CLIENT CODE. : K	XOS DIAGNOSTIC LAB	R	EPORTING DATE	: 14/Nov/2024 08:41PM		
CLIENT ADDRESS : 6	349/1, NICHOLSON ROAD, A	MBALA CANTT				
Test Name		Value	Unit	Biological Reference interva		
	CLINICA	AL CHEMIST	RY/BIOCHEMISTR	Y		
	KIDN	EY FUNCTION	TEST (COMPLETE)			
UREA: SERUM		41.08	mg/dL	10.00 - 50.00		
by UREASE - GLUTAMATE	DEHYDROGENASE (GLDH)			0.40, 1.80		
CREATININE: SERUM by enzymatic, spectrophotometery BLOOD UREA NITROGEN (BUN): SERUM by calculated, spectrophotometry BLOOD UREA NITROGEN (BUN)/CREATININE		1.62 ^H	mg/dL	0.40 - 1.20		
		19.2	mg/dL	7.0 - 25.0		
		11.85	RATIO	10.0 - 20.0		
RATIO: SERUM						
by CALCULATED, SPECTR UREA/CREATININE RA		25.36	RATIO			
by CALCULATED, SPECTR						
URIC ACID: SERUM by URICASE - OXIDASE PE	ROXIDASE	5.12	mg/dL	2.50 - 6.80		
CALCIUM: SERUM		9.55	mg/dL	8.50 - 10.60		
by ARSENAZO III, SPECTRO PHOSPHOROUS: SERUN		3.3	mg/dI	2.30 - 4.70		
by PHOSPHOMOLYBDATE,		3.3	mg/dL	2.30 - 4.70		
ELECTROLYTES						
SODIUM: SERUM		146.6	mmol/L	135.0 - 150.0		
by ISE (ION SELECTIVE ELI POTASSIUM: SERUM		4.85	mmol/L	3.50 - 5.00		
by ISE (ION SELECTIVE EL	ECTRODE)					
CHLORIDE: SERUM by ISE (ION SELECTIVE ELI	ECTRODE)	109.95	mmol/L	90.0 - 110.0		
	ULAR FILTERATION RATE					
	LAR FILTERATION RATE	39.4				
(eGFR): SERUM by CALCULATED						
NOTE 2		RESULT RE	CHECKED TWICE			
			INDLY CORRELATE CLINICALLY			

To differentiate between pre- and post renal azotemia.



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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.





MDD (Pathology) Chairman & Consultant Pathology) CEO & Consultant Pathology CEO & Consultant									
ACC GENDER: :: 46 YRS/FEMALE PATIENT ID :: 1564280 COLLECTED BY ::			MD (Pathology & I	Microbiology)					
CULLECTED EY :: REG. NO,/LAB NO. :: 12141140059 REFERED BY :: IS20813 COLLECTION DATE :: 14/Nov/2024 06:43 PM BARCODE NO. :: 01520813 COLLECTION DATE :: 14/Nov/2024 06:43 PM CLIENT CODE :: KOS DIAGNOSTIC LAB REPORTING DATE :: 14/Nov/2024 08:41PM CLIENT ADDRESS :: :: 36349/1, NICHOLSON ROAD, AMBALA CANTF Biological Reference inte INCREASED RATIO (-20:1) WITH NORMAL CREATINNE: 1. Percenal azotemia (BLINT 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. 3. Gi haemornage. 4. High protein intake 9. Order and function plus <t< th=""><th>NAME</th><th>: Mrs. ASH</th><th>(U</th><th></th><th></th><th></th><th></th><th></th><th></th></t<>	NAME	: Mrs. ASH	(U						
REFEREND BY: I:	AGE/ GENDER	: 46 YRS/F	EMALE]	PATIENT ID	:1	564280		
REFEREND BY: I:	COLI FCTED BV			1	REC NO /LAB NO	• 0	19/111/0050		
BARCODE NO. : 01520813		·							
CLIENT CODE: : KOS DIAGNOSTIC LAB REPORTING DATE : 14/Nov/2024 08:41PM CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit Biological Reference inter INCREASED RATIO (>20:1) WITH NORMAL CREATINIE: .		:							
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit Biological Reference intel NICREASED RATIO (>20:1) UTH NORMAL CREATINNE .	BARCODE NO.	:01520813	3		COLLECTION DAT	E :1	4/Nov/2024 07:33	3PM	
Test Name Value Unit Biological Reference inter INCREASED RATIO (>20:1) WITH NORMAL CREATININE: .	CLIENT CODE.	: KOS DIAC	NOSTIC LAB]	REPORTING DATI	E : 1	4/Nov/2024 08:42	1PM	
 INCREASED RATIO (<20:1) WITH NORMAL CREATININE: Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate. Catabolic states with increased tissue breakdown. G haemorrhage. High protein intake. Impaired renal function plus Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein dit burns, surgery, cachexia, high fever). Urine reabsorption (e.g. ureter colostomy) Reduced muscle mass (subnormal creatinine production) Pcertain drugs (e.g. tetracycline, glucocorticoids) INCREASED RATIO (<20:1) WITH ELEVATED CREATININE LEVELS: Prerenal azotemia superimopsed on renal disease. Decreased dialysis (urea rather than creatinine diffuses out of extracellular fluid). Severe liver disease. 4. Other causes of decreased urea synthesis. S. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid). 6. Inherited hyperammonemias (urea is virtually absent in blood). 7. SIADI (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea. 8. Preguenze. 8. Precensing. 7. SIADI (syndrome of inappropiate antidiuretic harmone) due to cubular secretion of urea. 8. Preguenze. 8. Precensing (Urea rather than creatinine to creatinine). 2. Rhadomyolysis (releases muscle creatinne). 3. Muscular patients who develop renal failure. INAPPROPALE RATIO : 1. Debut ReATIO : 1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when debus should produce an increased muscle measurement). 2. Cephalosport in the ray (Interfere with creatinine measurement).	CLIENT ADDRESS	:6349/1,1	VICHOLSON ROAD, A	MBALA CANTT					
 Prerenal azotemia (BUN rises without increase in creatinine) e.g. heart failure, salt depletion, dehydration, blood loss) due to decreased glomerular filtration rate. Catabolic states with increased tissue breakdown. Gi haemorrhage. High protein intake. Impaired renal function plus Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein di burns, surgery, cachexia, high fever). Urine reabsorption (e.g. ureter colostomy) Reduced muscle mass (subnormal creatinine production) Certain drugs (e.g. tetracycline, glucocorticoids) INCREASED RATIO (>20.1 VITH ELEVATED CREATININE LEVELS: Postrenal azotemia superimposed on renal disease. DECREASED RATIO (>20.1 VITH ELEVATED CREATININE LEVELS: Acute tubular necrosis. Low protein diet and starvation. Severe liver disease. Acute tubular necrosis. Other causes of decreased urea synthesis. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid). Inherited hyperamonemias (urea is virtually absent in blood). SIADI (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea. Prepanacy. DECREASED RATIO (<1.1) WITH INCREASED CREATININE: Phenacimide therapy (accelerates conversion of creatine to creatinine). Ambording (Equation) Subadomyolysis (releases muscle creatinine). Ambording (accelerate causes false increase in creatinine). Ambording (accelerate causes false increase in creatinine with certain methodologies, resulting in normal ratio when develos oportion at ratio when develop renal failure. Nubsecular patients who develop renal failure.	Test Name			Value	Un	it	Biological	Reference inter	rval
 Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehy should produce an increased BUN/creatinine ratio). Cephalosporin therapy (interferes with creatinine measurement). 	2. Prerenal azotemia DECREASED RATIO (< 1. Acute tubular necr 2. Low protein diet ar 3. Severe liver disease 4. Other causes of de 5. Repeated dialysis (6. Inherited hyperam 7. SIADH (syndrome of 8. Pregnancy. DECREASED RATIO (< 1. Phenacimide thera 2. Rhabdomyolysis (r 3. Muscular patients	superimpose (0:1) WITH D osis. ad starvation e. creased urea urea rather monemias (u of inappropia (0:1) WITH IN py (accelerate eleases music who develop	ed on renal disease. ECREASED BUN : a synthesis. than creatinine diffus urea is virtually absen te antidiuretic harmo ICREASED CREATININE tes conversion of creaticle creatinine).	ses out of extrace It in blood). Ine) due to tubula	Ilular fluid). ar secretion of urea				
2. Cephalosporin therapy (interferes with creatinine measurement).	1. Diabetic ketoacido	sis (acetoace		rease in creatinin	e with certain met	hodologies,r	esulting in normal	l ratio when dehy	/dratio
SCTIMATED CLONAEDUI AD EU TEDATION DATE.	2. Cephalosporin ther	apy (interfer	es with creatinine me	easurement).					
ESTIMATED GLOMERULAR FILTERATION RATE: CKD STAGE DESCRIPTION GFR (mL/min/1.73m2) ASSOCIATED FINDINGS	ESTIMATED GLOMERU	JLAR FILTERA	TION RATE:			40000		1	

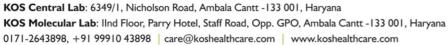
CKD STAGE	DESCRIPTION	GFR (mL/min/1.73m2)	ASSOCIATED FINDINGS		
G1	Normal kidney function	>90	No proteinuria		
G2	Kidney damage with normal or high GFR	>90	Presence of Protein , Albumin or cast in urine		
G3a	Mild decrease in GFR	60 -89			
G3b	Moderate decrease in GFR	30-59			





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	Dr. Vinay ChopraDr. Yugam ChopraMD (Pathology & Microbiology)MD (Pathology)Chairman & Consultant PathologistCEO & Consultant Pathologist						
NAME	: Mrs. ASHU						
AGE/ GENDER	: 46 YRS/FEMALE	PATIENT ID	: 1564280				
COLLECTED BY	:	REG. NO./LAB NO.	: 012411140059				
REFERRED BY	:	REGISTRATION DATE	: 14/Nov/2024 06:43 PM				
BARCODE NO.	: 01520813	COLLECTION DATE	: 14/Nov/2024 07:33PM				
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA	A CANTT					
Test Name	Va	alue Unit	Biological Reference interval				
G4	Severe decrease in GFR	15-29					
G5	Kidney failure	<15					

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

 Estimated Glomerular Intration rate (GGFR) is the sum of intration rates in all functioning hephrons 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 eGFR with Cystatin C for confirmation of CKD
 eGFR category G1 OR G2 does not fullfill the criteria for CKD, in the absence of evidence of Kidney Damage
 In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
 eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFP should be calculated using Serum Cystatin C 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 Chop MD (Pathology & M Chairman & Consul	licrobiology)	Dr. Yugam MD O & Consultant	(Pathology)
NAME	: Mrs. ASHU			
AGE/ GENDER	: 46 YRS/FEMALE	PATIENT I	D	: 1564280
COLLECTED BY	:	REG. NO./I	LAB NO.	: 012411140059
REFERRED BY	:	REGISTRA	TION DATE	: 14/Nov/2024 06:45 PM
BARCODE NO.	: 01520813	COLLECTIO	ON DATE	: 14/Nov/2024 07:33PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTIN	IG DATE	: 14/Nov/2024 09:27PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AM	IBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
		CLINICAL PATHO	LOGY	
		TINE & MICROSCOP		ATION
PHYSICAL EXAMIN	ATION			
QUANTITY RECIEV	ED TANCE SPECTROPHOTOMETRY	10	ml	
COLOUR		PALE YELLOW		PALE YELLOW
TRANSPARANCY	TANCE SPECTROPHOTOMETRY	HAZY		CLEAR
SPECIFIC GRAVITY		1.02		1.002 - 1.030
CHEMICAL EXAMI				
REACTION by DIP STICK/REFLEC	TANCE SPECTROPHOTOMETRY	ACIDIC		
PROTEIN		3+		NEGATIVE (-ve)
SUGAR	TANCE SPECTROPHOTOMETRY	2+		NEGATIVE (-ve)
pН	TANCE SPECTROPHOTOMETRY	6		5.0 - 7.5
BILIRUBIN	TANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
NITRITE		Negative		NEGATIVE (-ve)
UROBILINOGEN	TANCE SPECTROPHOTOMETRY. TANCE SPECTROPHOTOMETRY	Normal	EU/dL	0.2 - 1.0
KETONE BODIES	TANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
BLOOD	TANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
ASCORBIC ACID by DIP STICK/REFLEC	TANCE SPECTROPHOTOMETRY	NEGATIVE (-ve)		NEGATIVE (-ve)
MICROSCOPIC EXA RED BLOOD CELLS by MICROSCOPY ON C		NEGATIVE (-ve)	/HPF	0 - 3

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

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

NAME	: Mrs. ASHU					
AGE/ GENDER	: : : 01520813		PATIENT ID	: 1564280		
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AI	MBALA CANT	г			
Test Name		Value	Unit	Biological Reference interval		
PUS CELLS by MICROSCOPY ON C	CENTRIFUGED URINARY SEDIMENT	3-6	/HPF	0 - 5		
EPITHELIAL CELLS	S	1-3	/HPF	ABSENT		

by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	10	/ 111 1	HIDDERVI	
CRYSTALS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)	
CASTS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)	
BACTERIA by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)	
OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)		NEGATIVE (-ve)	
TRICHOMONAS VAGINALIS (PROTOZOA)	ABSENT		ABSENT	

by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT

End Of Report



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