

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.



	Dr. Vinay Chopra MD (Pathology & Micr Chairman & Consultar	obiology)	Dr. Yugam MD (CEO & Consultant F	Pathology)
NAME	: Mrs. ANJU SHARMA			
AGE/ GENDER	: 49 YRS/FEMALE	PA	ATIENT ID	: 1676916
COLLECTED BY	: SURJESH	RI	EG. NO./LAB NO.	: 012411200023
REFERRED BY	:	RI	EGISTRATION DATE	: 20/Nov/2024 10:40 AM
BARCODE NO.	:01521135		DLLECTION DATE	: 20/Nov/2024 10:46AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		EPORTING DATE	: 20/Nov/2024 04:52PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMB/	ALA CANTI		
Test Name		Value	Unit	Biological Reference interval
			NECC DANEL 1 0	
			NESS PANEL: 1.0	
		LELE BLOC	DD COUNT (CBC)	
RED BLOOD CELLS HAEMOGLOBIN (H	S (RBCS) COUNT AND INDICES	r ol	gm/dL	12.0 - 16.0
by CALORIMETRIC		7.8 ^L	Ŭ	
RED BLOOD CELL (RBC) COUNT	2.31 ^L	Millions/o	cmm 3.50 - 5.00
PACKED CELL VOLU	JME (PCV)	24.1 ^L	%	37.0 - 50.0
by CALCULATED BY A MEAN CORPUSCUL	utomated hematology analyzer AR VOLUME (MCV)	104.6 ^H	fL	80.0 - 100.0
	UTOMATED HEMATOLOGY ANALYZER	34	20	27.0 24.0
	AR HAEMOGLOBIN (MCH) UTOMATED HEMATOLOGY ANALYZER		pg	27.0 - 34.0
	AR HEMOGLOBIN CONC. (MCHC) UTOMATED HEMATOLOGY ANALYZER	32.5	g/dL	32.0 - 36.0
RED CELL DISTRIB	UTION WIDTH (RDW-CV)	19.2 ^H	%	11.00 - 16.00
RED CELL DISTRIB	UTOMATED HEMATOLOGY ANALYZER UTION WIDTH (RDW-SD)	73.7 ^H	fL	35.0 - 56.0
by CALCULATED BY A MENTZERS INDEX	UTOMATED HEMATOLOGY ANALYZER	45.28	RATIO	BETA THALASSEMIA TRAIT: <
by CALCULATED		10.20	in the second se	13.0
				IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING IND	DEX	87.54	RATIO	BETA THALASSEMIA TRAIT:<=
by CALCULATED				65.0 IRON DEFICIENCY ANEMIA: >
				65.0
WHITE BLOOD CE				
TOTAL LEUCOCYTE	E COUNT (TLC) / by sf cube & microscopy	7150	/cmm	4000 - 11000
NUCLEATED RED B	BLOOD CELLS (nRBCS)	NIL		0.00 - 20.00
	RT HEMATOLOGY ANALYZER SLOOD CELLS (nRBCS) %	NIL	%	< 10 %
	UTOMATED HEMATOLOGY ANALYZER			



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, Haryana

 KOS Molecular Lab: IInd Floor, Parry Hotel, Staff Road, Opp. GPO, Ambala Cantt -133 001, Haryana

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 care@koshealthcare.com



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Dr. Vinay Chopra Dr. Yugam Chopra MD (Pathology & Microbiology) MD (Pathology) Chairman & Consultant Pathologist **CEO & Consultant Pathologist** NAME : Mrs. ANJU SHARMA AGE/ GENDER : 49 YRS/FEMALE **PATIENT ID** :1676916 **COLLECTED BY** : SURJESH :012411200023 REG. NO./LAB NO. **REFERRED BY REGISTRATION DATE** : 20/Nov/2024 10:40 AM : **BARCODE NO.** :01521135 **COLLECTION DATE** : 20/Nov/2024 10:46AM CLIENT CODE. : KOS DIAGNOSTIC LAB **REPORTING DATE** : 20/Nov/2024 04:52PM **CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit **Biological Reference interval DIFFERENTIAL LEUCOCYTE COUNT (DLC)** NEUTROPHILS 52 % 50 - 70 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY LYMPHOCYTES 33 % 20 - 40 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY EOSINOPHILS 2 % 1 - 6 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY MONOCYTES 13^H % 2 - 12by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY BASOPHILS 0 % 0 - 1 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY **ABSOLUTE LEUKOCYTES (WBC) COUNT** ABSOLUTE NEUTROPHIL COUNT 3718 2000 - 7500 /cmm by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE LYMPHOCYTE COUNT 2360 800 - 4900 /cmm by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE EOSINOPHIL COUNT 143 /cmm 40 - 440 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE MONOCYTE COUNT 930^H /cmm 80 - 880 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE BASOPHIL COUNT 0 /cmm 0 - 110 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE IMMATURE GRANULOCYTE COUNT 0.0 - 999.00 /cmm by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS. PLATELET COUNT (PLT) 201000 /cmm 150000 - 450000 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE PLATELETCRIT (PCT) 0.26% 0.10 - 0.36 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE MEAN PLATELET VOLUME (MPV) 13^H fL 6.50 - 12.0 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE PLATELET LARGE CELL COUNT (P-LCC) 89000 /cmm 30000 - 90000 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE PLATELET LARGE CELL RATIO (P-LCR) 44.3% 11.0 - 45.0 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE PLATELET DISTRIBUTION WIDTH (PDW) 15.9% 15.0 - 17.0 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE



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







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NAME	: Mrs. ANJU SHARMA		
	MD (Pathology & Mi Chairman & Consult	icrobiology) ME) (Pathology)
	Dr. Vinay Chop	ora I Dr. Yugar	n Chopra

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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

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







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LIENT CODE.	: KOS DIAGNOSTIC LAB		REPORTING DATE	: 20/Nov/2024 12:02PM
LIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AN	MBALA CANTT		
est Name		Value	Unit	Biological Reference interval
y RED CELL AGGRE TERPRETATION: ESR is a non-speci mune disease, but An ESR can be affe C-reactive protein	does not tell the health practitione ected by other conditions besides in	er exactly wher Iflammation. Fo	re the inflammation is in the or this reason, the ESR is ty	ion associated with infection, cancer and auto e body or what is causing it. pically used in conjunction with other test sucl
stemic lupus eryth DNDITION WITH LO low ESR can be see olycythaemia), sigi sickle cells in sick OTE: ESR and C - reactiv Generally, ESR doe CRP is not affected If the ESR is elevat Women tend to ha Drugs such as dex	ematosus W ESR en with conditions that inhibit the m nificantly high white blood cell cou- le cell anaemia) also lower the ESR re protein (C-RP) are both markers of es not change as rapidly as does CR I by as many other factors as is ESR, ed, it is typically a result of two typ we a higher ESR, and menstruation	nt (leucocytosi c pf inflammatior P, either at the making it a b e bes of proteins, and pregnancy	ntation of red blood cells, s (s) , and some protein abno n. e start of inflammation or a: tter marker of inflammatior (globulins or fibrinogen.) (can cause temporary eleval)	uch as a high red blood cell count rmalities. Some changes in red cell shape (suc s it resolves. n .





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



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		hopra & Microbiology) onsultant Patholog		(Pathology)
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD), AMBALA CANT	Т	
Test Name		Value	Unit	Biological Reference interval
	CLINI		STRY/BIOCHEMIST E FASTING (F)	'nY
GLUCOSE FASTING by glucose oxidas	(F): PLASMA E - PEROXIDASE (GOD-POD)	95.97	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0

KOS Diagnostic Lab (A Unit of KOS Healthcare)

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)







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TRICLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC) 67.39 mg/dL 240.0 OPTIMAL: < 150.0 BORDERLINE HIGH: 150 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500. VERY HIGH: > OR = 500. DO HIGH: HDL: < > OR = 500. DO HIGH: DO - 499.0 VERY HIGH: > OR = 60.0 HIGH HDL: > OR = 60.0 HIGH HDL: > OR = 60.0 HIGH HDL: > OR = 60.0 HIGH: 100.0 ABOVE OPTIMAL: 100.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: > OR = 190.NON HDL CHOLESTEROL: SERUM by CALCULATED. SPECTROPHOTOMETRY 67.74 mg/dL OPTIMAL: < 100.0 ABOVE OPTIMAL: 130.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: > OR = 220. VERY HIGH: > OR = 220. VERY HIGH: > OR = 220. VIDL CHOLESTEROL: SERUM by CALCULATED. SPECTROPHOTOMETRY 13.48 mg/dL $0.00 - 45.00$ VERY HIGH: > OR = 220. VERY HIGH: SERUM by CALCULATED. SPECTROPHOTOMETRY 2.99 RATIOLOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 4.50 - 7.							
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)67.39mg/dLOPTIMAL: < 150.0 BORDERLINE HIGH: 150 199.0 HIGH: 200.0 - 499.0 VERY HIGH: > OR = 500. UOW HDL: < 30.0 BORDERLINE HIGH HDL 60.0 HIGH HDL: > OR = 60.0 HIGH HDL: > OR = 60.0 HIGH: 200.0 - 189.0 VERY HIGH: > OR = 190.0 OBORDERLINE HIGH: 130.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: > OR = 190.0 VERY HIGH: > OR = 220.0 VERY HIGH: > OR	L: > OR =						
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LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY54.26mg/dLOPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: 130.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0 VERY HIGH: > OR = 190.0 BORDERLINE HIGH: 130.0 BORDERLINE HIGH: 160.0 BORDERLINE HIGH: 100.0 BORDERLINE HIGH:	HDL: 30 (mg/dL	33.99			
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY54.26mg/dLOPTIMAL: < 100.0 ABOVE OPTIMAL: 100.0 BORDERLINE HIGH: 130.0 HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0 VERY HIGH: > OR = 190.0 VERY HIGH: > OR = 190.0 OPTIMAL: < 130.0 BORDERLINE HIGH: 160.0 BORDERLINE HIGH: 30.0 BORDERLINE		60.0					
by CALCULATED, SPECTROPHOTOMETRY NON HDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY FOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY FOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY FOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL: HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL/HDL RATIO: SERUM BY CALCU	0.0		/ 11	54.00			
NON HDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY (TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY (TOTAL LIPIDS) SERUM (TOTAL LIPIDS) SERUM	00.0 - 129		mg/dL	54.26			
NON HDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY67.74mg/dLOPTIMAL: < 130.0 ABOVE OPTIMAL: < 130.0 BORDERLINE HIGH: 160 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY13.48mg/dL0.00 - 45.00 VERY HIGH: > OR = 220.0VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY270.85Lmg/dL350.00 - 700.00 AVERY HIGH: > 0.00 - 45.00VLDL CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY2.99RATIOLOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -		BORDERLINE HIGH:					
NON HDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY67.74mg/dLVERY HIGH: > OR = 190. OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 BORDERLINE HIGH: 160 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY13.48mg/dL0.00 - 45.00 VERY HIGH: > OR = 220.VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY270.85Lmg/dL350.00 - 700.00 AVERAGE RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -	1						
by CALCULATED, SPECTROPHOTOMETRY ABOVE OPTIMAL: 130.0 BORDERLINE HIGH: 160 189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220. VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL							
Indext ConstructionIndext ConstructionBORDERLINE HIGH: 1600BORDERLINE HIGH: 1600BORDERLINE HIGH: 1600BORDERLINE HIGH: 1600HIGH: 190.0 - 219.0VLDL CHOLESTEROL: SERUMby CALCULATED, SPECTROPHOTOMETRYTOTAL LIPIDS: SERUMby CALCULATED, SPECTROPHOTOMETRYCHOLESTEROL/HDL RATIO: SERUMCHOLESTEROL/HDL RATIO: SERUMBORDERATERISK: 7.10 -			mg/dL	67.74			
NUDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY13.48mg/dL189.0 HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY13.48mg/dL0.00 - 45.00CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY270.85Lmg/dL350.00 - 700.00LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -2.99RATIOLOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -					ECTROPHOTOMETRY	by CALCULATED, SPE	
VLDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY13.48mg/dL0.00 - 45.00TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY270.85Lmg/dL350.00 - 700.00CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY2.99RATIOLOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -		189.0					
VLDL CHOLESTEROL: SERUM 13.48 mg/dL 0.00 - 45.00 by CALCULATED, SPECTROPHOTOMETRY 270.85 ^L mg/dL 350.00 - 700.00 by CALCULATED, SPECTROPHOTOMETRY 2.99 RATIO LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -							
by CALCULATED, SPECTROPHOTOMETRY TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL/HDL RATIO: SERUM cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol cholesterol choleste	££0.0		mg/dL	13.48	OL: SERUM	VLDL CHOLESTERC	
by CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY De CALCULATED, SPECTROPHOTOMETRY CHOLESTEROL/HDL RATIO: SERUM DE CALCULATED, SPECTROPHOTOMETRY					ECTROPHOTOMETRY	by CALCULATED, SPE	
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY 2.99 RATIO AVERAGE RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7. MODERATE RISK: 7.10 -		350.00 - 700.00	mg/dL	270.85 ^L			
MODERATE RISK: 7.10 -			RATIO	2.99	DL RATIO: SERUM	CHOLESTEROL/HD	
					ECTROPHOTOMETRY	by CALCULATED, SPE	
HIGH RISK: > 11.0	10 - 11.0	HIGH RISK: > 11.0					



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

yhoira







	Dr. Vinay Ch MD (Pathology & Chairman & Cor		Dr. Yugam MD CEO & Consultant	(Pathology)
NAME	: Mrs. ANJU SHARMA			
AGE/ GENDER	: 49 YRS/FEMALE	P	ATIENT ID	: 1676916
COLLECTED BY	: SURJESH	R	EG. NO./LAB NO.	: 012411200023
REFERRED BY	:	R	EGISTRATION DATE	: 20/Nov/2024 10:40 AM
BARCODE NO.	:01521135	C	OLLECTION DATE	: 20/Nov/2024 10:46AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	R	EPORTING DATE	: 20/Nov/2024 12:33PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD,	AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
LDL/HDL RATIO: S by CALCULATED, SPE		1.6	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/H by CALCULATED, SPE	IDL RATIO: SERUM	1.98 ^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





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







	Dr. Vinay Chop MD (Pathology & Mi Chairman & Consult	crobiology)		(Pathology)
NAME	: Mrs. ANJU SHARMA			
AGE/ GENDER	: 49 YRS/FEMALE		PATIENT ID	: 1676916
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AM	BALA CANTT		
Test Name		Value	Unit	Biological Reference interval
	: SERUM PECTROPHOTOMETRY	0.67 0.32	N TEST (COMPLETE) mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
	C (CONJUGATED): SERUM	0.32	mg/dL	0.00 - 0.40
BILIRUBIN INDIRE	CT (UNCONJUGATED): SERUM	0.35	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PY	RIDOXAL PHOSPHATE	36.1	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PY	RIDOXAL PHOSPHATE	24.3	U/L	0.00 - 49.00
AST/ALT RATIO: S by CALCULATED, SPE		1.49	RATIO	0.00 - 46.00
ALKALINE PHOSPI by PARA NITROPHEN PROPANOL	HATASE: SERUM YL PHOSPHATASE BY AMINO METHYL	328.82 ^H	U/L	40.0 - 130.0
GAMMA GLUTAMY by SZASZ, SPECTROF	L TRANSFERASE (GGT): SERUM PHTOMETRY	224.65 ^H	U/L	0.00 - 55.0
TOTAL PROTEINS: by BIURET, SPECTRO		6.36	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL G		4.36	gm/dL	3.50 - 5.50
GLOBULIN: SERUM	1	2 ^L	gm/dL	2.30 - 3.50
A : G RATIO: SERUN by CALCULATED, SPE		2.18 ^H	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:

> 2
> 2 (Highly Suggestive)
1.4 - 2.0
> 1.5
> 1.3 (Slightly Increased)



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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.





	Dr. Vinay Chopi MD (Pathology & Mic Chairman & Consulta	crobiology) ME	n Chopra 9 (Pathology) t Pathologist
NAME	: Mrs. ANJU SHARMA		
AGE/ GENDER	: 49 YRS/FEMALE	PATIENT ID	: 1676916
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMI	BALA CANTT	
Test Name		Value Unit	Biological Reference interv

DECREASED:

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).

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 Cho MD (Pathology & N Chairman & Consu	1icrobiology)	Dr. Yugam MD (CEO & Consultant	(Pathology)
NAME	: Mrs. ANJU SHARMA			
AGE/ GENDER	: 49 YRS/FEMALE]	PATIENT ID	: 1676916
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CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AN	MBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
	KIDNI	EY FUNCTION	N TEST (COMPLETE)	
UREA: SERUM by UREASE - GLUTAM	IATE DEHYDROGENASE (GLDH)	10.33	mg/dL	10.00 - 50.00
CREATININE: SERU by ENZYMATIC, SPEC		0.74	mg/dL	0.40 - 1.20
by CALCULATED, SPE		4.83 ^L	mg/dL	7.0 - 25.0
BLOOD UREA NITE RATIO: SERUM by Calculated, spe	ROGEN (BUN)/CREATININE	6.53 ^L	RATIO	10.0 - 20.0
UREA/CREATININ by CALCULATED, SPE		13.96	RATIO	
URIC ACID: SERUM by URICASE - OXIDAS		2.36 ^L	mg/dL	2.50 - 6.80
CALCIUM: SERUM by ARSENAZO III, SPE		9.46	mg/dL	8.50 - 10.60
	ERUM DATE, SPECTROPHOTOMETRY	4.11	mg/dL	2.30 - 4.70
<u>ELECTROLYTES</u> SODIUM: SERUM		144.3	mmol/L	135.0 - 150.0
by ISE (ION SELECTIV POTASSIUM: SERU	M	4.12	mmol/L	3.50 - 5.00
by ISE (ION SELECTIV CHLORIDE: SERUM by ISE (ION SELECTIV FSTIMATED CLOM	1	108.23	mmol/L	90.0 - 110.0
ESTIMATED GLOM (eGFR): SERUM by calculated INTERPRETATION:	ERULAR FILTERATION RATE reen pre- and post renal azotemia.	99.1		

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.

3. GI haemorrhage.



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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.





	Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Pathologist			Dr. Yugam Chopra MD (Pathology) t CEO & Consultant Pathologist				
IAME	: Mrs. ANJU	SHARMA						
AGE/ GENDER	: 49 YRS/FEM	IALE		PATIENT ID		: 1676916		
COLLECTED BY	: SURJESH			REG. NO./LAB NO).	:0124112000	23	
REFERRED BY	:			REGISTRATION I	DATE	: 20/Nov/2024	10:40 AM	
BARCODE NO.	:01521135			COLLECTION DAT		: 20/Nov/2024	0:46AM	
CLIENT CODE.	: KOS DIAGNOSTIC LAB			REPORTING DATE		: 20/Nov/2024 12:33PM		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANT							
Test Name			Value	Uı	nit	Biolog	ical Reference i	nterval
burns, surgery, cache 7. Urine reabsorption 8. Reduced muscle m 9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal azotemia 2. Prerenal azotemia DECREASED RATIO (<1	kia, high fever) (e.g. ureter co ass (subnorma cetracycline, g D:1) WITH ELEV (BUN rises dis superimposed D:1) WITH DEC	lostomy) I creatinine productio ucocorticoids) / ATED CREATININE LEV proportionately more on renal disease.	n) ELS:				rome, high protei	n diet,
burns, surgery, cache 7. Urine reabsorption 8. Reduced muscle m 9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal 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 (ro 3. Muscular patients INAPPROPIATE RATIO 1. Diabetic ketoacido should produce an ind 2. Cephalosporin ther ESTIMATED GLOMERU CKD STAGE G1 G2	te or production tia, high fever) (e.g. ureter co ass (subnorman tetracycline, g D:1) WITH ELEV (BUN rises dis- superimposed D:1) WITH DEC bis. d starvation. treased urea s urea rather than nonemias (urea f inappropiate D:1) WITH INCI by (accelerates teases muscle who develop r tis (acetoaceta reased BUN/co apy (interferess LAR FILTERATION Noted to the second Noted to the sec	A creatinine production ucocorticoids) (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE IN THE INFORMATION AND AND AND AND AND AND AND AND AND AND	n) ELS: than creatinin out of extract blood). due to tubul e to creatinin se in creatinin urement).	ne) (e.g. obstructiv ellular fluid). ar secretion of ure ne). he with certain me <u>hL/min/1.73m2) >90 >90</u>	e uropath ea. ethodologi	y).	rmal ratio when c	
Courns, surgery, cache 7. Urine reabsorption 3. Reduced muscle m 4. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal 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 3. Pregnancy. DECREASED RATIO (<1 1. Phenacimide thera 2. Rhabdomyolysis (ro 3. Muscular patients INAPPROPIATE RATIO 1. Diabetic ketoacido should produce an ind 2. Cephalosporin ther ESTIMATED GLOMERU G1 G2 G3 G3a	te or production tia, high fever) (e.g. ureter co ass (subnorman tetracycline, g D:1) WITH ELEN (BUN rises dis- superimposed D:1) WITH DEC bis. d starvation. treased urea s urea rather than nonemias (urea f inappropiate D:1) WITH INCI by (accelerates teases muscle who develop r tis (acetoaceta reased BUN/ca apy (interferes LAR FILTERATION NON NON NON NON NON NON NON	A creatinine production ucocorticoids) (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE: a creatinine diffuses the causes false increating creatinine ratio). (ATED CREATININE: a conversion of creating creatinine ratio). (ATED CREATININE: (ATED CREATINIC: (ATED CREATIN	n) ELS: than creatinin out of extrace blood). due to tubul e to creatinin se in creatinin urement). GFR (m	ne) (e.g. obstructiv ellular fluid). ar secretion of ure ne). he with certain me <u>hL/min/1.73m2) >90 >90 60 -89</u>	e uropath ea. ethodologi	y). es,resulting in no CIATED FINDINGS lo proteinuria sence of Protein ,	rmal ratio when c	
burns, surgery, cache 7. Urine reabsorption 8. Reduced muscle m 9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal 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 (ro 3. Muscular patients INAPPROPIATE RATIO 1. Diabetic ketoacido should produce an ind 2. Cephalosporin ther ESTIMATED GLOMERU CKD STAGE G1 G2	te or production tia, high fever) (e.g. ureter co ass (subnorman tetracycline, g D:1) WITH ELEN (BUN rises dis- superimposed D:1) WITH DEC bis. d starvation. treased urea s urea rather than nonemias (urea f inappropiate D:1) WITH INCI by (accelerates teases muscle who develop r tis (acetoaceta reased BUN/ca apy (interferes LAR FILTERATION NO NO NO NO NO NO NO	A creatinine production ucocorticoids) (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE LEV proportionately more on renal disease. REASED BUN : (ATED CREATININE IN THE INFORMATION AND AND AND AND AND AND AND AND AND AND	n) ELS: than creatinin out of extrace blood). due to tubul e to creatinin se in creatinin urement). GFR (m	ne) (e.g. obstructiv ellular fluid). ar secretion of ure ne). he with certain me <u>hL/min/1.73m2) >90 >90</u>	e uropath ea. ethodologi	y). es,resulting in no CIATED FINDINGS lo proteinuria sence of Protein ,	rmal ratio when c	



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Test Name		Value Unit	Biological Reference interval
	, - ,		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, A	MBALA CANTT	
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 20/Nov/2024 12:33PM
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AGE/ GENDER	: 49 YRS/FEMALE	PATIENT ID	: 1676916
NAME	: Mrs. ANJU SHARMA		
	MD (Pathology & N Chairman & Consu		D (Pathology) Int Pathologist
	Dr. Vinay Cho		ım Chopra

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 Chopra MD (Pathology & Microbiolog Chairman & Consultant Patho		Dr. Yugam MD & Consultant	(Pathology)	
		PATIENT II REG. NO./L REGISTRAT COLLECTIO REPORTING	AB NO. TION DATE N DATE	: 1676916 : 012411200023 : 20/Nov/2024 10:40 AM : 20/Nov/2024 10:46AM : 20/Nov/2024 11:53AM	
Test Name	Value		Unit	Biological Reference interval	
		AL PATHOL			
	URINE ROUTINE &	MICROSCOPI	C EXAMINA	ATION	
PHYSICAL EXAMINATION QUANTITY RECIEVED	10		ml		
by DIP STICK/REFLECTANCE SPECTI		ER YELLOW		PALE YELLOW	
by DIP STICK/REFLECTANCE SPECTI TRANSPARANCY				CLEAR	
by DIP STICK/REFLECTANCE SPECT	ROPHOTOMETRY	ıĸ			
SPECIFIC GRAVITY by DIP STICK/REFLECTANCE SPECT	1.01 ROPHOTOMETRY			1.002 - 1.030	
CHEMICAL EXAMINATION	ACID	10			
REACTION by DIP STICK/REFLECTANCE SPECTI					
PROTEIN by DIP STICK/REFLECTANCE SPECTI	Nega ROPHOTOMETRY	tive		NEGATIVE (-ve)	
SUGAR by DIP STICK/REFLECTANCE SPECTI	Nega	tive		NEGATIVE (-ve)	
pH by DIP STICK/REFLECTANCE SPECTI	6.5			5.0 - 7.5	
BILIRUBIN	Nega	tive		NEGATIVE (-ve)	
by DIP STICK/REFLECTANCE SPECTI NITRITE	ROPHOTOMETRY Nega	tive		NEGATIVE (-ve)	
by DIP STICK/REFLECTANCE SPECTI UROBILINOGEN			EU/dL	0.2 - 1.0	
by DIP STICK/REFLECTANCE SPECTI KETONE BODIES				NEGATIVE (-ve)	
by DIP STICK/REFLECTANCE SPECTI	ROPHOTOMETRY				
BLOOD by DIP STICK/REFLECTANCE SPECTI				NEGATIVE (-ve)	
ASCORBIC ACID by DIP STICK/REFLECTANCE SPECTI MICROSCOPIC EXAMINATION	ROPHOTOMETRY	ATIVE (-ve)		NEGATIVE (-ve)	
RED BLOOD CELLS (RBCs)		ATIVE (-ve)	/HPF	0 - 3	

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

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.







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



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

NAME	: Mrs. ANJU SHARMA			
AGE/ GENDER	: 49 YRS/FEMALE		PATIENT ID	: 1676916
COLLECTED BY	: SURJESH		REG. NO./LAB NO.	: 012411200023
REFERRED BY	:		REGISTRATION DATE	: 20/Nov/2024 10:40 AM
BARCODE NO.	:01521135		COLLECTION DATE	: 20/Nov/2024 10:46AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		REPORTING DATE	: 20/Nov/2024 11:53AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AI	MBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
by MICROSCOPY ON C	CENTRIFUGED URINARY SEDIMENT			
PUS CELLS		1-3	/HPF	0 - 5

PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	1-3	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	2-4	/HPF	ABSENT
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) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	ABSENT		ABSENT

End Of Report





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

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

