

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

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

NAME : Mr. ROHAN GOEL
AGE/ GENDER : 25 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01522882
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT
PATIENT ID : 1706294
REG. NO./LAB NO. : 012412230016
REGISTRATION DATE : 23/Dec/2024 09:54 AM
COLLECTION DATE : 23/Dec/2024 10:00AM
REPORTING DATE : 23/Dec/2024 10:37AM

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

SWASTHYA WELLNESS PANEL: 1.5
COMPLETE BLOOD COUNT (CBC)

RED BLOOD CELLS (RBCS) COUNT AND INDICES

HAEMOGLOBIN (HB) by CALORIMETRIC	15	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	5.2 ^H	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	48.2	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	92.6	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.9	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.2 ^L	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	13.7	%	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	17.81	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	24.44	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	8260	/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 %



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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 10:37AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
<u>DIFFERENTIAL LEUCOCYTE COUNT (DLC)</u>			
NEUTROPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	45 ^L	%	50 - 70
LYMPHOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	45 ^H	%	20 - 40
EOSINOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	2	%	1 - 6
MONOCYTES <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	8	%	2 - 12
BASOPHILS <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	%	0 - 1
<u>ABSOLUTE LEUKOCYTES (WBC) COUNT</u>			
ABSOLUTE NEUTROPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3717	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	3717	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	165	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	661	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT <i>by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY</i>	0	/cmm	0 - 110
<u>PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS.</u>			
PLATELET COUNT (PLT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	225000	/cmm	150000 - 450000
PLATELETCRIT (PCT) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	0.27	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	12 ^H	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	92000 ^H	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	40.9	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW) <i>by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE</i>	16.4	%	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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 10:37AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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




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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 01:49PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

GLYCOSYLATED HAEMOGLOBIN (HbA1c)

GLYCOSYLATED HAEMOGLOBIN (HbA1c): WHOLE BLOOD <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	5.1	%	4.0 - 6.4
ESTIMATED AVERAGE PLASMA GLUCOSE <i>by HPLC (HIGH PERFORMANCE LIQUID CHROMATOGRAPHY)</i>	99.67	mg/dL	60.00 - 140.00


INTERPRETATION:


AS PER AMERICAN DIABETES ASSOCIATION (ADA):		
REFERENCE GROUP	GLYCOSYLATED HEMOGLOBIN (HbA1c) in %	
Non diabetic Adults \geq 18 years	<5.7	
At Risk (Prediabetes)	5.7 – 6.4	
Diagnosing Diabetes	\geq 6.5	
Therapeutic goals for glycemic control	Age > 19 Years	
	Goals of Therapy:	< 7.0
	Actions Suggested:	>8.0
	Age < 19 Years	
	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, targetting 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 shorten RBC life span like acute blood loss, hemolytic anemia falsely lower 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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 11:00AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

ERYTHROCYTE SEDIMENTATION RATE (ESR)

ERYTHROCYTE SEDIMENTATION RATE (ESR)	11	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

NAME : Mr. ROHAN GOEL
AGE/ GENDER : 25 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01522882
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1706294
REG. NO./LAB NO. : 012412230016
REGISTRATION DATE : 23/Dec/2024 09:54 AM
COLLECTION DATE : 23/Dec/2024 10:00AM
REPORTING DATE : 23/Dec/2024 11:04AM

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

CLINICAL CHEMISTRY/BIOCHEMISTRY

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD)	89.77	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

NAME : Mr. ROHAN GOEL
AGE/ GENDER : 25 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01522882
CLIENT CODE : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1706294
REG. NO./LAB NO. : 012412230016
REGISTRATION DATE : 23/Dec/2024 09:54 AM
COLLECTION DATE : 23/Dec/2024 10:00AM
REPORTING DATE : 23/Dec/2024 12:14PM

Test Name	Value	Unit	Biological Reference interval
LIPID PROFILE : BASIC			
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	140.19	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	94.38	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	31.42	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	89.89	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	108.77	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	18.88	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY	374.76	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	4.46 ^H	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0



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

NAME	: Mr. ROHAN GOEL		
AGE/ GENDER	: 25 YRS/MALE	PATIENT ID	: 1706294
COLLECTED BY	: SURJESH	REG. NO./LAB NO.	: 012412230016
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
BARCODE NO.	: 01522882	COLLECTION DATE	: 23/Dec/2024 10:00AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.86	RATIO	LOW RISK: 0.50 - 3.0 MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	3	RATIO	3.00 - 5.00

INTERPRETATION:

- 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.
- 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 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.
- 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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 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>	0.69	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM <i>by DIAZO MODIFIED, SPECTROPHOTOMETRY</i>	0.16	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.53	mg/dL	0.10 - 1.00
SGOT/AST: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	16.7	U/L	7.00 - 45.00
SGPT/ALT: SERUM <i>by IFCC, WITHOUT PYRIDOXAL PHOSPHATE</i>	31.7	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	0.53	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM <i>by PARA NITROPHENYL PHOSPHATASE BY AMINO METHYL PROPANOL</i>	129.48	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM <i>by SZASZ, SPECTROPHOTOMETRY</i>	29.4	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM <i>by BIURET, SPECTROPHOTOMETRY</i>	6.99	gm/dL	6.20 - 8.00
ALBUMIN: SERUM <i>by BROMOCRESOL GREEN</i>	4.25	gm/dL	3.50 - 5.50
GLOBULIN: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	2.74	gm/dL	2.30 - 3.50
A : G RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	1.55	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 CHOLESTASIS	> 1.5
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS	> 1.3 (Slightly Increased)



Dr. Vinay Chopra

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

Dr. Yugam Chopra

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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM <i>by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)</i>	21.58	mg/dL	10.00 - 50.00
CREATININE: SERUM <i>by ENZYMATIC, SPECTROPHOTOMETRY</i>	0.9	mg/dL	0.40 - 1.40
BLOOD UREA NITROGEN (BUN): SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	10.08	mg/dL	7.0 - 25.0
BLOOD UREA NITROGEN (BUN)/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	11.2	RATIO	10.0 - 20.0
UREA/CREATININE RATIO: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY</i>	23.98	RATIO	
URIC ACID: SERUM <i>by URICASE - OXIDASE PEROXIDASE</i>	6.61	mg/dL	3.60 - 7.70
CALCIUM: SERUM <i>by ARSENAZO III, SPECTROPHOTOMETRY</i>	10.37	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERUM <i>by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY</i>	3.44	mg/dL	2.30 - 4.70

ELECTROLYTES

SODIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	142.2	mmol/L	135.0 - 150.0
POTASSIUM: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	4.05	mmol/L	3.50 - 5.00
CHLORIDE: SERUM <i>by ISE (ION SELECTIVE ELECTRODE)</i>	106.65	mmol/L	90.0 - 110.0

ESTIMATED GLOMERULAR FILTRATION RATE

ESTIMATED GLOMERULAR FILTRATION RATE (eGFR): SERUM <i>by CALCULATED</i>	121.6
--	-------

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.
3. GI haemorrhage.




 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. ROHAN GOEL		
AGE/ GENDER	: 25 YRS/MALE	PATIENT ID	: 1706294
COLLECTED BY	: SURJESH	REG. NO./LAB NO.	: 012412230016
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
BARCODE NO.	: 01522882	COLLECTION DATE	: 23/Dec/2024 10:00AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

- 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 diet, 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) WITH ELEVATED CREATININE LEVELS:

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

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

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

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

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

INAPPROPRIATE RATIO:

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

ESTIMATED GLOMERULAR FILTRATION RATE:

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	
G4	Severe decrease in GFR	15-29	
G5	Kidney failure	<15	




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. ROHAN GOEL		
AGE/ GENDER	: 25 YRS/MALE	PATIENT ID	: 1706294
COLLECTED BY	: SURJESH	REG. NO./LAB NO.	: 012412230016
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
BARCODE NO.	: 01522882	COLLECTION DATE	: 23/Dec/2024 10:00AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 23/Dec/2024 12:14PM
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 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
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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

IRON PROFILE

IRON: SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	120.01	µg/dL	59.0 - 158.0
UNSATURATED IRON BINDING CAPACITY (UIBC) :SERUM <i>by FERROZINE, SPECTROPHOTOMETRY</i>	226.79	µg/dL	150.0 - 336.0
TOTAL IRON BINDING CAPACITY (TIBC) :SERUM <i>by SPECTROPHOTOMETRY</i>	346.8	µg/dL	230 - 430
%TRANSFERRIN SATURATION: SERUM <i>by CALCULATED, SPECTROPHOTOMETRY (FERENE)</i>	34.6	%	15.0 - 50.0
TRANSFERRIN: SERUM <i>by SPECTROPHOTOMETRY (FERENE)</i>	246.23	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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 11:35AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

FERRITIN

FERRITIN: SERUM	77.41	ng/mL	21.81 - 274.66
-----------------	-------	-------	----------------

by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

INTERPRETATION:

Serum ferritin appears to be in equilibrium with tissue ferritin and is a good indicator of storage iron in normal subjects and in most disorders. In patients with some hepatocellular diseases, malignancies and inflammatory diseases, serum ferritin is a disproportionately high estimate of storage iron because serum ferritin is an acute phase reactant. In such disorders iron deficiency anemia may exist with a normal serum ferritin concentration. In the presence of inflammation, persons with low serum ferritin are likely to respond to iron therapy.

DECREASED:

1. Iron depletion appears to be the only condition associated with reduced serum ferritin concentrations.
2. Hypothyroidism.
3. Vitamin-C deficiency.

INCREASED FERRITIN DUE TO IRON OVERLOAD (PRIMARY):

1. Hemochromatosis or hemosiderosis.
2. Wilson Disease.

INCREASED FERRITIN DUE TO IRON OVERLOAD (SECONDARY):

1. Transfusion overload
2. Excess dietary Iron
3. Porphyria Cutanea tarda
4. Ineffective erythropoiesis.

INCREASED FERRITIN WITHOUT IRON OVERLOAD:

1. Liver disorders (NASH) or viral hepatitis (B/C).
2. Inflammatory conditions (Ferritin is a acute phase reactant) both acute and chronic.
3. Leukaemia, hodgkin's disease.
4. Alcohol excess.

5. Other malignancies in which increases probably reflect the escape of ferritin from damaged liver cells, impaired clearance from the plasma, synthesis of ferritin by tumour cells.

6. Ferritin levels below 10 ng/ml have been reported as indicative of iron deficiency anemia.

NOTE:

1. As Ferritin is an acute phase reactant, it is often raised in both acute and chronic inflammatory condition of the body such as infections leading to false positive results. It can therefore mask a diagnostically low result. In such Cases serum ferritin levels should always be correlated with C-Reactive proteins to rule out any inflammatory conditions.

2. Patients with iron deficiency anaemia may occasionally have elevated or normal ferritin levels. This is usually seen in patients already receiving iron therapy or in patients with concomitant hepatocellular injury.





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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 05:17PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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


APOLIPOPROTEIN A-1 (APO-A1)

APOLIPOPROTEIN A-1: SERUM by NEPHLOMETRY	111.05	mg/dL	101.00 - 223.00
---	--------	-------	-----------------

INTERPRETATION:

1. Apolipoprotein A1 (ApoA1) is the primary protein associated with high-density lipoprotein (HDL) particles, and plays a central role in reverse cholesterol transport. (1) HDL cholesterol (HDL-C) and ApoA1 concentrations are inversely related to the risk for coronary artery disease (CAD).
2. There are a variable number of ApoA1 proteins per HDL particle. Therefore, ApoA1 is not a 1:1 surrogate marker for HDL particles. Similarly, the number of ApoA1 proteins and the amount of cholesterol contained in HDL particles is highly variable. This heterogeneity has led to unique clinical findings related to ApoA1 compared with HDL-C.
3. Increased ApoA1 concentrations are more strongly associated with a reduction in risk of a first myocardial infarction than HDL-C concentrations.
4. Low concentrations of ApoA1, but not HDL-C, are predictive of preclinical atherosclerosis as assessed by computed tomography estimated coronary artery calcium (CAC) scoring.
5. Increased ApoA1, but not HDL-C concentrations, are associated with reduced cardiovascular events among statin-treated patients, even when LDL-C <50 mg/dL. (5) In statin-treated patients, patients whose ApoA1 increased while on treatment were at lower risk than those whose ApoA1 did not increase.
6. Low levels of apolipoprotein A1 (ApoA1) confer increased risk of atherosclerotic cardiovascular disease.
7. ApoA1 <25 mg/dL may aid in the detection of a genetic disorder such as Tangier disease




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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 03:06PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

APOLIPOPROTEIN B (APO-B)

APOLIPOPROTEIN B: SERUM by NEPHLOMETRY	121.5	mg/dL	53.0 - 182.0
---	-------	-------	--------------

INTERPRETATION:

1. Apolipoprotein B (ApoB) is the primary protein component of low-density lipoprotein (LDL). LDL contains a variable amount of cholesterol, but each LDL contains exactly 1 ApoB protein. Therefore, ApoB is a superior indicator of circulating LDL compared to LDL cholesterol (LDL-C).
2. ApoB has been demonstrated to perform equally with LDL particles measured by nuclear magnetic resonance spectroscopy.
3. ApoB is strongly associated with increased risk of developing cardiovascular disease (CVD) and often outperforms LDL-C at predicting risk of coronary heart disease.
4. Patients with acceptable non-HDL-C (or LDL-C) but elevated ApoB remain at higher risk of developing CVD; conversely, patients with acceptably low ApoB but moderate non-HDL-C or LDL-C elevations are at a reduced risk for CVD.

SIGNIFICANCE


Elevated ApoB confers increased risk of coronary artery disease ApoB can be used as a therapeutic target analogous to non-HDL-C and LDL-C.

RISK CATEGORY	THERAPEUTIC TARGET		
	APO B	NON HDL-C	LDL-C
MODERATE TO HIGH	< 90 mg/dL	< 130 mg/dL	< 100 mg/dL
VERY HIGH	< 80 mg/dL	< 100 mg/dL	< 70 mg/dL

Extremely low values of ApoB (<48 mg/dL) are related to malabsorption of food lipids and can lead to polyneuropathy.




 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. ROHAN GOEL
AGE/ GENDER : 25 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01522882
CLIENT CODE. : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT

PATIENT ID : 1706294
REG. NO./LAB NO. : 012412230016
REGISTRATION DATE : 23/Dec/2024 09:54 AM
COLLECTION DATE : 23/Dec/2024 10:00AM
REPORTING DATE : 23/Dec/2024 11:35AM

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

ENDOCRINOLOGY

THYROID FUNCTION TEST: TOTAL

TRIIODOTHYRONINE (T3): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	1.37	ng/mL	0.35 - 1.93
THYROXINE (T4): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	8.46	µg/dL	4.87 - 12.60
THYROID STIMULATING HORMONE (TSH): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)	2.519	µIU/mL	0.35 - 5.50

3rd GENERATION, ULTRASENSITIVE

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:-

- 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.
- 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 (e.g.: phenytoin, salicylates).
- 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.
- 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
6 - 12 Months	0.74 - 2.40	6 - 12 Months	7.10 - 16.16	6 - 12 Months	0.70 - 7.00




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. ROHAN GOEL		
AGE/ GENDER	: 25 YRS/MALE	PATIENT ID	: 1706294
COLLECTED BY	: SURJESH	REG. NO./LAB NO.	: 012412230016
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
BARCODE NO.	: 01522882	COLLECTION DATE	: 23/Dec/2024 10:00AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 23/Dec/2024 11:35AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

Test Name	Value	Unit	Biological Reference interval
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 (μ 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, iodine 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 goiter & 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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 11:35AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

TESTOSTERONE: TOTAL

TESTOSTERONE - TOTAL: SERUM	4.09	ng/mL	0.47 - 9.80
-----------------------------	------	-------	-------------

by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)

INTERPRETATION:

1. Testosterone is secreted in females by the ovary and formed indirectly from androstenedione in adrenal glands.
2. In males it is secreted by the testes. It circulates in blood bound largely to sex hormone binding globulin (SHBG). Less than 1% of the total testosterone is in the free form.
3. The bioavailable fraction includes the free form and that "weakly bound" to albumin (40% of the total in men and 20% of the total in women) and bound to cortisol binding globulin (CBG). It is the most potent circulating androgenic hormone.
4. The total testosterone bound to SHBG fluctuates since SHBG levels are affected by medication, disease, sex steroids and insulin.

CLINIC USE:

1. Assessment of testicular functions in males
2. Management of hirsutism and virilization in females


INCREASED LEVELS:

1. Precocious puberty (Males)
2. Androgen resistance
3. Testotoxicosis
4. Congenital Adrenal Hyperplasia
5. Polycystic ovarian disease
7. Ovarian tumors

DECREASED LEVELS:

1. Delayed puberty (Males)
2. Gonadotropin deficiency
3. Testicular defects
4. Systemic diseases




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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 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 **20^L** ng/mL
 by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)

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 resevoir 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 homeostatis. 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 Hyperparathroidism (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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 12:14PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

VITAMIN B12/COBALAMIN

VITAMIN B12/COBALAMIN: SERUM **151^L** 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

NAME	: Mr. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 01:22PM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

VITAMIN B9/FOLIC ACID/FOLATE

VITAMIN B9/FOLIC ACID/FOLATE: SERUM by CLIA (CHEMILUMINESCENCE IMMUNOASSAY)	3.96	ng/mL	DEFICIENT: < 3.37 INTERMEDIATE: 3.37 - 5.38 NORMAL: > 5.38
--	------	-------	--

INTERPRETATION

RESULT IN ng/mL	REMARKS
0.35 – 3.37	DEFICIENT
3.38 – 5.38	INTERMEDIATE
5.39 – 100.00	NORMAL

NOTE:

1. Drugs like Methotrexate & Leucovorin interfere with folate measurement
2. To differentiate vitamin B12 & folate deficiency, measurement of Methyl malonic acid in urine & serum Homocysteine level is suggested
3. Risk of toxicity from folic acid is low as it is a water soluble vitamin regularly excreted in urine

COMMENTS:

1. Folate plays an important role in the synthesis of purine & pyrimidines in the body and is important for the maturation of erythrocytes.
2. It is widely available from plants and to a lesser extent organ meats, but more than half the folate content of food is lost during cooking.
3. Folate deficiency is commonly prevalent in alcoholic liver disease, pregnancy and the elderly. It may result from poor intestinal absorption, nutrition deficiency, excessive demand as in pregnancy or in malignancy and in response to certain drugs like Methotrexate & anticonvulsants.
4. Decreased Levels Megaloblastic anemia, Infantile hyperthyroidism, Alcoholism, Malnutrition, Scurvy, Liver disease, B12 deficiency, dietary amino acid excess, adult Celiac disease, Tropical Sprue, Crohn's disease, Hemolytic anemias, Carcinomas, Myelofibrosis, vitamin B6 deficiency, pregnancy, Whipple's disease, extensive intestinal resection and severe exfoliative dermatitis




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. ROHAN GOEL
AGE/ GENDER : 25 YRS/MALE
COLLECTED BY : SURJESH
REFERRED BY : CENTRAL PHOENIX CLUB (AMBALA CANTT)
BARCODE NO. : 01522882
CLIENT CODE : KOS DIAGNOSTIC LAB
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT
PATIENT ID : 1706294
REG. NO./LAB NO. : 012412230016
REGISTRATION DATE : 23/Dec/2024 09:54 AM
COLLECTION DATE : 23/Dec/2024 10:00AM
REPORTING DATE : 23/Dec/2024 10:19AM

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

CLINICAL PATHOLOGY

URINE ROUTINE & MICROSCOPIC EXAMINATION

PHYSICAL EXAMINATION

QUANTITY RECEIVED	10	ml	
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
COLOUR	PALE YELLOW		PALE YELLOW
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
TRANSPARANCY	CLEAR		CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY			
SPECIFIC GRAVITY	>=1.030		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	Negative		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

RED BLOOD CELLS (RBCs)	NEGATIVE (-ve)	/HPF	0 - 3
------------------------	----------------	------	-------



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. ROHAN GOEL	PATIENT ID	: 1706294
AGE/ GENDER	: 25 YRS/MALE	REG. NO./LAB NO.	: 012412230016
COLLECTED BY	: SURJESH	REGISTRATION DATE	: 23/Dec/2024 09:54 AM
REFERRED BY	: CENTRAL PHOENIX CLUB (AMBALA CANTT)	COLLECTION DATE	: 23/Dec/2024 10:00AM
BARCODE NO.	: 01522882	REPORTING DATE	: 23/Dec/2024 10:19AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CANTT		

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

*** End Of Report ***




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


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

