

TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.



rs. GEETA DEVI		t CEO & Consultant	t Pathologist
YRS/FEMALE		PATIENT ID	: 1736037
		REG. NO./LAB NO.	: 012501270024
		REGISTRATION DATE	: 27/Jan/2025 10:11 AM
		COLLECTION DATE	: 27/Jan/2025 10:14AM
			: 27/Jan/2025 10:50AM
497 I, NICHOLSON ROAD, AMB	ALA CANTI		
	Value	Unit	Biological Reference interval
SWAST	HYA WE	LLNESS PANEL: 1.	2
	11.9 ^L	gm/dL	12.0 - 16.0
COUNT	131	Millions	/cmm 3.50 - 5.00
ING, ELECTRICAL IMPEDENCE			
	36.6 ^L	%	37.0 - 50.0
OLUME (MCV)	84.9	fL	80.0 - 100.0
AEMOGLOBIN (MCH)	27.7	pg	27.0 - 34.0
	22.6		32.0 - 36.0
ATED HEMATOLOGY ANALYZER		Ŭ	32.0 - 30.0
	13.9	%	11.00 - 16.00
N WIDTH (RDW-SD)	44	fL	35.0 - 56.0
ATED HEMATOLOGY ANALYZER	197	RATIO	BETA THALASSEMIA TRAIT: <
	1011		13.0
			IRON DEFICIENCY ANEMIA: >13.0
	27.47	RATIO	BETA THALASSEMIA TRAIT:<=
			65.0 IRON DEFICIENCY ANEMIA: >
			65.0
	6470	/cmm	4000 - 11000
D CELLS (nRBCS)	NIL		0.00 - 20.00
	NH	0/2	< 10 %
	INIL	70	< 10 /0
	SWAST	DS DIAGNOSTIC LAB 349/1, NICHOLSON ROAD, AMBALA CANTT Value Value SWASTHYA WE COMPLETE BL COMPLETE BL COUNT AND INDICES (COUNT AND INDICES (PCV) 4.31 SING, ELECTRICAL IMPEDENCE (PCV) 84.9 ATED HEMATOLOGY ANALYZER OLUME (MCV) 84.9 ATED HEMATOLOGY ANALYZER NAEMOGLOBIN (MCH) 27.7 ATED HEMATOLOGY ANALYZER IEMOGLOBIN CONC. (MCHC) 32.6 ATED HEMATOLOGY ANALYZER N WIDTH (RDW-CV) 13.9 ATED HEMATOLOGY ANALYZER N WIDTH (RDW-SD) 44 ATED HEMATOLOGY ANALYZER N M ATED HEMATOLOGY ANALYZER N M A A A A A A A	BAS DIAGNOSTIC LAB REPORTING DATE BAS DIAGNOSTIC LAB REPORTING DATE BAS DIAGNOSTIC LAB Value Unit SWASTIC LAB CANTT INT COLONT AND INDICES ILE COLONT COUNT (CBC) AGE COUNT AND INDICES ILE TATICAL MPEDEENCE (PCV) AGE COLONT (MCC) AGE COLONT (MCC) AGE COLONT (MCC) IATED HEMATOLOGY ANALYZER IN WIDTH (RDW-CV) IATED HEMATOLOGY ANALYZER





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

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

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Dr. Yugam Chopra

MD (Pathology & Microbiology) MD (Pathology) Chairman & Consultant Pathologist **CEO & Consultant Pathologist** NAME : Mrs. GEETA DEVI AGE/ GENDER : 44 YRS/FEMALE **PATIENT ID** :1736037 **COLLECTED BY** :012501270024 REG. NO./LAB NO. **REFERRED BY REGISTRATION DATE** : 27/Jan/2025 10:11 AM **BARCODE NO.** :01524495 **COLLECTION DATE** : 27/Jan/2025 10:14AM CLIENT CODE. : KOS DIAGNOSTIC LAB **REPORTING DATE** : 27/Jan/2025 10:50AM **CLIENT ADDRESS** : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit **Biological Reference interval DIFFERENTIAL LEUCOCYTE COUNT (DLC)** NEUTROPHILS 63 % 50 - 70 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY LYMPHOCYTES 30 % 20 - 40 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY EOSINOPHILS 2 % 1 - 6 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY MONOCYTES 5 % 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 4076 2000 - 7500 /cmm by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE LYMPHOCYTE COUNT 1941 800 - 4900 /cmm by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE EOSINOPHIL COUNT 129/cmm 40 - 440 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE MONOCYTE COUNT 324 /cmm 80 - 880 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY ABSOLUTE BASOPHIL COUNT 0 /cmm 0 - 110 by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY PLATELETS AND OTHER PLATELET PREDICTIVE MARKERS. PLATELET COUNT (PLT) 150000 - 450000 262000 /cmm by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE 0.4^H PLATELETCRIT (PCT) % 0.10 - 0.36 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE MEAN PLATELET VOLUME (MPV) 15^H fL 6.50 - 12.0 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE 30000 - 90000 PLATELET LARGE CELL COUNT (P-LCC) /cmm 165000^H by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE % PLATELET LARGE CELL RATIO (P-LCR) 62.8^H 11.0 - 45.0 by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE PLATELET DISTRIBUTION WIDTH (PDW) 15.0 - 17.0 16.2% by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE

Dr. Vinay Chopra

NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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







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Test Name	Value	Unit	Biological Reference interval





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COLLECTED BY : CEFERRED BY : CEFERRED BY : CARCODE NO. : 015244 CLIENT CODE. : KOS DL CLIENT ADDRESS : 6349/1 CLIENT ADDRESS : 6349/1 CEST NAME CEST NAME CE	AGNOSTIC LAB , NICHOLSON ROAD, AMBA ERYTHROCY TION RATE (ESR) CAPILLARY PHOTOMETRY suse an elevated result often ell the health practitioner ex her conditions besides inflam	RE RE CO RE ALA CANTT Value TTE SEDIME 52 ^H en indicates the xactly where th mmation. For th	e inflammation is in th	(ESR) t hr 0 - 20 tion associated with infe be body or what is causir	AM AM Reference interval
REFERRED BY : BARCODE NO. : 015244 CLIENT CODE. : KOS DL CLIENT ADDRESS : 6349/1 CLIENT ADDRESS : 6349/1 CERYTHROCYTE SEDIMENTAT by RED CELL AGGREGATION BY CONTERPRETATION: L. ESR is a non-specific test becammune disease, but does not t chan ESR can be affected by oth is C-reactive protein B. This test may also be used to systemic lupus erythematosus conDITION WITH LOW ESR A low ESR can be seen with con State Seen with con	AGNOSTIC LAB , NICHOLSON ROAD, AMBA ERYTHROCY TION RATE (ESR) CAPILLARY PHOTOMETRY suse an elevated result often ell the health practitioner ex her conditions besides inflam	RE CO RE ALA CANTT Value TTE SEDIME 52 ^H en indicates the xactly where th mmation. For th	GISTRATION DATE LLECTION DATE PORTING DATE Unit Unit NTATION RATE (mm/1st presence of inflammaries in the	: 27/Jan/2025 10:11 : 27/Jan/2025 10:14 : 27/Jan/2025 11:31 Biological (ESR) t hr 0 - 20 tion associated with infe	AM AM Reference interval
ARCODE NO. : 015244 CLIENT CODE. : KOS DL CLIENT ADDRESS : 6349/1 Fest Name ERYTHROCYTE SEDIMENTA by RED CELL AGGREGATION BY O NTERPRETATION: . ESR is a non-specific test beca mmune disease, but does not t 2. An ESR can be affected by oth is C-reactive protein 3. This test may also be used to ystemic lupus erythematosus CONDITION WITH LOW ESR A low ESR can be seen with con	AGNOSTIC LAB , NICHOLSON ROAD, AMBA ERYTHROCY TION RATE (ESR) CAPILLARY PHOTOMETRY suse an elevated result often ell the health practitioner ex her conditions besides inflam	CO RE ALA CANTT Value TTE SEDIME 52H en indicates the xactly where th mmation. For th	LLECTION DATE PORTING DATE Unit NTATION RATE (mm/1st presence of inflamma: e inflammation is in th	: 27/Jan/2025 10:14 : 27/Jan/2025 11:31 Biological (ESR) t hr 0 - 20 tion associated with infe te body or what is causir	AM AM Reference interval
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CRYTHROCYTE SEDIMENTA ERYTHROCYTE SEDIMENTA by RED CELL AGGREGATION BY ON NTERPRETATION: . ESR is a non-specific test beca mmune disease, but does not t . An ESR can be affected by oth s C-reactive protein . This test may also be used to ystemic lupus erythematosus SONDITION WITH LOW ESR low ESR can be seen with con	, NICHOLSON ROAD, AMBA ERYTHROCY FION RATE (ESR) CAPILLARY PHOTOMETRY ause an elevated result ofter ell the health practitioner en her conditions besides inflam	ALA CANTT Value TE SEDIME 52 ^H en indicates the xactly where th mmation. For th	Unit NTATION RATE (mm/1st presence of inflamma e inflammation is in th	Biological (ESR) t hr 0 - 20 tion associated with infe te body or what is causir	Reference interval
ERYTHROCYTE SEDIMENTA' by RED CELL AGGREGATION BY ON NERPRETATION: . ESR is a non-specific test beca mmune disease, but does not t 2. An ESR can be affected by oth is C-reactive protein 3. This test may also be used to ystemic lupus erythematosus CONDITION WITH LOW ESR Now ESR can be seen with con	ERYTHROCY TION RATE (ESR) CAPILLARY PHOTOMETRY HUSE an elevated result often ell the health practitioner ex her conditions besides inflam	TTE SEDIME 52 ^H en indicates the xactly where th mmation. For th	NTATION RATE (mm/1st presence of inflamma e inflammation is in th	(ESR) t hr 0 - 20 tion associated with infe be body or what is causir	ection, cancer and auto-
by RED CELL AGGREGATION BY ON NTERPRETATION: . ESR is a non-specific test becar mmune disease, but does not t . An ESR can be affected by oth s C-reactive protein . This test may also be used to ystemic lupus erythematosus CONDITION WITH LOW ESR low ESR can be seen with con	TION RATE (ESR) CAPILLARY PHOTOMETRY Buse an elevated result often ell the health practitioner en her conditions besides inflan	52^H en indicates the xactly where th mmation. For th	mm/1st presence of inflamma e inflammation is in th	(ESR) t hr 0 - 20 tion associated with infe be body or what is causir	ection, cancer and auto-
= 1 + 2 + 3 + 1 + 2 + 3 + 3 + 3 + 3 + 3 + 3 + 3 + 3 + 3	ditions that inhibit the norm	' nal sedimentati	on of red blood cells, s	above diseases as well a such as a high red blood	s some others, such as cell count
bolycythaemia), significantly h s sickle cells in sickle cell anae IOTE: . ESR and C - reactive protein (. Generally, ESR does not chan . CRP is not affected by as man . If the ESR is elevated, it is typ . Women tend to have a higher . Drugs such as dextran, methy spirin, cortisone, and quinine	mia) also lower the ESR. C-RP) are both markers of in ge as rapidly as does CRP, ei y other factors as is ESR, mai cally a result of two types of ESR, and menstruation and dopa, oral contraceptives,	iflammation. ither at the star king it a better of proteins, glod pregnancy can	rt of inflammation or a marker of inflammatio pulins or fibrinogen. cause temporary elev.	as it resolves. n. ations.	





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



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		h opra & Microbiology) nsultant Pathologist	Dr. Yugan MD CEO & Consultant	(Pathology)
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CLIENT CODE.	: KOS DIAGNOSTIC LAB	RE	PORTING DATE	: 27/Jan/2025 12:16PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD	, AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
	CLINI	CAL CHEMISTR GLUCOSE FA	RY/BIOCHEMIST ASTING (F)	'nY
GLUCOSE FASTING by GLUCOSE OXIDAS	(F): PLASMA E - PEROXIDASE (GOD-POD)	95.47	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0

IN ACCRDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES: 1. A fasting plasma glucose level below 100 mg/dl is considered normal. 2. A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood

test (after consumption of 75 gms of glucose) is recommended for all such patients. 3. A fasting plasma glucose level of above 125 mg/dl is highly suggestive of diabetic state. A repeat post-prandial is strongly recommended for all such patients. A fasting plasma glucose level in excess of 125 mg/dl on both occasions is confirmatory for diabetic state.



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Test Name		Value	Unit	Biological Reference interval
		LIPID PRO	FILE : BASIC	
CHOLESTEROL TO	ΓΔΙ · SFRUM	155.51	mg/dL	OPTIMAL: < 200.0
by CHOLESTEROL OX		100.01	ilig/ dL	BORDERLINE HIGH: 200.0 - 239.0
				HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: S	ERUM	86.05	mg/dL	0PTIMAL: < 150.0
	PHATE OXIDASE (ENZYMATIC)			BORDERLINE HIGH: 150.0 -
				199.0 HIGH: 200.0 - 499.0
				VERY HIGH: > OR = 500.0
	L (DIRECT): SERUM	78.95	mg/dL	LOW HDL: < 30.0
by SELECTIVE INHIBIT	ION			BORDERLINE HIGH HDL: 30.0 60.0
				HIGH HDL: $> OR = 60.0$
LDL CHOLESTERO		59.35	mg/dL	OPTIMAL: < 100.0
by CALCULATED, SPE	CTROPHOTOMETRY			ABOVE OPTIMAL: 100.0 - 129.
				BORDERLINE HIGH: 130.0 - 159.0
				HIGH: 160.0 - 189.0
		70 70	()7	VERY HIGH: $> OR = 190.0$
NON HDL CHOLES by CALCULATED, SPE		76.56	mg/dL	OPTIMAL: < 130.0 ABOVE OPTIMAL: 130.0 - 159.
-,,,				BORDERLINE HIGH: 160.0 -
				189.0
				HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTER	DL: SERUM	17.21	mg/dL	0.00 - 45.00
by CALCULATED, SPE	CTROPHOTOMETRY			
FOTAL LIPIDS: SER by CALCULATED, SPE		397.07	mg/dL	350.00 - 700.00
CHOLESTEROL/HE	DL RATIO: SERUM	1.97	RATIO	LOW RISK: 3.30 - 4.40
by CALCULATED, SPE	CTROPHOTOMETRY			AVERAGE RISK: 4.50 - 7.0 MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0





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Test Name		Value	Unit	Biological Reference interval
LDL/HDL RATIO: S by CALCULATED, SPE		0.75	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	1.09 ^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





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BILIRUBIN TOTAL	: SERUM	FUNCTION 0.25	N TEST (COMPLETE) mg/dL	INFANT: 0.20 - 8.00
BILIRUBIN DIRECT	PECTROPHOTOMETRY Γ (CONJUGATED): SERUM	0.09	mg/dL	ADULT: 0.00 - 1.20 0.00 - 0.40
	SPECTROPHOTOMETRY CCT (UNCONJUGATED): SERUM	0.16	mg/dL	0.10 - 1.00
SGOT/AST: SERUM		23.9	U/L	7.00 - 45.00
SGPT/ALT: SERUM		18.8	U/L	0.00 - 49.00
AST/ALT RATIO: S	ERUM ECTROPHOTOMETRY	1.27	RATIO	0.00 - 46.00
ALKALINE PHOSPI by PARA NITROPHEN PROPANOL	HATASE: SERUM YL PHOSPHATASE BY AMINO METHYL	70.08	U/L	40.0 - 130.0
GAMMA GLUTAMY by SZASZ, SPECTRO	L TRANSFERASE (GGT): SERUM PHTOMETRY	19.58	U/L	0.00 - 55.0
TOTAL PROTEINS: by BIURET, SPECTRO		7.21	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL G		3.77	gm/dL	3.50 - 5.50
GLOBULIN: SERUN by CALCULATED, SPE	I ECTROPHOTOMETRY	3.44	gm/dL	2.30 - 3.50
A : G RATIO: SERU		1.1	RATIO	1.00 - 2.00

by CALCULATED, SPECTROPHOTOMETRY

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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INTERPRETATION





	Dr. Vinay Chopra MD (Pathology & Micro Chairman & Consultant	biology) ME	n Chopra D (Pathology) ht Pathologist
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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).

PROGNOSTIC	SIGNIFICANCE:

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



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	Dr. Vinay Cho MD (Pathology & M Chairman & Consu	Microbiology) MD (F		Pathology)		
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BARCODE NO.	: 01524495	COL	LECTION DATE	: 27/Jan/2025 10:14AM		
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REP	ORTING DATE	: 27/Jan/2025 12:23PM		
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, A	MBALA CANTT				
Test Name		Value	Unit	Biological Reference interval		
	KIDNI	EY FUNCTION T	EST (COMPLETE)			
UREA: SERUM		18.39	mg/dL	10.00 - 50.00		
	/ATE DEHYDROGENASE (GLDH) UM	0.84	mg/dL	0.40 - 1.20		
	REATININE: SERUM by enzymatic, spectrophotometery		nig/ uL	0.40 - 1.20		
	ROGEN (BUN): SERUM	8.59	mg/dL	7.0 - 25.0		
	ROGEN (BUN)/CREATININE	10.23	RATIO	10.0 - 20.0		
RATIO: SERUM						
UREA/CREATININ	ECTROPHOTOMETRY E RATIO: SERUM	21.89	RATIO			
by CALCULATED, SPE	ECTROPHOTOMETRY					
URIC ACID: SERUN by URICASE - OXIDAS		4.02	mg/dL	2.50 - 6.80		
CALCIUM: SERUM		9.07	mg/dL	8.50 - 10.60		
by ARSENAZO III, SPE PHOSPHOROUS: SE		2.76	ma /dI	2 20 4 70		
	DATE, SPECTROPHOTOMETRY	2.70	mg/dL	2.30 - 4.70		
ELECTROLYTES						
SODIUM: SERUM		138.9	mmol/L	135.0 - 150.0		
by ISE (ION SELECTIV POTASSIUM: SERU		3.94	mmol/L	3.50 - 5.00		
by ISE (ION SELECTIVE ELECTRODE)						
CHLORIDE: SERUN by ISE (ION SELECTIV		104.18	mmol/L	90.0 - 110.0		
	MERULAR FILTERATION RATE					
ESTIMATED GLOM	IERULAR FILTERATION RATE	87.8				
(eGFR): SERUM by CALCULATED						
INTERPRETATION:						
T 1100						

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)

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ACC / GENDER : 44 YRS/FEMALE PATIENT ID : 1736037 XXLECTED BY : REG. NO./LAB NO. : 012501270024 REFERED BY : REGISTRATION DATE : 27/Jan/2025 10:11 AM XARCODE NO. :01524495 COLLECTION DATE : 27/Jan/2025 10:14AM XARCODE NO. :01524495 COLLECTION DATE : 27/Jan/2025 10:14AM XILENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT : 27/Jan/2025 12:23PM Free Name Value Unit Biological Reference interest I. High protein intake. : Impaired renal function plus : Kress protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein died purs, surgery, cachekia, high fever). : Unice reabsorption (e.g. ureter colostomy) 8. Reduced muscle mass (subnormal creatinine production) : Greatin drugs (e.g. tetracycline, glucocorticolds) NCREASED RATIO (-20:1) WITH LEVATED CREATININE LEVELSI : Porenal azotemia superimposed on renal disease. VECREASED RATIO (-10:1) WITH DECREASED BUN : : Augustantion. 1. Other causes of decreased urea synthesis. : Regenarcy. 2. Other causes of decreased urea synthesis. : Regenarcy. 9. Standard (suctore of nappropiate antidiuretic harmone) due to tubular secretion of			Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Pathologist			Dr. Yugam Chopra MD (Pathology) t CEO & Consultant Pathologist			
COLLECTED BY E. REG. NO./LAB NO. : 012501270024 REFERED BY :: REGISTRATION DATE :: :: 27./lan/2025 10:11 AM ABACODE NO. :: 01524495 COLLECTION DATE :: :: 27./lan/2025 10:14 AM SILENT CODE :: KOS DIAGNOSTIC LAB REPORTING DATE :: :: 27./lan/2025 10:14 AM LIENT ADDRESS :: :: Status ::	IAME	: Mrs. GEETA	Mrs. GEETA DEVI						
REFERED BY: E. EXCLASTRATION DATE 27/Jan/2025 10:11 AM BARCODE NO. :01524495 COLLECTION DATE :27/Jan/2025 10:14 AM BARCODE NO. :01524495 COLLECTION DATE :27/Jan/2025 10:14 AM CLIENT ADDRESS :6349/1, NICHOLSON ROAD, AMBALA CANTT Biological Reference Inter 1. High protein intake.	AGE/ GENDER	: 44 YRS/FEM	ALE		PATIENT ID	:1	736037		
BARCODE NO. 1: 01524495 COLLECTION DATE 1: 27/Jan/2025 10:14AM CLIENT CODE KOS DIAGNOSTIC LAB REPORTING DATE 1: 27/Jan/2025 12:23PM CLIENT ADDRESS 6:349/1, NICHOLSON ROAD, AMBALA CANTT Biological Reference inter 4. High protein intake. Unit Biological Reference inter 5. Impaired renal function plus Excess protein intake or production or tissue breakdown (e.g. infection, Gi bleeding, thyrotoxicosis, Cushing's syndrome, high protein die burns, surgery, cachexia, high fever). Norme reabsorption (e.g. ureter colostomy) 8. Reduced muscle mass (ubnormal creatinine production) 9. Certain drugs (e.g. tetracycline, glucocorticoids) NICREASED RATIO (-20:1) WITH LEVATED CREATININE LEVELS: 1. Portenal azotemia lugueringosed on renal disease. 9. Other disease of decreased urea synthesis. 1. Portenal azotemia superinas (urea is virtually absent in blod). 9. Other disease of decreased urea synthesis. 1. Portenal azotemia superinas (urea is virtually absent in blod). 9. Horgarmoy. EXCERSPERATIO (-10:1) WITH INCREASED CREATINNE: 1. Protenal azotemia (Urea is virtually absent in blod). 1. Portenal azotemia (Urea is virtually absent in blod). 9. Regarmacy. Excess protein distaine to creatinine). 2. Regarmacy. 9. Ceremand Surger is virtually absent in blod). 1. Portenal azotemia (Urea is vir	COLLECTED BY	:			REG. NO./LAB NO.	. :0	125012700	24	
BARCODE NO. 1: 01524495 COLLECTION DATE 1: 27/Jan/2025 10:14AM CLIENT CODE KOS DIAGNOSTIC LAB REPORTING DATE 1: 27/Jan/2025 12:23PM CLIENT ADDRESS 6:349/1, NICHOLSON ROAD, AMBALA CANTT Biological Reference inter 4. High protein intake. Unit Biological Reference inter 5. Impaired renal function plus Excess protein intake or production or tissue breakdown (e.g. infection, Gi bleeding, thyrotoxicosis, Cushing's syndrome, high protein die burns, surgery, cachexia, high fever). Norme reabsorption (e.g. ureter colostomy) 8. Reduced muscle mass (ubnormal creatinine production) 9. Certain drugs (e.g. tetracycline, glucocorticoids) NICREASED RATIO (-20:1) WITH LEVATED CREATININE LEVELS: 1. Portenal azotemia lugueringosed on renal disease. 9. Other disease of decreased urea synthesis. 1. Portenal azotemia superinas (urea is virtually absent in blod). 9. Other disease of decreased urea synthesis. 1. Portenal azotemia superinas (urea is virtually absent in blod). 9. Horgarmoy. EXCERSPERATIO (-10:1) WITH INCREASED CREATINNE: 1. Protenal azotemia (Urea is virtually absent in blod). 1. Portenal azotemia (Urea is virtually absent in blod). 9. Regarmacy. Excess protein distaine to creatinine). 2. Regarmacy. 9. Ceremand Surger is virtually absent in blod). 1. Portenal azotemia (Urea is vir	REFERRED BY				REGISTRATION D	ATE · 2	7/Ian/2025 1	0·11 AM	
CLIENT CODE :: SOS DIAGNOSTIC LAB :: SPORTINC DATE :: 27/Jan/2025 12:23PM CLIENT ADDRESS :: 6349/1, NICHOLSON ROAD, AMBALA CANTE Test Name Value Unit Biological Reference inter 4. High protein intake. :		· · 01524495							
CLIENT ADDRESS : 6349/1, NICHOLSON ROAD, AMBALA CANTT Test Name Value Unit Biological Reference internation of the set of the se			STIC LAR						
4. High protein intake. 5. Impaired renal function plus 6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein die burns, surgery, cacheka, high fever). 7. Urine reabsorption (e.g. ureter colostomy) 8. Reduced muscle mass (subnormal creatinine production) 9. Certain drugs (e.g. tetracycline, glucocorticoids) INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS: 1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 3. Pregnancy. 0. Other causes of decreased urea synthesis. 5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid). 6. Inherited hyperammonemias (urea is virtually absent in blood). 7. SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea. 8. Pregnancy. <tr< td=""><td></td><td></td><td></td><td></td><td>REFORTING DATI</td><td>L . 2</td><td>77 Jan 2023 I</td><td>2.23F WI</td><td></td></tr<>					REFORTING DATI	L . 2	77 Jan 2023 I	2.23F WI	
4. High protein intake. 5. Impaired renal function plus 6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein die burns, surgery, cacheka, high fever). 7. Urine reabsorption (e.g. ureter colostomy) 8. Reduced muscle mass (subnormal creatinine production) 9. Certain drugs (e.g. tetracycline, glucocorticoids) INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS: 1. Postrenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 2. Prerenal azotemia (BUN rises disproportionately more than creatinine) (e.g. obstructive uropathy). 3. Pregnancy. 0. Other causes of decreased urea synthesis. 5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid). 6. Inherited hyperammonemias (urea is virtually absent in blood). 7. SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea. 8. Pregnancy. <tr< td=""><td>Tost Nama</td><td></td><td>_</td><td>Valuo</td><td>Un</td><td>;+</td><td>Biolog</td><td>nical Poforo</td><td>nco intorval</td></tr<>	Tost Nama		_	Valuo	Un	;+	Biolog	nical Poforo	nco intorval
1. Phenacimide therapy (accelerates conversion of creatine to creatinine). 2. Rhabdomyolysis (releases muscle creatinine). 3. Muscular patients who develop renal failure. INAPPROPIATE RATIO: 1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehyd should produce an increased BUN/creatinine ratio). 2. Cephalosporin therapy (interferes with creatinine measurement). ESTIMATED GLOMERULAR FILTERATION RATE: CKD STAGE DESCRIPTION G1 Normal kidney function 90 No proteinuria G2 Kidney damage with ormal or high GFR 0. 03a Mild decrease in GFR 63b Moderate decrease in GFR	7. Urine reabsorption		octomy						
G1Normal kidney function>90No proteinuriaG2Kidney damage with normal or high GFR>90Presence of Protein , Albumin or cast in urineG3aMild decrease in GFR60 -89G3bModerate decrease in GFR30-59	 P. Certain drugs (e.g. INCREASED RATIO (>2 Postrenal azotemia Prerenal azotemia DECREASED RATIO (< 1. Acute tubular necr Low protein diet ar Severe liver diseas Other causes of de Repeated dialysis (Inherited hyperam SIADH (syndrome of Pregnancy. DECREASED RATIO (ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed (0:1) WITH DECF osis. ad starvation. e. creased urea sy urea rather tha monemias (ure of inappropiate 0:1) WITH INCR	creatinine productic accorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : In creatinine diffuses a is virtually absent in antidiuretic harmone EASED CREATININE:	YELS: than creatinin out of extrace h blood).) due to tubula	ellular fluid). ar secretion of urea				
G2Kidney damage with normal or high GFR>90Presence of Protein , Albumin or cast in urineG3aMild decrease in GFR60 -89G3bModerate decrease in GFR30-59	9. Certain drugs (e.g. INCREASED RATIO (>2 1. Postrenal azotemia 2. Prerenal azotemia DECREASED RATIO (< 1. Acute tubular necr 2. Low protein diet ar 3. Severe liver diseas 4. Other causes of de 5. Repeated dialysis (6. Inherited hyperam 7. SIADH (syndrome (8. Pregnancy. DECREASED RATIO (< 1. Phenacimide thera 2. Rhabdomyolysis (r 3. Muscular patients INAPPROPIATE RATIO 1. Diabetic ketoacido should produce an in 2. Cephalosporin ther ESTIMATED GLOMER	ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed of 0:1) WITH DECF osis. ad starvation. 2. creased urea sy urea rather tha monemias (urea of inappropiate 0:1) WITH INCR py (accelerates eleases muscle who develop re- sis (acetoacetation creased BUN/cr apy (interferes	creatinine productic accorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : antidiuretic harmone EASED CREATININE: conversion of creatin creatinine). nal failure. e causes false increated eatinine ratio). with creatinine meas N RATE:	FELS: than creatinin out of extrace h blood).) due to tubul the to creatinin se in creatinin urement).	ellular fluid). ar secretion of urea e). ne with certain met	a. hodologies,r			hen dehydra
G3aMild decrease in GFR60 -89G3bModerate decrease in GFR30-59	 P. Certain drugs (e.g., INCREASED RATIO (>2 Postrenal azotemia Prerenal azotemia DECREASED RATIO (< Acute tubular necr Low protein diet ar Severe liver diseas Other causes of de Repeated dialysis (SIADH (syndrome of Pregnancy, DECREASED RATIO (Rhabdomyolysis (r Muscular patients MAPPROPIATE RATIO Diabetic ketoacido should produce an in Cephalosporin their ESTIMATED GLOMERIC 	ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed of 0:1) WITH DECF osis. Ind starvation. 2. creased urea sy urea rather tha monemias (urea of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate sis (acelerates eleases muscle who develop re- sis (acetoacetat creased BUN/cr apy (interferes ULAR FILTERATIO	creatinine productic ucocorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : In creatinine diffuses a is virtually absent in antidiuretic harmone EASED CREATININE: conversion of creatin creatinine). nal failure. e causes false increated eatinine ratio). with creatinine meas N RATE: DESCRIPTION	FELS: than creatinin out of extrace h blood).) due to tubul the to creatinin se in creatinin urement).	ellular fluid). ar secretion of urea ne). he with certain met	a. hodologies,r	TED FINDINGS		'hen dehydra'
	 P. Certain drugs (e.g., INCREASED RATIO (>2 Postrenal azotemia Prerenal azotemia DECREASED RATIO (< Acute tubular necr Low protein diet ar Severe liver diseas Other causes of de Repeated dialysis (SIADH (syndrome of Pregnancy. DECREASED RATIO (Rhabdomyolysis (r Muscular patients Muscular patients Mosting produce an in Cephalosporin their ESTIMATED GLOMERI G1 	ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed of 0:1) WITH DECF osis. ad starvation. creased urea sy urea rather tha monemias (urea of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate sis (acelerates eleases muscle who develop re- sis (acetoacetat creased BUN/cr apy (interferes of a content of the source of the source of the source of the source of the source of the source of the source of the source of the source of the source	creatinine productic accorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : ATED CREATININE EASED CREATININE: conversion of creatin creatinine). nal failure. e causes false increate eatinine ratio). with creatinine meas N RATE: DESCRIPTION mal kidney function dney damage with	FELS: than creatinin out of extrace h blood).) due to tubul the to creatinin se in creatinin urement).	ellular fluid). ar secretion of urea ne). he with certain met uL/min/1.73m2) >90	hodologies,r ASSOCIA	TED FINDINGS roteinuria e of Protein ,	5	'hen dehydra'
GA Severe decrease in GER 15-20	 A. Certain drugs (e.g., NCREASED RATIO (>2 Postrenal azotemia Prerenal azotemia DECREASED RATIO (< Acute tubular necr Low protein diet and Severe liver diseas Other causes of de Repeated dialysis (SIADH (syndrome of Pregnancy. DECREASED RATIO (Rhabdomyolysis (r Muscular patients NAPPROPIATE RATIO Diabetic ketoacido Should produce an in Cephalosporin there CETIMATED GLOMERI G1 	ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed of 0:1) WITH DECF osis. Ind starvation. 2. creased urea sy urea rather tha monemias (urea of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate of inappropiate sis (acetoacetates creased BUN/cr apy (interferes of a cetoacetates of a cetoacetates creased BUN/cr apy (interferes of a cetoacetates of a cetoac	creatinine productic accorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : ATED CREATININE LEV exact of the sease a is virtually absent in antidiuretic harmone EASED CREATININE: conversion of creatin creatinine). nal failure. e causes false increate eatinine ratio). with creatinine meas N RATE: DESCRIPTION mal kidney function dney damage with ormal or high GFR_	FELS: than creatinin out of extrace h blood).) due to tubul the to creatinin se in creatinin urement).	ellular fluid). ar secretion of urea ne). he with certain met <u>L/min/1.73m2) >90 >90 60 -89</u>	hodologies,r ASSOCIA	TED FINDINGS roteinuria e of Protein ,	5	'hen dehydra'
G5 Kidney failure <15	 P. Certain drugs (e.g., INCREASED RATIO (>2 1. Postrenal azotemia 2. Prerenal azotemia DECREASED RATIO (<' 1. Acute tubular necr 2. Low protein diet and 3. Severe liver diseas 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 INAPPROPIATE RATIO 1. Diabetic ketoacido should produce an in 2. Cephalosporin there ESTIMATED GLOMERI G1 G2 G3a G3b 	ass (subnormal tetracycline, glu 0:1) WITH ELEV. (BUN rises disp superimposed of 0:1) WITH DECF osis. Ind starvation. 2: creased urea sy urea rather tha monemias (urea f inappropiate of inappropiate of inappropiate f inappropiate of inappropiate of inappropiate f inappropiate f inappropiate f inappropiate of inappropiate f inappropiat	creatinine productic accorticoids) ATED CREATININE LEV proportionately more on renal disease. EASED BUN : In creatinine diffuses a is virtually absent in antidiuretic harmone EASED CREATININE: conversion of creatin creatinine). nal failure. e causes false increate eatinine ratio). with creatinine meas NRATE: DESCRIPTION mal kidney function dney damage with ormal or high GFR ild decrease in GFR erate decrease in GFR	YELS: than creatinin out of extrace h blood).) due to tubula the to creatinin se in creatinin urement).	ellular fluid). ar secretion of urea e). he with certain met <u>L/min/1.73m2) >90 >90 60 -89 30-59</u>	hodologies,r ASSOCIA	TED FINDINGS roteinuria e of Protein ,	5	'hen dehydra'





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

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CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 27/Jan/2025 12:23PM
BARCODE NO.	: 01524495	COLLECTION DATE	: 27/Jan/2025 10:14AM
REFERRED BY	:	REGISTRATION DATE	: 27/Jan/2025 10:11 AM
COLLECTED BY	:	REG. NO./LAB NO.	:012501270024
AGE/ GENDER	: 44 YRS/FEMALE	PATIENT ID	: 1736037
NAME	: Mrs. GEETA DEVI		
	MD (Pathology & M Chairman & Consul	licrobiology) MI	D (Pathology)
	Dr. Vinay Chor	pra 📔 Dr. Yuga	m 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

KOS Diagnostic Lab (A Unit of KOS Healthcare)

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





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

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	MD (Pathology &	Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Pathologist		n Chopra (Pathology) : Pathologist
NAME	: Mrs. GEETA DEVI			
AGE/ GENDER	: 44 YRS/FEMALE	PA	TIENT ID	: 1736037
COLLECTED BY	:	RI	EG. NO./LAB NO.	: 012501270024
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BARCODE NO.	: 01524495	CC	DLLECTION DATE	: 27/Jan/2025 10:14AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	RI	EPORTING DATE	: 27/Jan/2025 12:16PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD,	AMBALA CANTT		
Test Name		Value	Unit	Biological Reference interv
	TH	ENDOCRI IYROID FUNCTI	NOLOGY ON TEST: TOTAL	
TRIIODOTHYRONINE (T3): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)		0.925 SSAY)	ng/mL	0.35 - 1.93
by CMIA (CHEMILUMIN	THYROXINE (T4): SERUM by CMIA (CHEMILUMINESCENT MICROPARTICLE IMMUNOASSAY)			
THYROXINE (T4): S		11.94 SSAY)	µgm/dL	4.87 - 12.60
THYROXINE (T4): S by CMIA (CHEMILUMIN THYROID STIMULA	ESCENT MICROPARTICLE IMMUNOA: TING HORMONE (TSH): SERU ESCENT MICROPARTICLE IMMUNOA:	ssay) JM 1.12	μgm/dL μIU/mL	4.87 - 12.60 0.35 - 5.50
THYROXINE (T4): S by CMIA (CHEMILUMIN THYROID STIMULA by CMIA (CHEMILUMIN 3rd GENERATION, ULTI INTERPRETATION: TSH levels are subject to c day has influence on the r	ESCENT MICROPARTICLE IMMUNOA: TING HORMONE (TSH): SERU ESCENT MICROPARTICLE IMMUNOA: RASENSITIVE irrcadian variation, reaching peak levels measured serum TSH concentrations. TS ure at any level of regulation of the hy	SSAY) JM 1.12 SSAY) S between 2-4 a.m and all SH stimulates the produc	µIU/mL a minimum between 6-10 p ction and secretion of the n	
THYROXINE (T4): S by CMIA (CHEMILUMIN THYROID STIMULA by CMIA (CHEMILUMIN 3rd GENERATION, ULTI <u>INTERPRETATION</u> : TSH levels are subject to c day has influence on the r triiodothyronine (T3).Fail	ESCENT MICROPARTICLE IMMUNOAS TING HORMONE (TSH): SERU ESCENT MICROPARTICLE IMMUNOAS RASENSITIVE sircadian variation, reaching peak levels measured serum TSH concentrations. TS ure at any level of regulation of the hy roidism) of T4 and/or T3. T3	SSAY) JM 1.12 SSAY) S between 2-4 a.m and an SH stimulates the product ypothalamic-pituitary-th	µIU/mL a minimum between 6-10 p ction and secretion of the n yroid axis will result in eith	0.35 - 5.50 m. The variation is of the order of 50%.Hence time o netabolically active hormones, thyroxine (T4)and

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LIMITATION	<u>د</u>

Primary Hyperthyroidism:

Subclinical Hyperthyroidism:

1. T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, anabolic steroids and glucocorticoids may falsely affect the T3 and T4 levels and may cause false thyroid values for thyroid function tests.

Increased

Normal or High Normal

Reduced (at times undetectable)

Reduced

2. Normal levels of T4 can also be seen in Hyperthyroid patients with :T3 Thyrotoxicosis, Decreased binding capacity due to hypoproteinemia or ingestion of certain drugs (e.g.: phenytoin , salicylates).

3. Serum T4 levels in neonates and infants are higher than values in the normal adult , due to the increased concentration of TBG in neonate serum.

4. TSH may be normal in central hypothyroidism , recent rapid correction of hyperthyroidism or hypothyroidism , pregnancy , phenytoin therapy.

TRIIODOTHYRONINE (T3)		THYROX	(INE (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	

Increased

Normal or High Normal





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	Dr. Vinay Chopra MD (Pathology & Microbiology) Chairman & Consultant Patholo		(Pathology)
NAME	: Mrs. GEETA DEVI		
AGE/ GENDER	: 44 YRS/FEMALE	PATIENT ID	: 1736037
COLLECTED BY	:	REG. NO./LAB NO.	: 012501270024
REFERRED BY	:	REGISTRATION DATE	: 27/Jan/2025 10:11 AM
BARCODE NO.	: 01524495	COLLECTION DATE	: 27/Jan/2025 10:14AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPORTING DATE	: 27/Jan/2025 12:16PM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, AMBALA CAN	TT	

Test Name		Value	Unit	t	Biological Reference interval	
1 - 10 Years	0.92 - 2.28	1 - 10 Years	6.00 - 13.80	1 – 10 Years	0.60 - 5.50	
11- 19 Years	0.35 - 1.93	11 - 19 Years	4.87- 13.20	11 – 19 Years	0.50 - 5.50	
> 20 years (Adults)	0.35 - 1.93	> 20 Years (Adults)	4.87 - 12.60	> 20 Years (Adults)	0.35-5.50	
	RECON	IMENDATIONS OF TSH L	EVELS DURING PRE	GNANCY (µIU/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





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	Dr. Vinay Cho MD (Pathology & Chairman & Cons	Microbiology)	n Chopra (Pathology) : Pathologist	
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BARCODE NO.	: 01524495	COLL	ECTION DATE	: 27/Jan/2025 10:14AM
CLIENT CODE.	: KOS DIAGNOSTIC LAB	REPO	ORTING DATE	: 27/Jan/2025 10:38AM
CLIENT ADDRESS	: 6349/1, NICHOLSON ROAD, A	MBALA CANTT		
Test Name		Value	Unit	Biological Reference interval
		CLINICAL PAT	HOLOGY	
	URINE ROI	UTINE & MICROS	COPIC EXAMINA	ATION
PHYSICAL EXAMI	NATION			
QUANTITY RECIEV	ED STANCE SPECTROPHOTOMETRY	10	ml	
COLOUR	CTANCE SPECTROPHOTOMETRY	PALE YELLOW		PALE YELLOW
TRANSPARANCY		CLEAR		CLEAR
SPECIFIC GRAVITY	CTANCE SPECTROPHOTOMETRY	1.02		1.002 - 1.030
CHEMICAL EXAMI	INATION			
REACTION		ACIDIC		
PROTEIN	CTANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
SUGAR		Negative		NEGATIVE (-ve)
рH	CTANCE SPECTROPHOTOMETRY	<=5.0		5.0 - 7.5
BILIRUBIN	CTANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
NITRITE		Negative		NEGATIVE (-ve)
UROBILINOGEN	TANCE SPECTROPHOTOMETRY.	Normal	EU/dL	0.2 - 1.0
KETONE BODIES		Negative		NEGATIVE (-ve)
BLOOD		Negative		NEGATIVE (-ve)
ASCORBIC ACID by DIP STICK/REFLEC	CTANCE SPECTROPHOTOMETRY	NEGATIVE (-ve		NEGATIVE (-ve)
MICROSCOPIC EX				
RED BLOOD CELLS	G (RBCs)	NEGATIVE (-ve	e) /HPF	0 - 3

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TEST PERFORMED AT KOS DIAGNOSTIC LAB, AMBALA CANTT.



NANGE



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

OPETA DEVI

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

NAME	: Mrs. GEETA DEVI			
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Test Name		Value	Unit	Biological Reference interval
by MICROSCOPY ON O	CENTRIFUGED URINARY SEDIMENT			
PUS CELLS by MICROSCOPY ON O	CENTRIFUGED URINARY SEDIMENT	1-3	/HPF	0 - 5

by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	10	,	0 0	
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 ***



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