

(A Unit of KOS Healthcare)



Dr. Vinay Chopra
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Dr. Yugam Chopra
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NAME : Mr. VIKRAM

AGE/ GENDER : 44 YRS/MALE PATIENT ID : 1816189

COLLECTED BY : REG. NO./LAB NO. : 012504030006

 REFERRED BY
 : 03/Apr/2025 07:56 AM

 BARCODE NO.
 : 01528262
 COLLECTION DATE
 : 03/Apr/2025 08:03AM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 03/Apr/2025 08:46AM

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

Test Name Value Unit Biological Reference interval

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

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

HAEMOGLOBIN (HB) by CALORIMETRIC	12.9	gm/dL	12.0 - 17.0
RED BLOOD CELL (RBC) COUNT by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	4.53	Millions/cmm	3.50 - 5.00
PACKED CELL VOLUME (PCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	40.6	%	40.0 - 54.0
MEAN CORPUSCULAR VOLUME (MCV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	89.7	fL	80.0 - 100.0
MEAN CORPUSCULAR HAEMOGLOBIN (MCH) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	28.4	pg	27.0 - 34.0
MEAN CORPUSCULAR HEMOGLOBIN CONC. (MCHC) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	31.7 <sup>L</sup>	g/dL	32.0 - 36.0
RED CELL DISTRIBUTION WIDTH (RDW-CV) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	13.8	%	11.00 - 16.00
RED CELL DISTRIBUTION WIDTH (RDW-SD) by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER	46.5	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED	19.8	RATIO	BETA THALASSEMIA TRAIT: < 13.0 IRON DEFICIENCY ANEMIA: >13.0
GREEN & KING INDEX by CALCULATED	86.07	RATIO	BETA THALASSEMIA TRAIT: <= 74.1 IRON DEFICIENCY ANEMIA: >= 74.1
WHITE BLOOD CELLS (WBCS)			
TOTAL LEUCOCYTE COUNT (TLC) by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	5050	/cmm	4000 - 11000
NUCLEATED RED BLOOD CELLS (nRBCS) by AUTOMATED 6 PART HEMATOLOGY ANALYZER	NIL		0.00 - 20.00



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**NIL** 



< 10 %

NUCLEATED RED BLOOD CELLS (nRBCS) %



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Test Name	Value	Unit	<b>Biological Reference interval</b>
by CALCULATED BY AUTOMATED HEMATOLOGY ANALYZER DIFFERENTIAL LEUCOCYTE COUNT (DLC)			
	57	0/	50. 70
NEUTROPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	57	%	50 - 70
LYMPHOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	34	%	20 - 40
EOSINOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	3	%	1 - 6
MONOCYTES by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	6	%	2 - 12
BASOPHILS by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY A DSOL LYTE LET WOCKYTES (MICROSCOPY)	0	%	0 - 1
ABSOLUTE LEUKOCYTES (WBC) COUNT			
ABSOLUTE NEUTROPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	2879	/cmm	2000 - 7500
ABSOLUTE LYMPHOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	1717	/cmm	800 - 4900
ABSOLUTE EOSINOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	152	/cmm	40 - 440
ABSOLUTE MONOCYTE COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	303	/cmm	80 - 880
ABSOLUTE BASOPHIL COUNT by FLOW CYTOMETRY BY SF CUBE & MICROSCOPY	0	/cmm	0 - 110
PLATELETS AND OTHER PLATELET PREDICTIV	E MARKERS.		
PLATELET COUNT (PLT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	154000	/cmm	150000 - 450000
PLATELETCRIT (PCT) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	0.25	%	0.10 - 0.36
MEAN PLATELET VOLUME (MPV) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	16 <sup>H</sup>	fL	6.50 - 12.0
PLATELET LARGE CELL COUNT (P-LCC) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	$104000^{\mathrm{H}}$	/cmm	30000 - 90000
PLATELET LARGE CELL RATIO (P-LCR) by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE	67.7 <sup>H</sup>	%	11.0 - 45.0
PLATELET DISTRIBUTION WIDTH (PDW)	16.3	%	15.0 - 17.0



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### **KOS Diagnostic Lab**

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Value Unit Test Name **Biological Reference interval** 

REPORTING DATE

by HYDRO DYNAMIC FOCUSING, ELECTRICAL IMPEDENCE NOTE: TEST CONDUCTED ON EDTA WHOLE BLOOD



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Value Unit Test Name **Biological Reference interval** 

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

ERYTHROCYTE SEDIMENTATION RATE (ESR)

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 autoimmune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it.
- 2. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test such as C-reactive protein
- 3. This test may also be used to monitor disease activity and response to therapy in both of the above diseases as well as some others, such as systemic lupus erythematosus CONDITION WITH LOW ESR

A low ESR can be seen with conditions that inhibit the normal sedimentation of red blood cells, such as a high red blood cell count (polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (such as sickle cells in sickle cell anaemia) also lower the ESR. NOTE:

- ESR and C reactive protein (C-RP) are both markers of inflammation.
   Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves.
   CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation.

- 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



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Value Unit Test Name **Biological Reference interval** 

### **CLINICAL CHEMISTRY/BIOCHEMISTRY**

GLUCOSE FASTING (F)

GLUCOSE FASTING (F): PLASMA  $103.27^{H}$ mg/dL NORMAL: < 100.0

by GLUCOSE OXIDASE - PEROXIDASE (GOD-POD) PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0

INTERPRETATION
IN ACCORDANCE WITH AMERICAN DIABETES ASSOCIATION GUIDELINES:

1. A fasting plasma glucose level below 100 mg/dl is considered normal.

2. A fasting plasma glucose level between 100 - 125 mg/dl is considered as glucose intolerant or prediabetic. A fasting and post-prandial blood test (after consumption of 75 gms of glucose) is recommended for all such patients.

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



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Test Name	Value	Unit	Biological Reference interval
	LIPID PROFILI	E : BASIC	
CHOLESTEROL TOTAL: SERUM by CHOLESTEROL OXIDASE PAP	152.31	mg/dL	OPTIMAL: < 200.0 BORDERLINE HIGH: 200.0 - 239.0 HIGH CHOLESTEROL: > OR = 240.0
TRIGLYCERIDES: SERUM by GLYCEROL PHOSPHATE OXIDASE (ENZYMATIC)	103.92	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	43.1	mg/dL	LOW HDL: < 30.0 BORDERLINE HIGH HDL: 30.0 - 60.0 HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SERUM by CALCULATED, SPECTROPHOTOMETRY	88.43	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	109.21	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	20.78	mg/dL	0.00 - 45.00
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY	408.54	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	3.53	RATIO	LOW RISK: 3.30 - 4.40 AVERAGE RISK: 4.50 - 7.0



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Test Name	Value	Unit	Biological Reference interval
LDL/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.05	RATIO	MODERATE RISK: 7.10 - 11.0 HIGH RISK: > 11.0 LOW RISK: 0.50 - 3.0
		DATIO	MODERATE RISK: 3.10 - 6.0 HIGH RISK: > 6.0
TRIGLYCERIDES/HDL RATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.41 <sup>L</sup>	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

3. Low HDL levels are associated with increased risk for Atherosclerotic Cardiovascular disease (ASCVD) due to insufficient HDL being available to participate in reverse cholesterol transport, the process by which cholesterol is eliminated from peripheral tissues.

4. NLA-2014 identifies Non HDL Cholesterol (an indicator of all atherogeniclipoproteins such as LDL, VLDL, IDL, Lpa, Chylomicron remnants) along with LDL-cholesterol as co-primary target for cholesterol lowering therapy. Note that major risk factors can modify treatment goals for LDL &Non

5. Additional testing for Apolipoprotein B, hsCRP,Lp(a) & LP-PLA2 should be considered among patients with moderate risk for ASCVD for risk refinement



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#### LIVER FUNCTION TEST (COMPLETE)

BILIRUBIN TOTAL: SERUM by DIAZOTIZATION, SPECTROPHOTOMETRY	0.67	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
BILIRUBIN DIRECT (CONJUGATED): SERUM by DIAZO MODIFIED, SPECTROPHOTOMETRY	0.15	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT (UNCONJUGATED): SERUM by CALCULATED, SPECTROPHOTOMETRY	0.52	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	29.5	U/L	7.00 - 45.00
SGPT/ALT: SERUM by IFCC, WITHOUT PYRIDOXAL PHOSPHATE	58.02 <sup>H</sup>	U/L	0.00 - 49.00
AST/ALT RATIO: SERUM  by Calculated, Spectrophotometry	0.51	RATIO	0.00 - 46.00
ALKALINE PHOSPHATASE: SERUM  by Para Nitrophenyl Phosphatase by Amino Methyl Propanol	94.32	U/L	40.0 - 130.0
GAMMA GLUTAMYL TRANSFERASE (GGT): SERUM by SZASZ, SPECTROPHTOMETRY	39.74	U/L	0.00 - 55.0
TOTAL PROTEINS: SERUM by BIURET, SPECTROPHOTOMETRY	7.06	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GREEN	4.31	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPECTROPHOTOMETRY	2.75	gm/dL	2.30 - 3.50
A: GRATIO: SERUM by CALCULATED, SPECTROPHOTOMETRY	1.57	RATIO	1.00 - 2.00

INTERPRETATION

NOTE:- To be correlated in individuals having SGOT and SGPT values higher than Normal Referance Range.

**USE**:- Differential diagnosis of diseases of hepatobiliary system and pancreas.

#### **INCREASED:**

DRUG HEPATOTOXICITY	> 2
ALCOHOLIC HEPATITIS	> 2 (Highly Suggestive)
CIRRHOSIS	1.4 - 2.0
INTRAHEPATIC CHOLESTATIS	> 1.5



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HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS		> 1.3 (Slightly Increased)	
DECDEASED.		-	

#### DECKEASED:

- 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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#### KIDNEY FUNCTION TEST (COMPLETE)

UREA: SERUM	20.83	mg/dL	10.00 - 50.00
by UREASE - GLUTAMATE DEHYDROGENASE (GLDH)			
CREATININE: SERUM	1.02	mg/dL	0.40 - 1.40
by ENZYMATIC, SPECTROPHOTOMETERY			
BLOOD UREA NITROGEN (BUN): SERUM	9.73	mg/dL	7.0 - 25.0
by CALCULATED, SPECTROPHOTOMETRY			
BLOOD UREA NITROGEN (BUN)/CREATININE	$9.54^{\mathrm{L}}$	RATIO	10.0 - 20.0
RATIO: SERUM			
by CALCULATED, SPECTROPHOTOMETRY			
UREA/CREATININE RATIO: SERUM	20.42	RATIO	
by CALCULATED, SPECTROPHOTOMETRY		/ 17	2 (0 = 50
URIC ACID: SERUM by URICASE - OXIDASE PEROXIDASE	6.5	mg/dL	3.60 - 7.70
CALCIUM: SERUM	10.56	~/dI	8.50 - 10.60
by ARSENAZO III, SPECTROPHOTOMETRY	10.56	mg/dL	8.30 - 10.00
PHOSPHOROUS: SERUM	3.06	mg/dL	2.30 - 4.70
by PHOSPHOMOLYBDATE, SPECTROPHOTOMETRY	3.00	mg/uL	2.30 - 4.70
ELECTROLYTES			
	100 10	. ~	
SODIUM: SERUM	139.62	mmol/L	135.0 - 150.0
by ISE (ION SELECTIVE ELECTRODE)	4.62	1.7	2.50 5.00
POTASSIUM: SERUM by ISE (ION SELECTIVE ELECTRODE)	4.62	mmol/L	3.50 - 5.00
CHLORIDE: SERUM	104.72	mmol/L	90.0 - 110.0
by ISE (ION SELECTIVE ELECTRODE)	104./2	IIIIIOI/L	90.0 - 110.0
by ICE (ICIV CELECTIVE ELECTRODE)			

#### **ESTIMATED GLOMERULAR FILTERATION RATE**

ESTIMATED GLOMERULAR FILTERATION RATE 92.9

(eGFR): SERUM by CALCULATED **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.



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Test Name Value Unit **Biological Reference interval** 

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- 2. Catabolic states with increased tissue breakdown.
- 3. GI haemorrhage.

CLIENT CODE.

- 4. High protein intake.
- 5. Impaired renal function plus
- 6. Excess protein intake or production or tissue breakdown (e.g. infection, GI bleeding, thyrotoxicosis, Cushing's syndrome, high protein diet, burns, surgery, cachexia, high fever).
- 7. Urine reabsorption (e.g. ureter colostomy)
- 8. Reduced muscle mass (subnormal creatinine production)
- 9. Certain drugs (e.g. tetracycline, glucocorticoids)

#### INCREASED RATIO (>20:1) WITH ELEVATED CREATININE LEVELS:

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

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

- 1. Acute tubular necrosis.
- 2. Low protein diet and starvation.
- 3. Severe liver disease.
- 4. Other causes of decreased urea synthesis.
- 5. Repeated dialysis (urea rather than creatinine diffuses out of extracellular fluid).
- 6. Inherited hyperammonemias (urea is virtually absent in blood).
- 7. SIADH (syndrome of inappropiate antidiuretic harmone) due to tubular secretion of urea.
- 8. Pregnancy.

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

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

#### **INAPPROPIATE RATIO:**

- 1. Diabetic ketoacidosis (acetoacetate causes false increase in creatinine with certain methodologies, resulting in normal ratio when dehydration should produce an increased BUN/creatinine ratio).
- 2. Cephalosporin therapy (interferes with creatinine measurement) **ESTIMATED GLOMERULAR FILTERATION RATE**:

STIMATED GEOMERGEARTIETERATION 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		



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

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



(A Unit of KOS Healthcare)



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

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

**NAME** : Mr. VIKRAM

AGE/ GENDER : 44 YRS/MALE **PATIENT ID** : 1816189

COLLECTED BY REG. NO./LAB NO. :012504030006

REFERRED BY **REGISTRATION DATE** : 03/Apr/2025 07:56 AM BARCODE NO. **COLLECTION DATE** : 03/Apr/2025 08:03AM :01528262

CLIENT CODE. : KOS DIAGNOSTIC LAB REPORTING DATE : 03/Apr/2025 11:22AM

**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

4. eGFR category G1 OR G2 does not fullfill the criteria for CKD, in the absence of evidence of Kidney Damage
5. In a suspected case of Acute Kidney Injury (AKI), measurement of eGFR should be done after 48-96 hours of any Intervention or procedure
6. eGFR calculated by Serum Creatinine may be less accurate due to certain factors like Race, Muscle Mass, Diet, Certain Drugs. In such cases, eGFR should be calculated using Serum Cystatin C
7. A decrease in eGFR implies either progressive renal disease, or a reversible process causing decreased nephron function (eg, severe dehydration).

KDIGO guideline, 2012 recommends Chronic Kidney Disease (CKD) should be classified based on cause, eGFR category and Albuminuria (ACR) category. GFR & ACR category combined together reflect risk of progression and helps Clinician to identify the individual who are progressing at more rapid rate than anticipated



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MD (Pathology & Microbiology)
Chairman & Consultant Pathologist

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NAME : Mr. VIKRAM

AGE/ GENDER : 44 YRS/MALE PATIENT ID : 1816189

COLLECTED BY : REG. NO./LAB NO. : 012504030006

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 : 01528262
 COLLECTION DATE
 : 03/Apr/2025 08:03AM

 CLIENT CODE.
 : KOS DIAGNOSTIC LAB
 REPORTING DATE
 : 03/Apr/2025 09:50AM

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

Test Name Value Unit Biological Reference interval

# CLINICAL PATHOLOGY URINE ROUTINE & MICROSCOPIC EXAMINATION

#### **PHYSICAL EXAMINATION**

QUANTITY RECIEVED 10 ml

COLOUR PALE YELLOW PALE YELLOW

by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

TRANSPARANCY CLEAR
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY

CLEAR

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 5.5 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



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





CLIENT CODE.

### **KOS Diagnostic Lab**

(A Unit of KOS Healthcare)



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

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

: 03/Apr/2025 09:50AM

**NAME** : Mr. VIKRAM

**AGE/ GENDER PATIENT ID** :1816189 : 44 YRS/MALE

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REFERRED BY **REGISTRATION DATE** : 03/Apr/2025 07:56 AM **COLLECTION DATE** BARCODE NO. :01528262 : 03/Apr/2025 08:03AM

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Test Name	Value	Unit	Biological Reference interval
RED BLOOD CELLS (RBCs) by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	NEGATIVE (-ve)	/HPF	0 - 3
PUS CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	2-4	/HPF	0 - 5
EPITHELIAL CELLS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT	1-3	/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

REPORTING DATE

End Of Report



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

