A PIONEER DIAGNOSTIC CENTRE

【 0171-2532620, 8222896961 🛛 🖾 pkrjainhealthcare@gmail.com

NAME	: Mr. BALKAR SINGH			
AGE/ GENDER	: 48 YRS/MALE		PATIENT ID	: 1601532
COLLECTED BY	:		REG. NO./LAB NO.	: 122409040001
REFERRED BY	:		REGISTRATION DATE	: 04/Sep/2024 08:37 AM
BARCODE NO.	: 12504479		COLLECTION DATE	: 04/Sep/2024 09:29AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITU	JTE	REPORTING DATE	:04/Sep/202401:12PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBA	LA CITY - H	ARYANA	
Test Name		Value	Unit	Biological Reference interval
	SWAS	THYA W	ELLNESS PANEL: 1.0	
	COM	NPLETE BL	OOD COUNT (CBC)	
RED BLOOD CELLS (F	RBCS) COUNT AND INDICES			
HAEMOGLOBIN (HB))	15.9	gm/dL	12.0 - 17.0
RED BLOOD CELL (RE		4.79	Millions/cr	nm 3.50 - 5.00
PACKED CELL VOLUN		44.2	%	40.0 - 54.0
MEAN CORPUSCULA		92.3	KR fl	80.0 - 100.0
MEAN CORPUSCULA	UTOMATED HEMATOLOGY ANALYZER R HAEMOGLOBIN (MCH) UTOMATED HEMATOLOGY ANALYZER	33.1	pg	27.0 - 34.0
MEAN CORPUSCULA	R HEMOGLOBIN CONC. (MCHC)	35.9	g/dL	32.0 - 36.0
RED CELL DISTRIBUT	ION WIDTH (RDW-CV)	14.9	%	11.00 - 16.00
RED CELL DISTRIBUT	ION WIDTH (RDW-SD)	52	fL	35.0 - 56.0
MENTZERS INDEX by CALCULATED		19.27	RATIO	BETA THALASSEMIA TRAIT: < 13 IRON DEFICIENCY ANEMIA: >13.
GREEN & KING INDE	Х	28.63	RATIO	BETA THALASSEMIA TRAIT:<= 65 IRON DEFICIENCY ANEMIA: > 65
WHITE BLOOD CELL	<u>S (WBCS)</u>			
TOTAL LEUCOCYTE C	OUNT (TLC) y by sf cube & microscopy	8560	/cmm	4000 - 11000
DIFFERENTIAL LEUC	<u> DCYTE COUNT (DLC)</u>			
NEUTROPHILS		69	%	50 - 70
LYMPHOCYTES	Y BY SF CUBE & MICROSCOPY Y BY SF CUBE & MICROSCOPY	19 ^L	%	20 - 40
EOSINOPHILS	Y BY SF CUBE & MICROSCOPY	7 ^H	%	1-6



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

DR.YUGAM CHOPRA CONSULTANT PATHOLOGIST

NOT VALID FOR MEDICO LEGAL PURPOSE



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Test Name		Value	Unit	Biological Reference interval
MONOCYTES		5	%	2 - 12
BASOPHILS	Y BY SF CUBE & MICROSCOPY Y BY SF CUBE & MICROSCOPY (TES (WBC) COUNT	0	%	0 - 1
ABSOLUTE NEUTROI	PHIL COUNT	5906	/cmm	2000 - 7500
ABSOLUTE LYMPHO	Y BY SF CUBE & MICROSCOPY CYTE COUNT Y BY SF CUBE & MICROSCOPY	1626 ^L	/cmm	800 - 4900
ABSOLUTE EOSINOP	PHIL COUNT	599 ^H	/cmm	40 - 440
ABSOLUTE MONOCY	Y BY SF CUBE & MICROSCOPY /TE COUNT Y BY SF CUBE & MICROSCOPY	428 P	KR /cmm	80 - 880
ABSOLUTE BASOPHI		0	/cmm	0 - 110
PLATELETS AND OTI	HER PLATELET PREDICTIVE MARKER	<u>RS.</u>		
PLATELET COUNT (P	LT) FOCUSING, ELECTRICAL IMPEDENCE	132000 ^L	/cmm	150000 - 450000
PLATELETCRIT (PCT)		0.14	%	0.10 - 0.36
MEAN PLATELET VO		12 ^H	fL	6.50 - 12.0
PLATELET LARGE CEI		49000	/cmm	30000 - 90000
PLATELET LARGE CE		40.5	%	11.0 - 45.0
PLATELET DISTRIBU	TION WIDTH (PDW) Focusing, electrical impedence ICTED ON EDTA WHOLE BLOOD	17.2 ^H	%	15.0 - 17.0





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Itest Name Value Unit Biological Reference interval ERYTHROCYTE SEDIMENTATION RATE (ESR) SRYTHROCYTE SEDIMENTATION RATE (ESR) by MODIFIED WESTERGREN AUTOMATE (ESR) TREPRETATION: LSR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autommune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test suits C-reactive protein An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test suits C-reactive protein An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test suits C-reactive protein An ESR can be affected by other 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 (suits sciele cells in sickle cell anaemia) also lower the ESR. ONDITION WITH LOW ESR And C - reactive protein (C-RP) are both markers of inflammation. Corenoreaffected by as many other	CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	REPORTING DATE	: 04/Sep/2024 01:12PM
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 RYTHROCYTE SEDIMENTATION RATE (ESR) by MODIFIED WESTERGREN AUTOMATED METHOD SRR is a non-specific test because an elevated result often indicates the presence of inflammation associated with infection, cancer and autommune disease, but does not tell the health practitioner exactly where the inflammation is in the body or what is causing it. An ESR can be affected by other conditions besides inflammation. For this reason, the ESR is typically used in conjunction with other test survey to creative protein. 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 ystemic lupus erythematosus. MONDIFION WITH LOW ESR Now 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 (survey state) is sickle cells in sickle cell anaemia) also lower the ESR. 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. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while 	Test Name	Va	lue Unit	Biological Reference interval
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 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 (su sockle cells in sickle cell anaemia) also lower the ESR. NOTE: ESR and C - reactive protein (C-RP) are both markers of inflammation. ESR and C - reactive protein (C-RP) are both markers of inflammation. Cenerally, 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. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while 	mmune disease, but 2. An ESR can be affe as C-reactive protein	does not tell the health practitioner exac cted by other conditions besides inflamm	tly where the inflammation is in the ation. For this reason, the ESR is typ	e body or what is causing it. bically used in conjunction with other test suc
polycythaemia), significantly high white blood cell count (leucocytosis), and some protein abnormalities. Some changes in red cell shape (su is sickle cells in sickle cell anaemia) also lower the ESR. JOTE: . ESR and C - reactive protein (C-RP) are both markers of inflammation. B. Generally, ESR does not change as rapidly as does CRP, either at the start of inflammation or as it resolves. B. CRP is not affected by as many other factors as is ESR, making it a better marker of inflammation. I. If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen. S. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. S. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while	mmune disease, but 2. An ESR can be affe as C-reactive protein 3. This test may also	does not tell the health practitioner exac cted by other conditions besides inflamm be used to monitor disease activity and re	tly where the inflammation is in the ation. For this reason, the ESR is typ	e body or what is causing it. bically used in conjunction with other test su
Is sickle cells in sickle cell anaemia) also lower the ESR. JOTE: . 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. I If the ESR is elevated, it is typically a result of two types of proteins, globulins or fibrinogen. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while	mmune disease, but 2. An ESR can be affe as C-reactive protein 3. This test may also systemic lupus erythe CONDITION WITH LOV	does not tell the health practitioner exac cted by other conditions besides inflamm be used to monitor disease activity and re ematosus N ESR	tly where the inflammation is in the ation. For this reason, the ESR is types to the the approximation of the a	e body or what is causing it. bically used in conjunction with other test sub bove diseases as well as some others, such a
. 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	mmune disease, but 2. An ESR can be affe as C-reactive protein 3. This test may also 1 systemic lupus erythe CONDITION WITH LOV A low ESR can be see	does not tell the health practitioner exacted by other conditions besides inflamm be used to monitor disease activity and re ematosus W ESR n with conditions that inhibit the normal	tly where the inflammation is in the lation. For this reason, the ESR is type esponse to therapy in both of the a sedimentation of red blood cells, si	e body or what is causing it. bically used in conjunction with other test su bove diseases as well as some others, such a uch as a high red blood cell count
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b. Women tend to have a higher ESR, and menstruation and pregnancy can cause temporary elevations. b. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while	mmune disease, but 2. An ESR can be affer as C-reactive protein 3. This test may also b condition with LOV A low ESR can be see polycythaemia), sign as sickle cells in sickl NOTE: 1. ESR and C - reactive	does not tell the health practitioner exac cted by other conditions besides inflamm be used to monitor disease activity and re ematosus N ESR n with conditions that inhibit the normal ificantly high white blood cell count (leu e cell anaemia) also lower the ESR. e protein (C-RP) are both markers of infla	tly where the inflammation is in the ation. For this reason, the ESR is typ esponse to therapy in both of the a sedimentation of red blood cells, si cocytosis), and some protein abno	e body or what is causing it. bically used in conjunction with other test su bove diseases as well as some others, such a uch as a high red blood cell count rmalities. Some changes in red cell shape (su
b. Drugs such as dextran, methyldopa, oral contraceptives, penicillamine procainamide, theophylline, and vitamin A can increase ESR, while spirin, cortisone, and quinine may decrease it	mmune disease, but 2. An ESR can be affe as C-reactive protein 3. This test may also 1 conDITION WITH LOV A low ESR can be see polycythaemia), sign as sickle cells in sickl NOTE: 1. ESR and C - reactive 2. Generally, ESR doe 3. CRP is not affected	does not tell the health practitioner exac cted by other conditions besides inflamm be used to monitor disease activity and re ematosus W ESR n with conditions that inhibit the normal ificantly high white blood cell count (leu e cell anaemia) also lower the ESR. e protein (C-RP) are both markers of inflan s not change as rapidly as does CRP, eith- by as many other factors as is ESR, makin	tly where the inflammation is in the lation. For this reason, the ESR is type esponse to therapy in both of the a sedimentation of red blood cells, si cocytosis), and some protein abno mmation. er at the start of inflammation or as g it a better marker of inflammation	e body or what is causing it. bically used in conjunction with other test sub bove diseases as well as some others, such a uch as a high red blood cell count rmalities. Some changes in red cell shape (su
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A PIONEER DIAGNOSTIC CENTRE

💟 0171-2532620, 8222896961 🛛 🖾 pkrjainhealthcare@gmail.com

NAME	: Mr. BALKAR SINGH		
AGE/ GENDER	: 48 YRS/MALE	PATIENT ID	: 1601532
COLLECTED BY	:	REG. NO./LAB NO.	: 122409040001
REFERRED BY	:	REGISTRATION DATE	: 04/Sep/2024 08:37 AM
BARCODE NO.	: 12504479	COLLECTION DATE	: 04/Sep/2024 09:29AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	REPORTING DATE	:04/Sep/202405:10PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - H	ARYANA	

PERIPHERAL BLOOD SMEAR

TEST NAME:

PERIPHERAL BLOOD FILM/SMEAR (PBF)

RED BLOOD CELLS (RBC'S):

RBCs mostly appear normocytic & normochromic.No polycrhomatic cells or normoblasts presnt.

WHITE BLOOD CELLS (WBC'S)

No immature leucocytes seen.

PLATELETS:

Platelets appear slightly reduced on smear.

HEMOPARASITES:

NOT SEEN.

IMPRESSION:

Normocytic normochromic picture.





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: 12504479	COL	LECTION DATE	: 04/Sep/2024 09:29AM
: P.K.R JAIN HEALTHCARE INS	STITUTE REP	ORTING DATE	:04/Sep/202401:12PM
: NASIRPUR, HISSAR ROAD, A	MBALA CITY - HARYAN	NA	
	Value	Unit	Biological Reference interval
CLIN	ICAL CHEMISTRY	/BIOCHEMISTRY	(
	GLUCOSE FAS	STING (F)	
	86.53	mg/dL	NORMAL: < 100.0 PREDIABETIC: 100.0 - 125.0 DIABETIC: > 0R = 126.0
	: : : 12504479 : P.K.R JAIN HEALTHCARE INS : NASIRPUR, HISSAR ROAD, A	: REG : REG : 12504479 COL : P.K.R JAIN HEALTHCARE INSTITUTE REP : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYAN Value Value CLINICAL CHEMISTRY GLUCOSE FAS PLASMA 86.53	: REG. NO./LAB NO. : REGISTRATION DATE : 12504479 COLLECTION DATE : P.K.R JAIN HEALTHCARE INSTITUTE REPORTING DATE : NASIRPUR, HISSAR ROAD, AMBALA CITY - HARYANA Value Unit CLINICAL CHEMISTRY/BIOCHEMISTRY GLUCOSE FASTING (F) PLASMA 86.53 mg/dL

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.
 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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CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, A	AMBALA CITY - HARYA	NA	
Test Name		Value	Unit	Biological Reference interval
		LIPID PROFIL	E : BASIC	
CHOLESTEROL TOTAL	SERUM	148.93	mg/dL	OPTIMAL: < 200.0
by CHOLESTEROL OXI	DASE PAP			BORDERLINE HIGH: 200.0 - 239.0
TRIGLYCERIDES: SERL		104.44	ma/dl	HIGH CHOLESTEROL: > OR = 240.0 OPTIMAL: < 150.0
	ATE OXIDASE (ENZYMATIC)	104.44	mg/dL	BORDERLINE HIGH: 150.0 - 199.0
-				HIGH: 200.0 - 499.0
				VERY HIGH: > OR = 500.0
HDL CHOLESTEROL (D		77.35	mg/dL	LOW HDL: < 30.0
by SELECTIVE INHIBITIC	0N			BORDERLINE HIGH HDL: 30.0 - 60.0
				HIGH HDL: > OR = 60.0
LDL CHOLESTEROL: SE	RUM	50.69	mg/dL	OPTIMAL: < 100.0
by CALCULATED, SPEC	TROPHOTOMETRY		3	ABOVE OPTIMAL: 100.0 - 129.0
				BORDERLINE HIGH: 130.0 - 159.0
				HIGH: 160.0 - 189.0 VERY HIGH: > OR = 190.0
NON HDL CHOLESTER	OL: SERUM	71.58	mg/dL	OPTIMAL: < 130.0
by CALCULATED, SPEC		71.00	ing, at	ABOVE OPTIMAL: 130.0 - 159.0
				BORDERLINE HIGH: 160.0 - 189.0
				HIGH: 190.0 - 219.0 VERY HIGH: > OR = 220.0
VLDL CHOLESTEROL: S	SFRUM	20.89	mg/dL	0.00 - 45.00
by CALCULATED, SPEC	TROPHOTOMETRY		Ũ	
TOTAL LIPIDS: SERUM by CALCULATED, SPECTROPHOTOMETRY		402.3	mg/dL	350.00 - 700.00
CHOLESTEROL/HDL R		1.93	RATIO	LOW RISK: 3.30 - 4.40
by CALCULATED, SPEC	TROPHOTOMETRY			AVERAGE RISK: 4.50 - 7.0
				MODERATE RISK: 7.10 - 11.0
LDL/HDL RATIO: SERU	15.4	0.66	RATIO	HIGH RISK: > 11.0 LOW RISK: 0.50 - 3.0
		0.66	KATIU	MODERATE RISK: 0.50 - 3.0
by CALCULATED, SPEC				

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440 Dated 17.5.2012 u/s 80 G OF INCOME TAX ACT. PAN NO. AAAAP1600. **REPORT ATTRACTS THE CONDITIONS PRINTED OVERLEAF (P.T.O.)**



Page 6 of 14



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CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - I	IARYANA	
Test Name	Value	Unit	Biological Reference interval

	Value	onit	biological Reference interval
TRIGLYCERIDES/HDL RATIO: SERUM	1.35 ^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.

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 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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Test Name		Value	Unit	Biological Reference interva
	LIV	ER FUNCTI	ON TEST (COMPLETE)	
BILIRUBIN TOTAL: SE		0.72	mg/dL	INFANT: 0.20 - 8.00 ADULT: 0.00 - 1.20
	ONJUGATED): SERUM	0.23	mg/dL	0.00 - 0.40
BILIRUBIN INDIRECT by CALCULATED, SPE	(UNCONJUGATED): SERUM <i>CTROPHOTOMETRY</i>	0.49	mg/dL	0.10 - 1.00
SGOT/AST: SERUM by IFCC, WITHOUT PY	RIDOXAL PHOSPHATE	26.44	U/L	7.00 - 45.00
SGPT/ALT: SERUM		24.36	U/L	0.00 - 49.00
by IFCC, WITHOUT PYI AST/ALT RATIO: SERI		1.09	RATIO	0.00 - 46.00
by CALCULATED, SPE		1.07	INTIO	0.00 10.00
ALKALINE PHOSPHAT by Para Nitropheny PROPANOL	TASE: SERUM VL PHOSPHATASE BY AMINO METHYL	98.27	U/L	40.0 - 130.0
	TRANSFERASE (GGT): SERUM	18.42	U/L	0.00 - 55.0
TOTAL PROTEINS: SE		6.65	gm/dL	6.20 - 8.00
ALBUMIN: SERUM by BROMOCRESOL GH	REEN	4.31	gm/dL	3.50 - 5.50
GLOBULIN: SERUM by CALCULATED, SPE	CTROPHOTOMETRY	2.34	gm/dL	2.30 - 3.50
A : G RATIO: SERUM		1.84	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:

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





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INTERPRETATION



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Test Name	Value	Unit	Biological Reference interval
HEPATOCELLULAR CARCINOMA & CHRONIC HEPATITIS		> 1.3 (Slightly Increased)	

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).

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





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Test Name		Value	Unit	Biological Reference interval
	KIE	ONEY FUNCTION 1	EST (COMPLETE)	
UREA: SERUM	ATE DEHYDROGENASE (GLDH)	28.13	mg/dL	10.00 - 50.00
CREATININE: SERUM by ENZYMATIC, SPECT		0.61	mg/dL	0.40 - 1.40
BLOOD UREA NITROC	GEN (BUN): SERUM	13.14	mg/dL	7.0 - 25.0
BLOOD UREA NITRO RATIO: SERUM by CALCULATED, SPE	GEN (BUN)/CREATININE	21.54 ^H	RATIO	10.0 - 20.0
UREA/CREATININE RA		46.11	RATIO	
URIC ACID: SERUM by URICASE - OXIDASE		4.49	mg/dL	3.60 - 7.70
CALCIUM: SERUM by ARSENAZO III, SPEC		10.1	mg/dL	8.50 - 10.60
PHOSPHOROUS: SERU by PHOSPHOMOLYBDA ELECTROLYTES	JM ate, spectrophotometry	2.95	mg/dL	2.30 - 4.70
SODIUM: SERUM by ISE (ION SELECTIVE		141.8	mmol/L	135.0 - 150.0
POTASSIUM: SERUM by ISE (ION SELECTIVE		4.5	mmol/L	3.50 - 5.00
CHLORIDE: SERUM by ISE (ION SELECTIVE		106.35	mmol/L	90.0 - 110.0
ESTIMATED GLOMER	ULAR FILTERATION RATE			
ESTIMATED GLOMER (eGFR): SERUM by calculated INTERPRETATION:	ULAR FILTERATION RATE	118.5		

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.



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A PIONEER DIAGNOSTIC CENTRE

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NAME	: Mr. BALKAR SINGH		
AGE/ GENDER	: 48 YRS/MALE	PATIENT ID	: 1601532
COLLECTED BY	:	REG. NO./LAB NO.	: 122409040001
REFERRED BY	:	REGISTRATION DATE	: 04/Sep/2024 08:37 AM
BARCODE NO.	: 12504479	COLLECTION DATE	:04/Sep/202409:29AM
CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	REPORTING DATE	:04/Sep/202401:12PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - I	HARYANA	
Test Name	Value	Unit	Biological Reference interval
3. GI haemorrhage.			

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).

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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CLIENT CODE.	: P.K.R JAIN HEALTHCARE INSTITUTE	REPORTING DATE	: 04/Sep/2024 01:12PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AMBALA CITY - H	IARYANA	

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 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).

ADVICE:

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



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CLIENT CODE.	: P.K.R JAIN HEALTHCARE INST	TTUTE	REPORTING DATE	: 04/Sep/2024 03:43PM
CLIENT ADDRESS	: NASIRPUR, HISSAR ROAD, AM	IBALA CITY - HA	RYANA	
Test Name		Value	Unit	Biological Reference interva
		CLINICAL	PATHOLOGY	
	URINE RC	OUTINE & MIC	ROSCOPIC EXAMINAT	ION
PHYSICAL EXAMINA	TION			
QUANTITY RECIEVE		10	ml	
by DIP STICK/REFLEC	TANCE SPECTROPHOTOMETRY	PALE YELL	OW	PALE YELLOW
	TANCE SPECTROPHOTOMETRY			
		CLEAR		CLEAR
by DIP STICK/REFLEC SPECIFIC GRAVITY	TANCE SPECTROPHOTOMETRY	1.02 P		1.002 - 1.030
	TANCE SPECTROPHOTOMETRY	1.02		1.002 - 1.030
CHEMICAL EXAMINA				
REACTION		ACIDIC		
-	TANCE SPECTROPHOTOMETRY			
PROTEIN	TANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
SUGAR		Negative		NEGATIVE (-ve)
	TANCE SPECTROPHOTOMETRY			
		<=5.0		5.0 - 7.5
by DIP STICK/REFLEC	TANCE SPECTROPHOTOMETRY	Negative		NEGATIVE (-ve)
DIEINODIN	TANCE SPECTROPHOTOMETRY	negative		
NITRITE		Negative		NEGATIVE (-ve)
by DIP STICK/REFLEC	TANCE SPECTROPHOTOMETRY.	Normal	EU/dL	0.2 - 1.0
	TANCE SPECTROPHOTOMETRY	INUITIAI	EU/UL	0.2 - 1.0
KETONE BODIES		Negative		NEGATIVE (-ve)
•	TANCE SPECTROPHOTOMETRY	Nie		
BLOOD by DIP STICK/REFLEC	TANCE SPECTROPHOTOMFTRY	Negative		NEGATIVE (-ve)
by DIP STICK/REFLECTANCE SPECTROPHOTOMETRY ASCORBIC ACID		NEGATIVE	(-ve)	NEGATIVE (-ve)
	TANCE SPECTROPHOTOMETRY		. ,	× /

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

OTHERS by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT TRICHOMONAS VAGINALIS (PROTOZOA)

by MICROSCOPY ON CENTRIFUGED URINARY SEDIMENT

** End Of Report

NEGATIVE (-ve)

ABSENT



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440 Dated 17.5.2012 u/s 80 G OF INCOME TAX ACT. PAN NO. AAAAP1600. **REPORT ATTRACTS THE CONDITIONS PRINTED OVERLEAF (P.T.O.)**



NEGATIVE (-ve)

ABSENT