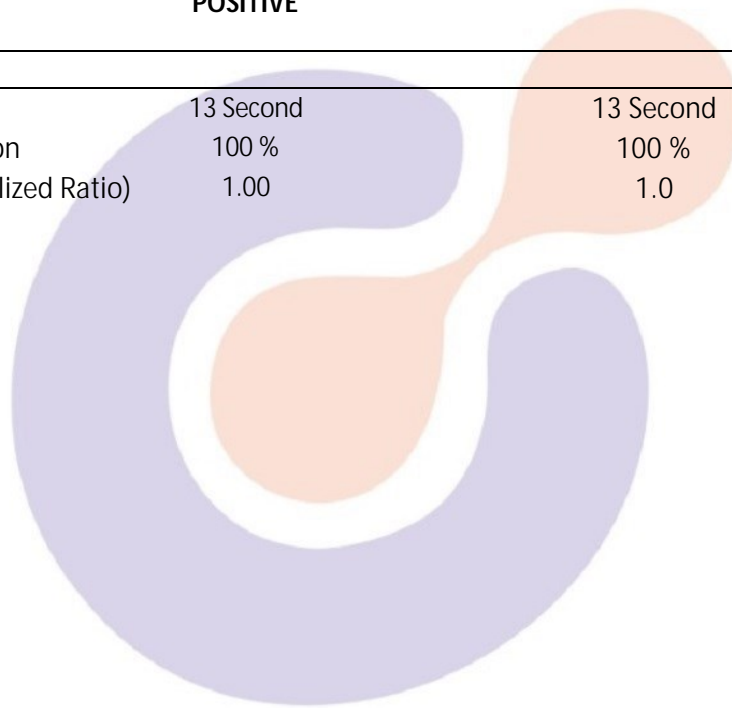


Patient Name : Ms. AAIRA	Visit No : CHA250035070
Age/Gender : 40 Y/F	Registration ON : 26/Feb/2025 08:59PM
Lab No : 10132366	Sample Collected ON : 26/Feb/2025 09:02PM
Referred By : Dr. U1	Sample Received ON : 26/Feb/2025 09:13PM
Refer Lab/Hosp : CHARAK NA	Report Generated ON : 27/Feb/2025 09:32AM
Doctor Advice : ECG,CHEST PA,TSH,HCV,HBSAg,HIV,PT/PC/INR,LFT,CREATININE,UREA,RANDOM,PLAT COUNT,BTCT,DLC,TLC,BLOOD GROUP,HB	



Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD GROUP				
Blood Group	"O"			
Rh (Anti -D)	POSITIVE			

PT/PC/INR				
PROTHROMBIN TIME	13 Second		13 Second	Clotting Assay
Prothromin concentration	100 %		100 %	
INR (International Normalized Ratio)	1.00		1.0	



CHARAK

[Checked By]

Print.Date/Time: 27-02-2025 10:30:18

*Patient Identity Has Not Been Verified. Not For Medicolegal



Sharma

DR. NISHANT SHARMA PATHOLOGIST DR. SHADAB PATHOLOGIST Dr. SYED SAIF AHMAD MD (MICROBIOLOGY)

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Test Name	Result	Unit	Bio. Ref. Range	Method
HEPATITIS B SURFACE ANTIGEN (HBsAg)				
Sample Type : SERUM				

HEPATITIS B SURFACE ANTIGEN	NON REACTIVE	<1 - Non Reactive >1 - Reactive	CMIA
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Note: This is only a Screening test. Confirmation of the result (Non Reactive/Reactive)should be done by performing a PCR based test.

COMMENTS:

- HBsAg is the first serological marker after infection with Hepatitis B Virus appearing one to ten weeks after exposure and two to eight weeks before the onset of clinical symptoms. HBsAg persists during the acute phase and clears late in the convalescence phase. Failure to clear HBsAg within six months indicates a chronic HBsAg carrier state. HBsAg assays are used to identify the persons infected with HBV and to prevent transmission of the virus by blood and blood products as well as to monitor the status of infected individuals in combination with other hepatitis B serological markers.
- Borderline cases must be confirmed with confirmatory neutralizing assay.

LIMITATIONS:

- Results should be used in conjunction with patient history and other hepatitis markers for diagnosis of acute and chronic infections.
- Specimens from patients who have received preparations of mouse monoclonal antibodies for diagnosis or therapy may contain human anti-mouse antibodies (HAMA) which may produce anomalous values when tested with assay kits that employs mouse monoclonal antibodies.
- Heterophilic antibodies in human serum can react with reagent immunoglobulins, interfering with in vitro immunoassays. Patients routinely exposed to animals or animal serum products can be prone to this interference and anomalous results may be observed.
- Cross reactivity for specimens from individual with medical conditions (Pregnancy, HIV etc) has been observed.
- HBsAg mutations may result in a false negative result in some HBsAg assays.
- If HBsAg results are inconsistent with clinical evidence, additional testing is suggested to confirm the result.

[Checked By]

Print.Date/Time: 27-02-2025 10:30:19

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Sharma

DR. NISHANT SHARMA DR. SHADAB Dr. SYED SAIF AHMAD
PATHOLOGIST PATHOLOGIST MD (MICROBIOLOGY)

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Test Name	Result	Unit	Bio. Ref. Range	Method
HAEMOGLOBIN				
Hb	11.3	g/dl	12 - 15	Non Cyanide
Comment: Hemoglobin screening helps to diagnose conditions that affect RBCs such as anemia or polycythemia.				
TLC				
TOTAL LEUCOCYTES COUNT	7870	/cmm	4000 - 10000	Floctometry
DLC				
NEUTROPHIL	53	%	40 - 75	Flowcytometry
LYMPHOCYTE	42	%	20-40	Flowcytometry
EOSINOPHIL	2	%	1 - 6	Flowcytometry
MONOCYTE	3	%	2 - 10	Flowcytometry
BASOPHIL	0	%	00 - 01	Flowcytometry
PLATELET COUNT				
PLATELET COUNT	443,000	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	443000	/cmm	150000 - 450000	Microscopy .
BLOOD SUGAR RANDOM				
BLOOD SUGAR RANDOM	111	mg/dl	70 - 170	Hexokinase
BLOOD UREA				
BLOOD UREA	15.00	mg/dl	15 - 45	Urease, UV, Serum
SERUM CREATININE				
CREATININE	0.60	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.41	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.09	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.32	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	126.00	U/L	30 - 120	PNPP, AMP Buffer
SGPT	10.7	U/L	5 - 40	UV without P5P
SGOT	18.2	U/L	5 - 40	UV without P5P



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DR. NISHANT SHARMA DR. SHADAB Dr. SYED SAIF AHMAD
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Test Name	Result	Unit	Bio. Ref. Range	Method
TSH				
TSH	2.60	uIU/ml	0.47 - 4.52	ECLIA

Note

- (1) Patients having low T3 & T4 levels but high TSH levels suffer from primary hypothyroidism, cretinism, juvenile myxedema or autoimmune disorders.
- (2) Patients having low T3 & T4 levels but high TSH levels suffer from grave's disease, toxic adenoma or sub-acute thyroiditis.
- (3) Patients having either low or normal T3 & T4 levels but low TSH values suffer from iodine deficiency or secondary hypothyroidism.
- (4) Patients having high T3 & T4 levels but normal TSH levels may suffer from toxic multinodular goitre. This condition is mostly asymptomatic and may cause transient hyperthyroidism but no persistent symptoms.
- (5) Patient with high or normal T3 & T4 levels and low or normal TSH levels suffer either from T3 toxicosis or T4 Toxicosis respectively.
- (6) In patients with non thyroidal illness abnormal test results are not necessarily indicative of thyroidism but may be due to adaptation to the catabolic state and may revert to normal when the patient recovers.
- (7) There are many drugs for eg. Glucocorticoids, dopamine, Lithium, iodides, oral radiographic dyes, etc. Which may affect the thyroid function tests.
- (8) Generally when total T3 & T4 results are indecisive then Free T3 & Free T4 test are recommended for further confirmation along with
(1 Beckman Dxl-600 2. ELECTRO-CHEMILUMINESCENCE TECHNIQUE BY ELECSYS -E411)

*** End Of Report ***

CHARAK



[Checked By]



Sharma

DR. NISHANT SHARMA DR. SHADAB Dr. SYED SAIF AHMAD
PATHOLOGIST PATHOLOGIST MD (MICROBIOLOGY)

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SKIAGRAM CHEST PA VIEW

- Patchy opacities are seen in both lower lung field zone ...? Infective.
- Cardiac shadow is within normal limits.
- Both CP angles are clear.
- Soft tissue and bony cage are seen normally.
- Both domes of diaphragm are sharply defined.

Adv: Repeat X-ray after a course of antibiotics.

[DR. R. K. SINGH, MD]

TRANSCRIBED BY: ANUP

*** End Of Report ***

