

Patient Name : Mr. FARHAN ALI	Visit No : CHA250039659
Age/Gender : 22 Y/M	Registration ON : 05/Mar/2025 11:58AM
Lab No : 10136954	Sample Collected ON : 05/Mar/2025 12:04PM
Referred By : Dr. U1	Sample Received ON : 05/Mar/2025 12:04PM
Refer Lab/Hosp : CHARAK NA	Report Generated ON : 05/Mar/2025 04:19PM
Doctor Advice : 25 OH vit. D,VIT B12,ECG,CHEST PA,TSH,HIV,HCV,HBSAg,PT/PC/INR,LFT,CREATININE,UREA,RANDOM,PLAT COUNT,BTCT,DLC,TLC,Hb,BLOOD GROUP	



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

25 OH vit. D				
25 Hydroxy Vitamin D	16.69	ng/ml		ECLIA
Deficiency < 10				
Insufficiency 10 - 30				
Sufficiency 30 - 100				
Toxicity > 100				

DONE BY: ELECTROCHEMILUMINESCENCE IMMUNOASSAY (Cobas e 411,Unicel DxI600,vitros ECI)

VITAMIN B12				
VITAMIN B12	143	pg/mL		CLIA
			180 - 814 Normal	
			145 - 180 Intermediate	
			145.0 Deficient pg/ml	

Summary :-

Nutritional & macrocytic anemias can be caused by a deficiency of vitamin B12. This deficiency can result from diets devoid of meat & bacterial products, from alcoholism or from structural / functional damage to digestive or absorptive processes. Malabsorption is the major cause of this deficiency.

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

[Checked By]



Print.Date/Time: 05-03-2025 17:15:16

*Patient Identity Has Not Been Verified. Not For Medicolegal

DR. NISHANT SHARMA DR. SHADAB DR. ADITI D AGARWAL
PATHOLOGIST PATHOLOGIST PATHOLOGIST

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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]

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Test Name	Result	Unit	Bio. Ref. Range	Method
HIV				
HIV-SEROLOGY	NON REACTIVE		<1.0 : NON REACTIVE >1.0 : REACTIVE	

Done by: Vitros ECI (Sandwich Assay)

Note:-Elisa test is a screening method for HIV.It is known to give false Positive & Negative result.
Hence confirmation:"Western Blot" method is advised.

HEPATITIS C VIRUS (HCV) ANTIBODIES

HEPATITIS C VIRUS (HCV) ANTIBODIES NON REACTIVE Non Reactive

(TRIO DOT ASSAY)

Note:This is only a Screening test. Confirmation of the result (Non Reactive/Reactive)should be done by performing a PCR based test.

BT/CT

BLEEDING TIME (BT) 3 mint 15 sec mins 2 - 8
CLOTTING TIME (CT) 6 mint 30 sec 3 - 10 MINS.

CHARAK

[Checked By]

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DR. NISHANT SHARMA
PATHOLOGIST

DR. SHADAB
PATHOLOGIST

Dr. Aditi D Agarwal
DR. ADITI D AGARWAL
PATHOLOGIST

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Test Name	Result	Unit	Bio. Ref. Range	Method
HAEMOGLOBIN				
Hb	14.8	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	8600	/cmm	4000 - 10000	Floctometry
DLC				
NEUTROPHIL	61	%	40 - 75	Flowcytometry
LYMPHOCYTE	31	%	20-40	Flowcytometry
EOSINOPHIL	6	%	1 - 6	Flowcytometry
MONOCYTE	2	%	2 - 10	Flowcytometry
BASOPHIL	0	%	00 - 01	Flowcytometry
PLATELET COUNT				
PLATELET COUNT	273,000	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	273000	/cmm	150000 - 450000	Microscopy .
BLOOD SUGAR RANDOM				
BLOOD SUGAR RANDOM	98.1	mg/dl	70 - 170	Hexokinase
BLOOD UREA				
BLOOD UREA	28.40	mg/dl	15 - 45	Urease, UV, Serum
SERUM CREATININE				
CREATININE	0.70	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.70	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.30	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.40	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	108.00	U/L	30 - 120	PNPP, AMP Buffer
SGPT	23.8	U/L	5 - 40	UV without P5P
SGOT	26.6	U/L	5 - 40	UV without P5P



[Checked By]



Sham

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
TSH	1.40	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



Sharma

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ECG -REPORT

RATE : 67 bpm

* RHYTHM : Normal

* P wave : Normal

* PR interval : Normal

* QRS Axis : Normal

Duration : Normal

Configuration : Normal

* ST-T Changes : None

* QT interval :

* QTc interval : Sec.

* Other :

OPINION: ECG WITH IN NORMAL LIMITS

(FINDING TO BE CORRELATED CLINICALLY)

[DR. RAJIV RASTOGI, MD, DM]



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SKIAGRAM CHEST PA VIEW

- Both lung fields are clear.
- Bilateral hilar shadows are normal.
- 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.

IMPRESSION:

- **NO ACTIVE LUNG PARENCHYMAL LESION IS DISCERNIBLE.**

Clinical correlation is necessary.

[DR. RAJESH KUMAR SHARMA, MD]

transcribed by: anup

*** End Of Report ***

