Charak dhar DIAGNOSTICS Pvt. Ltd.

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CMO Reg. No. RMEE 2445133
NABL Reg. No. MC-2491
Certificate No. MIS-2023-0218

Patient Name	: Ms.PRAGATI GUPTA	Visit No	: CHA250042311
Age/Gender	: 15 Y/F	Registration ON	: 09/Mar/2025 10:18AM
Lab No	**: 10139606**	Sample Collected ON	: 09/Mar/2025 10:20AM
Referred By	: Dr.AMIT RASTOGI	Sample Received ON	: 09/Mar/2025 10:41AM
Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 09/Mar/2025 12:39PM
Doctor Advice	: HBSAg,HIV,CRP (Quantitative),ESR,URIC ACID,25 OH vit. D,T3T4TSH,NA+K+,CREATININE,UREA,LFT,LIPID-PROFILE,PP,FASTING,CBC (WHOLE BLOOD)		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
ESR				
Erythrocyte Sedimentation Rate ESR	14.00		0 - 15	Westergreen

Note:

1. Test conducted on EDTA whole blood at 37°C.
2. ESR readings are auto- corrected with respect to Hematocrit (PCV) values.
3. It indicates presence and intensity of an inflammatory process. It is a prognostic test and used to monitor the course or response to treatment of diseases like tuberculosis, acute rheumatic fever. It is also increased in multiple myeloma, hypothyroidism.

CRP-QUANTITATIVE				
CRP-QUANTITATIVE TEST	**3.9**	MG/L	0.10 - 2.80	

Method: Immunoturbidimetric

(Method: Immunoturbidimetric on photometry system)

SUMMARY : C - reactive protien (CRP) is the best known among the acute phase protiens, a group of protien whose concentration increases in blood as a response to inflammatory disorders.CRP is normally present in low concentration in blood of healthy individuals (< 1mg/L). It is elevated up to 500 mg/L in acute inflammatory processes associated with bacterial infections, post operative conditions tissue damage already after 6 hours reaching a peak at 48 hours.. The measurment of CRP represents a useful aboratory test for detection of acute infection as well as for monitoring inflammtory proceses also in acute rheumatic & gastrointestinal disease. In recent studies it has been shows that in apparrently healthy subjects there is a direct orrelation between CRP concentrations & the risk of developing oronary heart disease (CHD).

hsCRP cut off for risk assessment as per CDC/AHA

Level	Risk
<1.0	Low
1.0-3.0	Average
>3.0	High

All reports to be clinically corelated

URIC ACID				
Sample Type : SERUM				
SERUM URIC ACID	4.7	mg/dL	2.40 - 5.70	Uricase,Colorimetric

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DR. SHADAB
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Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID-PROFILE				
Cholesterol/HDL Ratio	2.51	Ratio		Calculated
LDL / HDL RATIO	1.33	Ratio		Calculated
			Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0-6.0 Elevated / High risk - >6.0	
			Desirable / low risk - 0.5 -3.0 Low/ Moderate risk - 3.0-6.0 Elevated / High risk - > 6.0	
25 OH vit. D				
25 Hydroxy Vitamin D	12.40	ng/ml		ECLIA

Deficiency < 10
Insufficiency 10 - 30
Sufficiency 30 - 100
Toxicity > 100

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

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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

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.

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.

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Doctor Advice	: HBSAg,HIV,CRP (Quantitative),ESR,URIC ACID,25 OH vit. D,T3T4TSH,NA+K+,CREATININE,UREA,LFT,LIPID-PROFILE,PP,FASTING,CBC (WHOLE BLOOD)		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
CBC (COMPLETE BLOOD COUNT)				
Hb	**11.4**	g/dl	12 - 15	Non Cyanide
R.B.C. COUNT	**3.70**	mil/cmm	3.8 - 4.8	Electrical Impedence
PCV	**35.1**	%	36 - 45	Pulse hieght detection
MCV	94.1	fL	80 - 96	calculated
MCH	30.6	pg	27 - 33	Calculated
MCHC	32.5	g/dL	30 - 36	Calculated
RDW	13.8	%	11 - 15	RBC histogram derivation
RETIC	0.7 %	%	0.5 - 2.5	Microscopy
TOTAL LEUCOCYTES COUNT	6650	/cmm	4000 - 10000	Flocytrometry
DIFFERENTIAL LEUCOCYTE COUNT				
NEUTROPHIL	66	%	40 - 70	Flowcytrometry
LYMPHOCYTES	**29**	%	30 - 50	Flowcytrometry
EOSINOPHIL	2	%	1 - 6	Flowcytrometry
MONOCYTE	3	%	2 - 10	Flowcytrometry
BASOPHIL	**0**	%	00 - 01	Flowcytrometry
PLATELET COUNT	292,000	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	292000	/cmm	150000 - 450000	Microscopy .
Absolute Neutrophils Count	4,389	/cmm	2000 - 7000	Calculated
Absolute Lymphocytes Count	1,928	/cmm	1000-3000	Calculated
Absolute Eosinophils Count	133	/cmm	20-500	Calculated
Absolute Monocytes Count	200	/cmm	200-1000	Calculated
Mentzer Index	25			
Peripheral Blood Picture	:			

Red blood cells show cytopenia+ with normocytic normochromic. Platelets are adequate. No immature cells or parasite seen.

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Refer Lab/Hosp	: CHARAK NA	Report Generated ON	: 09/Mar/2025 11:46AM
Doctor Advice	: HBSAg,HIV,CRP (Quantitative),ESR,URIC ACID,25 OH vit. D,T3T4TSH,NA+K+,CREATININE,UREA,LFT,LIPID-PROFILE,PP,FASTING,CBC (WHOLE BLOOD)		

PR.

Test Name	Result	Unit	Bio. Ref. Range	Method
FASTING				
Blood Sugar Fasting	91.5	mg/dl	70 - 110	Hexokinase
PP				
Blood Sugar PP	110.0	mg/dl	up to - 170	Hexokinase
NA+K+				
SODIUM Serum	143.0	MEq/L	135 - 155	ISE Direct
POTASSIUM Serum	4.1	MEq/L	3.5 - 5.5	ISE Direct
BLOOD UREA				
BLOOD UREA	15.80	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	0.49	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.09	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.40	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	103.20	U/L	82 - 331	PNPP, AMP Buffer
SGPT	11.0	U/L	5 - 40	UV without P5P
SGOT	19.0	U/L	5 - 40	UV without P5P

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Test Name	Result	Unit	Bio. Ref. Range	Method
LIPID-PROFILE				
TOTAL CHOLESTEROL	154.50	mg/dL	Desirable: <200 mg/dl Borderline-high: 200-239 mg/dl High:>/=240 mg/dl	CHOD-PAP
TRIGLYCERIDES	55.00	mg/dL	Normal: <150 mg/dl Borderline-high:150 - 199 mg/dl High: 200 - 499 mg/dl Very high:>/=500 mg/dl	Serum, Enzymatic, endpoint
H D L CHOLESTEROL	61.60	mg/dL	30-70 mg/dl	CHER-CHOD-PAP
L D L CHOLESTEROL	81.90	mg/dL	Optimal:<100 mg/dl Near Optimal:100 - 129 mg/dl Borderline High: 130 - 159 mg/dl High: 160 - 189 mg/dl Very High:>/= 190 mg/dl	CO-PAP
VLDL	11.00	mg/dL	10 - 40	Calculated

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Test Name	Result	Unit	Bio. Ref. Range	Method
T3T4TSH				
T3	2.26	nmol/L	1.49-2.96	ECLIA
T4	133.89	n mol/l	63 - 177	ECLIA
TSH	0.70	uIU/ml	0.7 - 6.4	ECLIA

Note

(1) Patients having low T3 & T4 levels but high TSH levels suffer from primary hypothyroidism,cretinism,juvenile mysedema 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 cacabolic state and may revert tonormal when the patient recovers.

(7) There are many drugs for eg.Glucocorticoids ,dopamine,Lithium,iodides ,oral radiographic dyes,ets.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 DxI-600 2. ELECTRO-CHEMILUMINISCENCE TECHINIQUE BY ELECSYSYS -E411)

***** End Of Report *****

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