

Patient Name : Mr.ABDUL ALEEM	Visit No : CHA250046157
Age/Gender : 59 Y/M	Registration ON : 16/Mar/2025 09:23AM
Lab No : 10143452	Sample Collected ON : 16/Mar/2025 09:28AM
Referred By : Dr.HEMALI JHA	Sample Received ON : 16/Mar/2025 09:50AM
Refer Lab/Hosp : CGHS (DEBIT)	Report Generated ON : 16/Mar/2025 11:15AM
Doctor Advice : CHEST PA,2D ECHO,VIT B12,HBA1C (EDTA),RANDOM,URIC ACID,T3T4TSH,USG WHOLE ABDOMEN,LFT,ECG,URINE COM. EXMAMINATION,Albumin,NA+K+,CREATININE,CRP (Quantitative),CBC+ESR	



Test Name	Result	Unit	Bio. Ref. Range	Method
CBC+ESR (COMPLETE BLOOD COUNT)				
Erythrocyte Sedimentation Rate ESR	12.00		0 - 20	Westergreen



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Print.Date/Time: 16-03-2025 18:55:08

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

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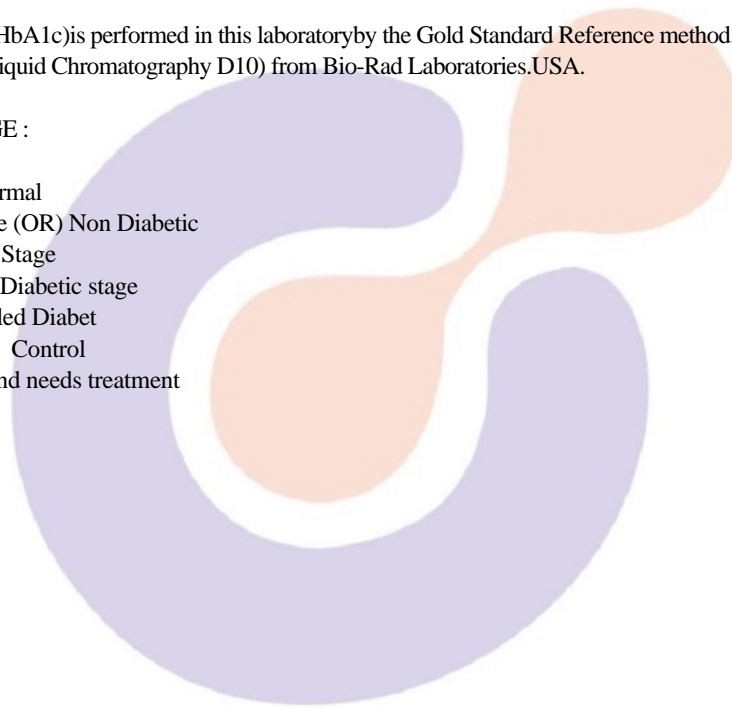
Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Glycosylated Hemoglobin (HbA1c)	5.5	%	4 - 5.7	HPLC (EDTA)

NOTE:-

Glycosylated Hemoglobin Test (HbA1c) is performed in this laboratory by the Gold Standard Reference method, ie: HPLC Technology (High performance Liquid Chromatography D10) from Bio-Rad Laboratories, USA.

EXPECTED (RESULT) RANGE :

Bio system	Degree of normal
4.0 - 5.7 %	Normal Value (OR) Non Diabetic
5.8 - 6.4 %	Pre Diabetic Stage
> 6.5 %	Diabetic (or) Diabetic stage
6.5 - 7.0 %	Well Controlled Diabet
7.1 - 8.0 %	Unsatisfactory Control
> 8.0 %	Poor Control and needs treatment



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Aditi D Agarwal
DR. ADITI D AGARWAL
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Test Name	Result	Unit	Bio. Ref. Range	Method
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CRP-QUANTITATIVE

CRP-QUANTITATIVE TEST	0.7	MG/L	0.1 - 6	
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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 measurement of CRP represents a useful laboratory 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	5.5	mg/dL	2.40 - 5.70	Uricase,Colorimetric
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SERUM ALBUMIN

ALBUMIN	4.2	gm/dl	3.20 - 5.50	Bromcresol Green (BCG)
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Test Name	Result	Unit	Bio. Ref. Range	Method
VITAMIN B12				
VITAMIN B12	113	pg/mL	180 - 814 Normal 145 - 180 Intermediate 145.0 Deficient pg/ml	CLIA

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.

URINE EXAMINATION REPORT

Colour-U	Light yellow		Light Yellow	
Appearance (Urine)	CLEAR		Clear	
Specific Gravity	1.015		1.005 - 1.025	
pH-Urine	Acidic (6.0)		4.5 - 8.0	
PROTEIN	Absent	mg/dl	ABSENT	Dipstick
Glucose	Absent			
Ketones	Absent		Absent	
Bilirubin-U	Absent		Absent	
Blood-U	Absent		Absent	
Urobilinogen-U	0.20	EU/dL	0.2 - 1.0	
Leukocytes-U	Absent		Absent	
NITRITE	Absent		Absent	
MICROSCOPIC EXAMINATION				
Pus cells / hpf	Occasional	/hpf	< 5/hpf	
Epithelial Cells	Occasional	/hpf	0 - 5	
RBC / hpf	Nil		< 3/hpf	

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Test Name	Result	Unit	Bio. Ref. Range	Method
CBC+ESR (COMPLETE BLOOD COUNT)				
Hb	14.1	g/dl	12 - 15	Non Cyanide
R.B.C. COUNT	4.80	mil/cmm	3.8 - 4.8	Electrical Impedence
PCV	43.7	%	36 - 45	Pulse hieght detection
MCV	91.2	fL	80 - 96	calculated
MCH	29.4	pg	27 - 33	Calculated
MCHC	32.3	g/dL	30 - 36	Calculated
RDW	13.2	%	11 - 15	RBC histogram derivation
RETIC	0.8 %	%	0.5 - 2.5	Microscopy
TOTAL LEUCOCYTES COUNT	7350	/cmm	4000 - 10000	Flocytometry
DIFFERENTIAL LEUCOCYTE COUNT				
NEUTROPHIL	56	%	40 - 75	Flowcytometry
LYMPHOCYTE	34	%	20-40	Flowcytometry
EOSINOPHIL	6	%	1 - 6	Flowcytometry
MONOCYTE	4	%	2 - 10	Flowcytometry
BASOPHIL	0	%	00 - 01	Flowcytometry
PLATELET COUNT	256,000	/cmm	150000 - 450000	Elect Imped..
PLATELET COUNT (MANUAL)	256000	/cmm	150000 - 450000	Microscopy .
Mentzer Index	19			
Peripheral Blood Picture	:			

Red blood cells are normocytic normochromic. Platelets are adequate. No immature cells or parasite seen.



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EXMAMINATION,Albumin,NA+K+,CREATININE,CRP (Quantitative),CBC+ESR



Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD SUGAR RANDOM				
BLOOD SUGAR RANDOM	106.7	mg/dl	70 - 170	Hexokinase
NA+K+				
SODIUM Serum	137.0	MEq/L	135 - 155	ISE Direct
POTASSIUM Serum	4.1	MEq/L	3.5 - 5.5	ISE Direct
SERUM CREATININE				
CREATININE	1.00	mg/dl	0.50 - 1.40	Alkaline picrate-kinetic
LIVER FUNCTION TEST				
TOTAL BILIRUBIN	0.61	mg/dl	0.4 - 1.1	Diazonium Ion
CONJUGATED (D. Bilirubin)	0.10	mg/dL	0.00-0.30	Diazotization
UNCONJUGATED (I.D. Bilirubin)	0.51	mg/dL	0.1 - 1.0	Calculated
ALK PHOS	74.40	U/L	30 - 120	PNPP, AMP Buffer
SGPT	19.0	U/L	5 - 40	UV without P5P
SGOT	18.0	U/L	5 - 40	UV without P5P

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Test Name	Result	Unit	Bio. Ref. Range	Method
T3T4TSH				
T3	1.52	nmol/L	1.49-2.96	ECLIA
T4	96.77	n mol/l	63 - 177	ECLIA
TSH	0.87	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 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 Dxl-600 2. ELECTRO-CHEMILUMINISCENCE TECHINIQUE BY ELECSYSYS -E411)

*** End Of Report ***

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