ONE PLUS LAB
BECAUSE YOUR LIFE MATTERS
H-56, Sector 51, Noida, U.P. 201301

Visit ID	**: MITD585**	Registration	: 14/Nov/2022 12:29PM
UHID/MR No	: AITD.0000000540	Collected	: 14/Nov/2022 12:31PM
Patient Name	**: Mr.DUMMY**	Received	: 14/Nov/2022 12:31PM
Age/Gender	: 45 Y 0 M 0 D /M	Reported	: 14/Nov/2022 12:41PM
Ref Doctor	: Dr.SELF	Status	: Final Report
Client Name	: STANDARD	Client Code	: 78
Client Add	: D 159, 1st Floor, Sector 7, No	Barcode No	: 10059528

DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
LIVER FUNCTION TEST				
Sample Type : SERUM				
TOTAL BILIRUBIN	1.1	mg/dl	0.1-1.2	Diazotized, Sulfanilic
CONJUGATED (D. Bilirubin)	0.11	mg/dl	0.00-0.30	Jendrassik & Groff
UNCONJUGATED (I.D. Bilirubin)	0.99	mg/dl	0.1-1.0	Calculated
TOTAL PROTEINS	7.32	gm/dl	6.40-8.30	Biuret
ALBUMIN	4.3	gm/dl	3.5-5.0	BCG
GLOBULIN	3.02	gm/dl	2.0-4.1	Calculated
A/G RATIO	1.42		1.0-2.0	Calculated
SGOT	44	U/L	8.0-45.0	Enzymatic,IFFC
S.G.P.T	32	U/L	10.0-35.0	Enzymatic,IFFC
GGT	45	U/L	8.0-55.0	Colorimetric Method
ALKALINE PHOSPHATASE	110	U/l	30-120	
LIPID PROFILE				
Sample Type : SERUM				
TOTAL CHOLESTEROL	180	mg/dl	Desirable : 80-200~Borderline: 200 – 239~High : >=240	Cholesterol oxidase/peroxidase
H D L CHOLESTEROL	50	mg/dl	40-60	Phosphotungstate/Mg-Cholesterol oxidase/ peroxidase
L D L CHOLESTEROL	102	mg/dl	70-106~Above Optimal : 100-129~Borderline High : 130-159~High : 160-189~Very High : >=190	Calculated
TRIGLYCERIDES	140	mg/dl	40-149~BorderLine : 150-199~High : 200-499~Very High : >=500	Glycerol phosphate oxidase/peroxidase
VLDL	28	mg/dl	15-30	Calculated
NON HDL CHOLESTEROL	130	mg/dl	Desirable: <130~BorderLine : 150-199~High : 200-499~Very High : >=500	Calculated
T. CHOLESTEROL/ HDL RATIO	3.6			Calculated
LDL / HDL RATIO	2.04			Calculated

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Test Name	Result	Unit	Bio. Ref. Range	Method
KIDNEY FUNCTION TEST				
Sample Type : SERUM				
SERUM UREA	32	mg/dL	15-39	Urease GLDH
SERUM CREATININE	0.8	mg/dl	0.60–1.30	Jafees
Estimated Glomerular Filtration Rate (eGFR)	22.00	mL/min/1.73m2	REFER INTERPRETAION	
TOTAL PROTEINS	7.20	gm/dl	6.40-8.30	Biuret
ALBUMIN	4.3	gm/dl	3.5-5.0	BCG
GLOBULIN	3.02	gm/dl	2.0-4.1	Calculated
A/G RATIO	1.42		1.0-2.0	Calculated
SERUM SODIUM	141.11	mmol/L	136.0-149.0	ISE
SERUM POTASSIUM	4.3	mmol/L	3.5-5.0	ISE
SERUM CHLORIDE	101.2	mmol/L	98.0-109.0	ISE
SERUM URIC ACID	4.56	mg/dl	3.7-9.20	URICASE
SERUM INORGANIC PHOSPHORUS	**44**	mg/dl	2.5-4.8	Phosphomolybelate
SERUM TOTAL CALCIUM	10	mg/dl	8.3-10.3	Arsenazo III
ALKALINE PHOSPHATASE	65	U/l	30-120	

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DEPARTMENT OF BIOCHEMISTRY

Test Name	Result	Unit	Bio. Ref. Range	Method
IRON PROFILE -I				
Sample Type : Serum				
SERUM IRON	98.00	ugm/dl	65-175	Ferrozine
TOTAL IRON BINDING CAPACITY	321	ugm/dl	250-450	Calculations
UIBC	223.00	ugm/dL	130 - 336	Ferrozine
TRANSFERRIN SATURATION	30.53	%	16-50	

INTERPRETATION:

SERUM IRON INCREASED IN:
-Hemosiderosis of excessive iron intake (e.g. repeated blood transfusion, iron therapy, iron containing vitamins).
-Decreased formation of RBCs (thalassemia, pyridoxal deficiency anaemia).
-Increased destruction of RBCs (hemolytic anaemia).
-Acute liver damage
-Acute iron toxicity

SERUM IRON DECREASED IN:
-Iron deficiency anaemia
-Normochromic anaemia of infections & chronic diseases
-Nephrosis
-Menorrhagia
-Diurnal variation: Normal in mid morning, low values in mid afternoon, and very low values near midnight.

TIBC/UIBC INCREASED IN:
-Iron deficiency anemia
-Acute & Chronic blood loss
-Acute liver damage
-Progesterone birth control pills

TIBC/UIBC DECREASED IN:
-Hemochromatosis
-Cirrhosis of the liver
-Thalassemia
-Anemia of infective & chronic disease
-Nephrosis

TRANSFERRIN SATURATION INCREASED IN:
- High Values in iron overload
- Raised transferrin saturation is an early indicator of Iron accumulation in hemochromatosis.

TRANSFERRIN SATURATION DECREASED IN:
- Low Values in iron deficiency

Test Name	Result	Unit	Bio. Ref. Range	Method
BLOOD SUGAR FASTING				
Sample Type : FLOURIDE PLASMA				
BLOOD SUGAR FASTING	80	mg/dl	60-110	

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DEPARTMENT OF CLINICAL PATHOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
URINE ROUTINE EXAMINATION				
Sample Type : URINE				
PHYSICAL EXAMINATION				
QUANTITY	2 ML	ml	0-50	
COLOUR	CLEAR		PALE YELLOW	
TRANSPARENCY	SLIGHTLY TURBID		Clear	
SPECIFIC GRAVITY	1.011		1.010 - 1.030	
CHEMICAL EXAMINATION				
pH	5		5-7	Double Indicator
PROTEIN	DETECTED (+)		Nil	Protein - error of Indicators
REDUCING SUGAR	DETECTED (+)		Nil	GOD-POD
UROBILINOGEN	DETECTED (++)		Nil	Ehrlichs Reaction
KETONE BODIES	DETECTED (+++)		Nil	Legals Nitroprasside
BILIRUBIN	DETECTED (+)		Nil	Azo-coupling Reaction
BLOOD	DETECTED (+)		Nil	Pseudo-peroxidase
LEUCOCYTE	DETECTED (++)		Nil	by an azo-coupling reaction
NITRITE	DETECTED (++)		Nil	Diazotization Reaction
MICROSCOPIC EXAMINATION				
PUS CELLS	3	cells/HPF	0-5	
RBCs	2	Cells/HPF	Nil	
EPITHELIAL CELLS	6	Cells/HPF	0 - 5	
CRYSTALS	3	Nil	Nil	
CASTS	5	/HPF	Nil	
OTHER	7.00			

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Age/Gender	: 45 Y 0 M 0 D /M	Reported	: 14/Nov/2022 12:36PM
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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
CBC				
Sample Type : WHOLE BLOOD EDTA				
HAEMOGLOBIN (HB)	14	gm/dl	13.00-17.00	Non-Cyanmethemoglobin
PCV/HAEMATOCRIT	45	%	40-50	RBC pulse height detection
MCV	**76**	fL	80-100	Automated/Calculated
MCH	31	pg	27-32	Automated/Calculated
MCHC	33	g/dl	32-36	Automated/Calculated
RDW-CV	12.11	%	11.5-14.5	Automated/Calculated
PLATELET COUNT	3.22	lac/mm3	1.50 - 4.50	Optical Flowcytometry
RBC COUNT(RED BLOOD CELL COUNT)	**4.44**	million/cmm	4.50-5.50	Optical Flowcytometry
TOTAL LEUCOCYTE COUNT (TLC)	6000	cell/cmm	4000-10000	Flow cytometry
DLC (by Flow cytometry/Microscopy)				
NEUTROPHIL	58	%	40-75	
LYMPHOCYTE	36	%	20-40	
EOSINOPHIL	3	%	01-07	
MONOCYTE	3	%	2-10	
BASOPHIL	0	%	00-02	
Blast	1	%		
Promyelocyte	2	%		
Myelocyte	**3**	%	0-2	
Metamyelocyte	2	%	0-2	
RDW-SD	43	fL	39-46	Calculated
PDW	22.21	fL	8.30-25.00	Calculated
MPV	**4.12**	fL	8.60-15.50	Calculated
PCT	**0.11**	%	0.15-0.62	
ABSOLUTE NEUTROPHIL COUNT	2.4	x10^3 Cells/uL	1.5-7.8	Automated Calculated
ABSOLUTE LYMPHOCYTE COUNT	**4.0**	x10^3 Cells/uL	2.0-3.9	Automated Calculated
ABSOLUTE EOSINOPHIL COUNT	0.4	x10^3 Cells/uL	0.2-0.5	Automated Calculated
ABSOLUTE MONOCYTE COUNT	0.87	x10^3 Cells/uL	0.2-0.95	Automated Calculated
ABSOLUTE BASOPHIL COUNT	0.2	x10^3 Cells/uL	0.02-0.2	Automated Calculated
Lymphoblast	2	%	0-2	

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DEPARTMENT OF HAEMATOLOGY

Test Name	Result	Unit	Bio. Ref. Range	Method
HBA1C				
Sample Type : WHOLE BLOOD EDTA				
HBA1c	5.3	%	Normal Glucose tolerance (non-diabetic): <5.6%~Pre-diabetic: 5.7-6.4%~Diabetic Mellitus: >6.5%	HPLC
ESTIMATED AVG. GLUCOSE	105.98	mg/dl		

INCREASED IN

1. Chronic renal failure with or without hemodialysis.
2. Iron deficiency anemia. Increased serum triglycerides.
3. Alcohol.
4. Salicylate treatment.

DECREASED IN

1. Shortened RBC life span (hemolytic anemia, blood loss), Pregnancy.
2. Ingestion of large amounts (>1g/day) of vitamin C or E.
3. Hemoglobinopathies (e.g.: spherocytes) produce variable increase or decrease.
4. Results of %HbA1c are not reliable in patients with chronic blood loss and consequent variable erythrocyte life span.

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Age/Gender	: 45 Y 0 M 0 D /M	Reported	: 14/Nov/2022 12:38PM
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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref. Range	Method
THYROID PROFILE (T3,T4,TSH)				
Sample Type : SERUM				
T3	**0.12**	ng/ml	0.61-1.81	CLIA
T4	6.12	ug/dl	5.01-12.45	CLIA
TSH	4.32	ulU/mL	0.35-5.50	CLIA

INTERPRETATION:

1. Serum T3, T4 and TSH are the measurements form three components of thyroid screening panel and are useful in diagnosing various disorders of thyroid gland function.
2. Primary hyperthyroidism is accompanied by elevated serum T3 and T4 values along with depressed TSH levels.
3. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values and elevated serum TSH levels.
4. Normal T4 levels accompanied by high T3 levels are seen in patients with T3 thyrotoxicosis. Slightly elevated T3 levels may be found in pregnancy and in estrogen therapy while depressed levels may be encountered in severe illness, malnutrition, renal failure and during therapy with drugs like propanolol and propylthiouracil.
5. Although elevated TSH levels are nearly always indicative of primary hypothyroidism, rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism).
6. Low levels of Thyroid hormones (T3, T4 & FT3, FT4) are seen in cases of primary, secondary and tertiary hypothyroidism and sometimes in non-thyroidal illness also.
7. Increased levels are found in Grave's disease, hyperthyroidism and thyroid hormone resistance.
8. TSH levels are raised in primary hypothyroidism and are low in hyperthyroidism and secondary hypothyroidism.
9. **REFERENCE RANGE :**

PREGNANCY	TSH in uIU/mL
1st Trimester	0.60 - 3.40
2nd Trimester	0.37 - 3.60
3rd Trimester	0.38 – 4.04

Age	TSH in uIU/mL
0 – 4 Days	1.00 - 39.00
2 Weeks to 5 Months	1.70 – 9.10
6 Months to 20 Yrs.	0.70 – 6.40
>55 Yrs.	0.50 - 8.90

(References range recommended by the American Thyroid Association)

Comments:

1. During pregnancy, Free thyroid profile (FT3, FT4 & Ultra-TSH) is recommended.
2. TSH levels are subject to circadian variation, reaches peak levels between 2-4 AM and at a minimum between 6-10 PM. The variation of the day has influence on the measured serum TSH concentrations.

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DEPARTMENT OF HORMONE ASSAYS

Test Name	Result	Unit	Bio. Ref. Range	Method
25 HYDROXY VITAMIN D				
Sample Type : SERUM				
VITAMIN D	80	ng/ml	30-100	CLIA

INTERPRETATION:

LEVEL	REFERENCE RANGE
Deficiency (serious deficient)	< 10 ng/ml
Insufficiency (Deficient)	10-30 ng/ml
Sufficient (adequate)	30-100 ng/ml
Toxicity	> 100 ng/ml

DECREASED LEVELS:
-Deficiency in children causes Rickets and in adults leads to Osteomalacia. It can also lead to Hypocalcemia and Tetany.
-Inadequate exposure to sunlight.
-Dietary deficiency.
-Vitamin D malabsorption.
-Severe Hepatocellular disease.
-Drugs like Anticonvulsants.
-Nephrotic syndrome.

INCREASED LEVELS:
-Vitamin D intoxication.

COMMENTS:
-Vitamin D (Cholecalciferol) promotes absorption of calcium and phosphorus and mineralization of bones and teeth. Vitamin D status is best determined by measurement of 25 hydroxy vitamin D, as it is the major circulating form and has longer half life (2-3 weeks) than 1, 25 Dihydronxy vitamin D (5-8 hrs).
-The assay measures D3 (Cholecaciferol) metabolites of vitamin D.
-25 (OH) D is influenced by sunlight, latitude, skin pigmentation, sunscreen use and hepatic function.
-Optimal calcium absorption requires vitamin D 25 (OH) levels exceeding 75 nmol/L.
-It shows seasonal variation, with values being 40-50% lower in winter than in summer.
-Levels vary with age and are increased in pregnancy.
-This is the recommended test for evaluation of vitamin D intoxication.

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

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