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Sample Collected At : C000000808-QUALITY CHECK
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Madhya Pradesh, INDIA

Name	: MR. DUMMY	Age/Gender	: 26 Years/MALE
Reg No	: 0001EA020907	Barcode No	: E1100001061
Sample Coll Dt	: 30-01-2026 04:48 PM	Reg Date	: 30-01-2026 04:49 PM
Sample Rcv Dt	: 30-01-2026 04:49 PM	Reported Date	: 30-01-2026 06:22 PM
Report Status	: Final	Referred By	: Dr. DUMMY

Tests	Results	Biological Ref Range	Units	Method
BIOCHEMISTRY				
SWASTH BHARAT ADVANCE				
COMPLETE BLOOD COUNT (CBC),WHOLE BLOOD				
HEMOGLOBIN	14.2	13.0-17.0	g/dL	SLS HEMOGLOBIN
HEMATOCRIT	42.3	40.0-50.0	%	CALCULATED
RBC COUNT	4.9	4.50-5.50	10^6/uL	HF & EI
MCV	99.2	83.0-101.0	fL	CALCULATED
MCH	29.2	27.0-32.0	pg	CALCULATED
MCHC	33.3	31.5-34.5	g/dL	CALCULATED
RDW-CV	12.2	11.6-14.0	%	CALCULATED
RDW-SD	40.0	39.0 - 46.0	fL	CALCULATED
PLATELET COUNT	388	150-410	10^3/uL	HF & EI
MEAN PLATELET VOLUME(MPV)	10.2	7.54 - 11.24	fL	CALCULATED
PLATELET DISTRIBUTION WIDTH (PDW)	12.0	9.6 - 15.2	fL	CALCULATED
PLATELETCRIT (PCT)	0.16	0.15 - 0.62	fl	CALCULATED
TOTAL LEUCOCYTE COUNT (WBC)	5.6	4.0 - 10.0	10^3/uL	HF & EI
Specimen: EDTA WHOLE BLOOD				
DIFFERENTIAL LEUCOCYTE COUNT				
NEUTROPHILS	61	40.0 - 80.0	%	FLOWCYTOMETRY
LYMPHOCYTES	33	20.0 - 40.0	%	FLOWCYTOMETRY
MONOCYTES	04	2.0 - 10.0	%	FLOWCYTOMETRY
EOSINOPHILS	02	1.0 - 6.0	%	FLOWCYTOMETRY
BASOPHILS	00	<2.0	%	FLOWCYTOMETRY
ABSOLUTE NEUTROPHIL COUNT	3.36	2.00 - 7.00	10^3/uL	CALCULATED
ABSOLUTE LYMPHOCYTE COUNT	1.85	1.00-3.00	10^3/uL	CALCULATED
ABSOLUTE MONOCYTE COUNT	0.22	0.20-1.00	10^3/uL	CALCULATED
ABSOLUTE EOSINOPHIL COUNT	0.11	0.02-0.50	10^3/uL	CALCULATED
ABSOLUTE BASOPHIL COUNT	0	0.02-0.10	10^3/uL	CALCULATED
Specimen: EDTA WHOLE BLOOD				

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Tests	Results	Biological Ref Range	Units	Method
ERYTHROCYTE SEDIMENTATION RATE (ESR)				
ESR	09		mm/hr	PHOTOMETRIC

Specimen:
EDTA WHOLE BLOOD

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Tests	Results	Biological Ref Range	Units	Method
GLUCOSE FASTING, PLASMA				
GLUCOSE FASTING	75.9	70 - 110	mg/dL	HEXOKINASE

Specimen:
FASTING PLASMA FL.

As per American Diabetic Association,(ADA) 2018 Guidelines

Fasting Plasma Glucose Value (in mg/dl) Interpretation

- 70 - 100 Normal
- 101 - 125 IFG (Impaired Fasting Glucose)
- >/= 126 Diabetes mellitus

It is recommended that fasting plasma glucose be repeated on TWO separate occasions or fasting plasma glucose with HbA1c should be done to confirm the diagnosis of Diabetes mellitus.

NOTE: Fasting is defined as no caloric intake for at least 8 hours

As per WHO guidelines, the normal range for fasting plasma glucose is 70 -110 mg/dl. Values ranging from 111 - 125 mg/dl are suggestive of Pre-Diabetes.

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Tests	Results	Biological Ref Range	Units	Method
HBA1C (GLYCOSYLATED HEMOGLOBIN), WHOLE BLOOD				
HBA1C	5.1	4.0 - 6.4	%	HPLC
ESTIMATED AVERAGE GLUCOSE	99.67	70 - 140	mg/dL	CALCULATED

Specimen:
EDTA WHOLE BLOOD

Interpretation:

As per American Diabetes Association (ADA) Guidelines
Below 5.7% : Normal
5.7% - 6.4% : Prediabetic
>=6.5% : Diabetic

NOTE:

1. Glycosylated hemoglobin (HbA1c) test is done to assess compliance with therapeutic regimen in diabetic patients.
2. A three monthly monitoring is recommended in clinical management of diabetes.
3. It is not affected by daily glucose fluctuations, exercise and recent food intake.
4. The HbA1c is linearly related to the average blood sugar over the past 1-3 months (but is heavily weighted to the past 2-4 weeks).
5. The HbA1c is strongly associated with the risk of development and progression of microvascular and nerve complications
6. High HbA1c (>9.0-9.5%) is associated with very rapid progression of microvascular complications
7. Any condition that shorten RBC life span like acute blood loss, hemolytic anemia falsely lower HbA1c results.
8. HbA1c results from patients with HbSS, HbCC, HbSC and HbD must be interpreted with caution, given the pathological processes including anemia, increased red cell turnover, and transfusion requirements that adversely impact HbA1c as a marker of long -term glycemic control.
9. Specimens from patients with polycythemia or post-splenectomy may exhibit increase in HbA1c values due to a somewhat longer life span of the red cells.
10. The relationship between eAG (Mean Plasma Glucose) and HbA1c based on linear regression analysis :eAG(mg/dl)= (28.7*HbA1c)-46.7, (Diabetes Care 2008;31:1-6).

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Tests	Results	Biological Ref Range	Units	Method
IRON PROFILE				
IRON	69	67 - 175	µg/dL	TPTZ
UNSATURATED IRON BINDING CAPACITY	320	120-470	µg/dL	PHOTOMETRIC
TOTAL IRON BINDING CAPACITY	389	250 - 450	µg/dL	CALCULATED
TRANSFERRIN SATURATION	17.7	14 - 50	%	CALCULATED

Specimen:
SERUM

Disease	Iron	TIBC	%Transferrin Saturation	Ferritin
Iron Deficiency	Low	High	Low	Low
Hemochromatosis	High	Low	High	High
Chronic Illness	Low	Low	Low	Normal/High
Hemolytic Anemia	High	Normal/High	High	High
Sideroblastic Anemia	Normal/High	Normal/High	High	High
Iron Poisoning	High	Normal	High	Normal

COMMENT

The test measures the extent to which iron-binding sites in the serum can be saturated. Because the iron-binding sites in the serum are almost entirely dependent on circulating transferrin, this is really an indirect measurement of the amount of transferrin in the blood. Taken together with serum iron and percent transferrin saturation clinicians usually perform this test when they are concerned about anaemia, iron deficiency or iron deficiency anaemia. However, because the liver produces transferrin, liver function must be considered when performing this test. It can also be an indirect test of liver function, but is rarely used for this purpose.

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Tests	Results	Biological Ref Range	Units	Method
C-REACTIVE PROTEIN (QUANTITATIVE), SERUM				
C-REACTIVE PROTEIN	0.6	<5.0	mg/L	TURBIDIMETRY

Specimen:
SERUM

CRP is used mainly as a marker of inflammation. Rapid, marked increases in CRP occur with inflammation, infection, trauma and tissue necrosis, malignancies, and autoimmune disorders. Because there are a large number of disparate conditions that can increase CRP production, an elevated CRP level does not diagnose a specific disease. Measuring and charting CRP values can prove useful in determining disease progress or the effectiveness of treatment.

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Tests	Results	Biological Ref Range	Units	Method
LIVER FUNCTION TEST				
BILIRUBIN TOTAL	0.40	0.30 - 1.10	mg/dL	DIAZONIUM ION
BILIRUBIN DIRECT	0.20	0.1 - 0.4	mg/dL	DPD
BILIRUBIN INDIRECT	0.2	0.20 - 1.00	mg /dL	CALCULATED
ASPARTATE AMINOTRANSFERASE (SGOT)	33	0 - 35	U/L	UV Without P5P
ALANINE AMINOTRANSFERASE (SGPT)	40	0 - 45	U/L	IFCC without P5P
ALKALINE PHOSPHATASE	115	40 - 140	U/L	IFCC
PROTEIN TOTAL	6.9	6.4 - 8.2	g/dL	BIURET
ALBUMIN	3.6	3.5 - 5.2	g/dL	BCG
GLOBULIN	3.3	2.0 - 4.10	g/dL	CALCULATED
A:G RATIO	1.09	1.0 - 2.1	Ratio	CALCULATED

Specimen:
SERUM

Note

1. In an asymptomatic patient, Non alcoholic fatty liver disease (NAFLD) is the most common cause of increased AST, ALT levels. NAFLD is considered as hepatic manifestation of metabolic syndrome.
2. In most type of liver disease, ALT activity is higher than that of AST; exception may be seen in Alcoholic Hepatitis, Hepatic Cirrhosis, and Liver neoplasia. In a patient with Chronic liver disease, AST:ALT ratio>1 is highly suggestive of advanced liver fibrosis.
3. In known cases of Chronic Liver disease due to Viral Hepatitis B & C, Alcoholic liver disease or NAFLD, Enhanced liver fibrosis (ELF) test may be used to evaluate liver fibrosis.
4. In a patient with Chronic Liver disease, AFP and Des-gamma carboxyprothrombin (DCP)/PIVKA II can be used to assess risk for development of Hepatocellular Carcinoma.

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Tests	Results	Biological Ref Range	Units	Method
KIDNEY FUNCTION TEST,				
UREA	16.2	15.0 - 38.5	mg/dL	URICASE
CREATININE	0.60	0.60 - 1.30	mg/dL	SARCOSINE OXIDASE
URIC ACID	3.8	3.5 - 7.2	mg/dL	URICASE
SODIUM	136.0	136 - 145	mmol/L	ISE DIRECT
POTASSIUM	3.9	3.5 - 5.5	mmol/L	ISE INDIRECT
CHLORIDE	101	98 - 111	mmol/L	ISE DIRECT
CALCIUM	9.0	8.5 - 10.1	mg/dL	ARSENAZO III
BLOOD UREA NITROGEN	7.57	7.0 - 18.0	mg/dL	UREASE-GLDH
BUN/CREATININE RATIO	12.6		Ratio	CALCULATED
AGE (YRS)	26			
GLOMERULAR FILTRATION RATE (MALE)	163	78 - 146	ml/min/1.73m	CALCULATED

Specimen:
SERUM

Note

This test is done to evaluate the function of your kidneys or if you have symptoms that may indicate a kidney disorder like painful urination, blood in urine, frequent urges to urinate, high blood pressure, or swelling of hands and feet. This test also helps to analyze other conditions that can harm the kidneys like diabetes or high blood pressure.

Increased levels of each of these parameters can indicate a number of conditions and not necessarily health disorders. For example, increased creatinine levels can occur due to heavy exercise, consumption of cooked meat, or taking protein supplements apart from kidney diseases. Thus, these parameters are also considered while interpreting the tests. Further tests are performed to confirm any health disorders.

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Tests	Results	Biological Ref Range	Units	Method
LIPID PROFILE, SERUM.				
CHOLESTEROL TOTAL	150	<200	mg/dL	CHOD- POD
TRIGLYCERIDES	70	<150	mg/dL	GPO-POD
HDL CHOLESTEROL	40	40 - 60	mg/dL	DIRECT
LDL CHOLESTEROL	96	<100	mg/dL	CALCULATED
VLDL CHOLESTEROL	14	</= 30.0	mg/dL	CALCULATED
CHOL / HDL RATIO	3.8	3.3 - 4.4	Ratio	CALCULATED
NON-HDL CHOLESTEROL	110	<130	Ratio	CALCULATED

Specimen:
SERUM

***REFERENCE RANGES AS PER NCEP ATP III GUIDELINES:**

TOTAL CHOLESTEROL	(mg/dL)	HDL	(mg/dL)	LDL	(mg/dL)	TRIGLYCERIDES	(mg/dL)
DESIRABLE	<200	LOW	<40	OPTIMAL	<100	NORMAL	<150
BORDERLINE HIGH	200-239	HIGH	>60	NEAR OPTIMAL	100-129	BORDERLINE HIGH	150-199
HIGH	>240			BORDERLINE HIGH	130-159	HIGH	200-499
				HIGH	160-189	VERY HIGH	>500
				VERY HIGH	>190		

NOTE- 10-12 Hours fasting is mandatory for lipid parameter. if not values might fluctuate.

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Tests	Results	Biological Ref Range	Units	Method
THYROID PROFILE,TOTAL, SERUM				
TRI-IODO THYRONIN, (T3)	1.20	0.60 - 1.81	ng/mL	CLIA
THYROXIN, (T4)	5.5	4.50 - 10.90	µg/dL	CLIA
THYROID STIMULATING HORMONE	0.36	0.35 - 4.94	uIU/ML	CLIA

Specimen:
SERUM

INTERPRETATION

1. Primary hyperthyroidism is accompanied by elevated serum T3 & T4 values along with depressed TSH level.
2. Primary hypothyroidism is accompanied by depressed serum T3 and T4 values & elevated serum TSH levels.
3. Normal T4 levels accompanied by high T3 levels and low TSH are seen in patients with T3 thyrotoxicosis.
4. Normal or low T3 & high T4 levels indicate T4 thyrotoxicosis (problem is conversion of T4 to T3)
5. Normal T3 & T4 along with low TSH indicate mild / subclinical HYPERTHYROIDISM .
6. Normal T3 & low T4 along with high TSH is seen in HYPOTHYROIDISM .
7. Normal T3 & T4 levels with high TSH indicate Mild / Subclinical HYPOTHYROIDISM .
8. 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.
9. Although elevated TSH levels are nearly always indicative of primary hypothyroidism . rarely they can result from TSH secreting pituitary tumors (secondary hyperthyroidism)

T3		T4		TSH	
Age	**Ref. Intervals (ng/mL)**	**Age**	**Ref. Intervals (ug/dL)**	**Age**	**Ref. Intervals (µIU/mL)**
01 - 03 Days	100 – 740	1 - 03 Days	11.8 - 22.6	0 - 4 Days	1.0 - 39.0
01 - 11 Months	105 – 245	1 - 02 Week	9.9 - 16.6	01 - 20 Weeks	1.7 - 9.1
01 - 05 Years	105 – 269	1 - 04 Months	7.2 - 14.4	0.5 - 20 Years	0.7 - 6.4
06 - 10 Years	94 – 241	4 – 12 Months	7.8 - 16.5	20 - 55 Years	0.5 - 4.8
11 - 15 Years	82 – 213	1 - 05 Years	7.3 - 15.0	> 55 years	0.5 - 8.9

PREGNANCY	REFERENCE RANGE for TSH IN µIU/mL (As per American Thyroid Association.)
1st Trimester	0.10-2.50 uIU/mL
2nd Trimester	0.20-3.00 uIU/mL
3rd Trimester	0.30-3.00 uIU/mL

Limitations: -

T3 and T4 circulates in reversibly bound form with Thyroid binding globulins (TBG), and to a lesser extent albumin and Thyroid binding Pre Albumin, so conditions in which TBG and protein levels alter such as pregnancy, excess estrogens, androgens, steroids may falsely affect the T3 and T4 levels. Normal levels of T4 can also be seen in Hyperthyroid patients with : T3 Thyrotoxicosis, hypoproteinemia or ingestion of certain drugs. Serum T4 levels in neonates and infants are higher than values in the normal adult, due to the increased concentration of TBG in neonate serum. TSH may be normal in central hypothyroidism, recent rapid correction of hyperthyroidism or hypothyroidism, pregnancy, phenytoin therapy. Autoimmune disorders may produce spurious results. Various drugs can interfere with the test result. TSH has a diurnal rhythm so values may vary if sample collection is done at different times of the day.

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Tests	Results	Biological Ref Range	Units	Method
VITAMIN-D, SERUM (25-HYDROXY)				
25-HYDROXY VITAMIN D	36.0	<20.0 DEFICIENCY 20.0 - 30.0 INSUFFICIENCY 30.0 - 100.0 SUFFICIENCY >100.0 TOXICITY	ng/mL	CLIA

Specimen:
SERUM

Uses for Vitamin D assay:

- Diagnosis of Vitamin D deficiency
- Differential Diagnosis of causes of Rickets and Osteomalacia
- Monitoring Vitamin D replacement therapy
- Diagnosis of Hypervitaminosis D

LIMITATION:

Various methods are available for measuring circulating concentrations of 25-OH vitamin D. The studies report reasonable correlation between methods, but with significant differences, the reasons for which are not well understood. Vitamin D values must be interpreted within the clinical context of each patient.

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Tests	Results	Biological Ref Range	Units	Method
VITAMIN B12				
VITAMIN B12	252	211 - 911	pg/mL	CLIA

Specimen:
SERUM

Uses of Vitamin B12 assay:
- Investigation of macrocytic anaemia
- Work up of deficiencies seen in Megaloblastic Anemia
- Assistance in Diagnosis of CNS Disorders
- Evaluation of Alcoholism
- Evaluation of Malabsorption syndrome

Limitation:
- The evaluation of Macrocytic Anemia requires simultaneous measurement of both Vitamin B12 and folate levels.
- Patients taking B12 supplementation may have misleading results.

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Tests	Results	Biological Ref Range	Units	Method
URINE ROUTINE EXAMINATION				
PHYSICAL EXAMINATION				
COLOUR	PALE YELLOW	PALE YELLOW		Visual Determination
APPEARANCE	CLEAR	CLEAR		Visual Determination
CHEMICAL EXAMINATION				
PH	6.5	4.5 - 7.5		Double Indicator Principle
SPECIFIC GRAVITY	1.020	1.005-1.035		Pretreated Polyelectrolyte Change
GLUCOSE	NOT DETECTED	NOT DETECTED		Oxidase Peroxidase
PROTEIN	NOT DETECTED	NOT DETECTED		Protein Error of indicator
KETONES	NOT DETECTED	NOT DETECTED		Aceto Acetic Reaction with Nitroprusside
BLOOD	NOT DETECTED	NOT DETECTED		Peroxidase reaction of hemoglobin
BILIRUBIN	NOT DETECTED	NOT DETECTED		Azo-coupling reaction
NITRITE	NOT DETECTED	NOT DETECTED		Diazotization
MICROSCOPIC EXAMINATION				
PUS CELLS/WBCS	0-1	0-5	/HPF	MICROSCOPY
EPITHELIAL CELLS	NIL	0-5	/HPF	MICROSCOPY
RED BLOOD CELLS	NIL	NIL	/HPF	MICROSCOPY
CASTS	NOT DETECTED	NOT DETECTED		MICROSCOPY
CRYSTALS	NOT SEEN			MICROSCOPY
BACTERIA	ABSENT	ABSENT		MICROSCOPY

Specimen:
URINE

End Of Report
This report is not subject to use for any medico-legal purposes

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